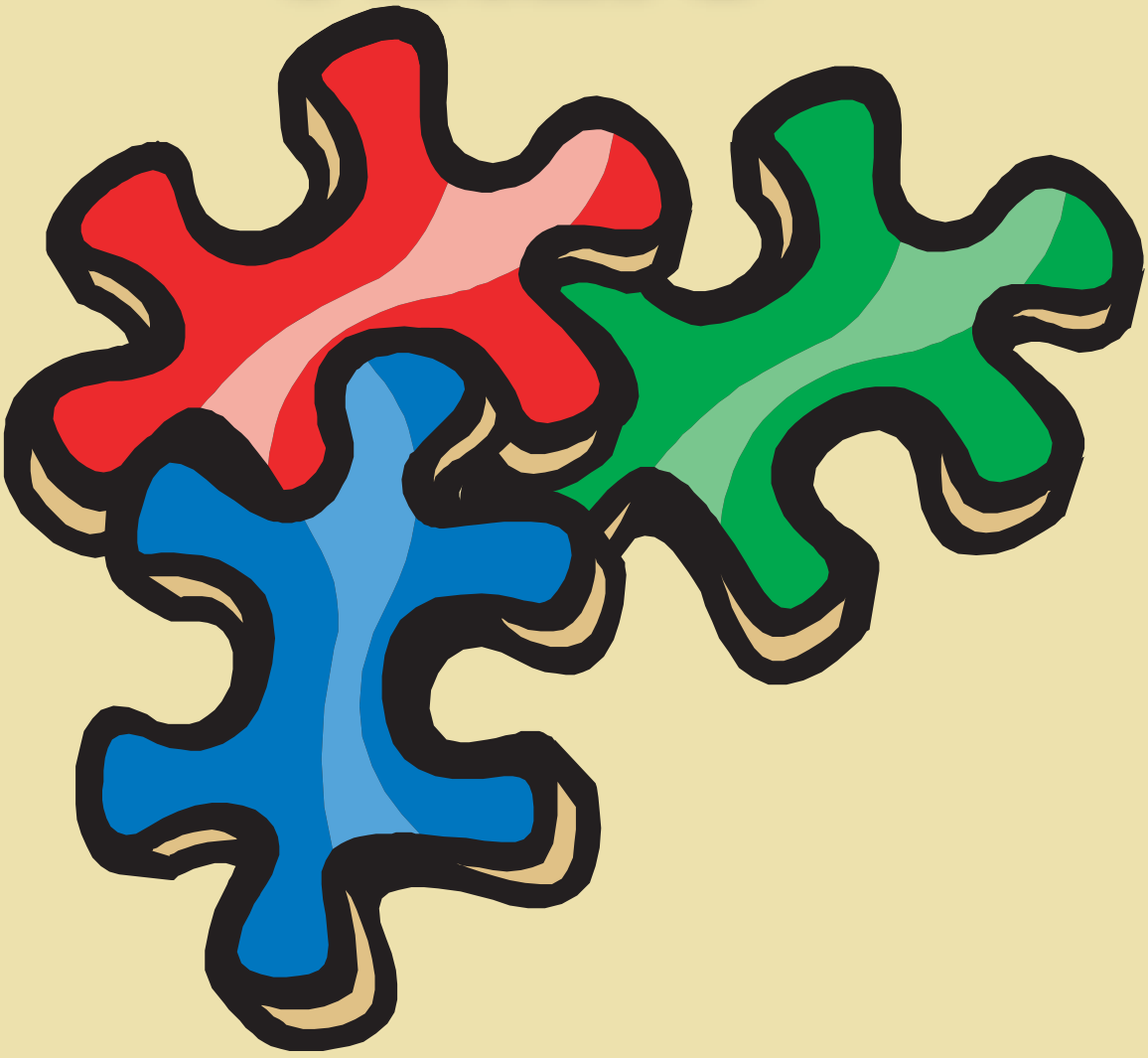
Children For Our Future



Saving Alabama's Kids...
Our Most Precious Resource

Alabama Child Death Review System
2004 Annual Report

DEATHS AMONG CHILDREN IN ALABAMA

ALABAMA CHILD DEATH REVIEW SYSTEM

ANNUAL REPORT - 2004

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May 16, 2007

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

In 1997, the ACDRS was created under state law and is funded totally by the Children First Trust Fund. The ACDRS studies the circumstances of all "unexplained or unexpected" infant and child deaths throughout the state and identifies all deaths that could be considered preventable. The findings are reported to the Governor and other state officials, as well as to the general public. In addition to collecting data, the ACDRS develops new literature and educational programs on a wide variety of topics including Sudden Infant Death Syndrome, All-Terrain Vehicle safety, and youth suicide. The data is also used to make recommendations about policy changes at the local and state levels.

The Child Death Review System is composed of the State Office, the Local Teams, and the State Team. The State Office staff is responsible for the coordination of review materials and is instrumental in creating strategies to make the public aware of ways to prevent future child deaths. The Local Team is responsible for analyzing cases sent to it by the ACDRS State Office and making recommendations about how to prevent future infant and child deaths. The State Team is comprised of 28 members who include medical and law enforcement professionals, attorneys, and legislators. This team serves as an advisory board for ACDRS. The ACDRS staff, Local Teams, State Team, and their partners remain committed to the task of preventing child deaths in Alabama through education and public awareness.

I am excited about the first five-year trend analysis included in this year's annual report. The trend analysis report covers the years 2000 through 2004 and is important to the ACDRS because it provides insight into what the program has accomplished since its inception.

Sincerely,

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

Alabama Child Deaths

2000 – 2004

There were 4,399 children under the age of 18 who died in Alabama during the years 2000 through 2004. An examination of the deaths on a year-by-year basis reveals that in 2000 there were 915 deaths, in 2001 there were 911 deaths, in 2002 there were 897 deaths, in 2003 there were 823 deaths, and in 2004 there were 853 deaths. This represents approximately 78 deaths per 100,000 children.

