DEATHS AMONG CHILDREN IN ALABAMA

Alabama Child Death Review System **ANNUAL REPORT 2014-2015**

DEATHS AMONG CHILDREN IN ALABAMA
ALABAMA CHILD DEATH REVIEW SYSTEM

2014-2015 REPORT

Scott Harris, M.D., M.P.H.
State Health Officer

Michele Jones, M.S.
Chief of Staff

Jamey Durham, M.B.A.
Director
Bureau of Prevention, Promotion, and Support

Diane Beeson, M.B.A.
Director
Behavioral Health Division

Gloria Davis, L.G.S.W.
Director
Injury Prevention and Fatality Review Branch

Carrea Dye, M.P.H.
Director
Alabama Child Death Review System

Stuart Hoyle, M.P.H.
Epidemiologist
Injury Prevention and Fatality Review Branch

Alabama Child Death Review System
The RSA Tower, Suite 960
201 Monroe Street, Montgomery, AL 36104
(334) 206-2085 • (334) 206-3723 (Fax)
www.alabamapublichealth.gov

Alabama Department of Public Health
Bureau of Prevention, Promotion, and Support
Injury Prevention and Fatality Review Branch

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EXECUTIVE SUMMARY

The purpose of the Alabama Child Death Review System's (ACDRS) annual report is two-fold: provide the State Team's findings of significant risk factors and trends in child deaths, and establish recommendations that can be utilized to prevent future child deaths. Aggregate data, trends, and patterns found in child deaths are identified to improve the health and safety of Alabama's children. Policies and practices that may better protect Alabama's children can by identified through comprehensive multidisciplinary reviews of child death.

Currently, all 67 counties in Alabama are represented by one of 42 multidisciplinary Local Child Death Review Teams (LCDRT). LCDRTs meet as deemed necessary by the local chair, but not less than annually. The reviews of child deaths occurring in 2014 and 2015 are the basis for this report. LCDRTs are based on each county's judicial circuit. The District Attorney within each judicial circuit is responsible for appointing a local coordinator and/or overseeing the Child Death Review process for their judicial circuit. The purpose of the LCDRTs are to decrease the incidence of unexpected/unexplained child injury and death primarily by holding local review sessions that assist in better understanding the circumstances surrounding death. The reviews of LCDRTs are essential in formulating recommendations that will modify risk factors at both local and state levels.

LCDRTs use the National Fatality Review Case Reporting System (NFR-CRS) to capture information regarding the circumstances surrounding each child death. This database serves as a case reporting tool that better documents the often complex conversations that happen during the review process. Its functionality and comprehensive approach allows for more complete analysis for all deaths. NFR-CRS also documents demographics, investigative actions, services provided or needed, key risk factors, and actions recommended or taken by the team to prevent other deaths.

This report examines unexpected and unexplained child deaths in Alabama for 2014 and 2015. There were 814 infant and child deaths in the state of Alabama in 2014. There were a total of 784 child deaths in Alabama in 2015. Every child death 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: maintain statistics on child mortality; identify deaths that may result of abuse, neglect, or other preventable causes; and develop and implement measures to help reduce the risk and incidence of future unexpected or unexplained deaths in Alabama.

Child Death Review makes a difference. ACDRS has identified sleep-related deaths; motor vehicle incidents; and firearm, weapons, and assault related deaths as the leading causes of death for 2014 and 2015. This report highlights the leading causes of death for Alabama's children, significant risk factors, and recommendations of the State Child Death Review Team (SCDRT) to reduce preventable child deaths and statewide initiatives that have resulted due to the child death review process. ACDRS seeks to honor the memory of children who have died in Alabama with this report. The hope is that these efforts will lead to a better understanding of how Alabama can be a safer, healthier place for children.

STATE CHILD DEATH REVIEW TEAM

Scott Harris, M.D., M.P.H.
State Health Officer/Chair

Scott Anderson
Alabama District Attorney's Association Appointee

Tom Anderson
Alabama District Attorney's Association Appointee

Jannah M. Bailey
Private Citizen
Governor Appointee

Lynn Beshear, Commissioner
Alabama Department of Mental Health

Melanie Bridgeforth
Private Citizen
Governor Appointee

Nancy Buckner, Commissioner
Alabama Department of Human Resources

Christina Cochran, M.D.
Medical Association of the State of Alabama Appointee

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

Angelo Della Manna, Director
Alabama Department of Forensic Sciences

Senator Gerald Dial
Chair
Senate Health Committee

Candice Dye, M.D.
Alabama Department of Public Health Appointee

Sheriff Bill Franklin
Alabama Sheriff's Association Appointee

Reverend Joseph Godfrey
Clergy
Governor Appointee

Timothy Kimbrell
Alabama Coroners Association Appointee

Marian Loftin
Private Citizen
Governor Appointee

Sallye Longshore
Private Citizen
Governor Appointee

Katie Beth McCarthy
Network of Children's Advocacy Centers Appointee

Chris Newlin
Private Citizen
Governor Appointee

Marsha Raulerson, M.D.
Alabama Academy of Pediatrics Appointee

Colonel John E. Richardson
Director
Alabama Department of Public Safety

David Rydzewski, M.D.
Alabama Department of Forensic Sciences Appointee

Gina South
Network of Children's Advocacy Centers Appointee

Michael Sparks, Director
Alabama Department of Forensic Sciences

Chief Jerry Taylor
Alabama Association of Chiefs of Police Appointee

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

Sheriff Bobby Timmons
Executive Director
Alabama Sheriff's Association

Charles Ward, Director
Alabama Department of Public Safety

Representative April Weaver
Chair
House Health Committee

Jerry H. Williams
Alabama Coroners Association Appointee

INTRODUCTION

The Alabama Legislature declares that: "Every child is entitled to live in safety and in health and to survive into adulthood." As a result of this declaration, Alabama enacted legislation establishing the ACDRS on September 11, 1997. Responding to unexpected/unexplained child deaths is a state and community responsibility that will always remain a priority for ACDRS. ACDRS's mission is to understand how and why children die in Alabama, in order to prevent other child deaths. Child Death Review is a collaborative process that brings individuals together at the state and local level, from various disciplines to share and discuss comprehensive information on the circumstances surrounding death and the response to that death. ACDRS is situated within the Alabama Department of Public Health (ADPH). There are three tiers of ACDRS: ADPH Central Office Staff, SCDRT, and LCDRTs.

ALABAMA DEPARTMENT OF PUBLIC HEALTH CENTRAL OFFICE STAFF

The State Child Death Review Office is situated within the ADPH, Bureau of Prevention, Promotion, and Support for administrative and budgetary purposes. ADPH's Central Office Staff consists of three staff members: the ACDRS Director, Public Health Educator, and Administrative Support Assistant. ADPH Central Office Staff is responsible for sending death certificates, providing technical assistance, and overseeing the data review process of local child death review teams. ADPH Central Office Staff also assists with the development of prevention initiatives, public awareness campaigns, and special interest programs.

STATE CHILD DEATH REVIEW TEAM

SCDRT is a multidisciplinary, multiagency review team composed of 28 members, the first 7 of whom are ex officio members. SCDRT is composed of the following members:

1. The Jefferson County Coroner, Medical Examiner.
2. The State Health Officer, who serves as Chair.
3. One member appointed by the Alabama Sheriff's Association.
4. The director of the Alabama Department of Forensic Sciences.
5. The Commissioner of the Alabama Department of Human Resources.
6. The Commissioner of the Alabama Department of Mental Health and Mental Retardation.
7. The director of the Alabama Department of Public Safety.
8. A pediatrician with expertise in Sudden Infant Death Syndrome appointed by the Alabama Chapter, American Academy of Pediatrics.
9. A health professional with expertise in child abuse and neglect appointed by ADPH.
10. A family practice physician appointed by the Alabama Academy of Family Physicians.
11. A pediatric pathologist appointed by the Alabama Department of Forensic Sciences.
12. Eight private citizens appointed by the Governor.
13. A member of the clergy appointed by the Governor.
14. A representative of the Alabama Coroner's Association.
15. A representative of the Alabama Network of Children's Advocacy Centers.
16. A representative of the Alabama Sheriff's Association.
17. A representative of the Alabama District Attorney's Association.
18. A specialist in Pediatric Emergency Medicine appointed by the Alabama Medical Association.
19. A representative of the Alabama Association of Chiefs of Police.
20. Chair of the Senate Health Committee or his or her designee.
21. Chair of the House Health Committee or his or her designee.

SCDRT serves as an advisory board with quarterly meetings to:

- Identify factors which make a child at risk for injury or death.
- Collect and share information among State Team members and agencies which provide services to children and families or investigate child deaths.
- Make suggestions and recommendations to appropriate participating agencies regarding improving coordination of services and investigations.
- Identify trends relevant to unexpected/unexplained child injury and death.
- Review reports from LCDRTs and upon request of a local team, individual cases of child deaths.
- Provide training and written materials to local teams to assist them in carrying out their duties.
- Develop a protocol for child death investigations and revise the protocol as needed.
- Educate the public in Alabama regarding the incidence and causes of child injury and death and the public role in aiding in reducing the risk of such injuries and deaths.
- Provide the Governor and the Legislature with an annual written report which includes the State Team's findings and recommendations, and other relevant information.

LOCAL CHILD DEATH REVIEW TEAMS

The reviews of LCDRTs lead to action through the development of strategies that will prevent future child deaths. Each county of the state is included in a LCDRT jurisdiction. LCDRT members include the following:

1. The County Health Officer.
2. The director of the County Department of Human Resources.
3. The County District Attorney.
4. The Medical Examiner.
5. The local coroner.
6. An investigator with a local sheriff's department who is familiar with homicide investigation.
7. An investigator with a local police department who is familiar with homicide investigation.
8. A pediatrician, or if no pediatrician is available, a primary care physician appointed by the county medical society.
9. A representative from a local child advocacy center, if one exists.

The purpose of LCDRT is to decrease the incidence of unexpected/unexplained child injury and death by completing the following tasks:

1. The identification of factors which make a child at risk or injury of death.
2. The dissemination of information among the agencies which provide services to children and families or which investigate child deaths or provide services.
3. The improvement of local investigations of unexpected/unexplained child deaths by participating agencies.
4. The improvement of existing services and systems and assisting in the establishment of additional services and systems to fill in gaps in the community.
5. The identification of trends relevant to unexpected/unexplained child injury and death.
6. Educating the local public regarding the incidence and causes of child injury and death and the public role in aiding and reducing the risk of such injuries and deaths.

FUNDING

ACDRS funding originates in Alabama's portion of the National Tobacco Settlement (NTS), through 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 some supplemental funding to ACDRS through a reimbursement agreement. These funds are used solely for education and outreach efforts.

KEY FINDINGS

Between 2014 and 2015, reviews were completed for 279 child deaths, which is 51 percent of the cases eligible for review. Cases that meet criteria for review are those involving deaths in Alabama of infants and children from live birth to less than 18 years of age whose deaths are considered unexpected or unexplained. Reviewed cases are categorized based on the manner and cause of death. Manner of death is classified based on the circumstances surrounding death. Cause of death refers to the primary underlying cause of a death which is the disease or injury/action initiating the sequence of events that lead directly to death, or the circumstances of the accident or violence that produced the fatal injury.

The five manner of death categories on Alabama's death certificates are natural, accident, homicide, suicide, or undetermined/pending.

- Accidents (unintentional injury deaths) accounted for 120 reviewed deaths.
- Natural deaths are a rarity in the Alabama Child Death Review and accounted for 9 reviewed deaths.
- Homicides accounted for 22 reviewed deaths.
- Suicides accounted for 20 reviewed deaths.
- Undetermined manner accounted for 83 reviewed deaths.
- Pending or unknown cases accounted for 25 reviewed deaths.

The following is a brief summary of the key details relating to child deaths in Alabama, and which will be expounded upon further in this report.

SLEEP RELATED

In 68 reviewed cases for 2014 and 2015, the child was sleeping at the time of death:

- In 45 reviewed sleep related cases, the child was less than 12 months of age.
- In 26 reviewed sleep related cases, the child had objects present in the sleeping area such as blankets, pillows, toys, and other objects (excluding mattresses).
- In 19 reviewed sleep related cases, the child was co-sleeping with an adult.

MOTOR VEHICLE INCIDENTS

In 65 reviewed cases for 2014 and 2015, the child was involved in a fatal motor vehicle incident:

- In 34 reviewed motor vehicle cases, the child was a passenger in the car during the incident.
- In 10 reviewed motor vehicle cases, the child was a pedestrian struck by a motor vehicle.
- In 12 reviewed motor vehicle cases, the child was the driver of the motor vehicle.
- In 8 reviewed motor vehicle cases, speeding contributed to death.
- In 9 reviewed motor vehicle cases, reckless driving contributed to death.

FIREARM, WEAPON, AND ASSAULT RELATED DEATHS

In 43 reviewed 2014 and 2015 cases, a firearm, weapon, or assault was involved.

- In 32 reviewed weapon and assault cases, the child's death involved firearms:
  - In 26 reviewed deaths, handguns were involved.
  - In 6 reviewed deaths, the firearm was not stored and the child had access to the firearm.
  - In 5 reviewed deaths, the firearm discharged while a child was playing with the firearm.
- In 22 reviewed cases, homicide was the cause of death.
- In 20 reviewed cases, suicide was the cause of death.
- In 12 reviewed deaths, the firearm was owned by the victim's biological parent.

OTHER EXTERNAL CAUSES OF DEATH

DROWNING

In 24 reviewed 2014 and 2015 cases, drowning was the cause of death:

- In 13 reviewed drowning deaths, open water was involved, and the majority of open water deaths (6 cases), occurred in lakes.
- In 5 reviewed drowning deaths, death occurred in pools, hot tubs, or spas.

FIRES

In 8 reviewed deaths for 2014 and 2015, fires and fire related injuries were the cause of death.

SUFFOCATION

In 12 reviewed deaths for 2014 and 2015, asphyxiation was the cause of death. Four of those asphyxiations were sleep-related.

POISONING OR OVERDOSE

In 3 reviewed deaths for 2014 and 2015, poisonings and intentional or unintentional overdoses were the cause of death.

LOCATION OF DEATH

In 138 reviewed deaths for 2014 and 2015, the death occurred at the child's residence.

DEATHS BY AGE CATEGORIES

LESS THAN 12 MONTHS OF AGE

In 117 reviewed deaths for 2014 and 2015, children were less than 12 months of age:

- In 37 reviewed deaths, children were less than 2 months of age.
- In 74 reviewed deaths, children were less than 4 months of age.

1 TO 4 YEARS

In 38 reviewed deaths for 2014 and 2015, children were aged 1 to 4 years of age:

- Accidents were the leading manner of death in this age group, with 28 deaths.
- Vehicle incidents were the leading cause of death, with 13 deaths.

5 TO 8 YEARS

In 25 reviewed deaths for 2014 and 2015, children were aged 5 to 8 years of age:

- Accidents were the leading manner of death in this age group, with 18 deaths.
- Vehicle incidents were the leading cause of death, with 9 deaths.

9 TO 12 YEARS

In 14 reviewed deaths for 2014 and 2015, children were aged 9 to 12 years of age:

- Accidents were the leading manner of death in this age group, with 11 deaths.
- Vehicle incidents were the leading cause of death, with 6 deaths.
- Assault or weapon related death was the second leading cause, with 5 deaths.

13 TO 16 YEARS

In 47 reviewed deaths for 2014 and 2015, children were aged 13 to 16 years of age:

- Accidents were the leading manner of death in this age group, with 29 deaths.
- The second leading manner of death was suicide, with 10 deaths.
- Vehicle incidents were the leading cause of death, with 23 deaths.
- Assault or weapon related death was the second leading cause, with 13 deaths.

17 YEARS OF AGE

In 38 reviewed deaths for 2014 and 2015, children were aged 17 years of age:

- Accidents were the leading manner of death in this age group, with 18 deaths.
- The second leading manners of death were suicide and homicide both with 8 deaths.
- Assault and weapon related death was the leading cause, with 17 deaths.
- Vehicle incidents were the second leading cause of death, with 13 deaths.

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 LCDRTs to answer requests for specific data and generate reports.

SCDRT meets quarterly to review the statewide data, consider LCDRT recommendations and performance, and conduct general ACDRS business. SCRDT takes action on ACDRS 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, 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.

**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.*

2014 ACDRS REPORT DATA

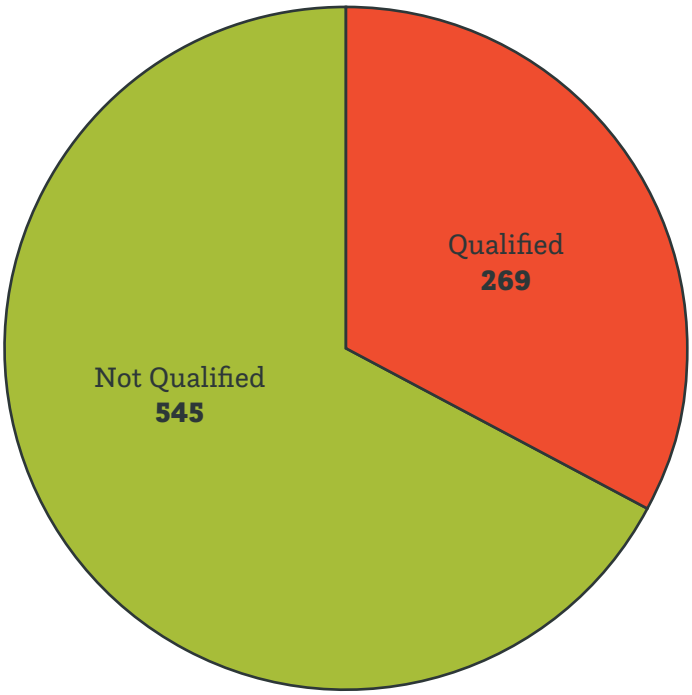
LCDRT SUCCESS RATES:

Between 2010 and 2014, 1,408 cases qualified for review under ACDRS (out of 4,086) which constitutes 35.5 percent of all child deaths. Of these qualifying cases for the 2010 to 2014 span, LCDRTs reviewed and returned 966 or 69 percent.

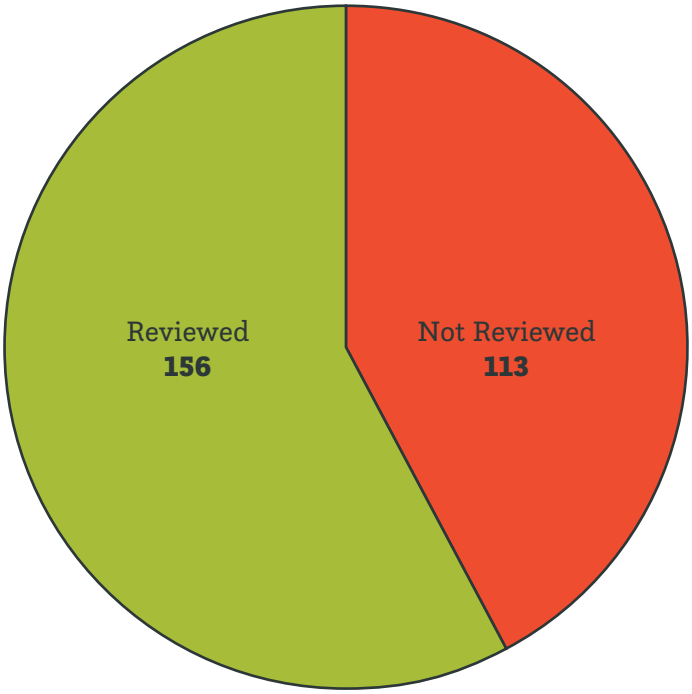
There were a total of 814 child deaths in Alabama in 2014,* and 269 qualified for review under ACDRS guidelines. Of qualified cases, LCDRT returned 156 completed reviews or 58 percent.

**Centers for Disease Control and Prevention (CDC) WONDER - https://wonder.cdc.gov/ucd-icd10.html*

2014 CASES QUALIFIED FOR ACDRS REVIEW



2014 CASES REVIEWED BY LCDRTS



2015 ACDRS REPORT DATA

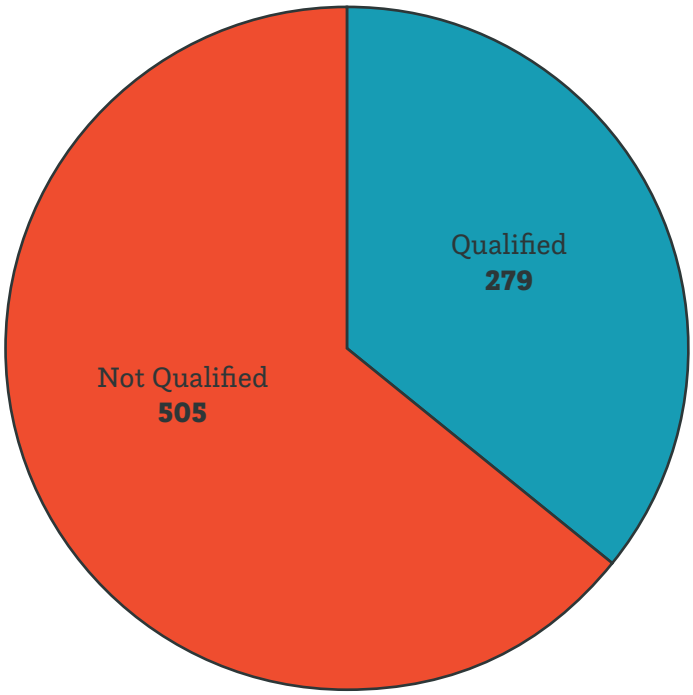
LCDRT SUCCESS RATES:

Between 2011 and 2015, 1,404 cases qualified for review under ACDRS (out of 4,032) or 34.8 percent. Of the qualifying cases for the 2011 to 2015 span, LCDRTs reviewed and returned 851 (61 percent).

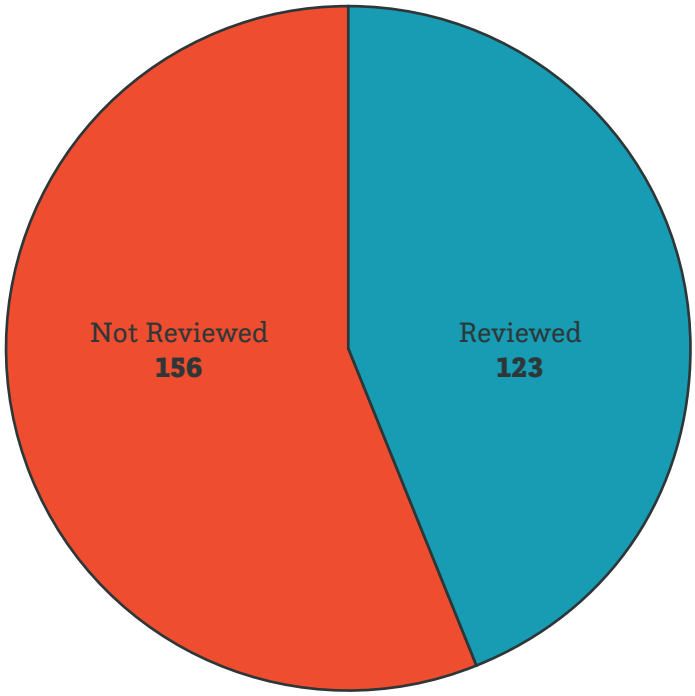
There were a total of 784 child deaths in Alabama in 2015*, and 279 qualified for review under ACDRS guidelines. Of qualifying cases, LCDRTS returned 123 completed reviews or 44.1 percent.

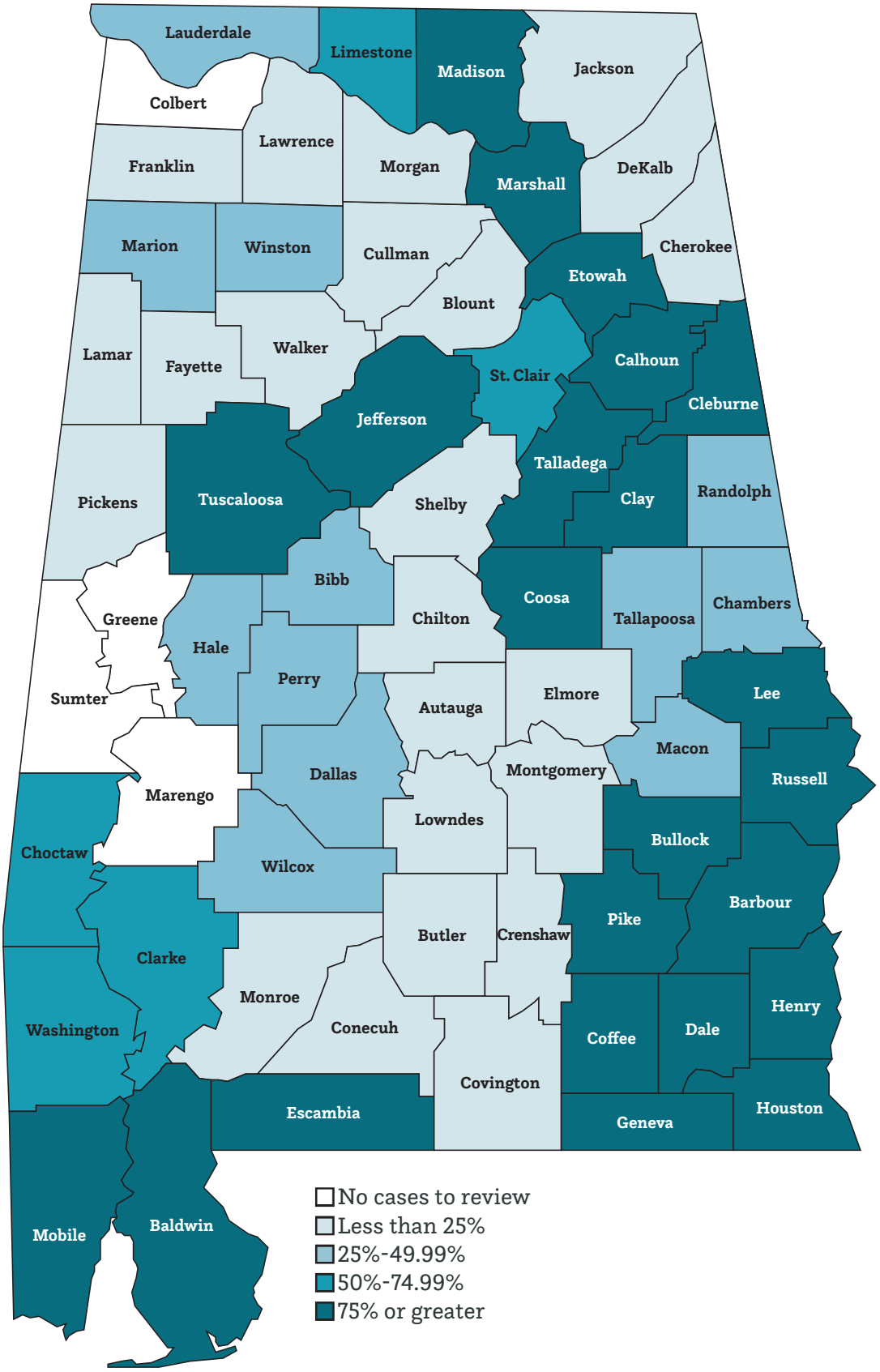
**CDC WONDER - https://wonder.cdc.gov/ucd-icd10.html*

2015 CASES QUALIFIED FOR ACDRS REVIEW

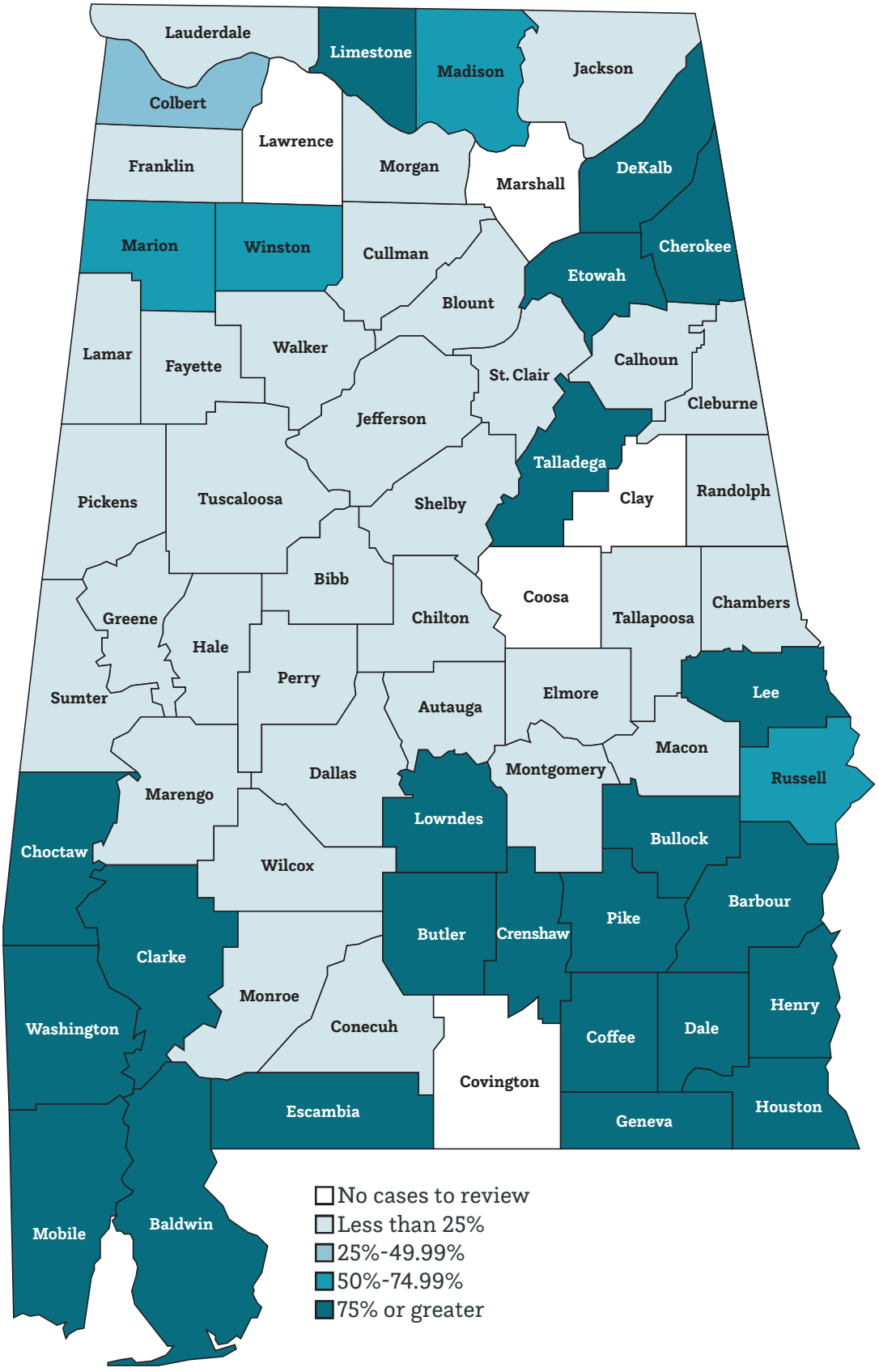


2015 CASES REVIEWED BY LCDRTS





LCDRT Recognition 2014	
Team 1	Choctaw, Clarke, Washington
Team 2	Butler, Crenshaw, Lowndes
Team 3	Barbour, Bullock
Team 4	Bibb, Dallas, Hale, Perry, Wilcox
Team 5	Chambers, Macon, Tallapoosa, Randolph
Team 6	Tuscaloosa
Team 7	Calhoun, Cleburne
Team 8	Morgan
Team 9	Cherokee, DeKalb
Team 10A	Jefferson
Team 10B	Bessemer
Team 11	Lauderdale
Team 12	Coffee, Pike
Team 13	Mobile
Team 14	Walker
Team 15	Montgomery
Team 16	Etowah
Team 17	Greene, Marengo, Sumter
Team 18	Shelby
Team 19	Autauga, Chilton, Elmore
Team 20	Henry, Houston
Team 21	Escambia
Team 22	Covington
Team 23	Madison
Team 24	Fayette, Lamar, Pickens
Team 25	Marion, Winston
Team 26	Russell
Team 27	Marshall
Team 28	Baldwin
Team 29	Talladega
Team 30	St. Clair
Team 31	Colbert
Team 32	Cullman
Team 33	Dale, Geneva
Team 34	Franklin
Team 35	Conecuh, Monroe
Team 36	Lawrence
Team 37	Lee
Team 38	Jackson
Team 39	Limestone
Team 40	Clay, Coosa
Team 41	Blount



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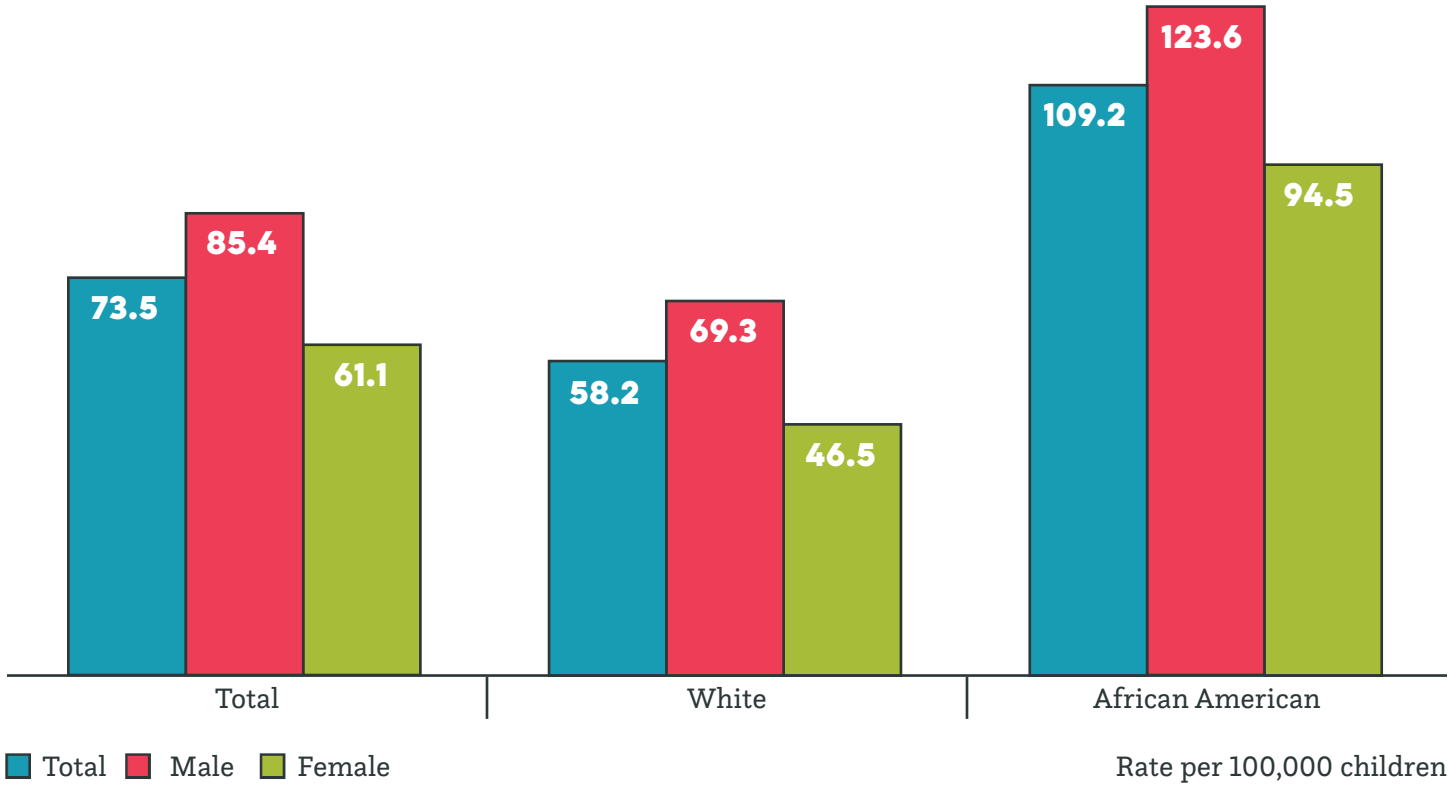
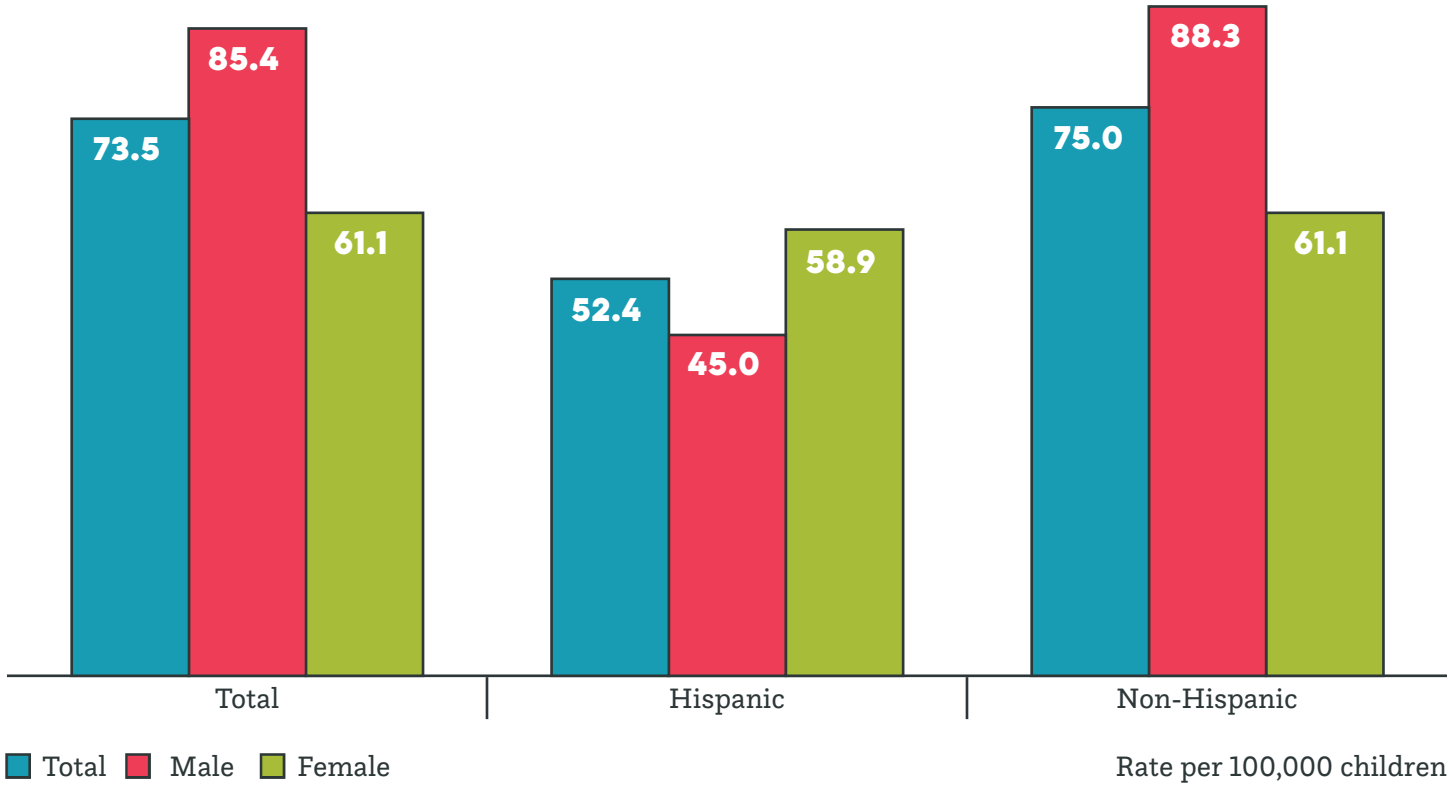
Team 38	Jackson
Team 39	Limestone
Team 40	Clay, Coosa
Team 41	Blount

DEATH RATES FOR ALABAMA CHILDREN

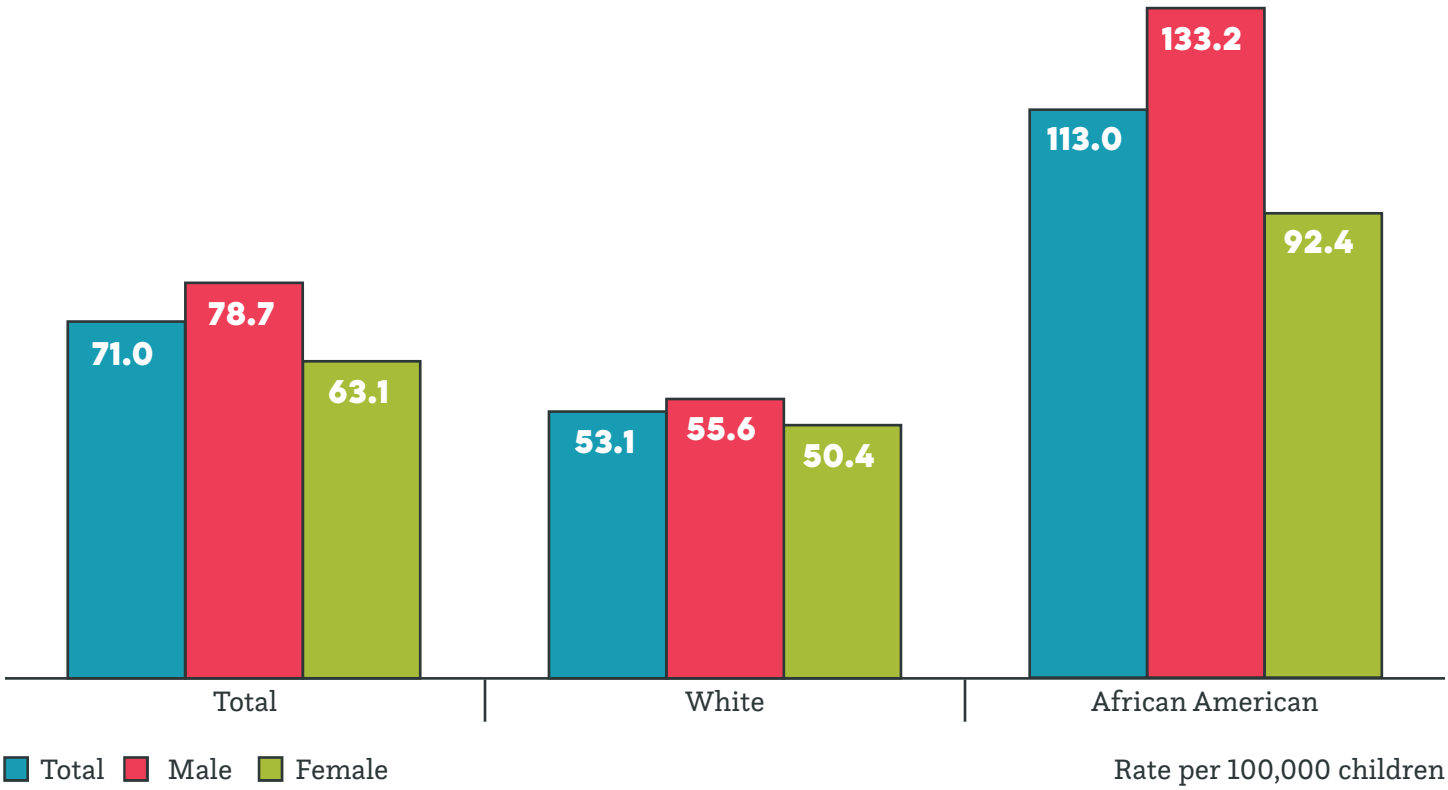
DEATH RATES FOR ALABAMA CHILDREN BY RACE - 2014



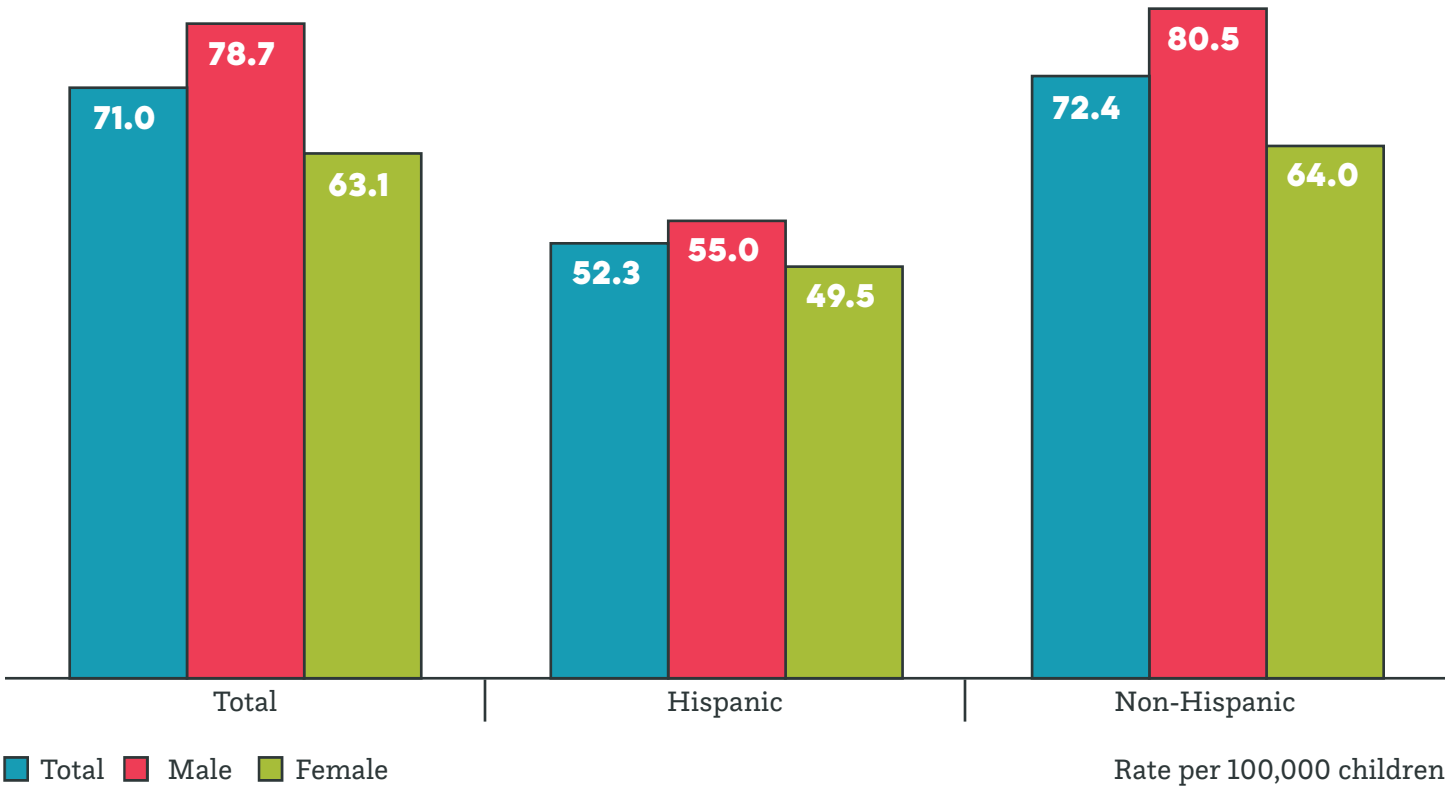
DEATH RATES FOR ALABAMA CHILDREN BY ETHNICITY - 2014



DEATH RATES FOR ALABAMA CHILDREN BY RACE - 2015



DEATH RATES FOR ALABAMA CHILDREN BY ETHNICITY - 2015

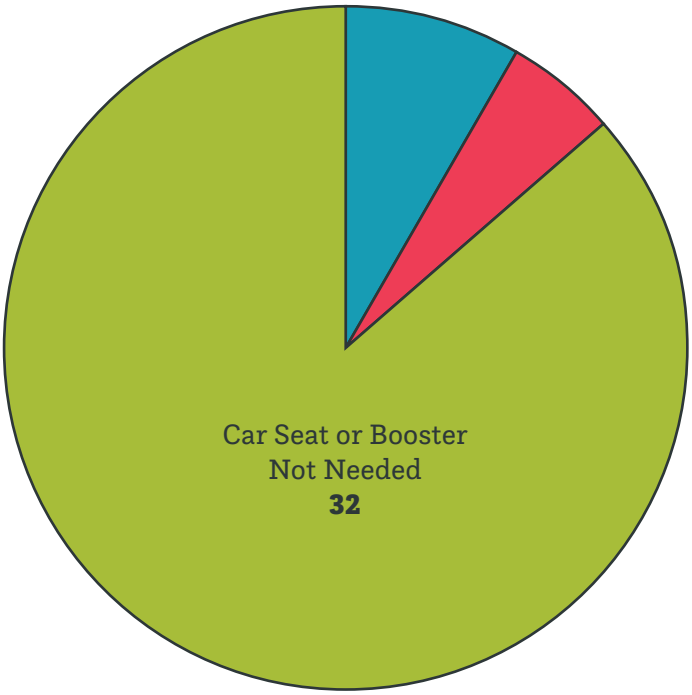


Death rates were calculated using information obtained from the CDC Wide-ranging Online Data for Epidemiologic Research (WONDER) database.*

**CDC WONDER - https://wonder.cdc.gov/ucd-icd10.html*

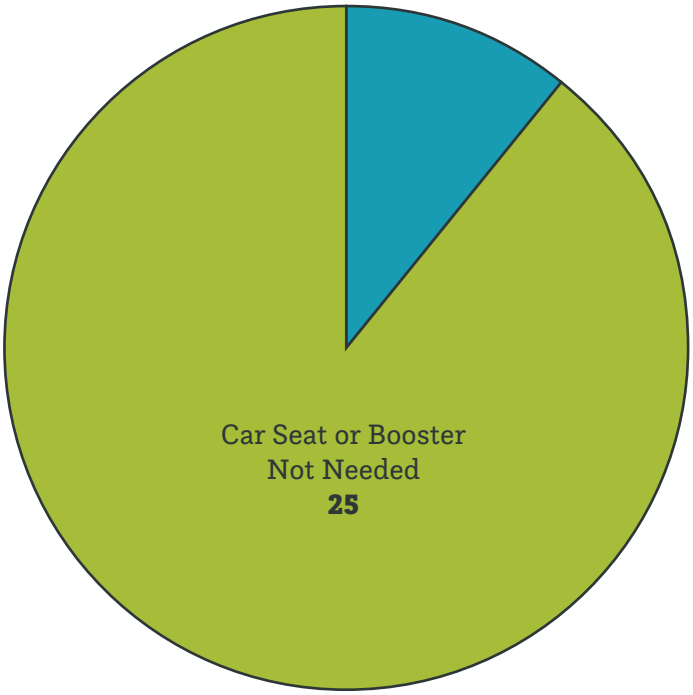
VEHICLE RELATED DEATHS

CAR SEAT AND BOOSTER SEAT USE 2014 REVIEWED CASES



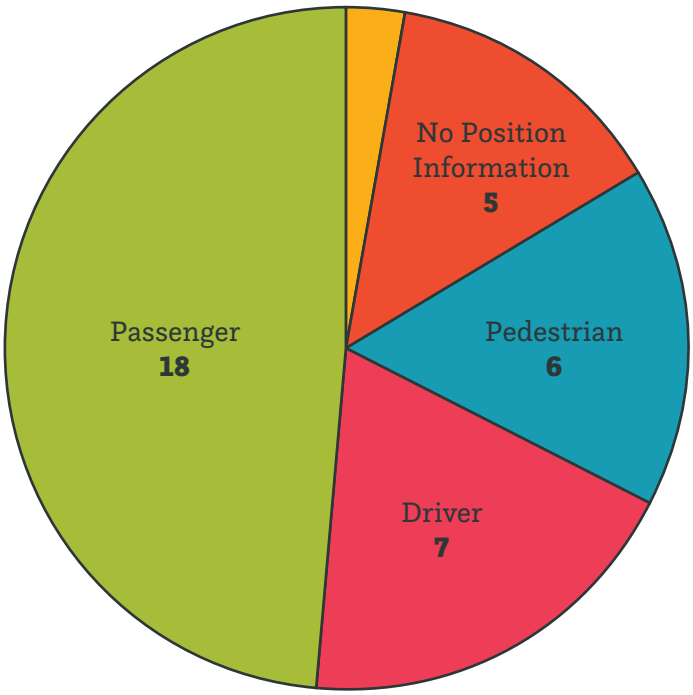
Needed But Not Present **2**
Present But Used Incorrectly **3**