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

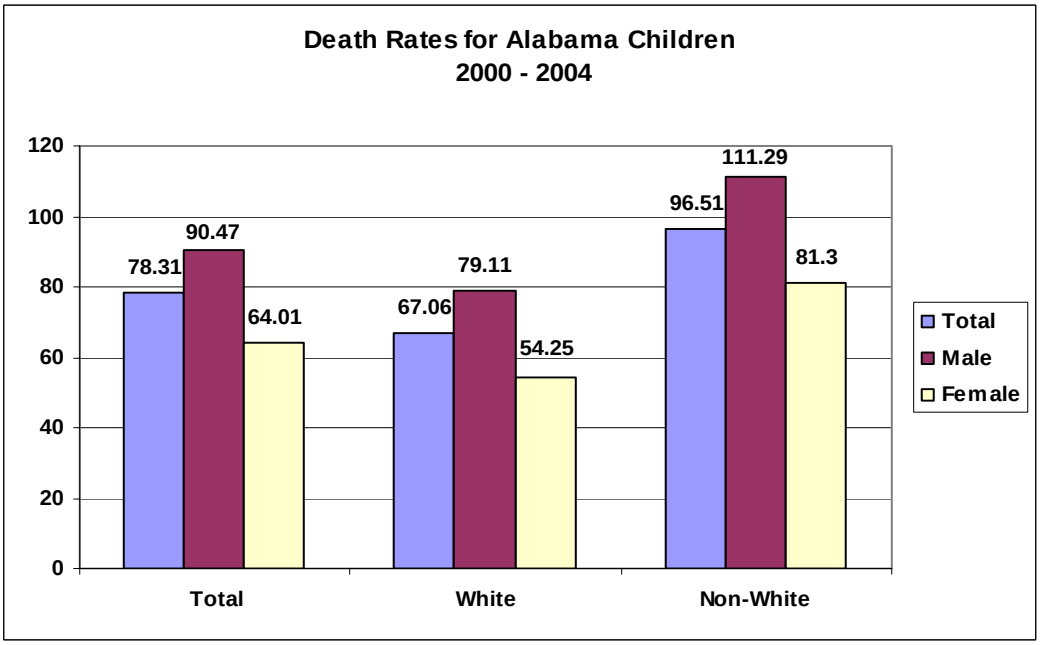
This report is a compilation of findings from Local Child Death Review Teams whose tasks are to: 1) identify factors that put a child at risk of injury or death; 2) share information among agencies that provide services to children and families or that investigate child deaths; 3) improve local investigations of unexpected/unexplained child deaths by participating agencies; 4) improve existing services and systems while identifying gaps in the community that require additional services; 5) identify trends relevant to unexpected/unexplained child deaths; and 6) educate the public about the causes of child deaths while also defining the public's role in helping to prevent such tragedies.

The Alabama Child Death Review System was created by state law in 1997 and has now been in place long enough to compile and analyze statistics on child deaths during a complete five-year period. What follows is a look at unexpected and unexplained child deaths in Alabama during the years 2000 through 2004, as well as statistics and information about the work of the ACDRS during 2004.

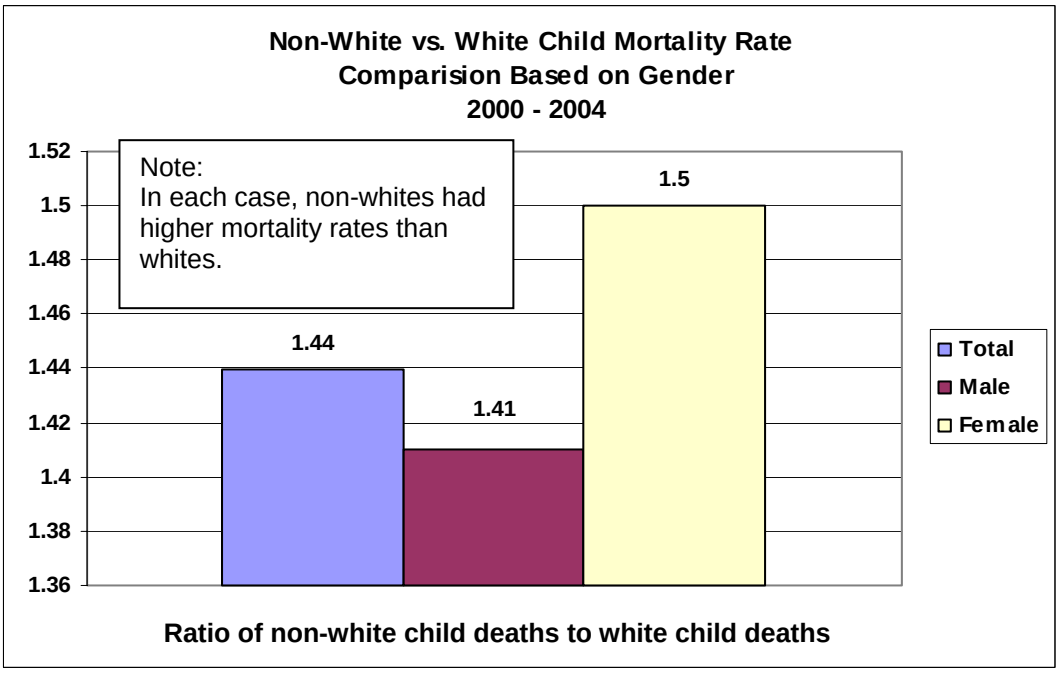
This report seeks to honor the memory of all those children who have died in Alabama. We hope that this report, and the work of the local Child Death Review Teams and the Alabama Child Death Review System, leads to a better understanding of how we can all work together to make Alabama a safer and healthier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

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

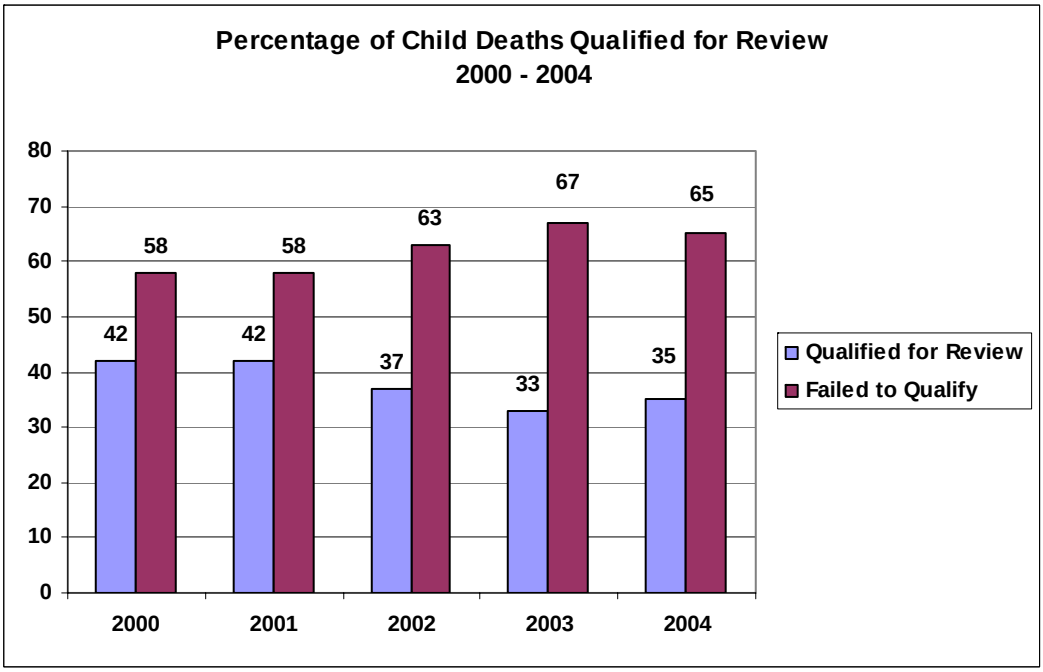
- Below is a graph showing the total race-specific and gender-specific death rates (per 100,000 children) among children in Alabama from 2000 to 2004. This allows for comparison of death rates among specific population groups.



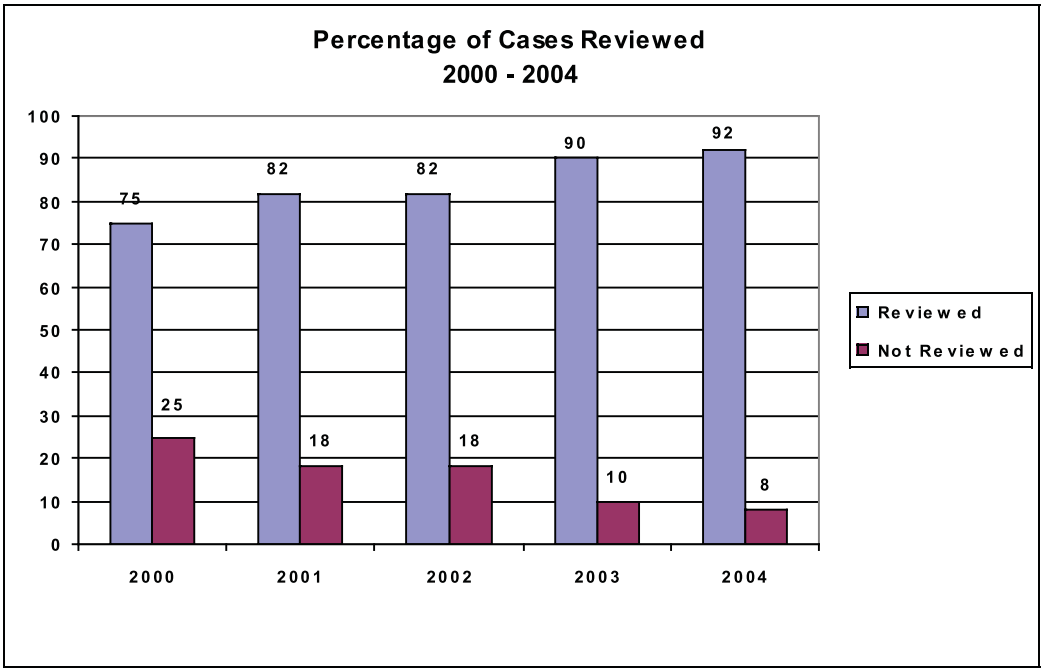
- Racial comparisons of the above rates are shown in the graph below. It should be noted that in each instance, non-whites have significantly higher mortality rates ($p < .05$) than do whites (i.e. non-white males had a child morality rate 1.41 times greater than white males).