CAR SEAT AND BOOSTER SEAT USE DURING INCIDENT 2015 REVIEWED CASES



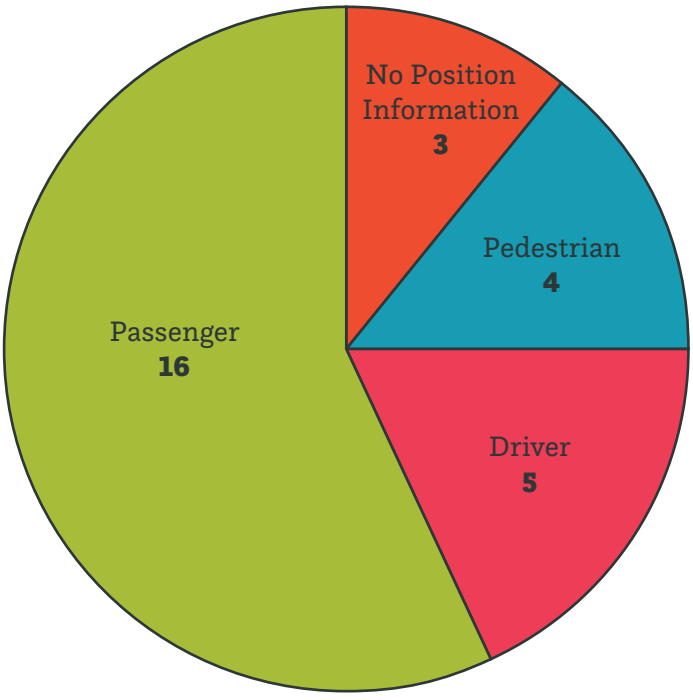
Needed But Not Present **3**

LOCATION OF CHILD AT TIME OF DEATH 2014 REVIEWED CASES

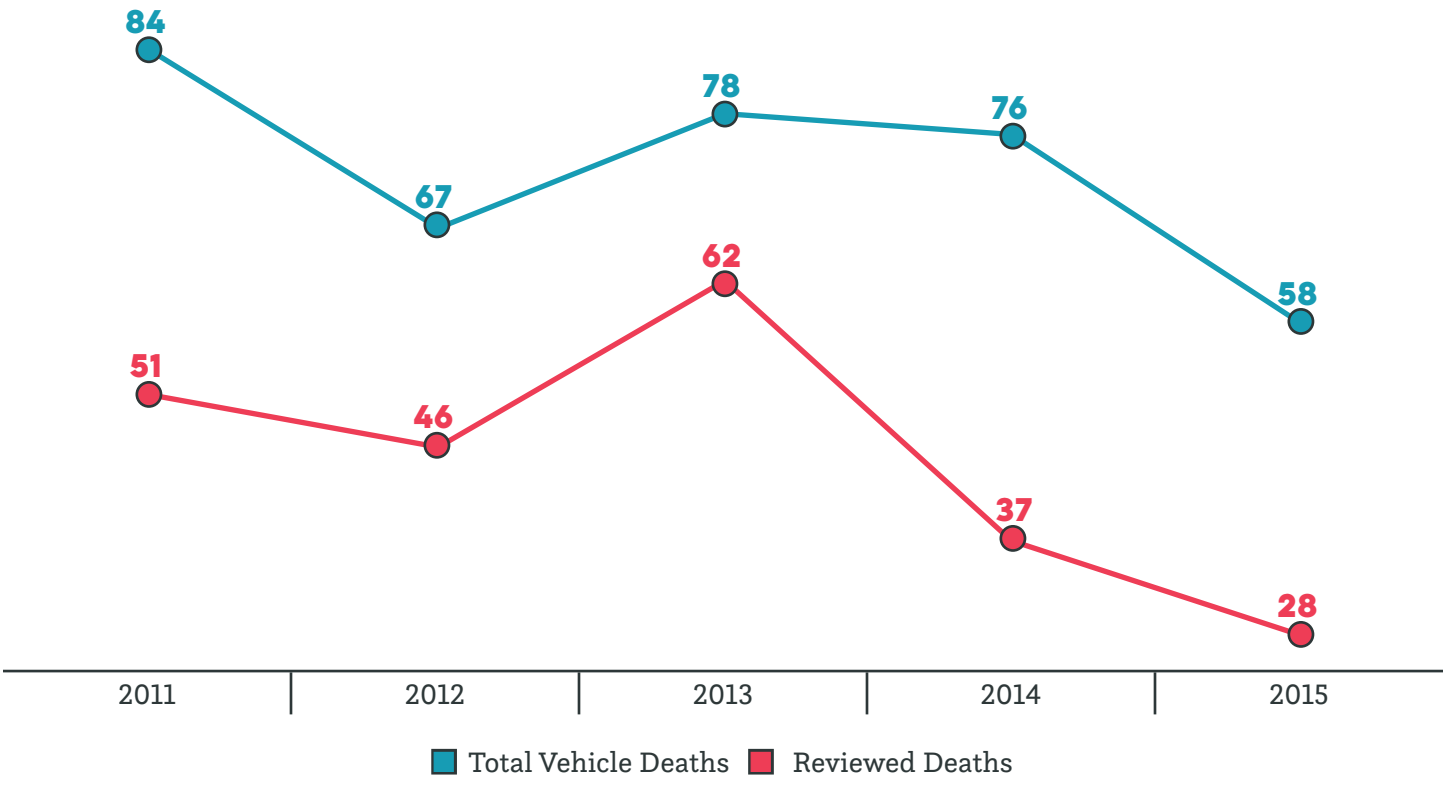


Bicycle **1**

LOCATION OF CHILD AT TIME OF DEATH 2015 REVIEWED CASES



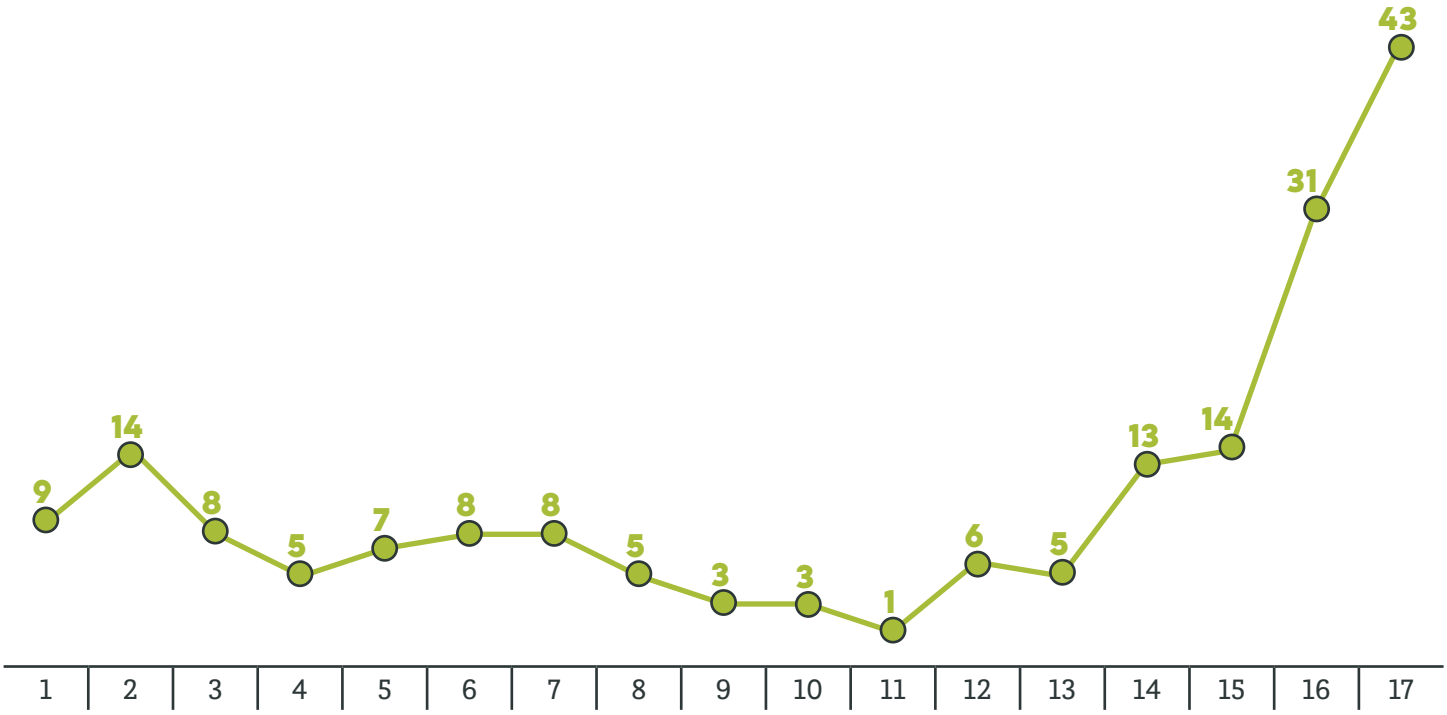
ALABAMA VEHICLE RELATED DEATHS - 2011 TO 2015



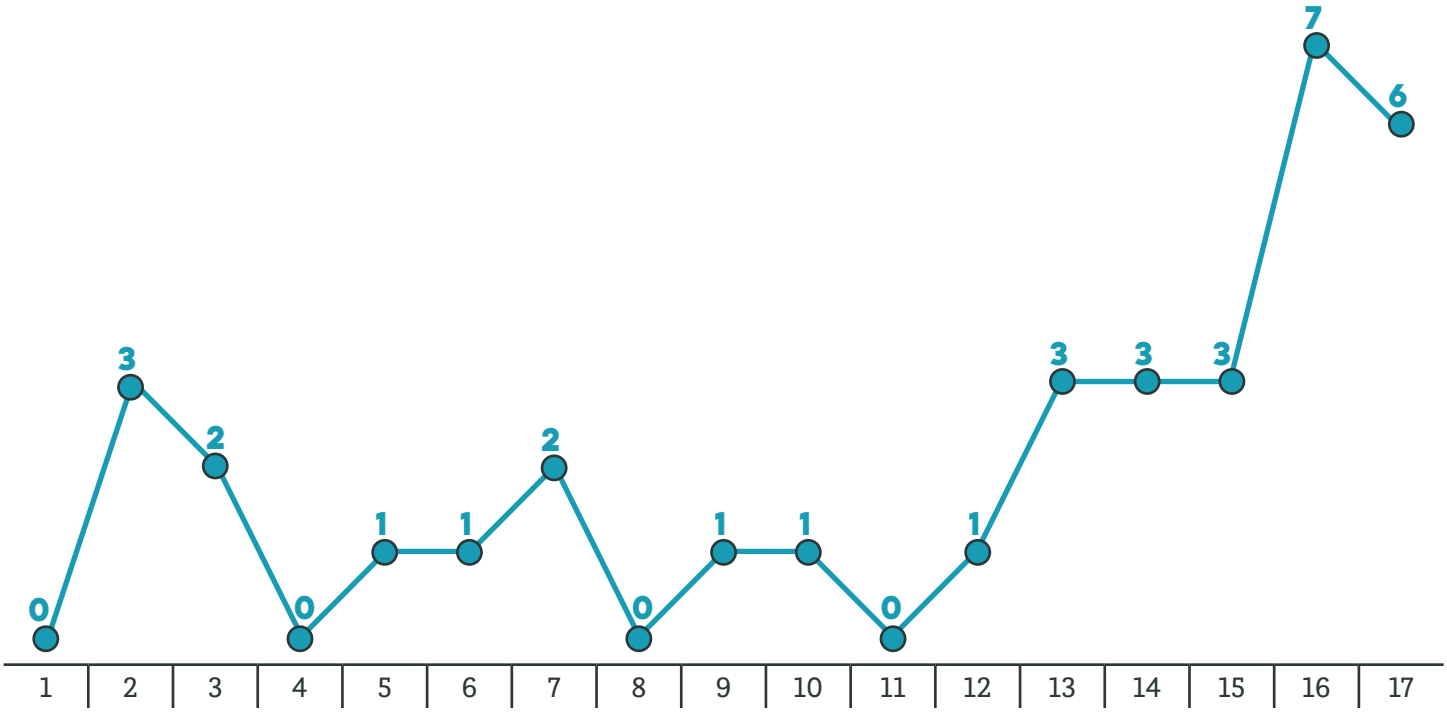
Age - Years

TREND LINES – CONDITIONS THAT CONTRIBUTED TO VEHICLE DEATHS - 2011 TO 2015

REVIEWED VEHICLE DEATHS - 2011 TO 2015

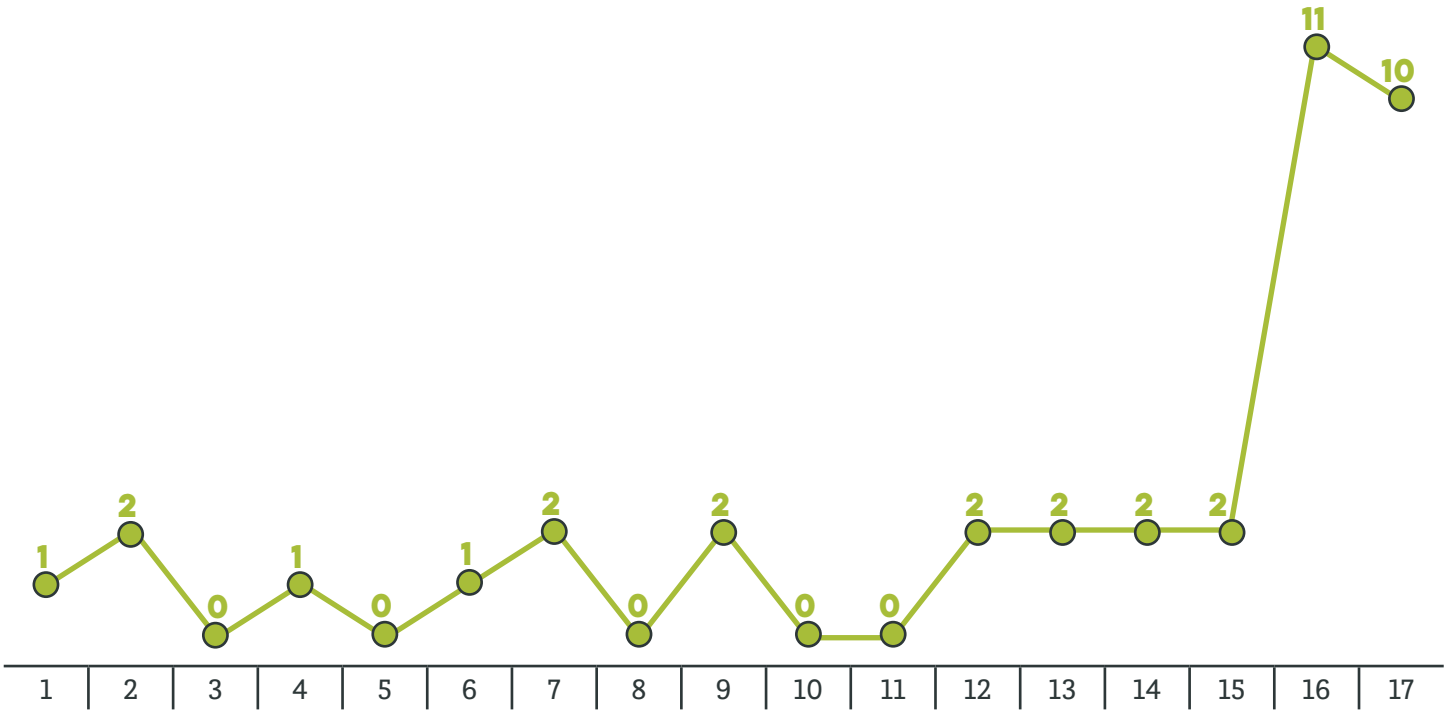


REVIEWED RECKLESS DRIVING DEATHS - 2011 TO 2015

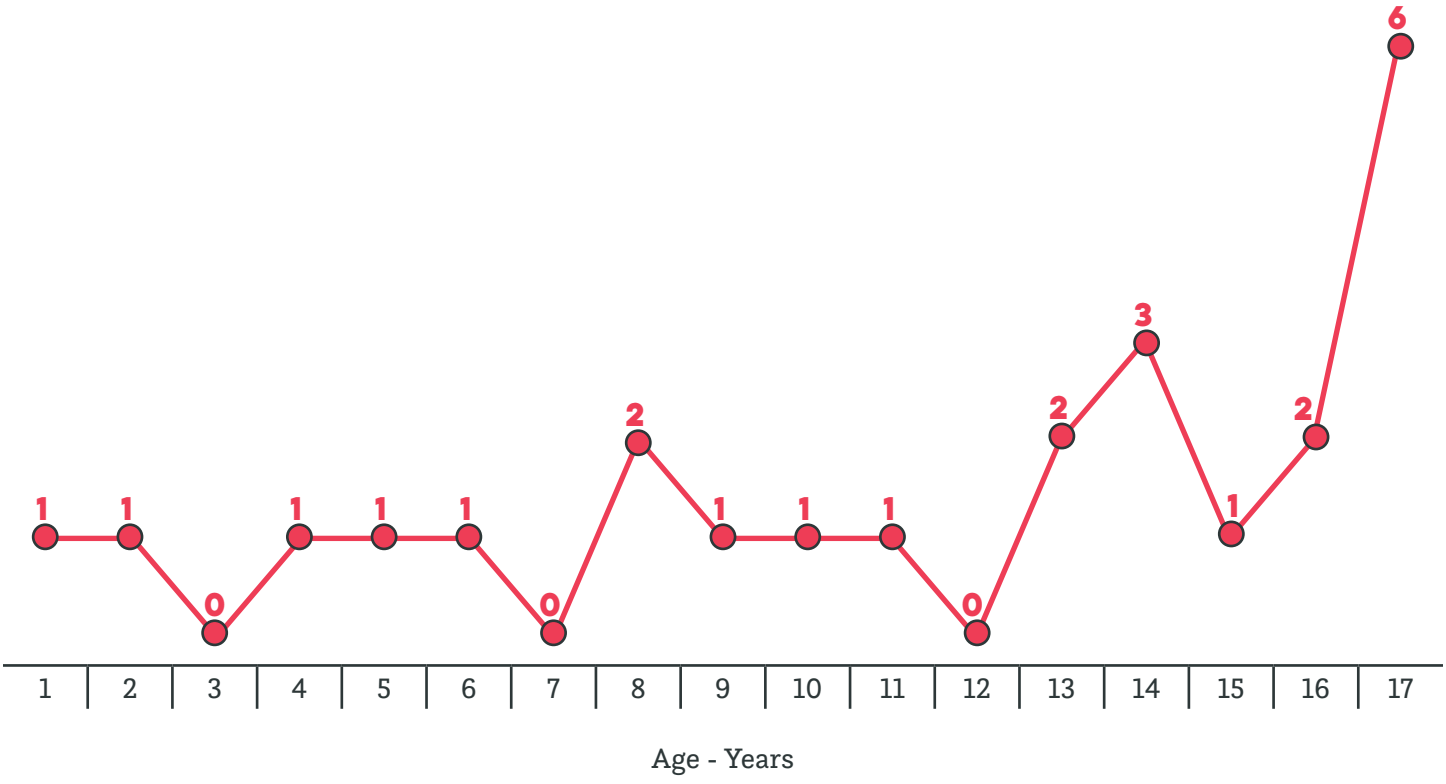


Age - Years

REVIEWED SPEEDING DEATHS - 2011 TO 2015

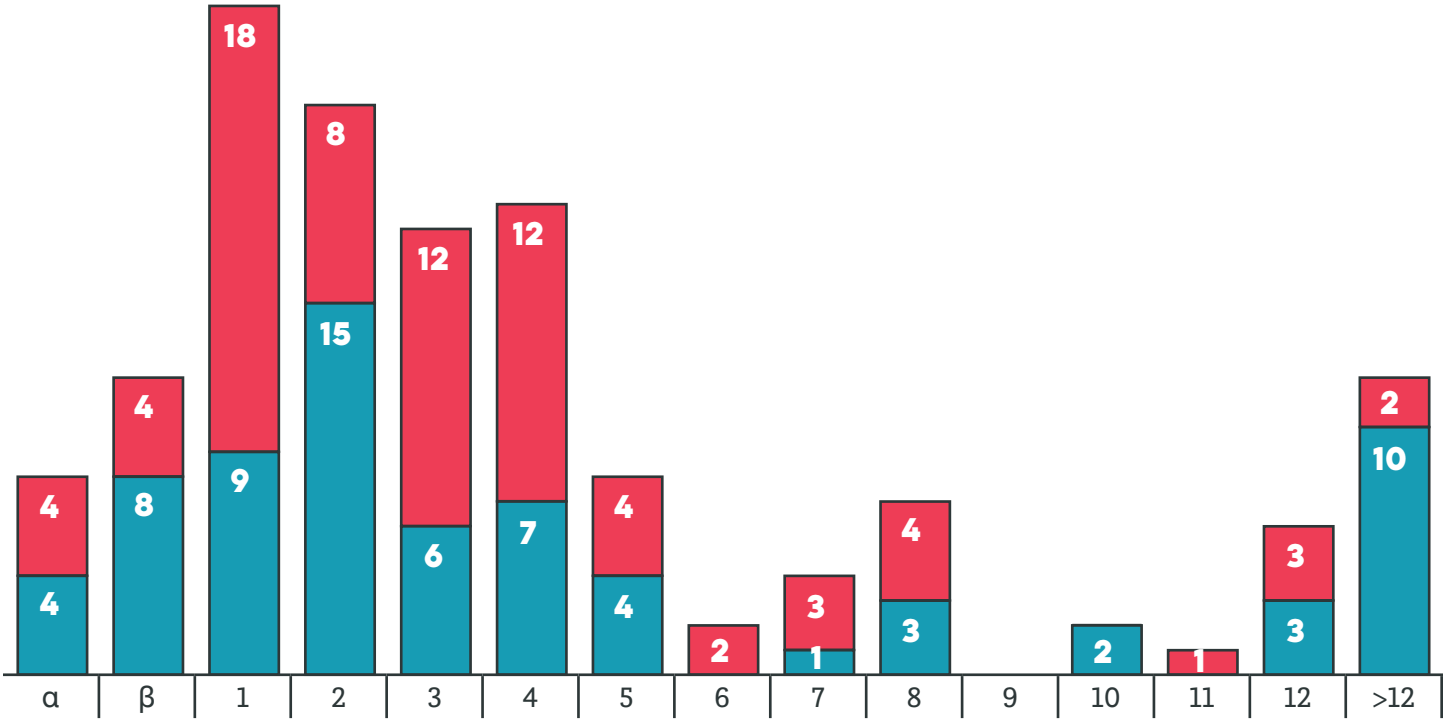


REVIEWED DRUG AND ALCOHOL USE DEATHS - 2011 TO 2015



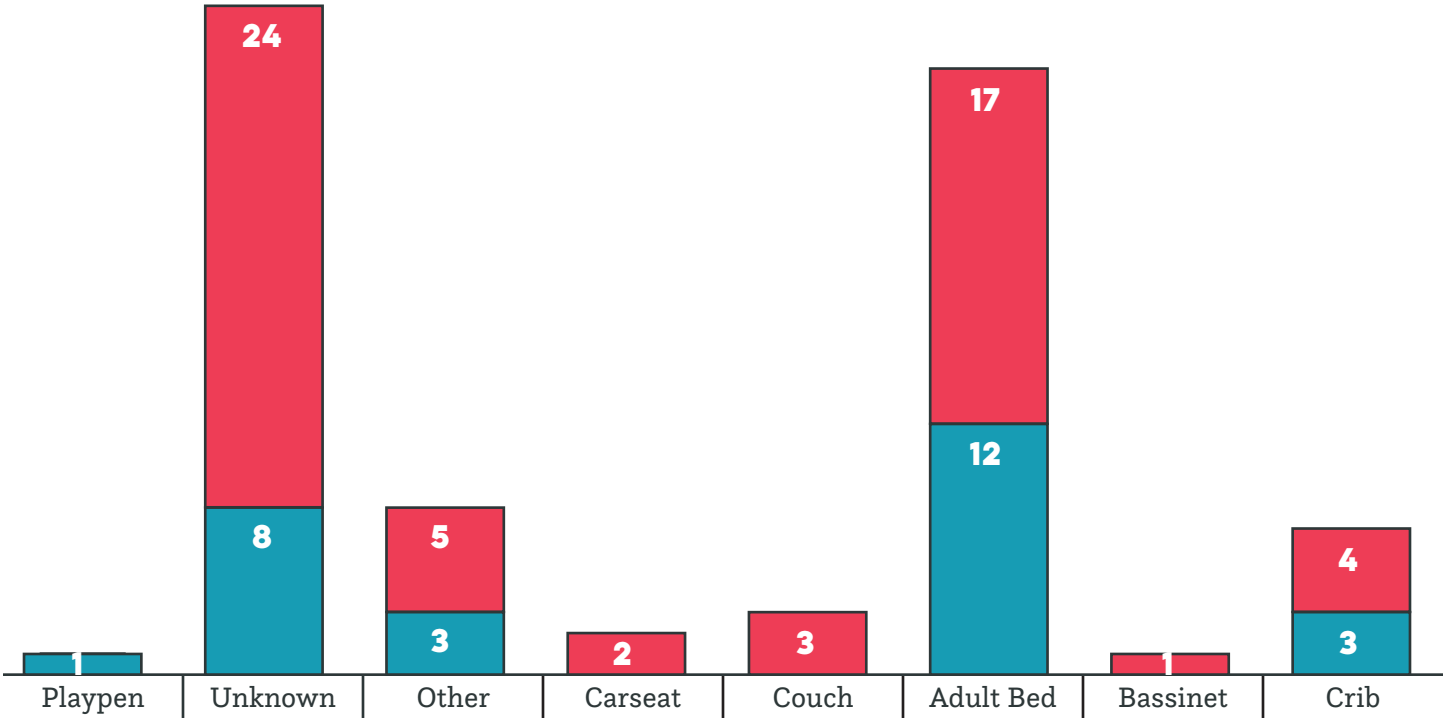
UNDETERMINED DEATHS

ALL UNDETERMINED DEATHS - 2014 AND 2015



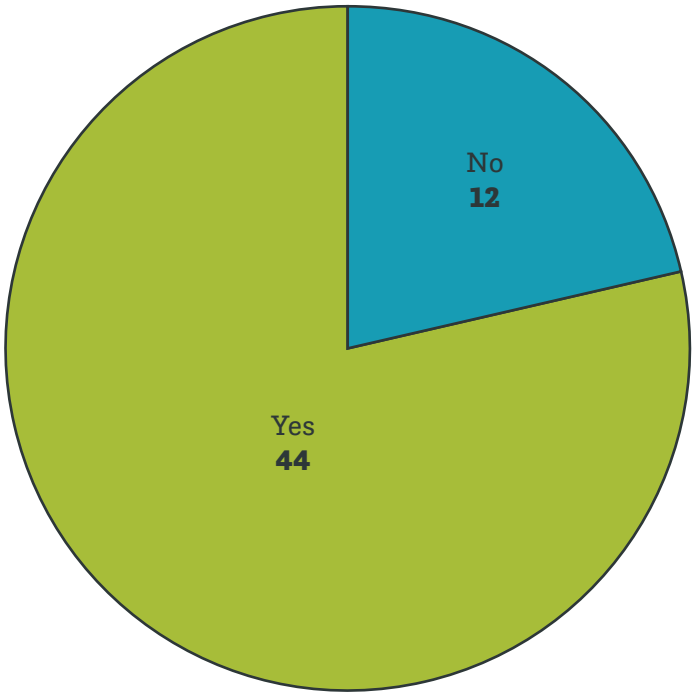
2014 2015 Age (Months). α – Children aged less than half a month old. β– Children aged one half to one month old.