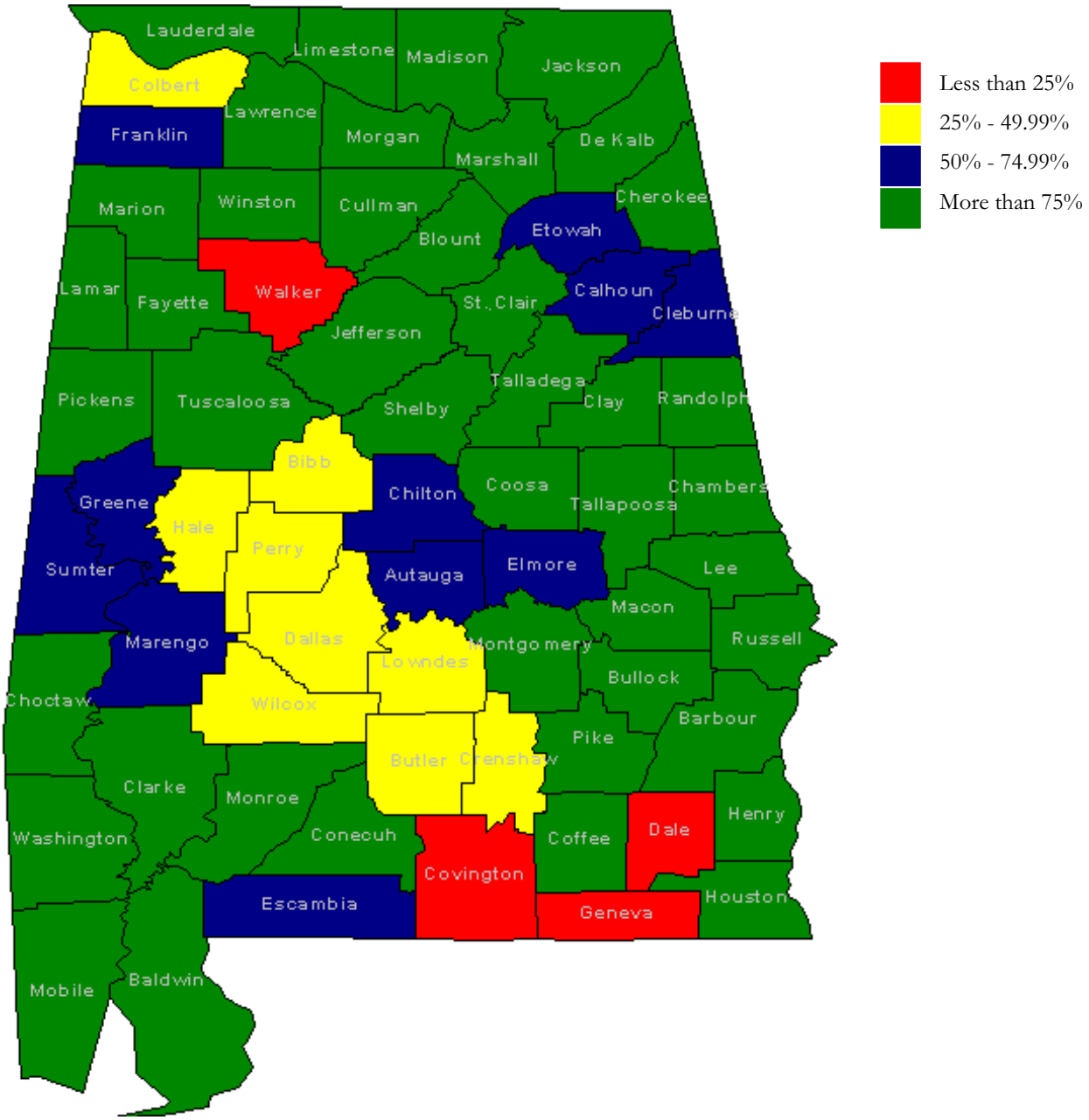
- Of the 4,399 child deaths that occurred during the years 2000 through 2004, those that qualified for review under the Alabama Child Death Review System totaled 1,675 (38 percent). The percentage of child deaths that have qualified for review has remained fairly constant over the five-year period.



- Of the total number of deaths that qualified for review during the years 2000 through 2004, the Local Child Death Review Teams reviewed and returned 1,401 cases (84 percent). The percentage of cases that qualified for review and were in fact reviewed has increased over the five-year period.

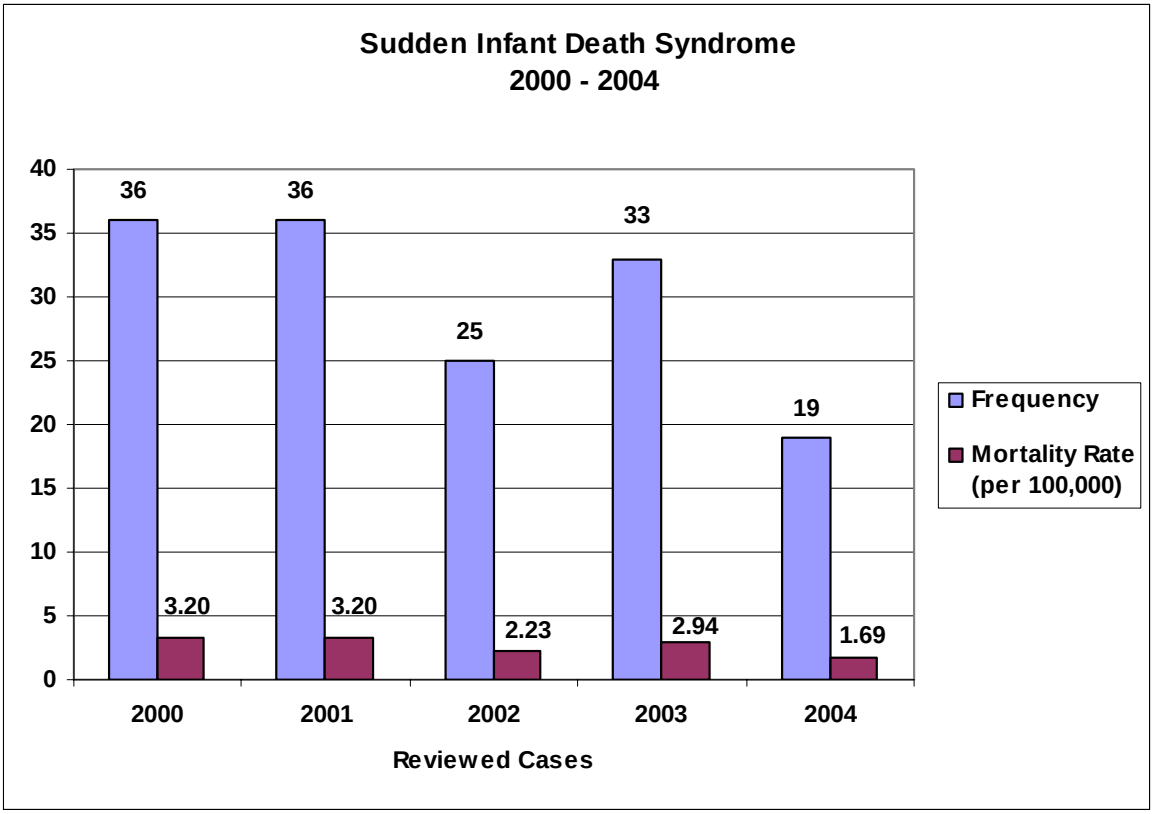


- The map below shows the case return rate of each Local Child Death Review Team for the years 2000 to 2004. While there are areas that can improve on the rate of review, all review teams should be commended for their efforts.

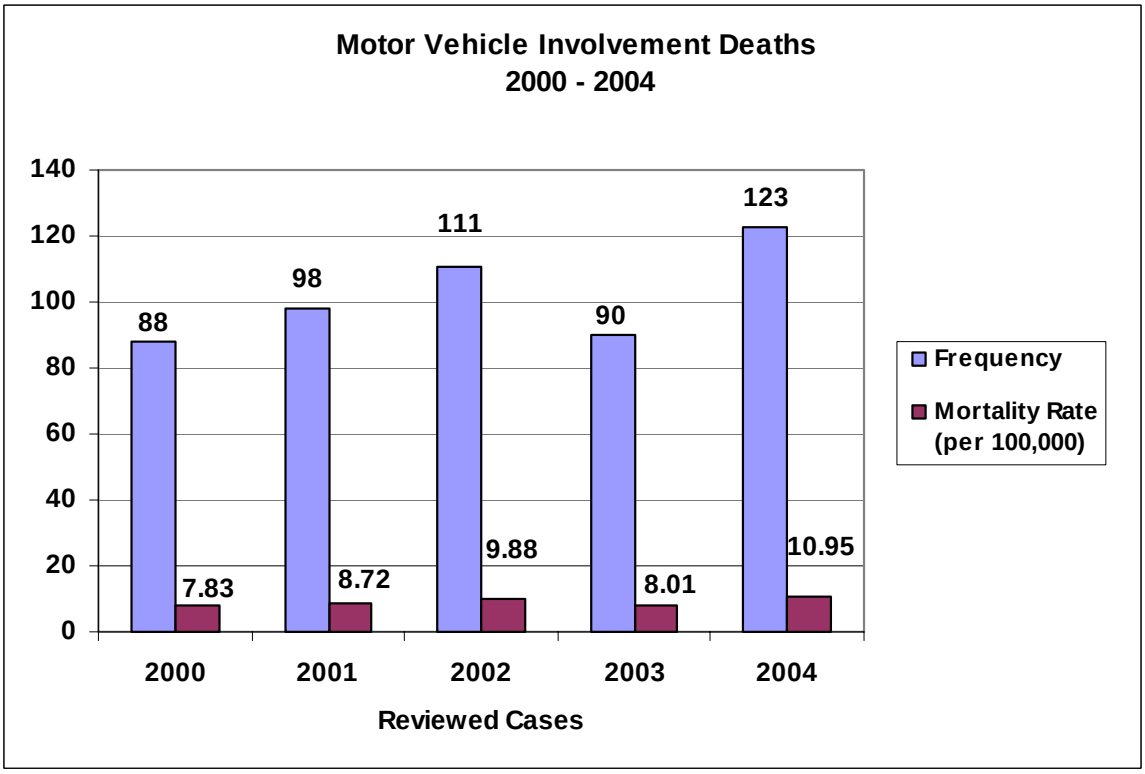


ALABAMA CHILD DEATHS

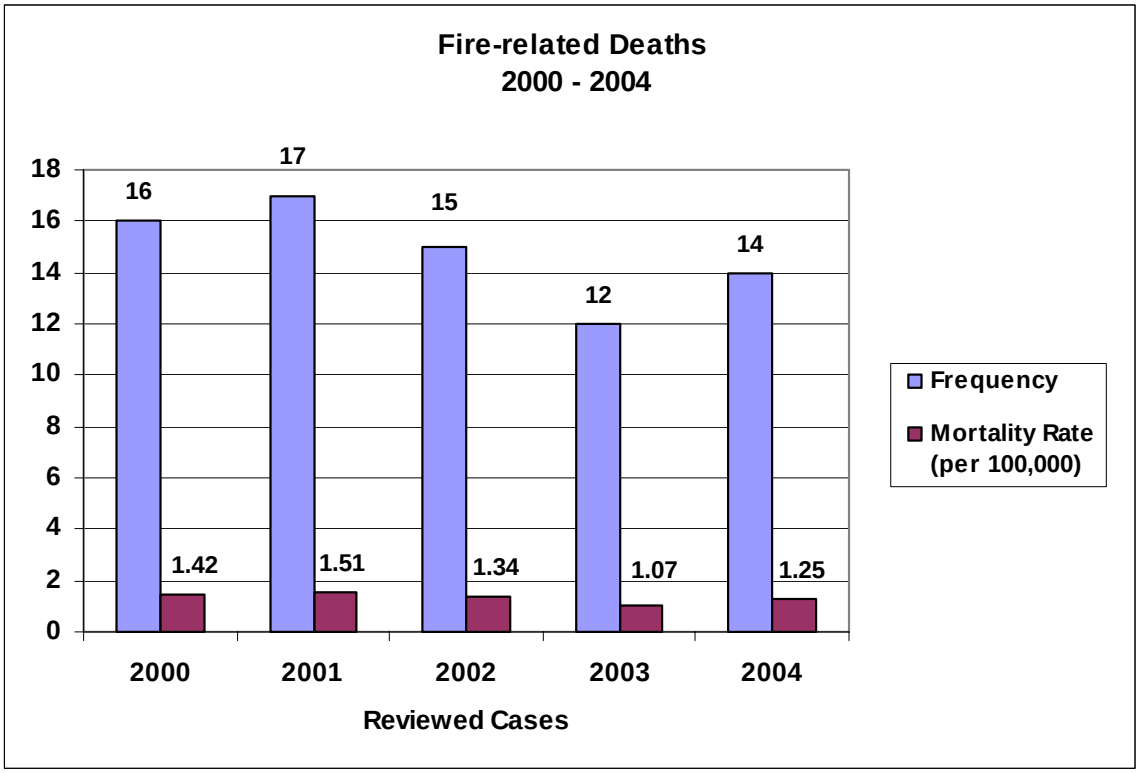
2000-2004



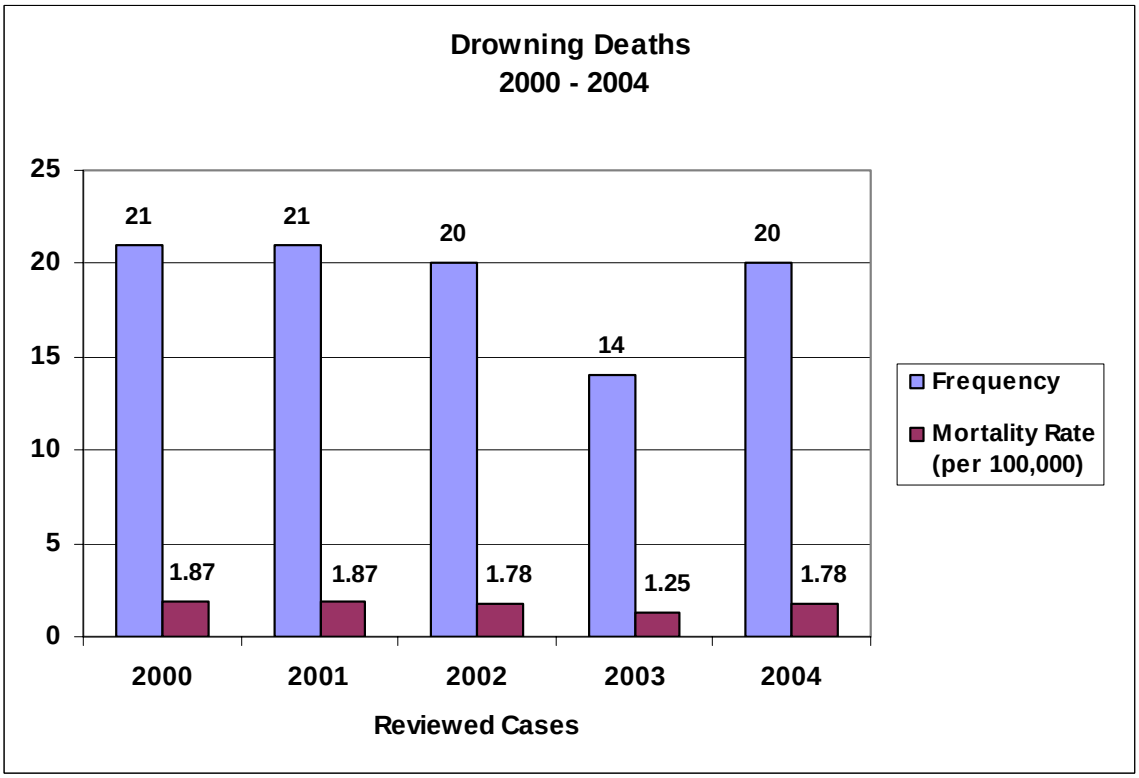
- While more data is needed, there does appear to be a general