CHILD'S PLACE OF SLEEP - 2014 AND 2015 REVIEWED UNDETERMINED CASES

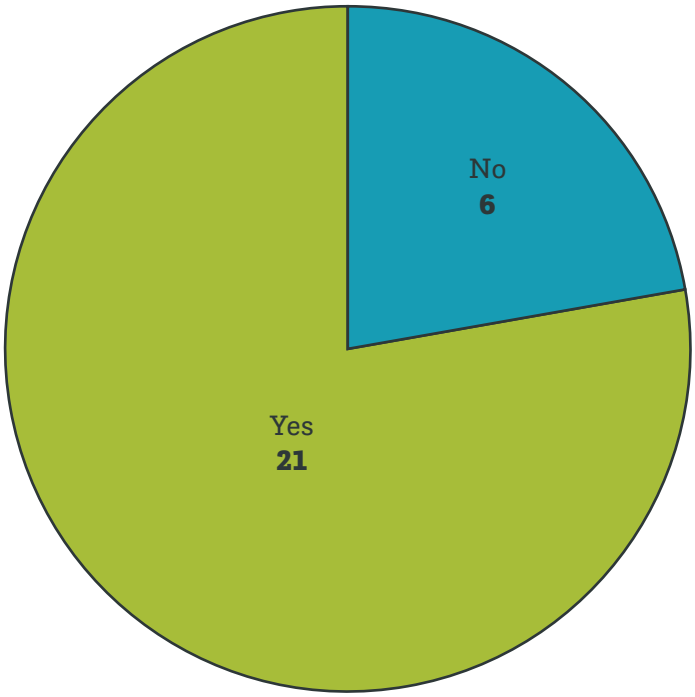


2014 2015

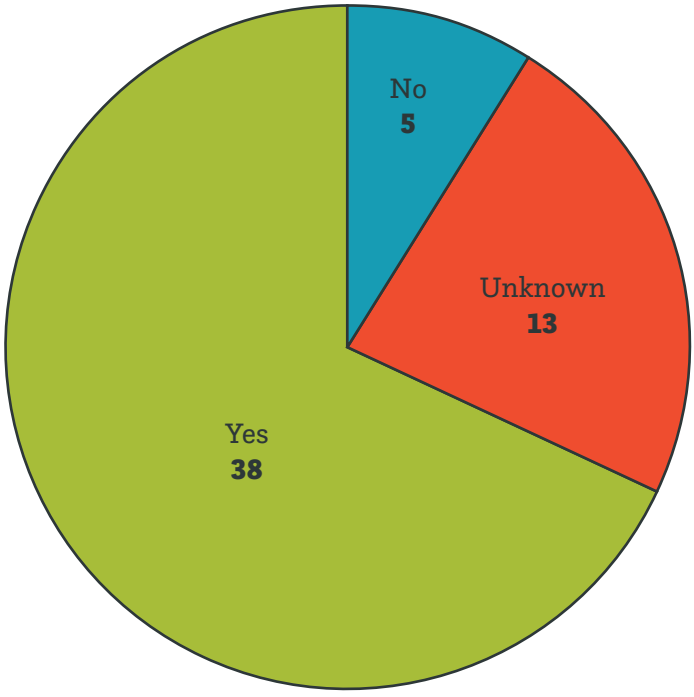
CHILD WAS SLEEPING AT TIME OF DEATH 2014 REVIEWED UNDETERMINED CASES



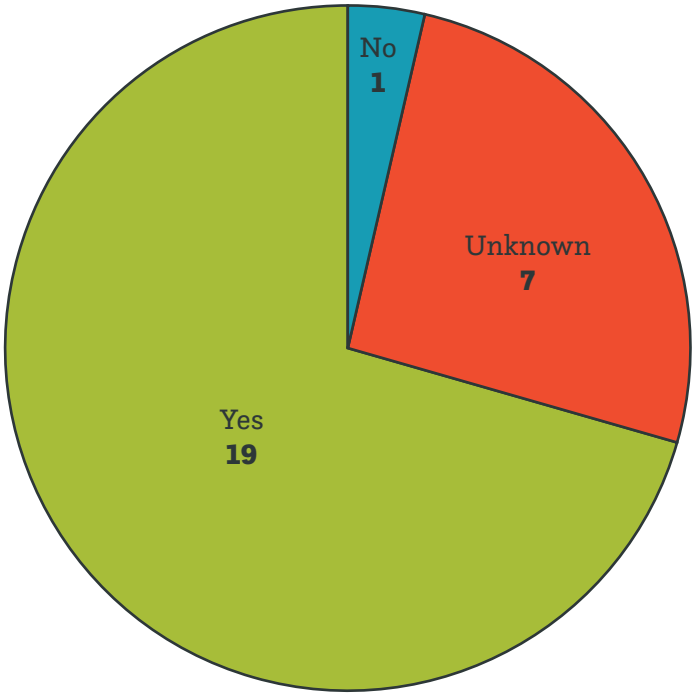
CHILD WAS SLEEPING AT TIME OF DEATH 2015 REVIEWED UNDETERMINED CASES



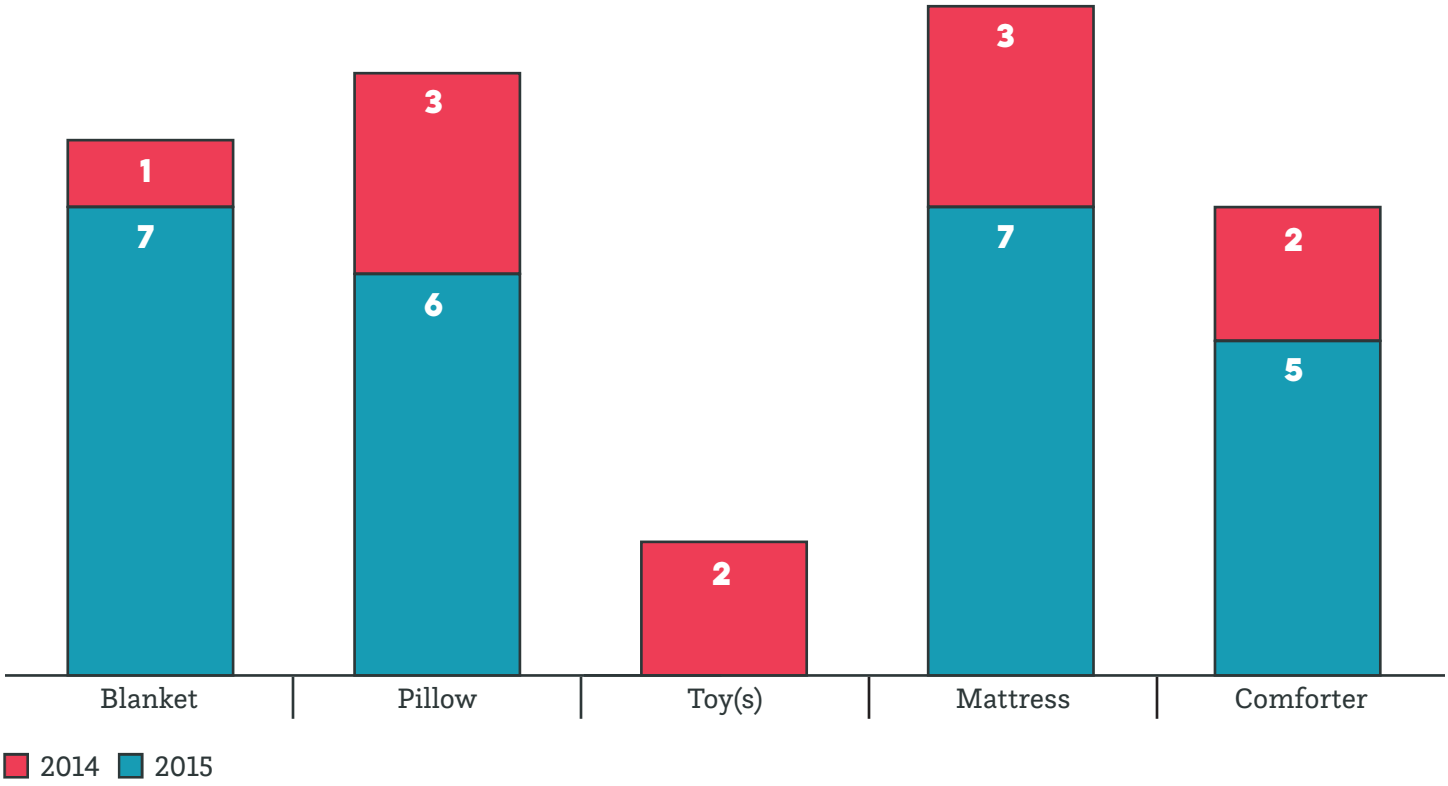
DEATH WAS RELATED TO SLEEP ENVIRONMENT 2014 REVIEWED UNDETERMINED CASES



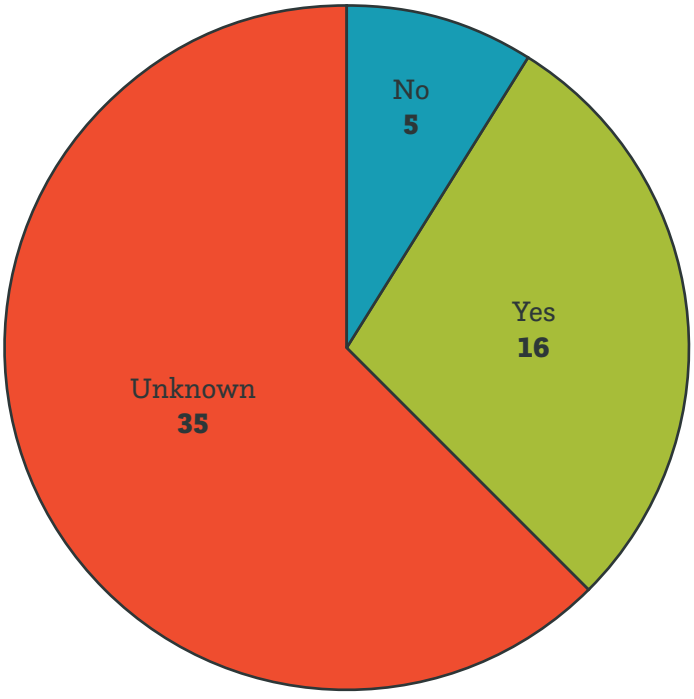
DEATH WAS RELATED TO SLEEP ENVIRONMENT 2015 REVIEWED UNDETERMINED CASES



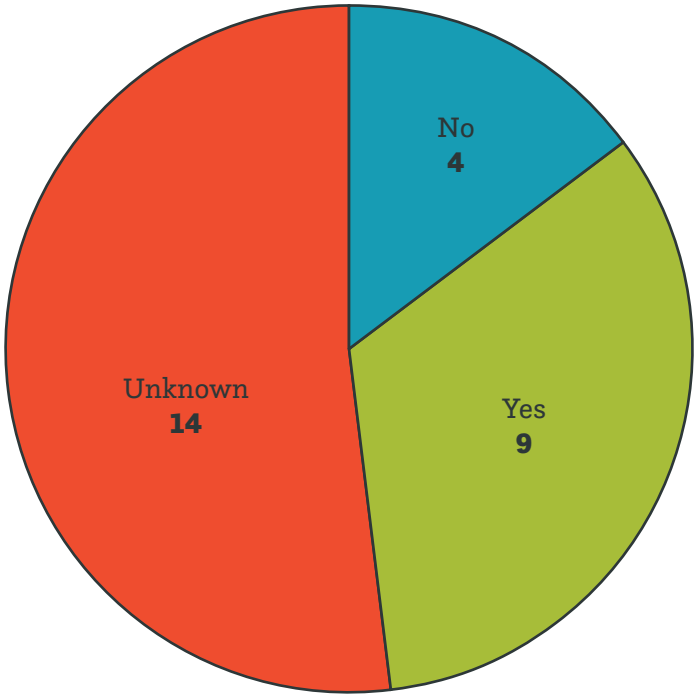
OBJECTS PRESENT IN CHILD'S SLEEP ENVIRONMENT 2014 AND 2015 REVIEWED UNDETERMINED CASES



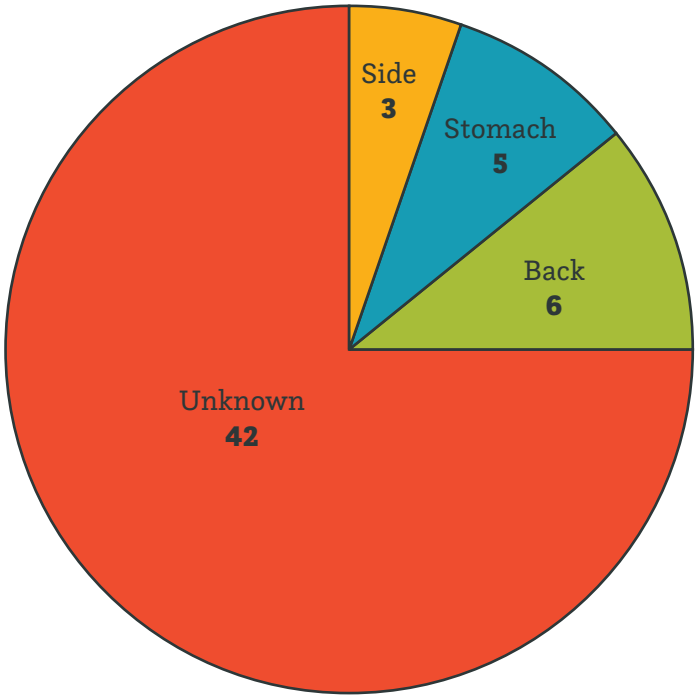
CHILD SLEEPING IN ROOM WITH CAREGIVER 2014 REVIEWED UNDETERMINED CASES



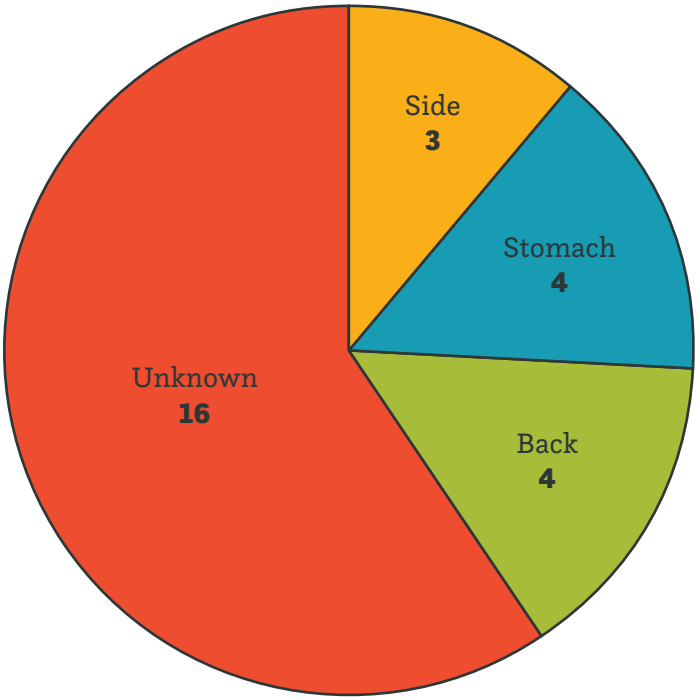
CHILD SLEEPING IN ROOM WITH CAREGIVER 2015 REVIEWED UNDETERMINED CASES



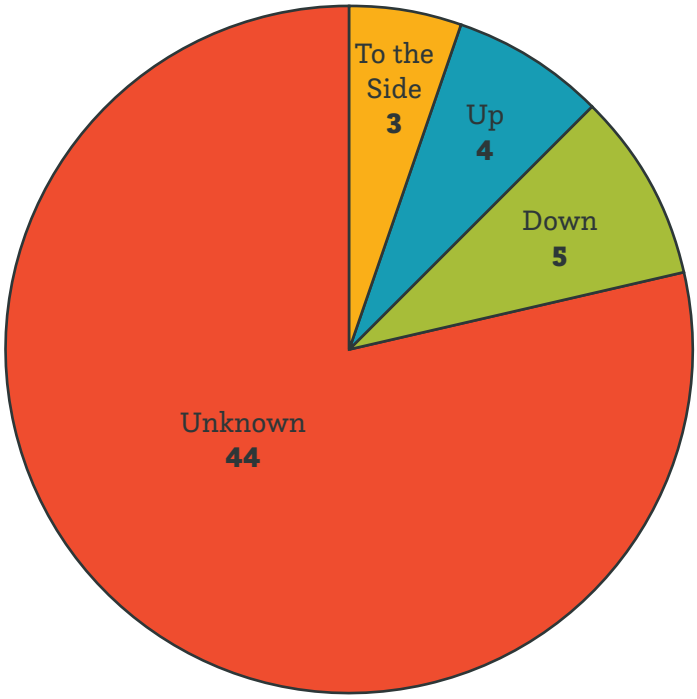
POSITION OF CHILD WHEN FOUND 2014 REVIEWED UNDETERMINED CASES



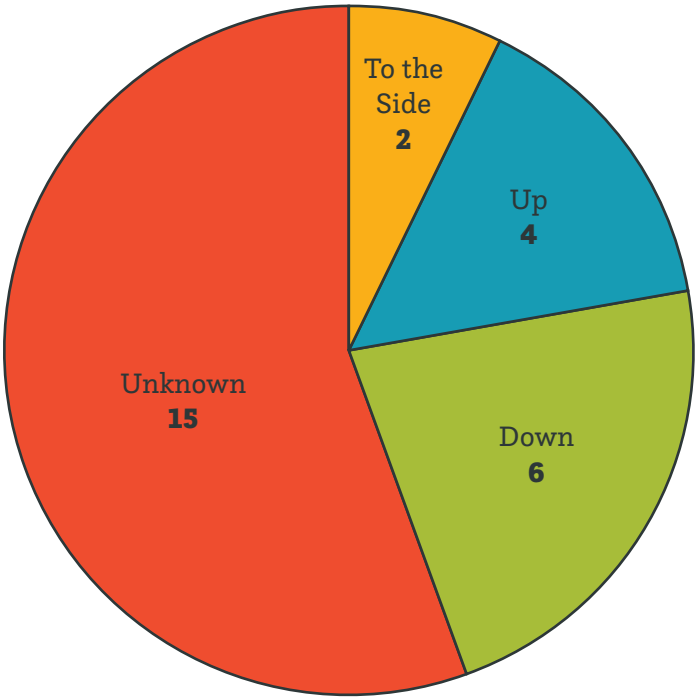
POSITION OF CHILD WHEN FOUND 2015 REVIEWED UNDETERMINED CASES



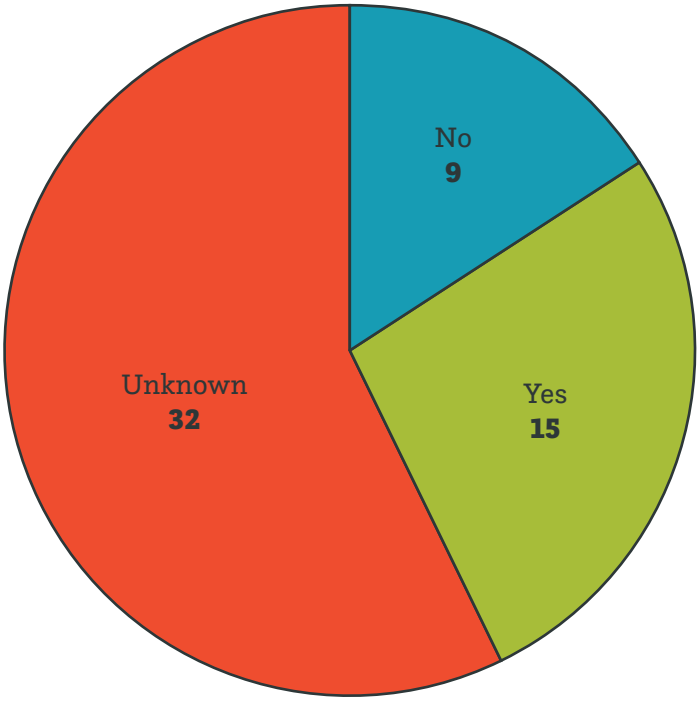
CHILD'S FACING WHEN FOUND 2014 REVIEWED UNDETERMINED CASES



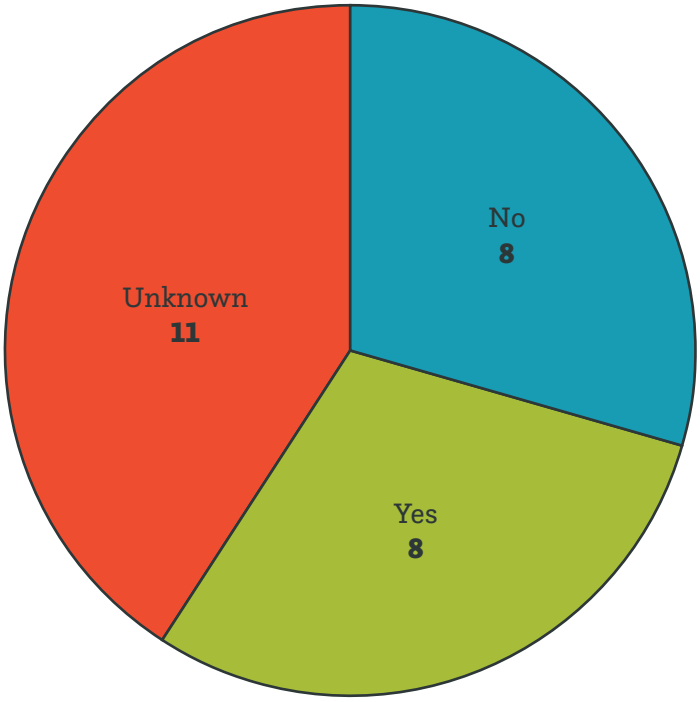
CHILD'S FACING WHEN FOUND 2015 REVIEWED UNDETERMINED CASES



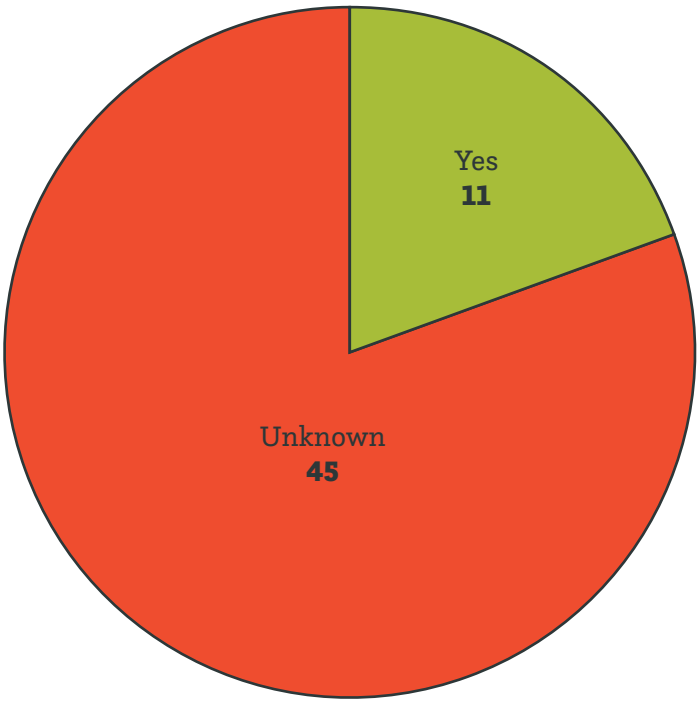
CHILD SLEEPING ON SAME SURFACE AS A PERSON OR ANIMAL 2014 REVIEWED UNDETERMINED CASES