decline in Sudden Infant Death Syndrome mortality during this period.



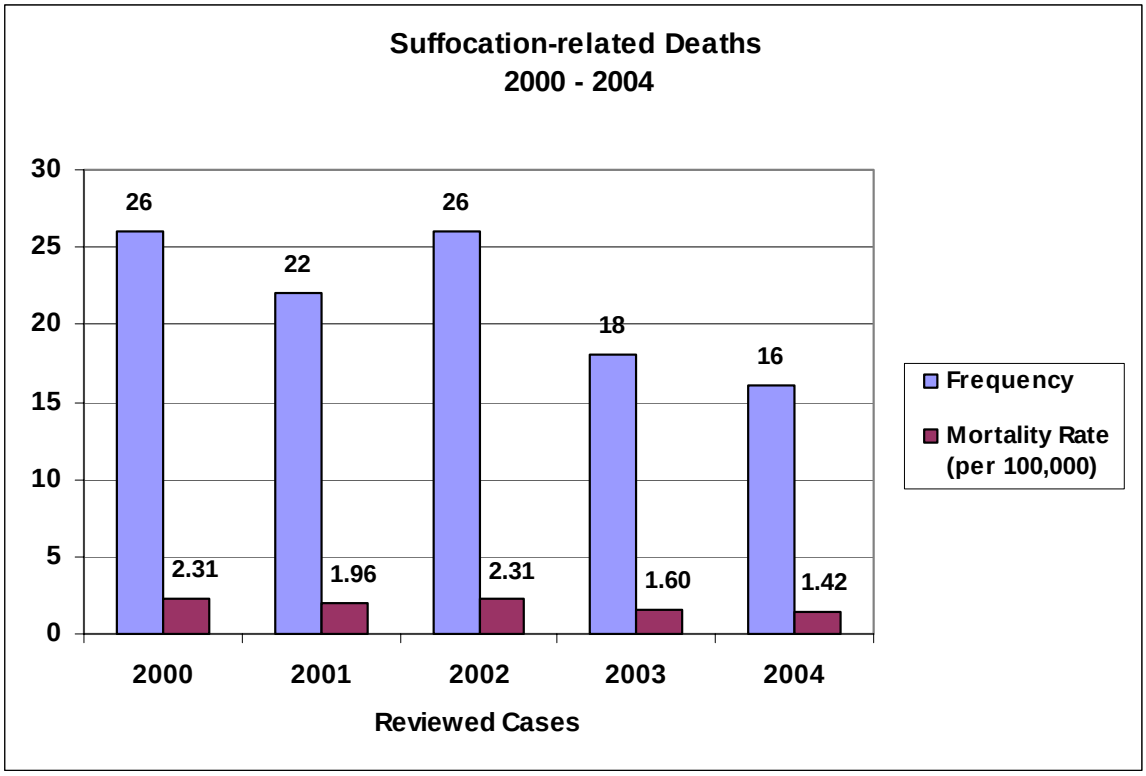
- Unfortunately, of the cases reviewed, this mortality rate has seen an increase over the five years reviewed.



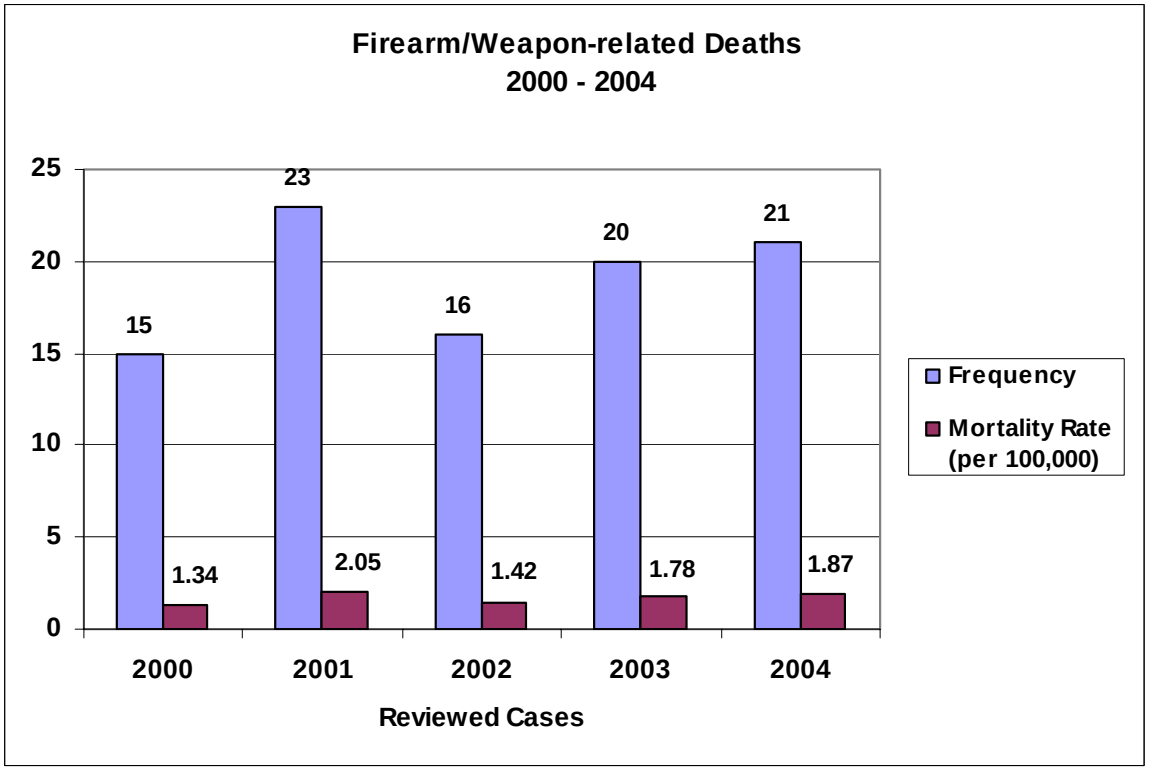
- Fire-related deaths have remained fairly constant for the five-year period.



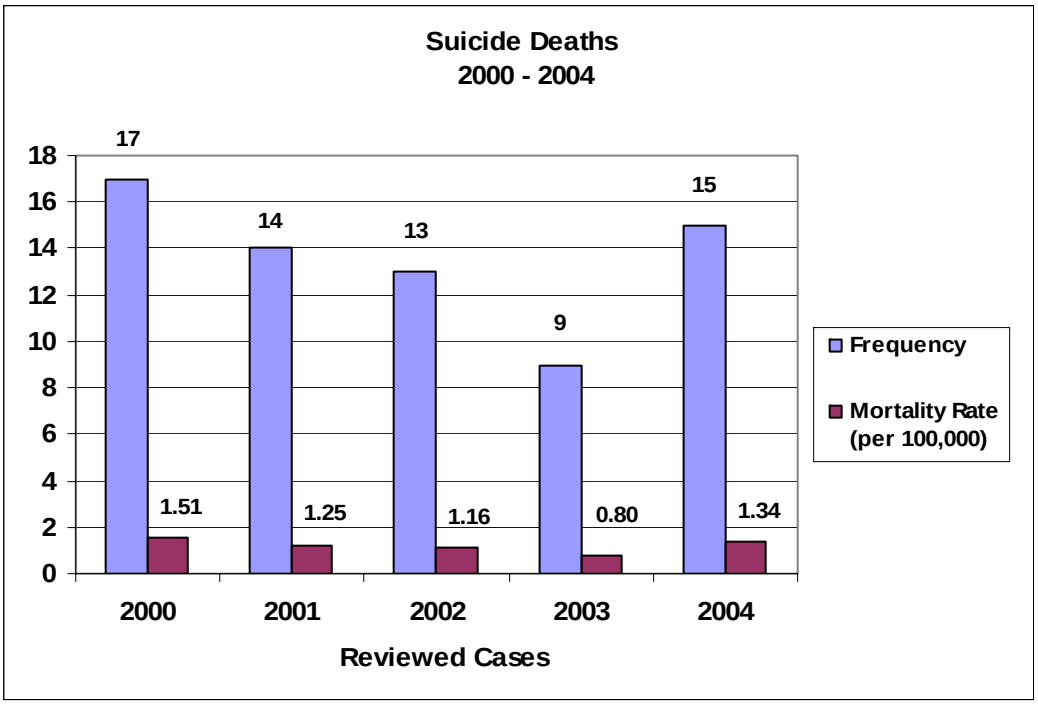
- With the exception of 2003, death rates due to drowning have been fairly constant.