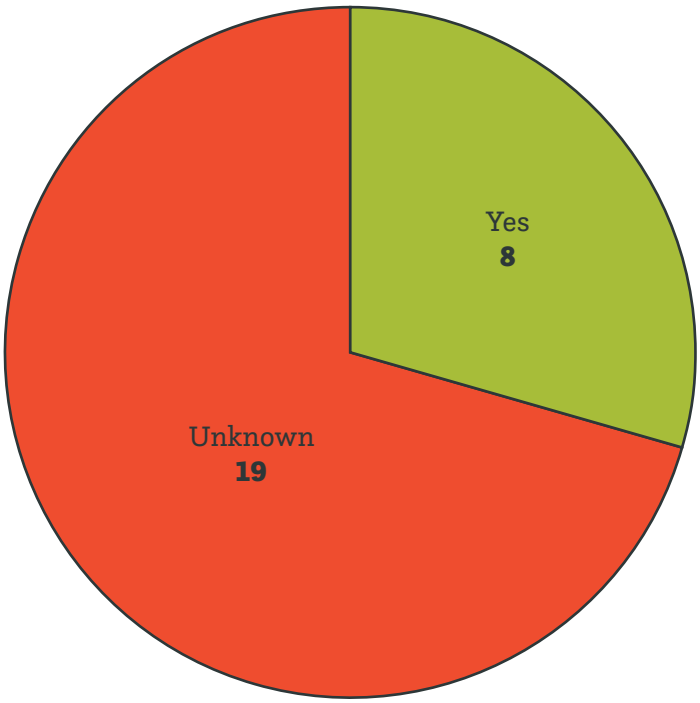
CHILD SLEEPING ON SAME SURFACE AS A PERSON OR ANIMAL 2015 REVIEWED UNDETERMINED CASES



CHILD SLEEPING WITH ADULT 2014 REVIEWED UNDETERMINED CASES

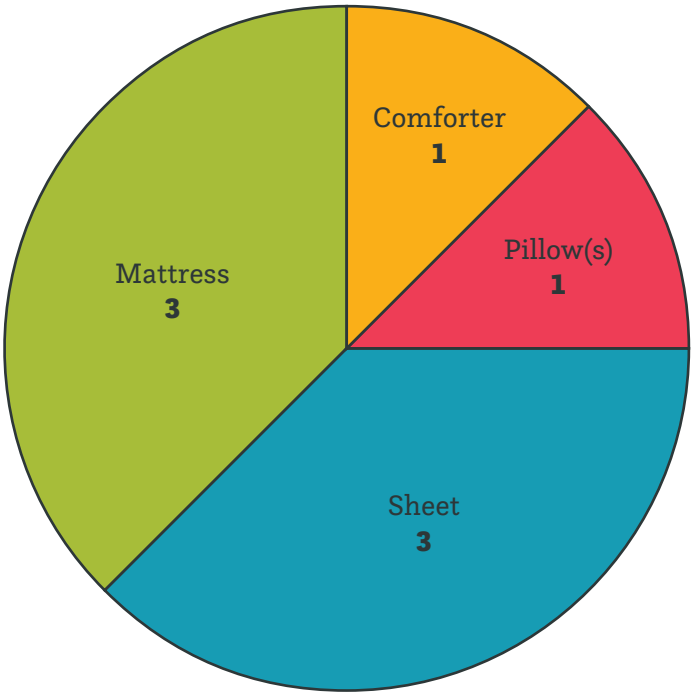


CHILD SLEEPING WITH ADULT 2015 REVIEWED UNDETERMINED CASES

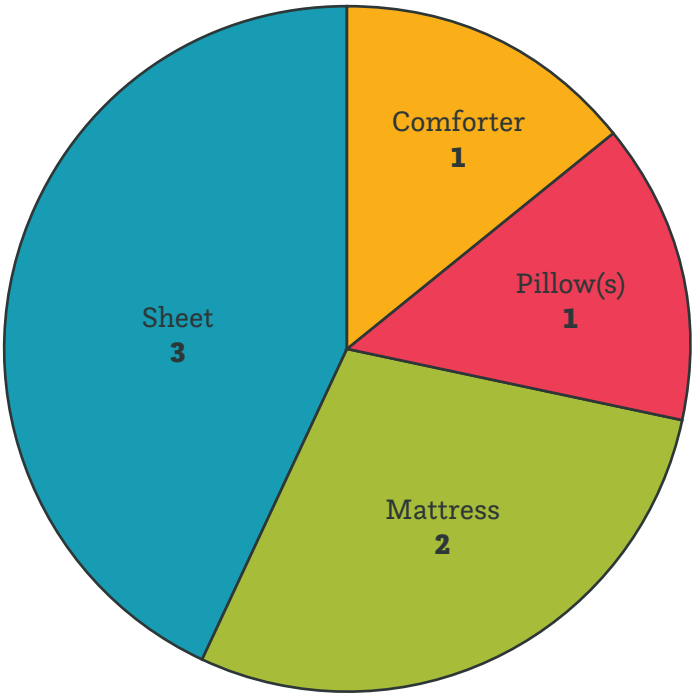


SUDDEN UNEXPLAINED INFANT DEATHS (SUID)

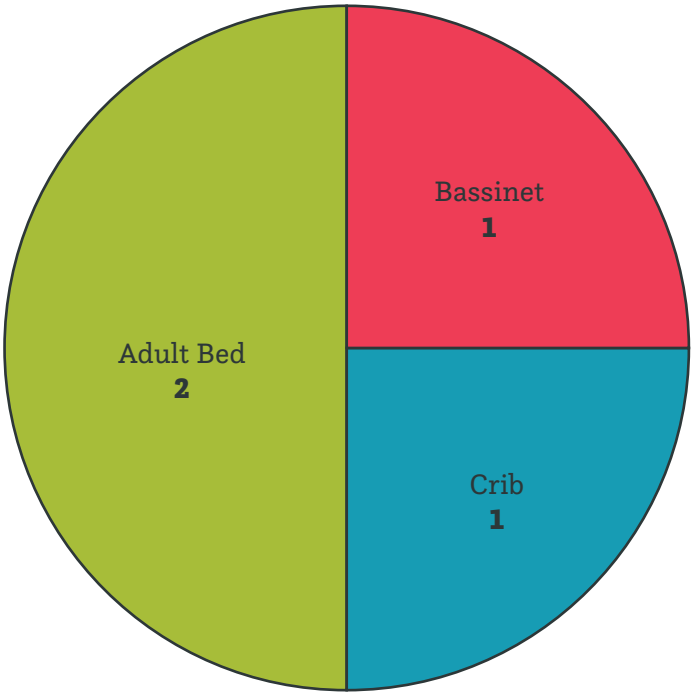
OBJECTS PRESENT IN CHILD'S SURROUNDINGS 2014 SUID DEATHS



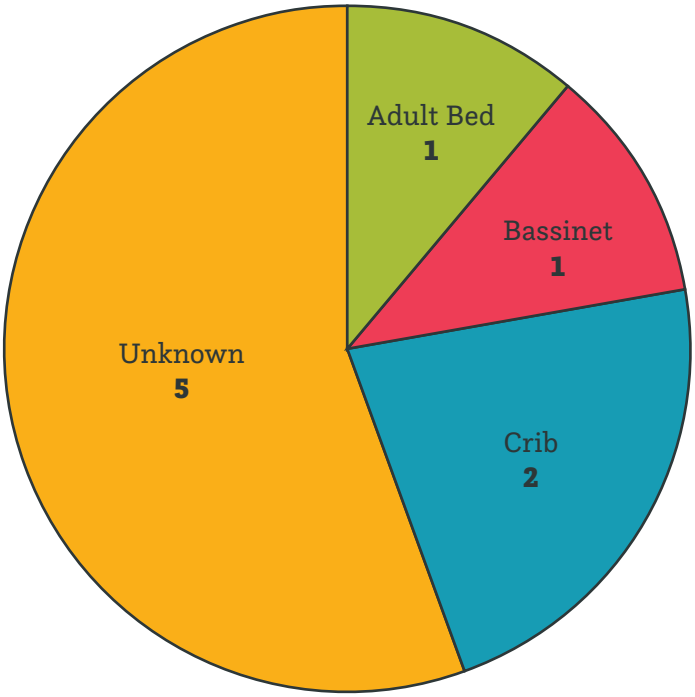
OBJECTS PRESENT IN CHILD'S SURROUNDINGS 2015 SUID DEATHS



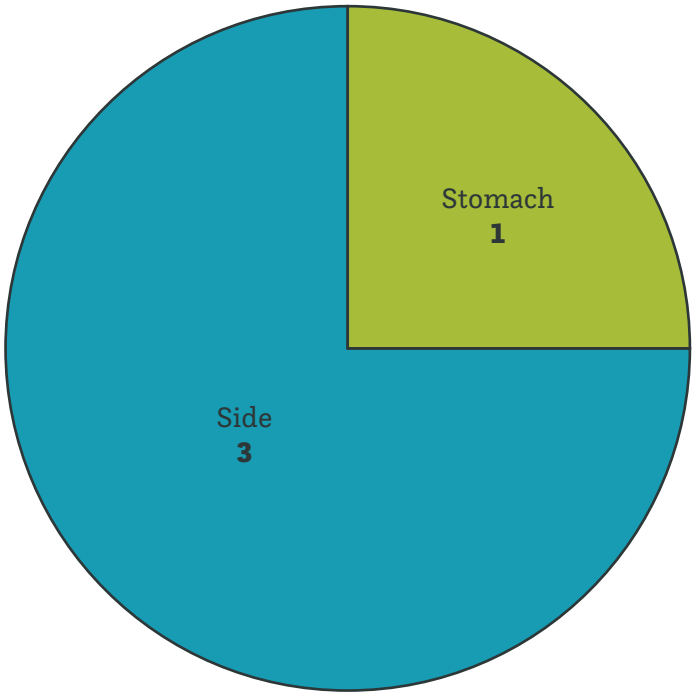
CHILD'S SLEEP LOCATION 2014 SUID DEATHS



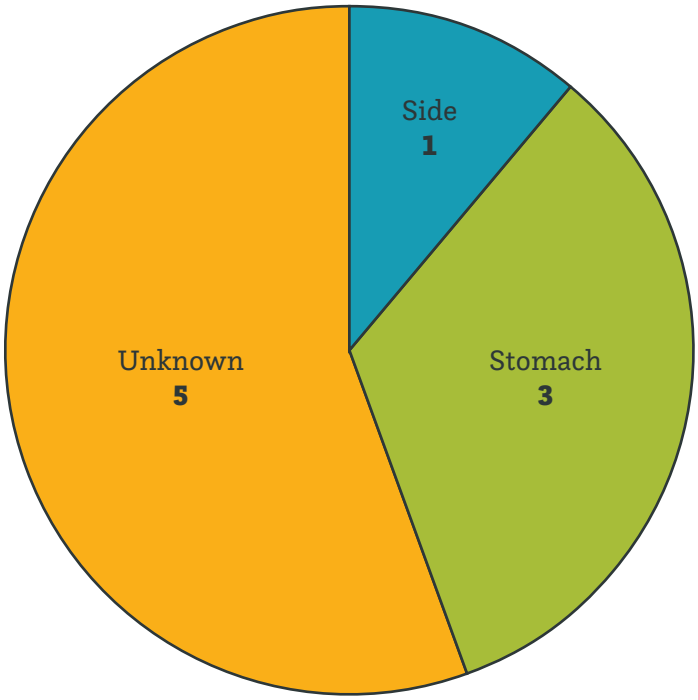
CHILD'S SLEEP LOCATION 2015 SUID DEATHS



POSITION OF CHILD WHEN FOUND 2014 SUID DEATHS



POSITION OF CHILD WHEN FOUND 2015 SUID DEATHS



FIRE, BURNS, SMOKE INHALATION, AND ELECTROCUTION RELATED DEATHS

2014 - 5 CASES

Method of Death: 3 fire-related, 1 burn-related (other), and 1 unknown method

Location of Death: 2 smoke inhalations, 1 other, and 2 unknown causes

2015 - 3 CASES

Method of Death: 3 fire-related

Source of Fire: 1 cooking stove and 1 space heater

Cause of Death: Burns: 1 case. Smoke inhalation: 2 cases

DROWNING DEATHS

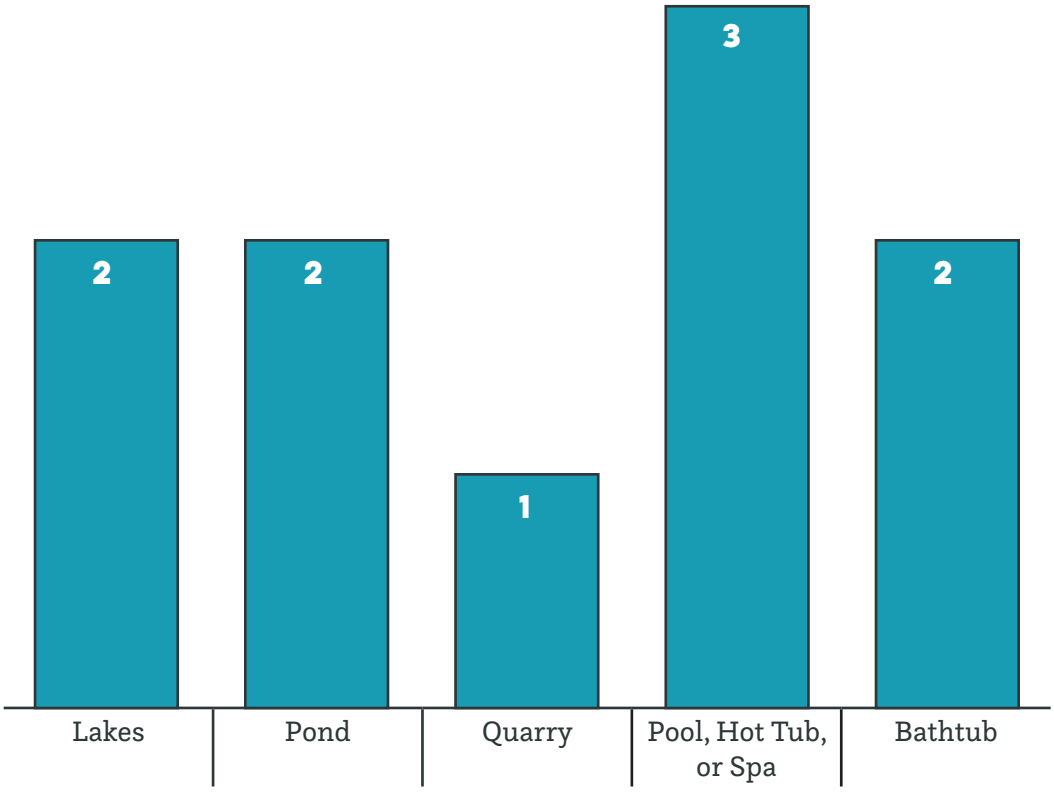
2014 - 12 CASES

Method of Death: 1 boating, 6 playing, and 5 "other"

Location of Death:
- Open water: 5
  - 2 in lakes, 2 in ponds, and 1 in a quarry
- Pool, hot tub, or spa: 3
- Bathtub: 2

Key Findings:
- No barriers to water: 2 cases
- No floatation device: 7 cases

2014 DROWNING DEATHS - WATER SOURCE



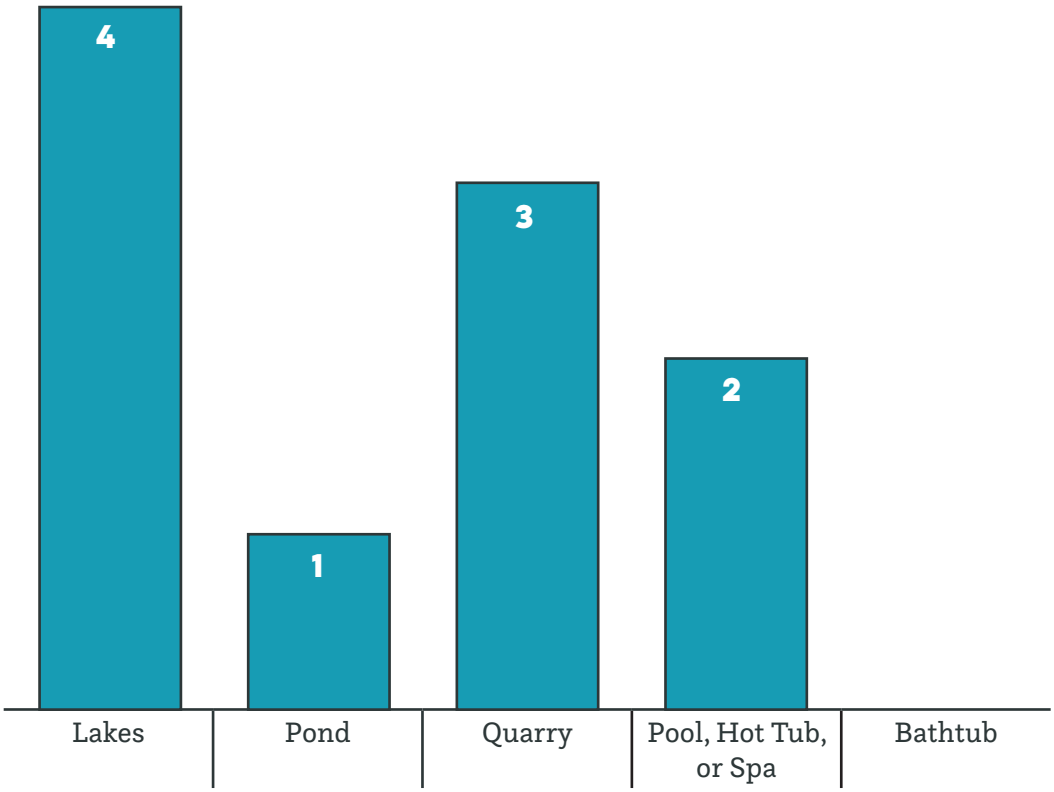
2015 - 12 CASES

Method of Death: 1 boating, 6 playing, and 5 "other"

Location of Death:
- Open water: 8
  - 4 in lakes, 1 in river, and 3 in the ocean
- Pool, hot tub, or spa: 2
- Bathtub: 0

Key Findings:
- No barriers to water: 2 cases
- No floatation device: 4 cases

2015 DROWNING DEATHS - WATER SOURCE



SUFFOCATION RELATED DEATHS

2014 - 8 CASES

Method of Death: 6 suffocation cases and 2 "other"

Cause of Death: 3 sleep-related, 1 not sleep-related, and 2 unknown

2015 - 4 CASES

Method of Death: 1 suffocation case, 1 choking case, and 2 "other"

Cause of Death: 1 sleep-related and 3 not sleep-related

FIREARM, WEAPON, AND ASSAULT RELATED DEATHS

2014 - 23 CASES

Manner of Death: 9 homicide, 10 suicides, and 2 accidents

Method of Death: 16 firearms (15 handguns and 1 shotgun), 1 sharp instrument, and 1 physical assault

Circumstances Relating to Use of a Weapon:

- Unlicensed firearm: 4 cases
- Use during the commission of a crime: 4 cases
- Discharge while playing with a weapon: 3 cases
- Random act of violence: 1 case
- Use during an argument: 3 cases

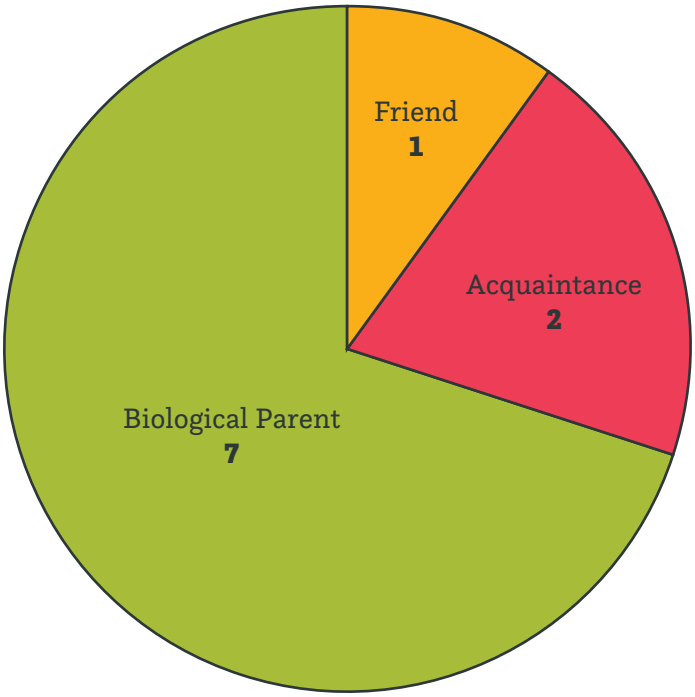
Storage and Access to Firearms:

- Stored with ammo: 4 cases
- Not stored: 2 cases
- Stored in locked location: 2 cases
- Stored under mattress/pillow: 2 cases
- Stored loaded: 4 cases

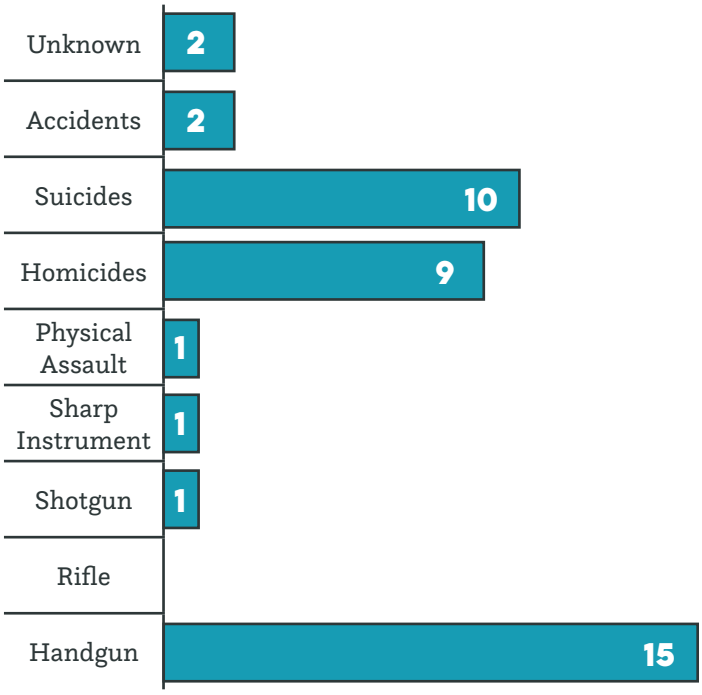
Owner of the Firearm:

- Biological parent: 7 cases (4 of which were suicides)
- Friend: 1 case
- Acquaintance: 2 cases

OWNER OF THE FIREARM INVOLVED 2014 ASSAULT AND WEAPON DEATHS



MANNER OF DEATH 2014 ASSAULT AND WEAPON DEATHS



2015 - 20 CASES

Manner of Death: 10 homicide, 8 suicides, 1 accident, and 1 pending

Method of Death: 16 firearms (11 handguns, 1 shotgun, and 2 hunting rifles), 1 sharp instrument, and 1 physical assault

Circumstances Relating to Use of a Weapon:

- Unlicensed firearm: 4 cases
- Use during the commission of a crime: 2 cases
- Discharge while playing with a weapon: 2 cases
- Random act of violence: 1 case
- Bystander: 1 case
- Self-defense: 1 case
- Drive by: 1 case

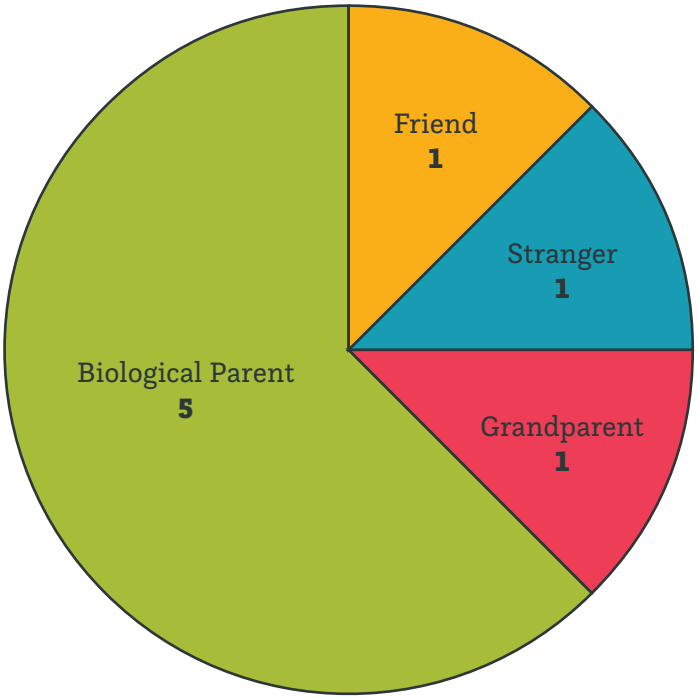
Storage and Access to Firearms:

- Stored with ammo: 1 case
- Not stored: 4 cases
- Stored in locked location: 0 cases
- Stored under mattress/pillow: 1 case
- Stored loaded: 1 case

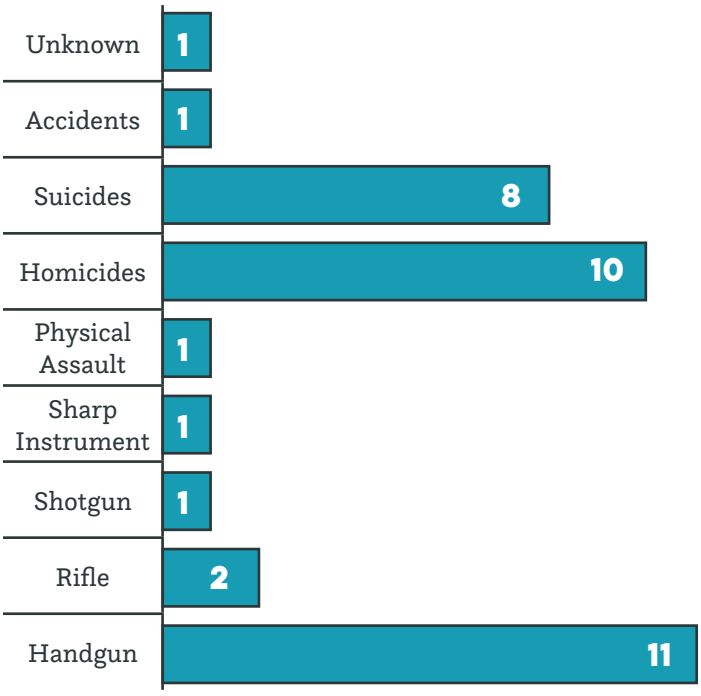
Owner of the Firearm:

- Biological parent: 5 cases (4 of which were suicides)
- Grandparent: 1 case
- Friend: 1 case
- Stranger: 1 case

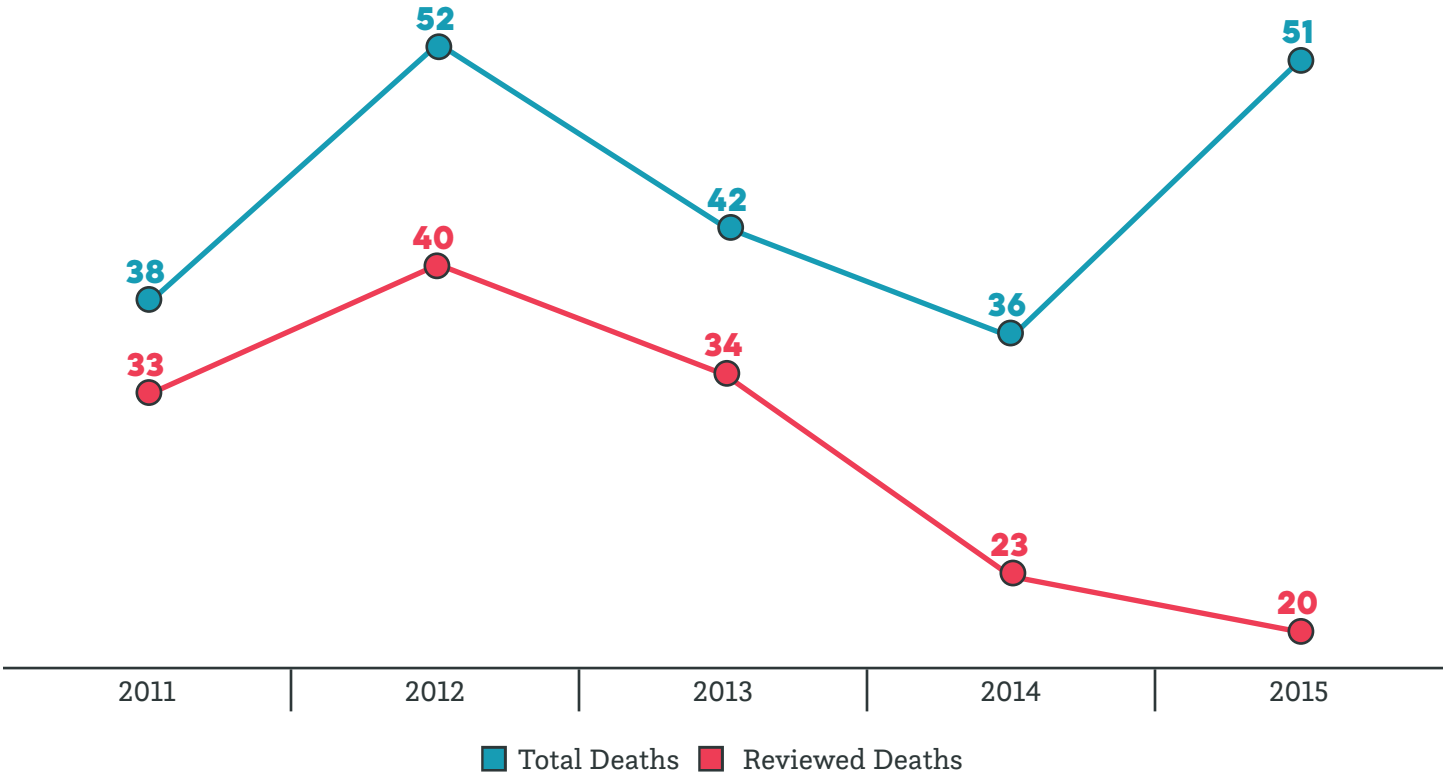
OWNER OF THE FIREARM INVOLVED 2015 ASSAULT AND WEAPON DEATHS



MANNER OF DEATH 2015 ASSAULT AND WEAPON DEATHS



ALABAMA ASSAULT AND FIREARM DEATHS - 2011 TO 2015



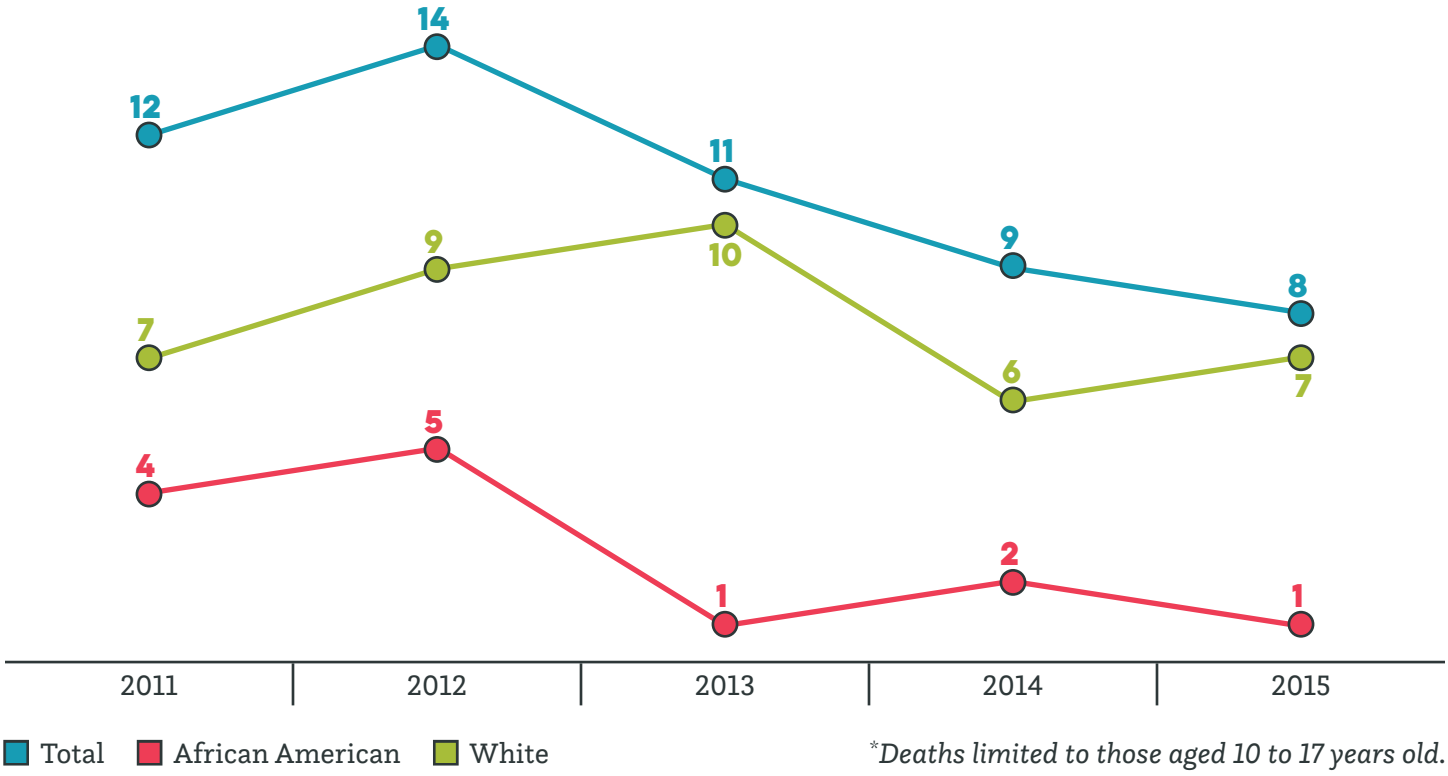
SUICIDE*					
Race	**2011**	**2012**	**2013**	**2014**	**2015**
Total	12	14	11	9	8
African American	4	5	1	2	1
White	7	9	10	6	7
Hispanic	1	0	0	1	1
Non-Hispanic	10	14	11	8	7

**Deaths limited to those aged 10 to 17 years old.*

HOMICIDE‡					
Race	**2011**	**2012**	**2013**	**2014**	**2015**
Total	21	23	18	10	10
African American	17	13	15	7	4
White	4	9	3	3	6
Hispanic	0	1	1	0	2
Non-Hispanic	21	22	16	10	9

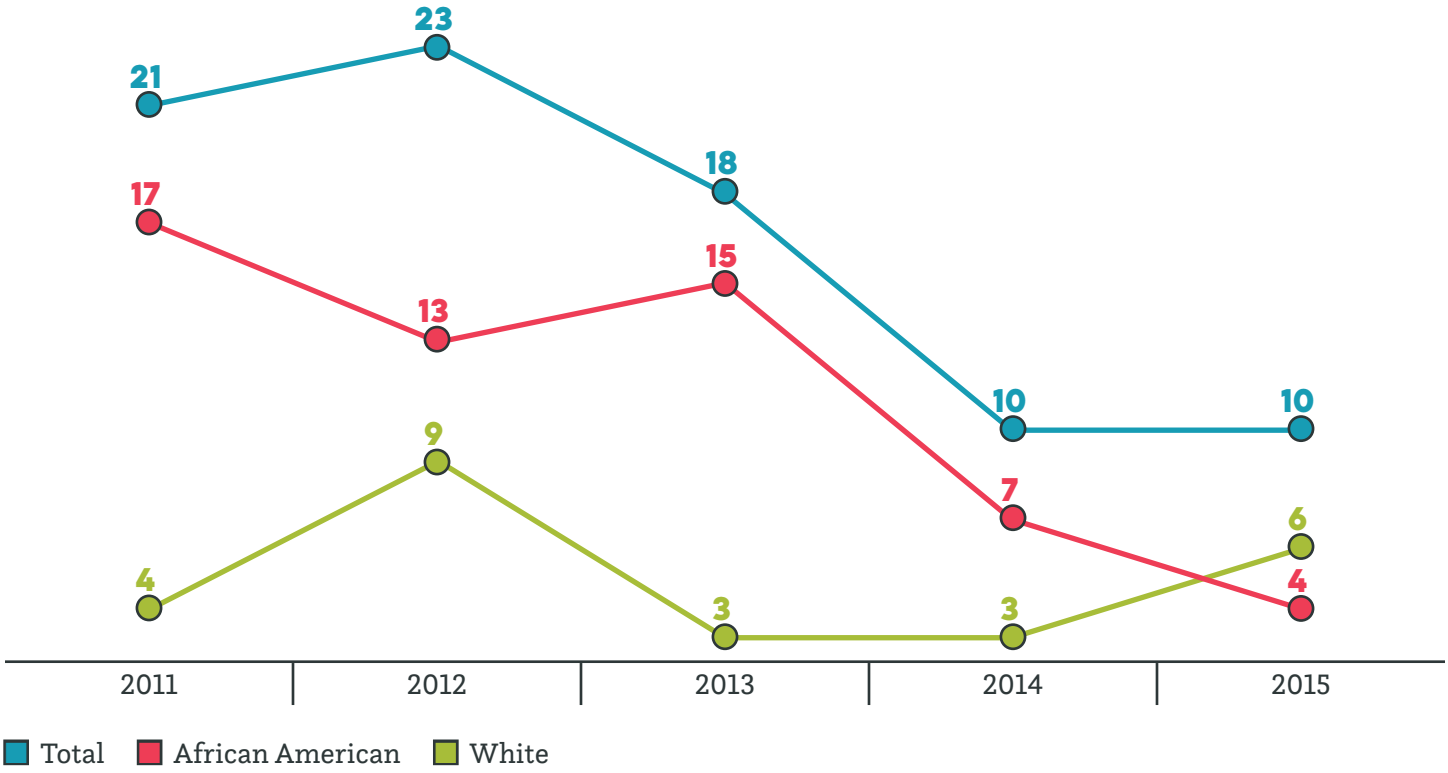
‡All ages included (0 to 17 years of age).

SUICIDES* AMONG CHILDREN BY RACE 2011 TO 2015 REVIEWED CASES



*Deaths limited to those aged 10 to 17 years old.

HOMICIDES AMONG CHILDREN BY RACE 2011 TO 2015 REVIEWED CASES



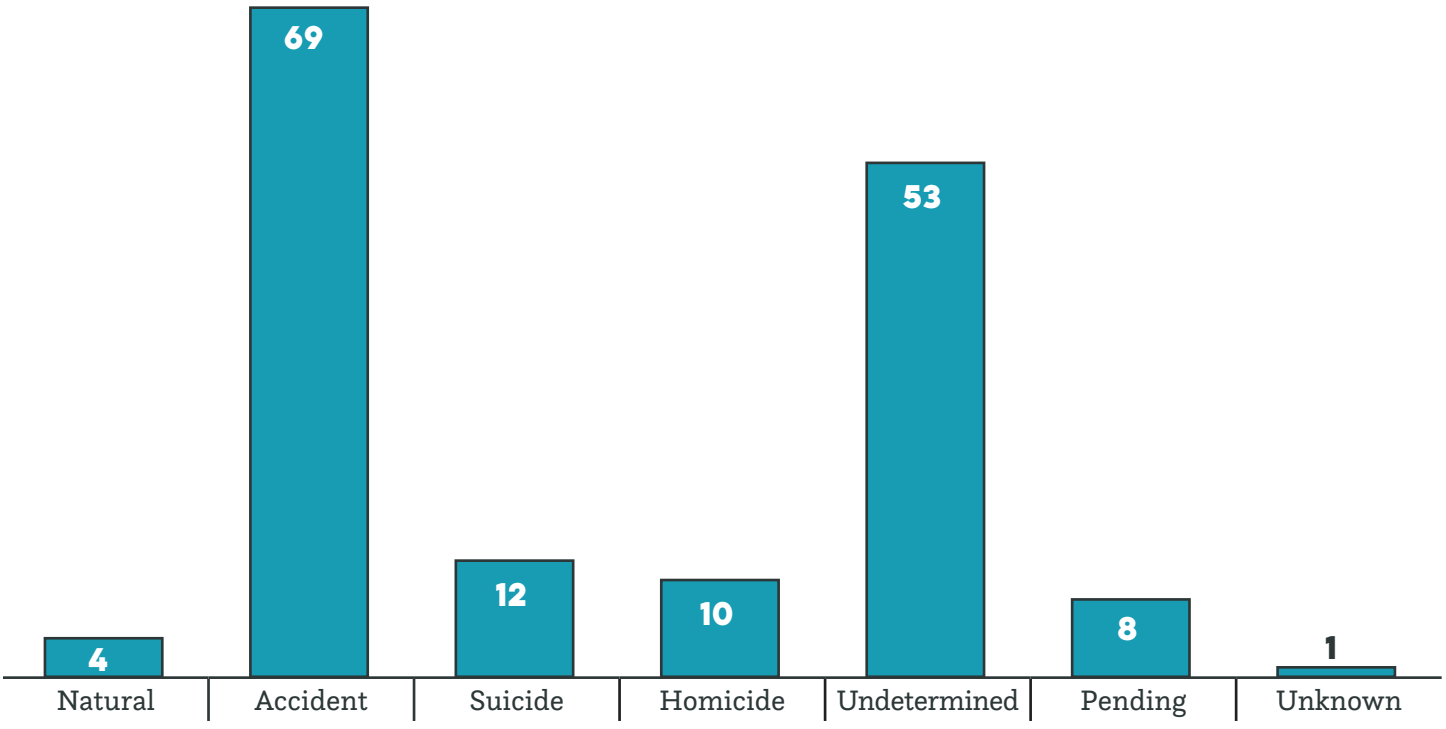
MANNER OF DEATH: (REVIEWED CASES)

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:

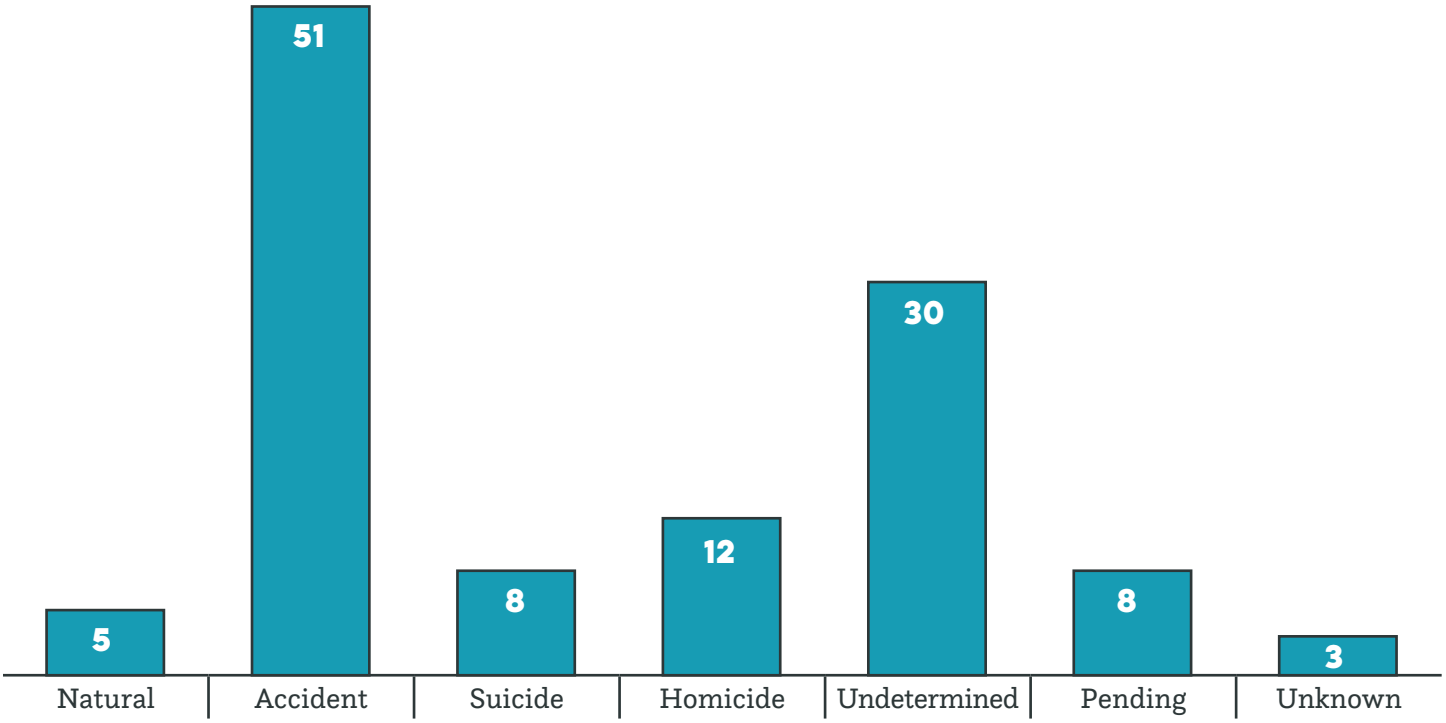
1. *Pending Investigation:* a death which is still under review by coroners or medical examiners.
2. *Accident:* a death resulting from a non-intentional injury.
3. *Homicide:* a death resulting from an intentional act committed by another person to cause fear, harm, or death.
4. *Suicide:* a death that 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, birth defect, or 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.

MANNER OF DEATH 2014 REVIEWED CASES



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

MANNER OF DEATH 2015 REVIEWED CASES



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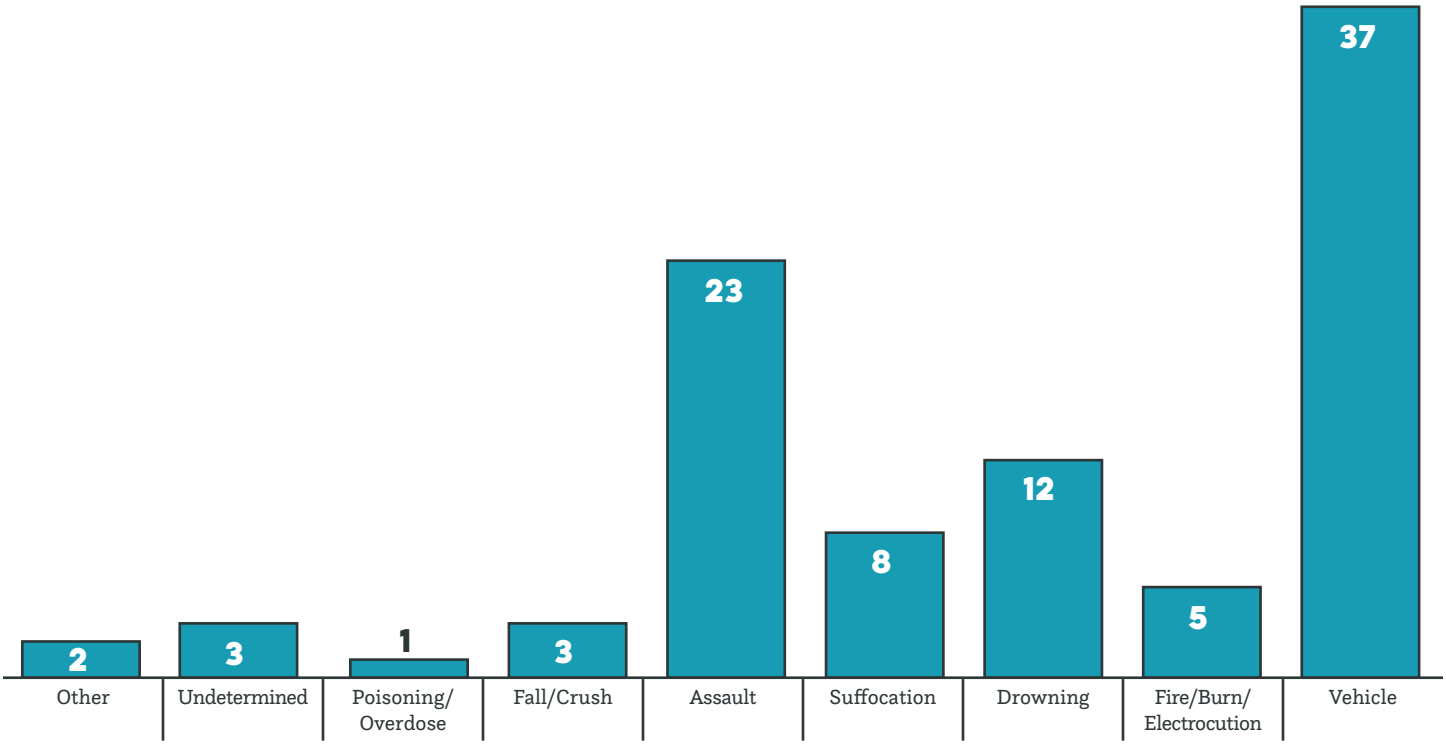
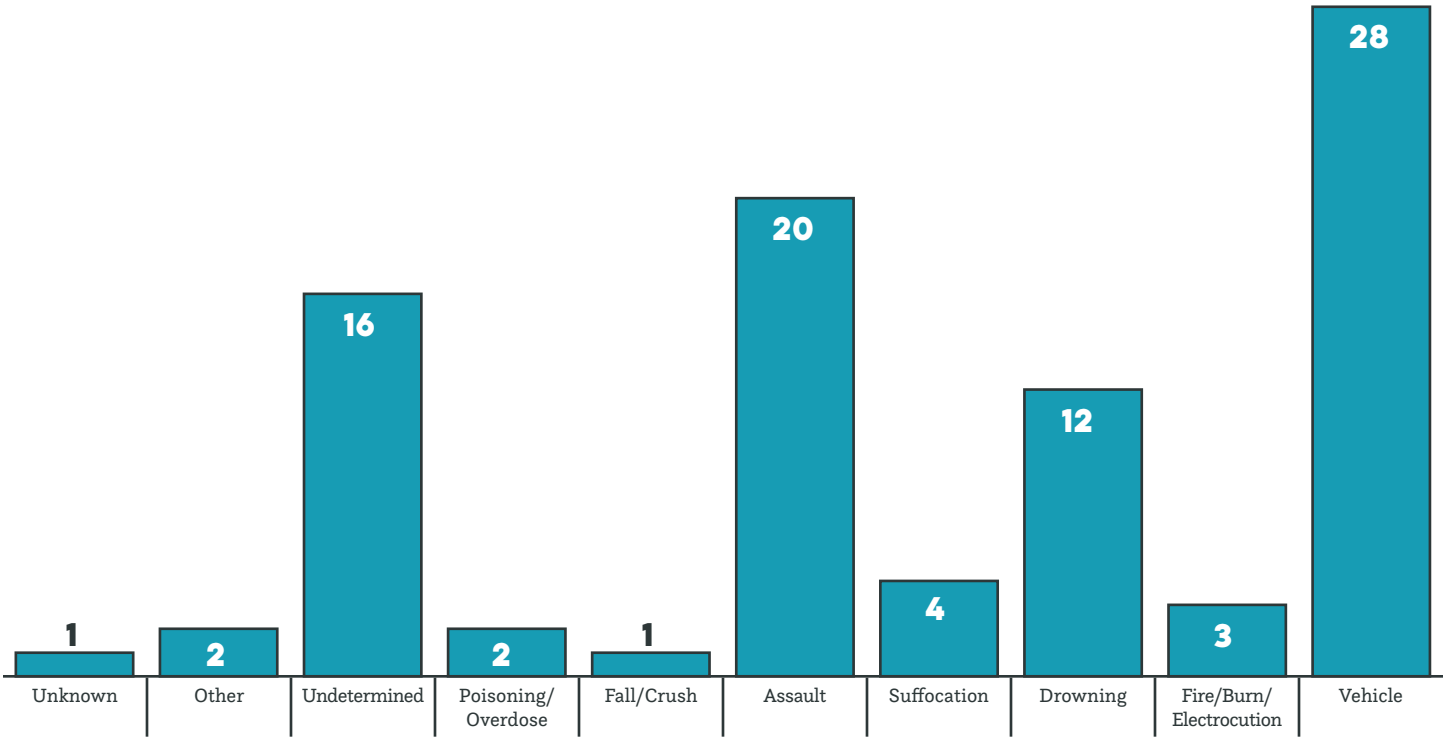
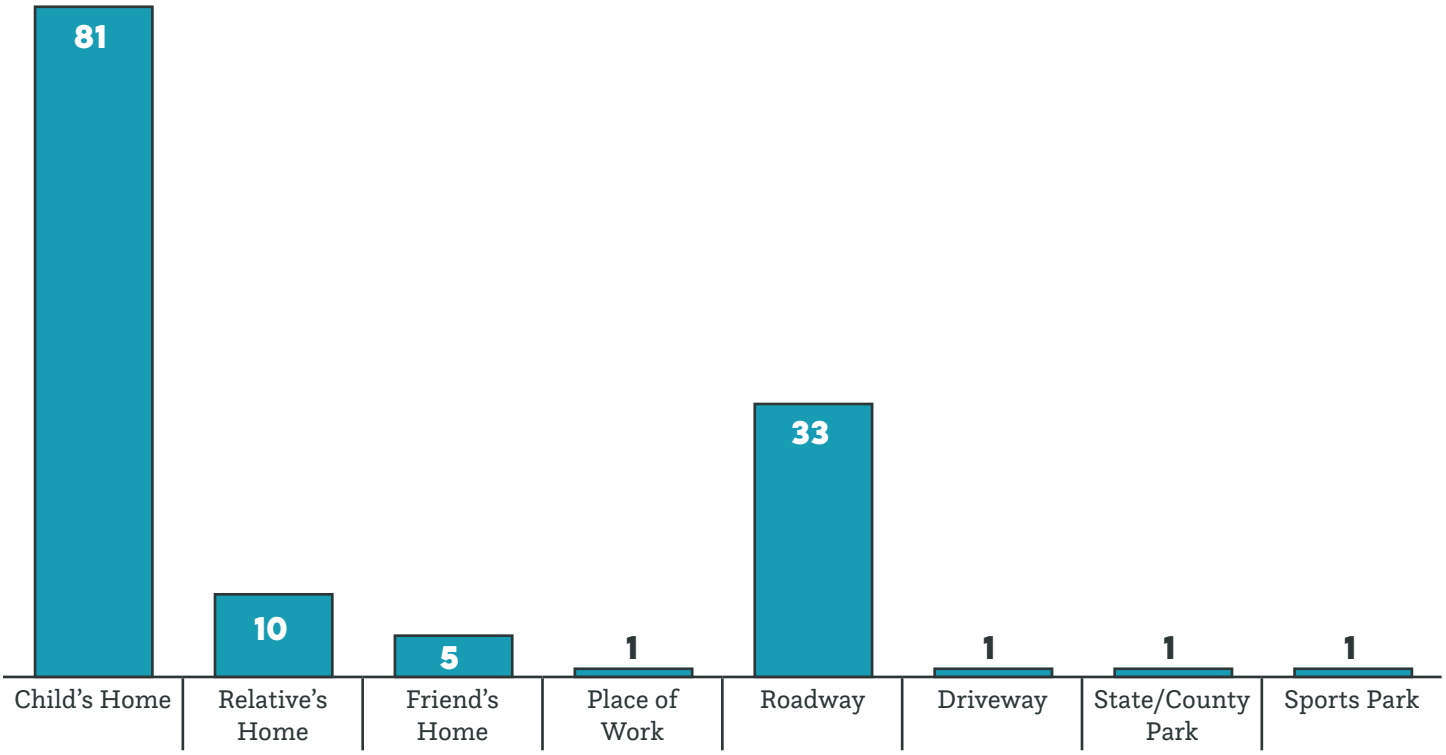
CAUSE OF DEATH: INJURY BY TYPE 2014 DEATHS



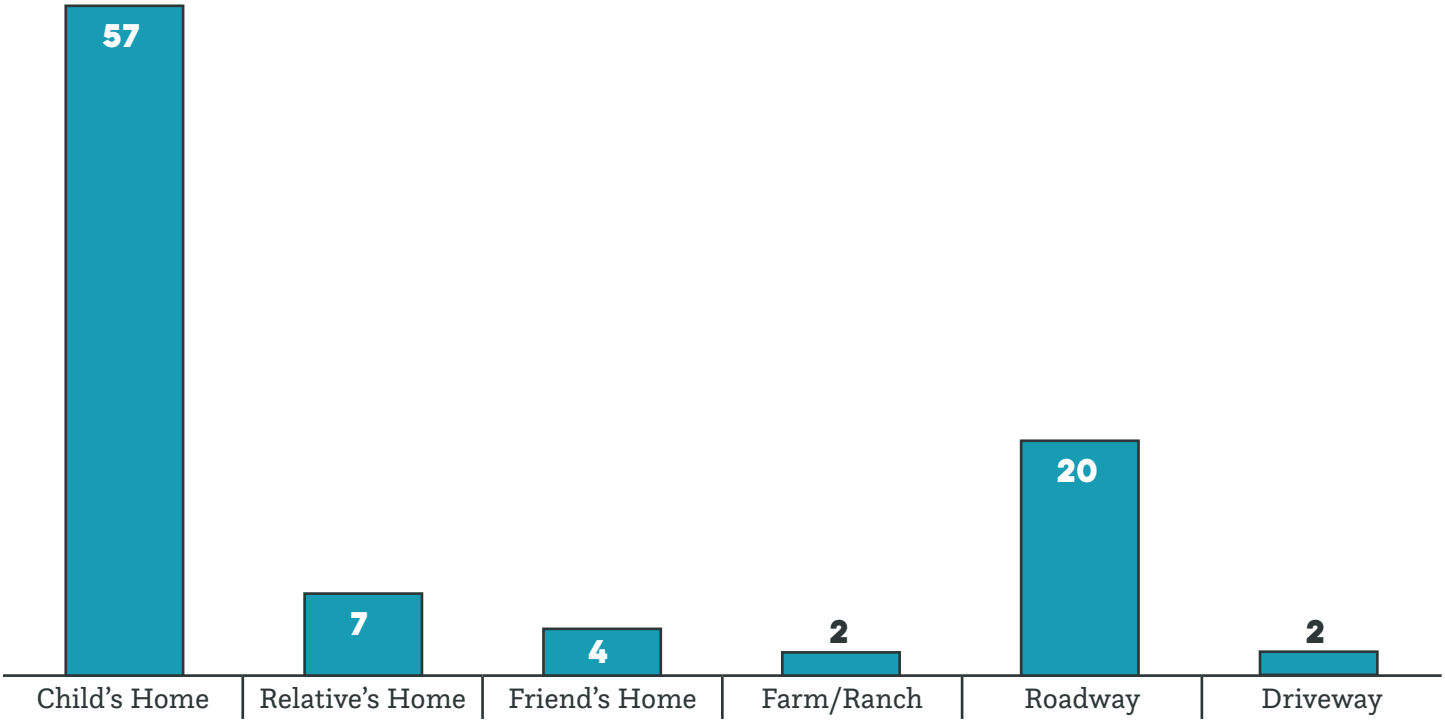
CAUSE OF DEATH: INJURY BY TYPE 2015 DEATHS



CHILD'S PLACE OF DEATH 2014 REVIEWED CASES



CHILD'S PLACE OF DEATH 2015 REVIEWED CASES

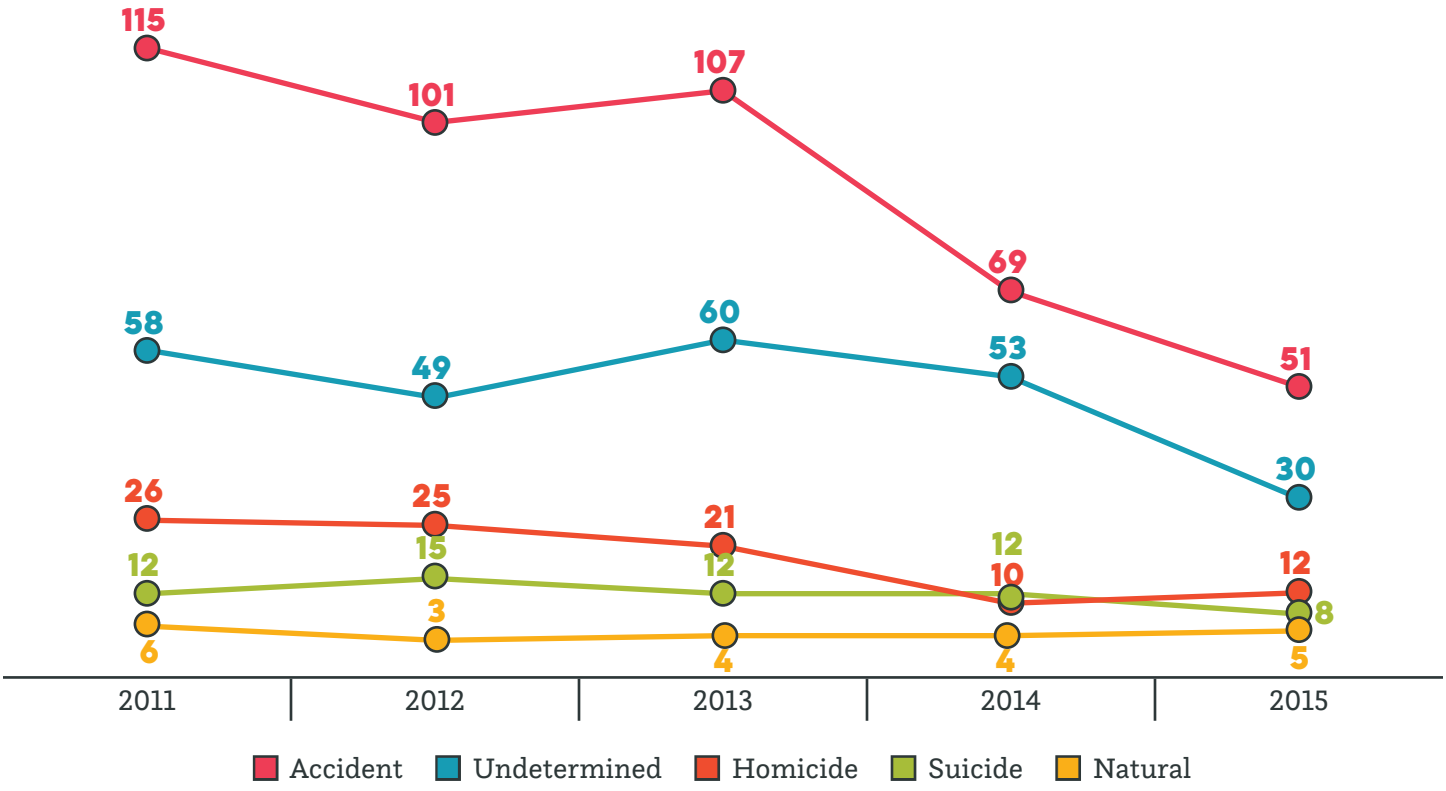


TRENDS BY MANNER AND CAUSE OF DEATH: (REVIEWED CASES)

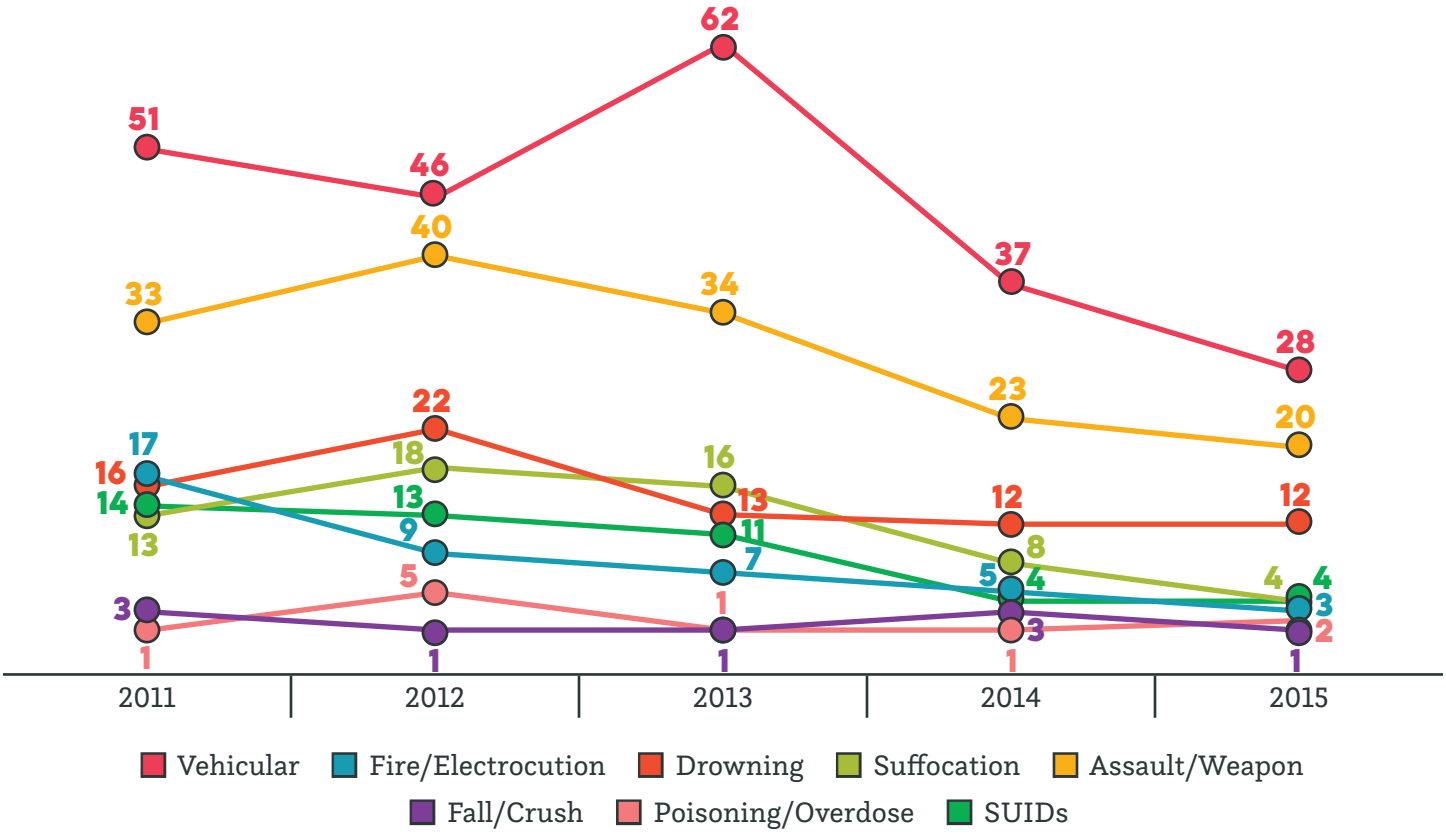
Manner of Death: Reviewed Cases	2011	2012	2013	2014	2015
Natural	6	3	4	4	5
Accident	115	101	107	69	51
Suicide	12	15	12	12	8
Homicide	26	25	21	10	12
Undetermined	58	49	60	53	30

Cause of Death: Reviewed Cases	2011	2012	2013	2014	2015
Vehicular	51	46	62	37	28
Fire/Electrocution	17	9	7	5	3
Drowning	16	22	13	12	12
Suffocation	13	18	16	8	4
Assault/Weapon	33	40	34	23	20
Fall/Crush	3	1	1	3	1
Poisoning/Overdose	1	5	1	1	2
SUIDs	14	13	11	4	4

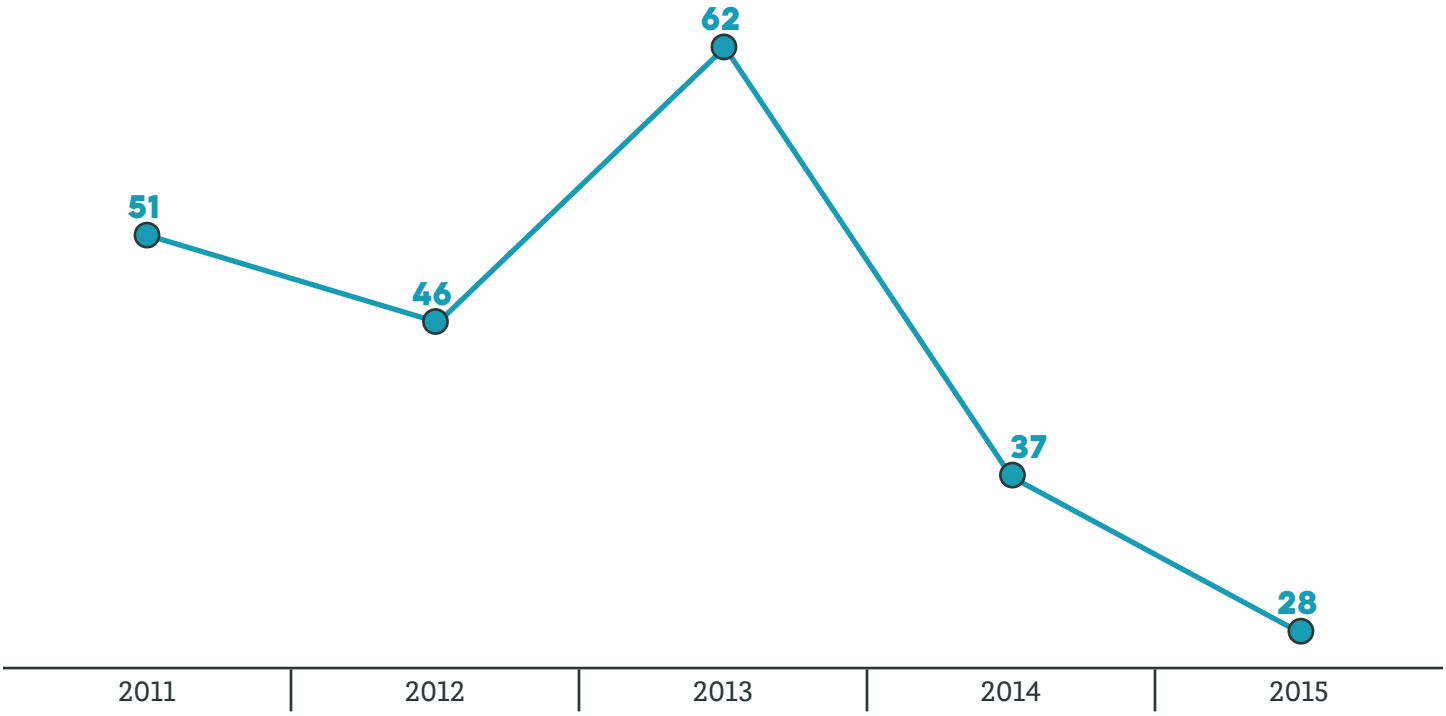
MANNER OF CHILD DEATH FOR REVIEWED CASES - 2011 TO 2015



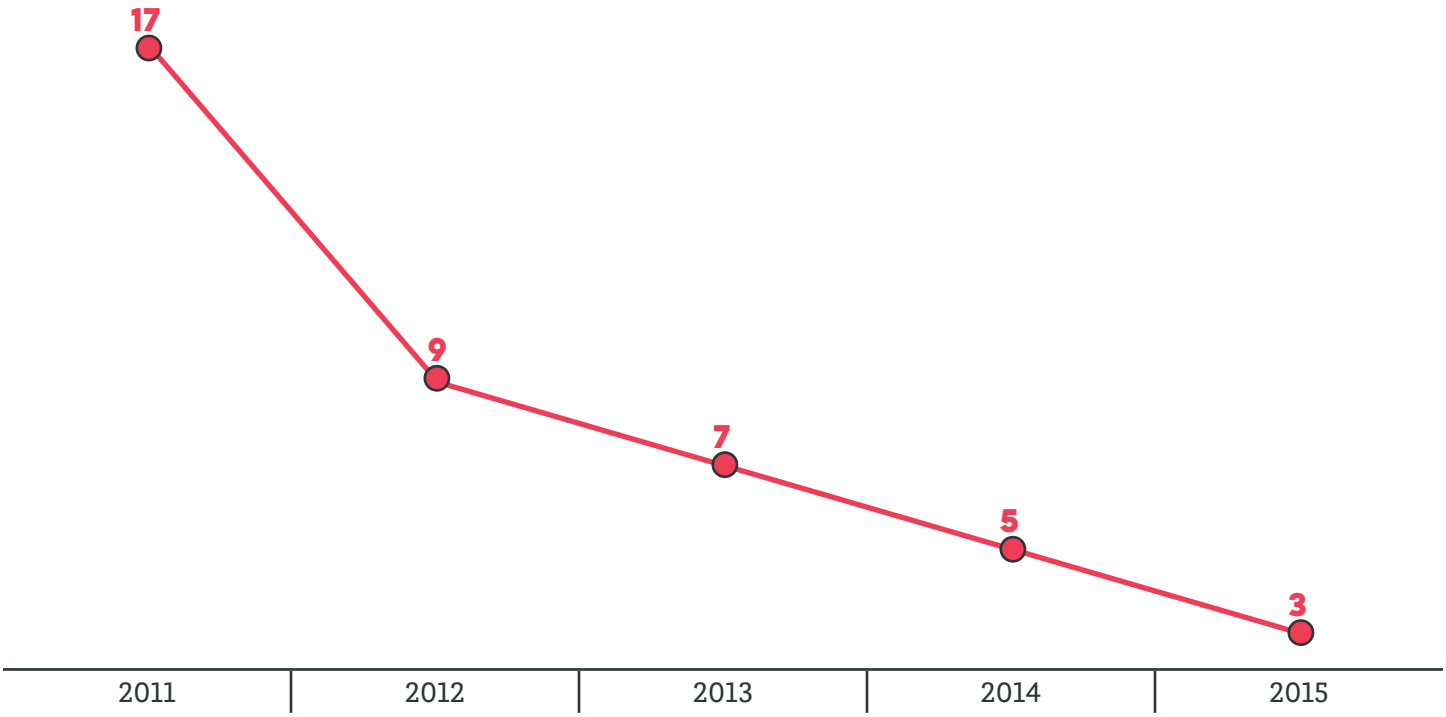
CAUSES OF CHILD DEATH FOR REVIEWED CASES - 2011 TO 2015



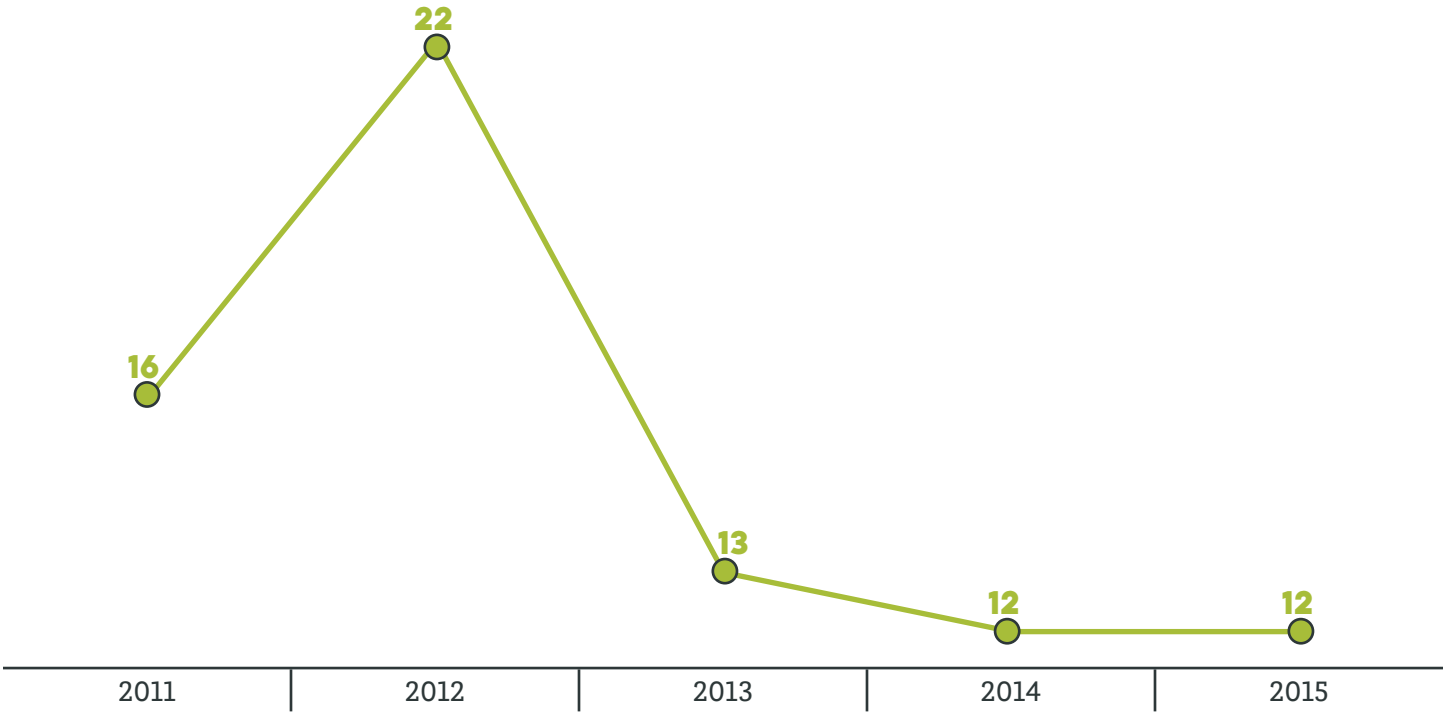
REVIEWED VEHICULAR ACCIDENT DEATHS - 2011 TO 2015



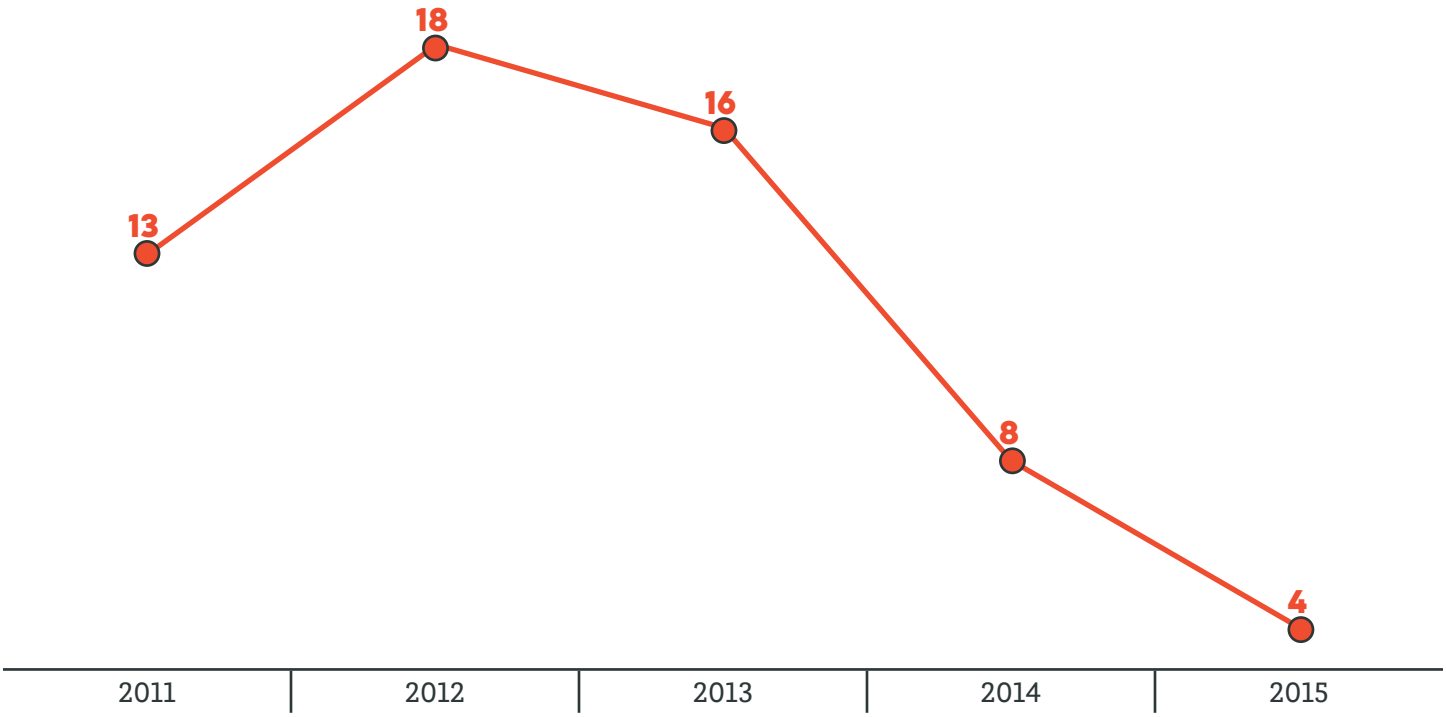
REVIEWED FIRE, BURNS, OR ELECTROCUTION DEATHS - 2011 TO 2015



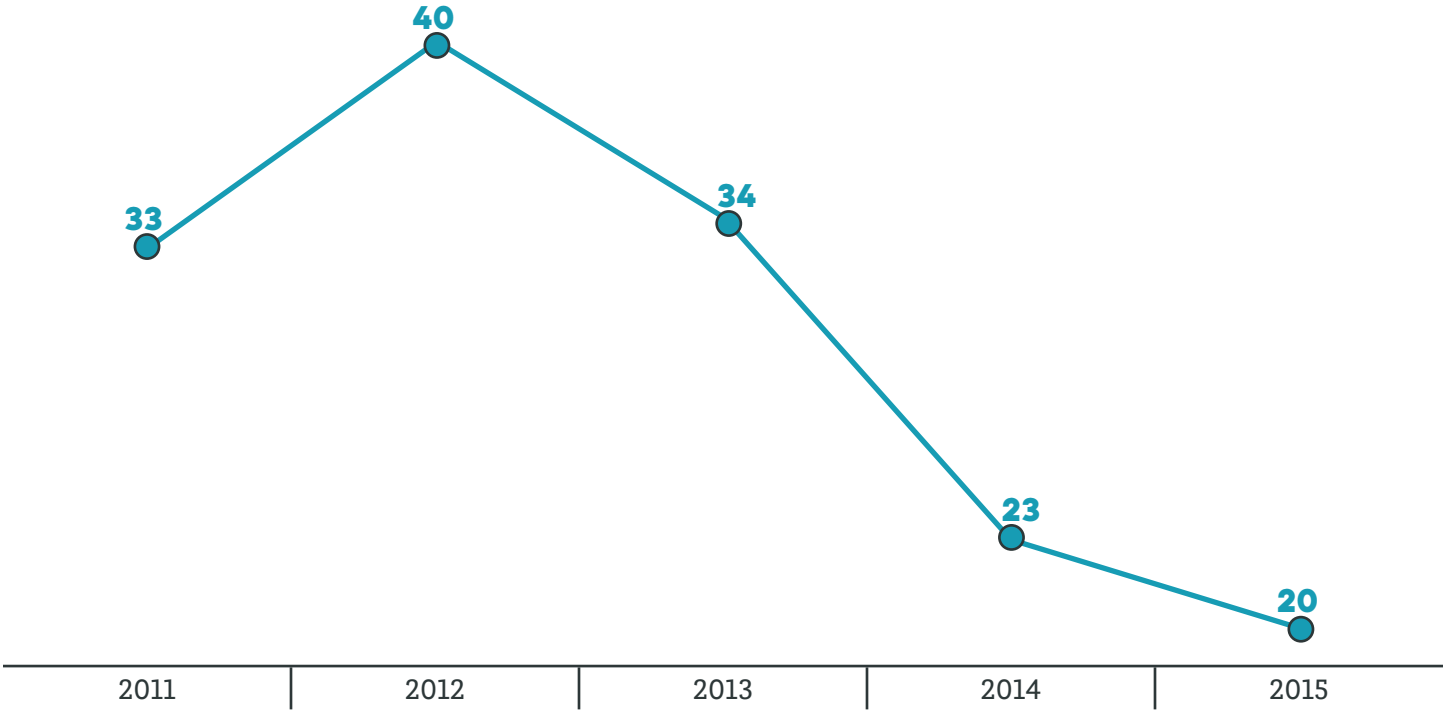
REVIEWED DROWNING DEATHS - 2011 TO 2015



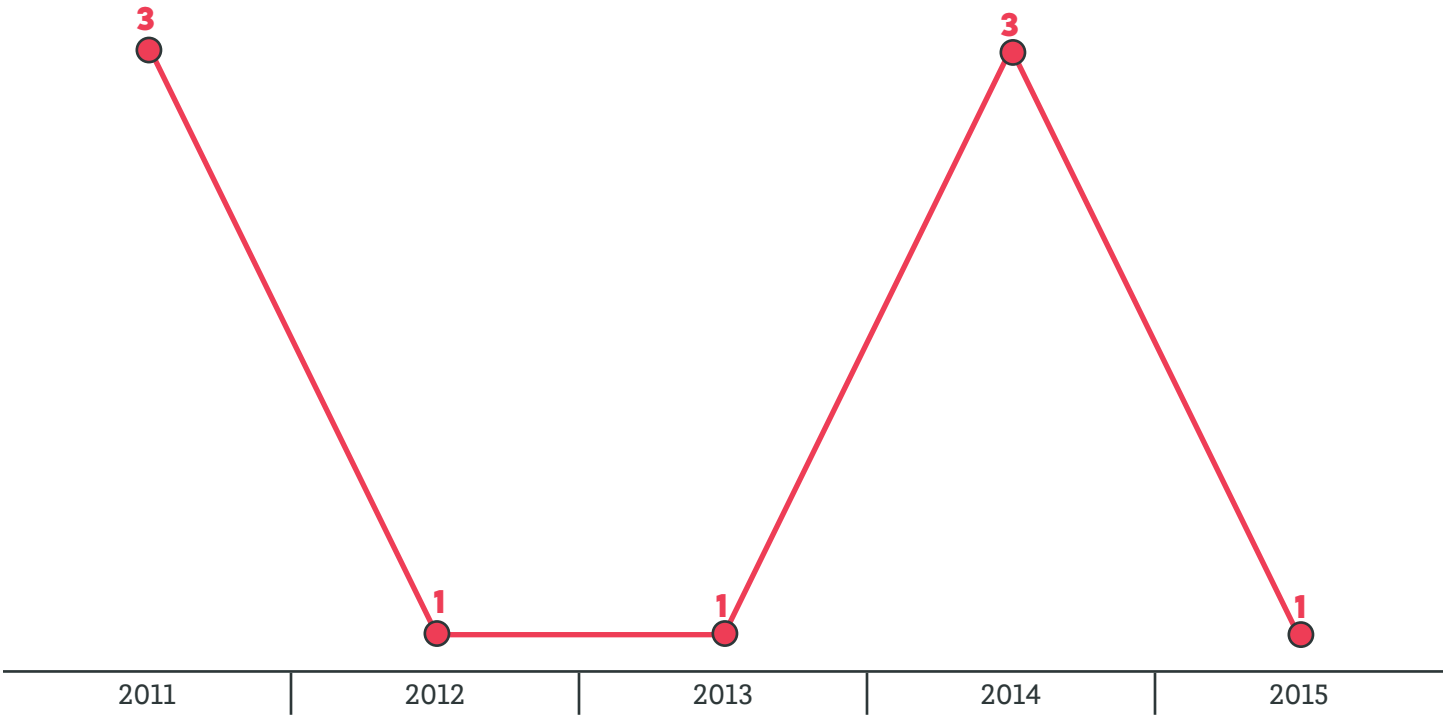
REVIEWED SUFFOCATION-RELATED DEATHS - 2011 TO 2015



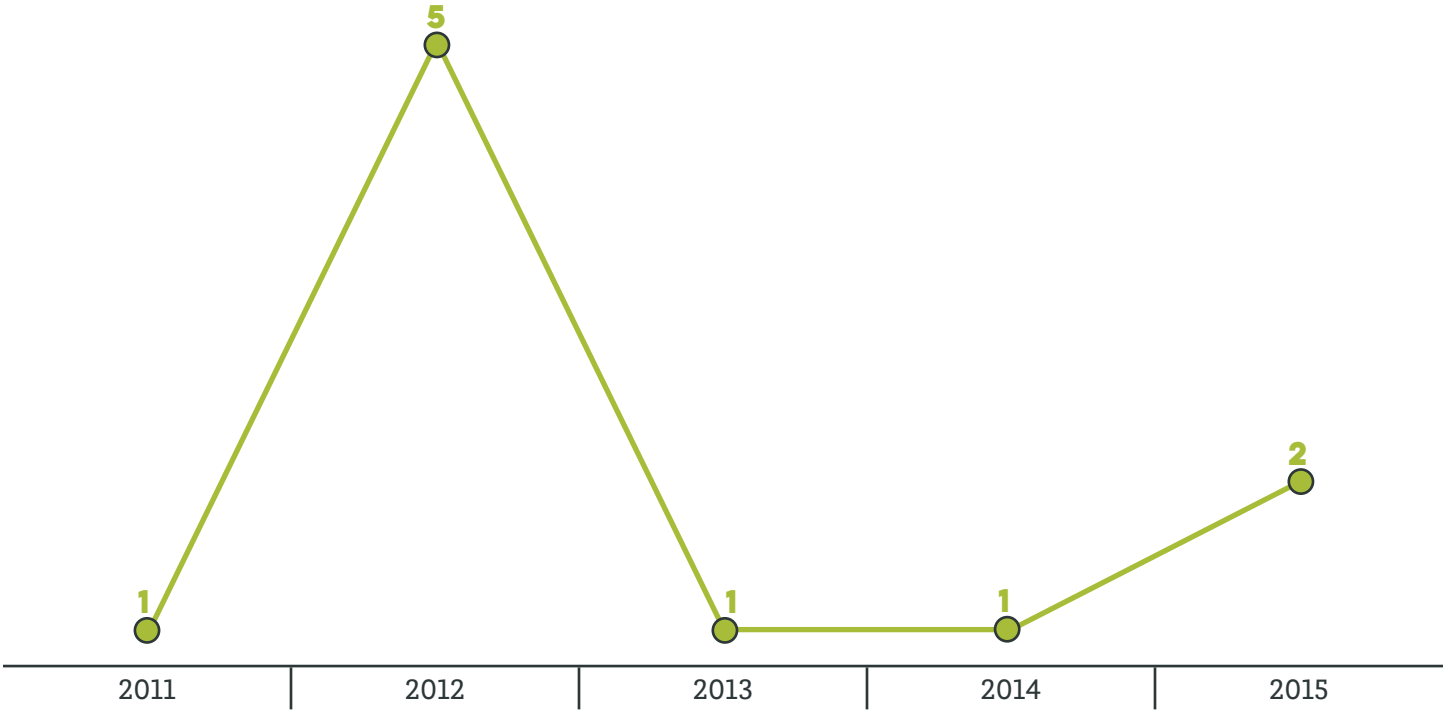
REVIEWED FIREARM, WEAPON, OR ASSAULT DEATHS - 2011 TO 2015



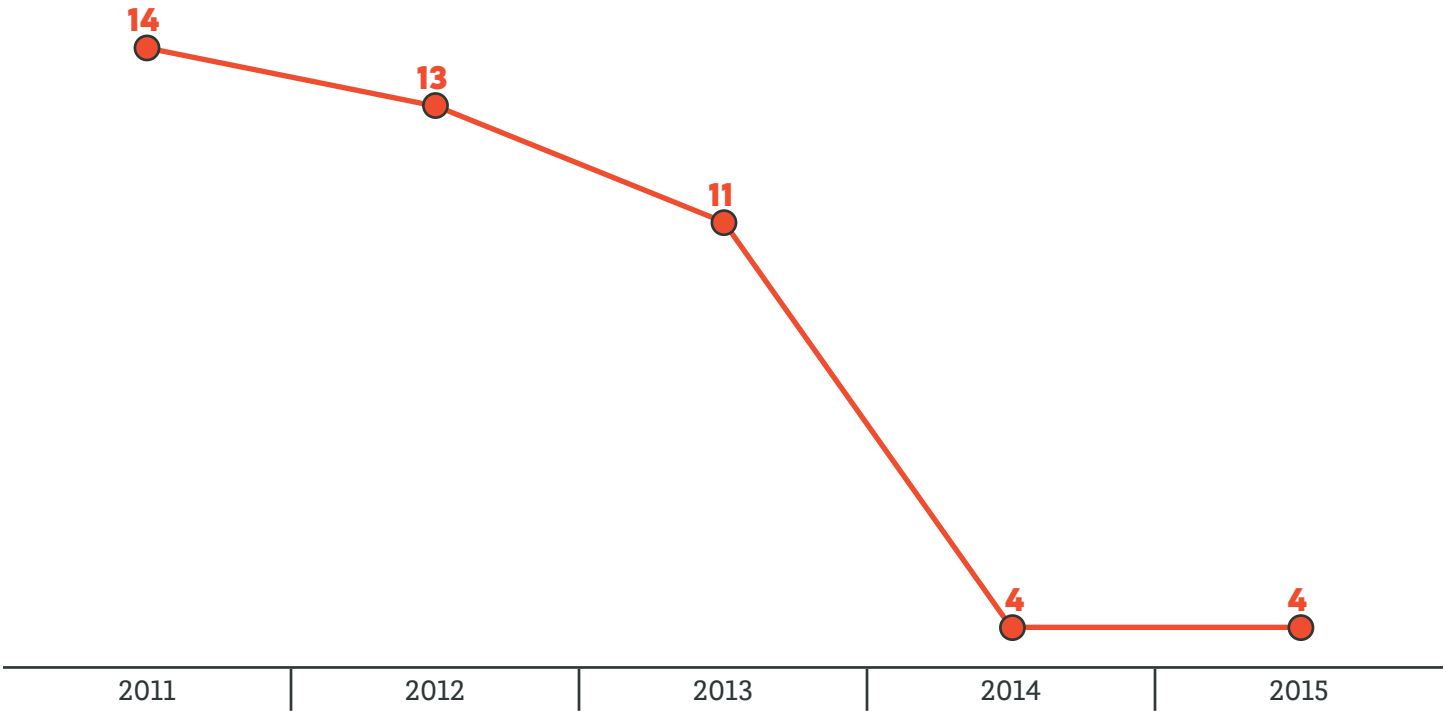
REVIEWED FALL OR CRUSH DEATHS - 2011 TO 2015



REVIEWED POISONING OR OVERDOSE DEATHS - 2011 TO 2015



REVIEWED SUDDEN UNEXPLAINED INFANT DEATHS - 2011 TO 2015



2018 RECOMMENDATIONS TO THE GOVERNOR AND LEGISLATURE

SCDRT RECOMMENDS THE FOLLOWING: IMPLEMENT PREVENTION EDUCATION

STATEWIDE

- Use innovative channels such as social service agencies, houses of worship, and YMCA to implement prevention education statewide.
- Improve media coverage on suicide prevention to encourage those who are vulnerable or at risk to seek help.
- Implement public education and awareness campaigns about the need for adult supervision around open bodies of water.
- Support annual suicide prevention education in schools to promote emotional well-being and connectedness among the entire school community.
- Expand and mandate Sudden Unexpected Infant Death Investigation (SUIDI) Training for emergency medical services (EMS), law enforcement, coroners, and child protective services.
- Encourage the safe storage of lethal means by distributing gun locks as a safety precaution.
- Provide new parent education.
- Increase rural car seat distribution/education.
- Prevent co-sleeping through public education and awareness campaigns.

BUILD PARTNERSHIPS TO SERVE ALABAMA'S CHILDREN AND FAMILIES

- Establish a partnership with Nurse-Family Partnership.
- Increase collaboration with the Alabama Suicide Prevention and Resources Coalition.
- Encourage implementation of a Drug Abuse Task Force.

EDUCATE, ENFORCE, AND IMPROVE GRADUATE DRIVERS' LICENSE POLICY

- Educate parents and law enforcement of Graduate Driver's License (GDL) Law.
- Support further enhancement of the GDL Law by improving night driving restrictions for teen drivers (10 PM-5 AM).
- Create a questionnaire to add to drivers' education exam.
- Implement Statewide Teen Driver Safety Course for high school seniors.

COOPERATE AND COLLABORATE FOR LEGISLATIVE ACTION

- Improve ACDRS case review rates by considering alternative lead agencies for LCDRTs.
- Improve gun safety laws.

IMPROVE PUBLIC AND PRIVATE FUNDING FOR CHILDREN'S SERVICES

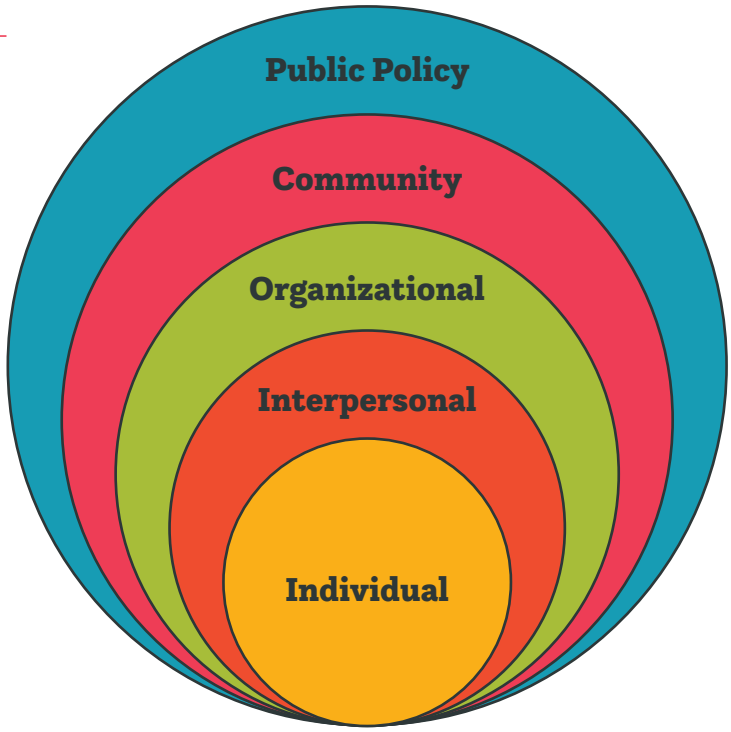
- Advocate for increased funding for children's services.
- Increase funding for mental health.
- Explore private funding as an avenue for additional support of ACDRS.

CREATE A COMPREHENSIVE DATA SYSTEM TO IMPROVE PREVENTION INITIATIVES

- Establish a central database for coroners and medical examiners.
- Increase collection and utilization of data.

THE SOCIAL-ECOLOGICAL MODEL: A FRAMEWORK FOR PREVENTION

Preventing child death requires a focused approach based on data and evidence. SCDRT recommendations to the legislature are based on the analysis of 2014 and 2015 ACDRS data and the Social-Ecological Model of Health Promotion.



The individual level represents the individual who might be affected by child injury and death risk factors. SCDRT recommends implementing prevention strategies that will increase the individual's knowledge and influence attitudes and beliefs regarding:

- Bed-sharing, prone sleep positioning, and excess bedding.
- Safer storage of lethal means (e.g., firearms, medications, sharp objects, etc.).
- Child maltreatment.

The interpersonal level examines close relationships that may increase the risk of child injury and death. SCDRT recommends implementing prevention strategies that will facilitate individual level behavior change by affecting social and cultural norms regarding:

- Education and family support to encourage positive child development.
- Parenting focused prevention programs.

The organizational level represents changing individual behaviors by influencing organizational systems (e.g., local health departments, coalitions, law enforcement, etc.). SCDRT recommends the following prevention strategies that are appropriate for this level:

- Expanding and mandating SUIDI Training for EMS, law enforcement, coroners, and child protective services to obtain better investigative data for child-injury cases and sleep-related deaths.
- Identifying innovative channels and agencies to establish partnerships for prevention education.

The community level focuses on identifying child injury and death risk factors within settings where relationships take place (e.g., schools, workplaces, neighborhoods, etc.). SCDRT recommends implementing prevention strategies that will improve the community response within these settings by:

- Approaching mental health as a community issue.
- Providing access to statewide prevention education.
- Conducting public awareness and educational campaigns.
- Collaborating with coalitions to expand resources.

The public policy level represents child injury and death prevention at the policy level. SCDRT recommends affecting change at the policy level by:

- Translating the GDL Law to parents and law enforcement statewide.
- Collaborating with coalitions and other community organizations to change or develop new teen driver safety policies, suicide prevention initiatives, and new parent education policies.
- Improving gun safety laws.

SUIDI TRAININGS

In order to improve data quality and reduce sleep-related deaths, ACDRS conducted six SUIDI training sessions. The purpose of these trainings was to standardize investigation protocols and reporting. Death scene investigations and autopsy findings play a critical role in providing information that may better explain how or why infants die suddenly and unexpectedly. The Centers for Disease Control and Prevention (CDC) established standardized tools and protocols adopted nationwide, for SUIDI. Each session provided training on these protocols for law enforcement, EMS, district attorneys, medical examiners, coroners and child protective services. ADPH social workers and nurses were also in attendance. Participants learned the skills that are necessary to provide investigations that will lead to a more accurate determination of the cause of injury and the persons responsible. CDC's standardized reporting forms, SUIDI dolls, and demonstration dolls were distributed to investigators. The training curriculum aligned with CDC's SUIDI guidelines. Investigators learned how to conduct witness interviews, doll reenactment, and develop narrative reports for forensic pathologists. At completion of the training, investigators were given the necessary tools and knowledge to accurately complete the SUIDI reporting form. These trainings 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. Thorough and standardized investigations will assist ACDRS in obtaining better data. Better data will lead to improved and targeted prevention strategies statewide.

ACDRS'S PREVENTION INITIATIVES

ACDRS reviewed more than 4,000 child deaths since enactment of the Child Death Review Law. As a result of these reviews, special interest programs such as the Teen Driver Safety Campaign, Alabama SUIDI Team, The Booster Seat Advocacy Program, and the Healthy Start: Never Ever Shake a Baby Program have been developed. In 2017, ACDRS's Teen Driver Safety Campaign collaborated with various state agencies to host teen driving summits across the state. As a result, a total of 791 students from 60 different schools in 31 counties were educated on topics such as the GDL Law, texting or drinking while driving, and more. ADPH has Child Passenger Safety Technicians certified through Safe Kids to educate caregivers on proper installation of their child's car seat. In addition to educating caregivers on proper installation, pregnant women and families receiving federal assistance are eligible to receive a car seat provided by ACDRS. In 2017, a total of 1,522 seats were provided to children of eligible families.

ACDRS contributed to legislation such as the GDL Law which was passed in 2002 and enhanced in 2017, and the SUIDI Law which was passed in 2011. As a result of the SUIDI Law, ACDRS implemented Child Injury and Death Scene Re-enactment and Scene Reconstruction Trainings statewide where 262 individuals were trained across a 2-year period. ACDRS continues to rely on SCDRT, LCDRTs, strategic partners, and the public to promote the program's mission. Although significant improvements have been made, ACDRS will continue to make strides that reduce child death through awareness, education, and prevention efforts.

SPECIAL THANKS FROM ADPH CENTRAL OFFICE STAFF

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 LCDRTs and SCDRT contributed significantly to identifying the leading causes of death in Alabama and developing prevention strategies. Our hope is that we continue to discover ways to prevent the untimely accidental deaths of many other children for years to come. On behalf of ADPH and the children of Alabama, thank you for all of the great work you have done for this program!

KEY EVENTS FOR 2019

JANUARY	State Team Meeting
APRIL	National Child Abuse Prevention Month
	Deadline for Completed 2016 Case Reviews
	State Team Meeting
JULY	State Team Meeting
SEPTEMBER	National Infant Mortality Awareness Month
	National Suicide Prevention Awareness Month
	World Suicide Prevention Day
	Child Passenger Safety Week
OCTOBER	National SIDS Awareness Month
	National Fire Prevention Week
	State Team Meeting
	National Teen Driver Safety Week