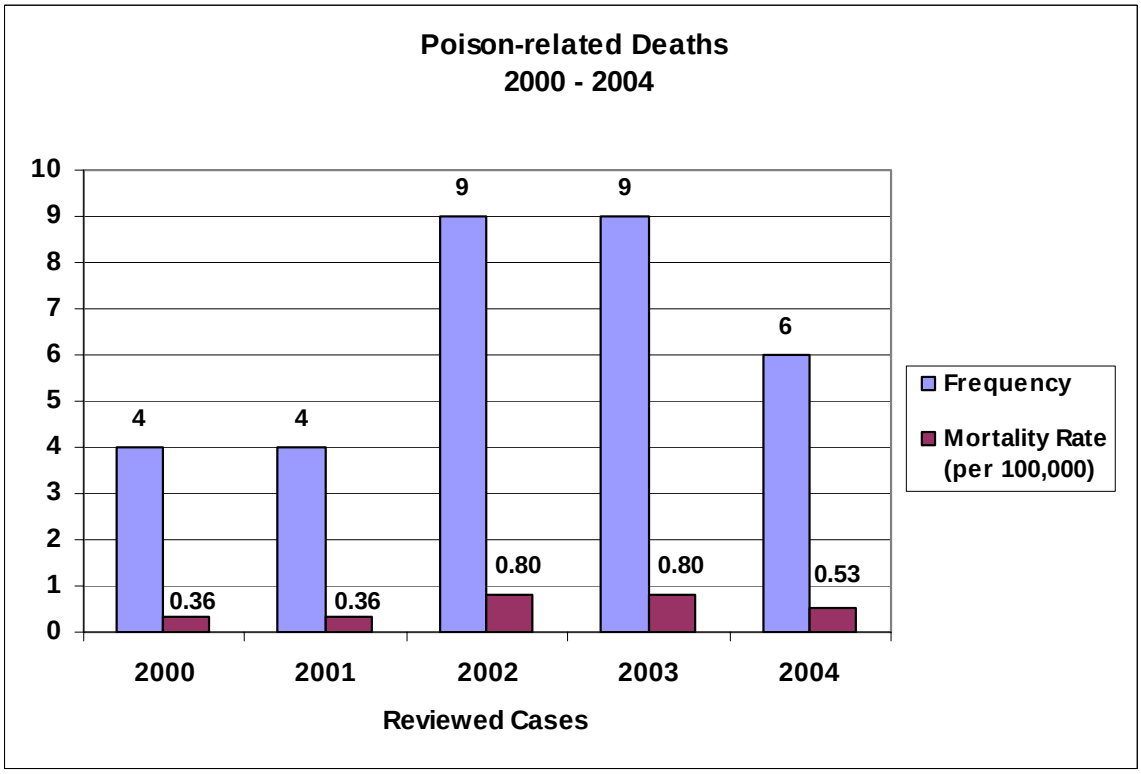
- Suffocation-related deaths appear to be on the decline, but more data will be needed to determine if this trend is significant.



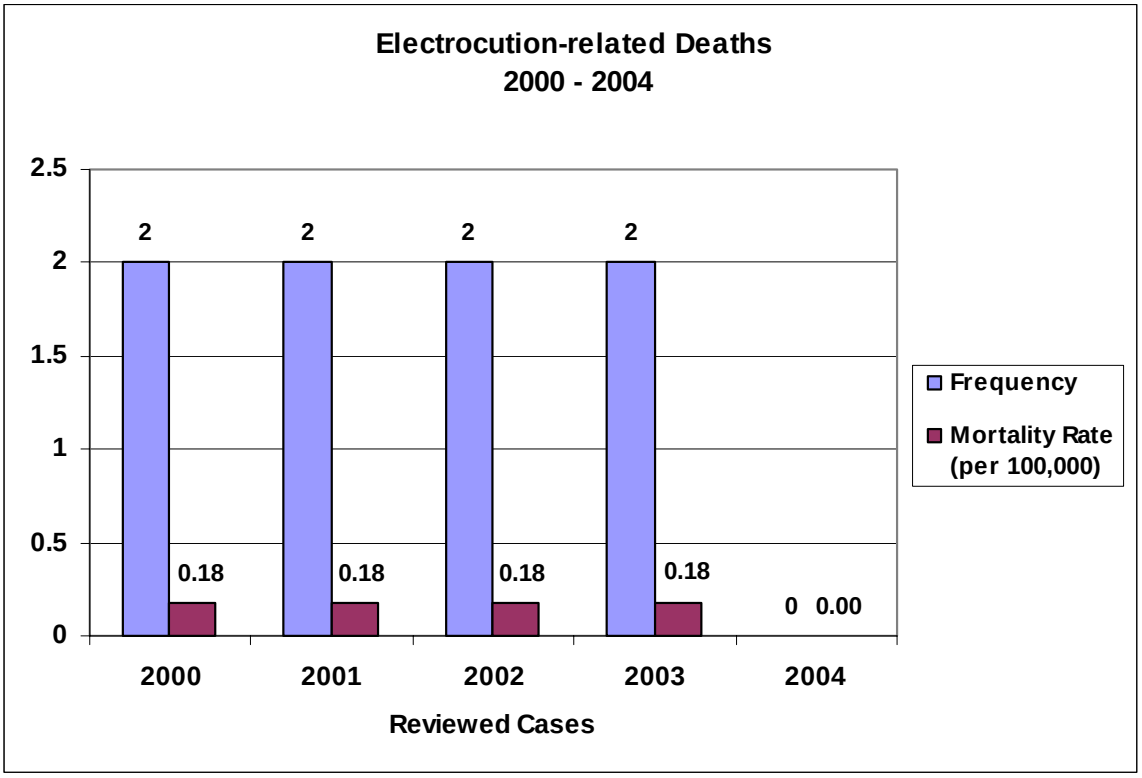
- While there has been some fluctuation in these death rates, overall they appear to be fairly consistent.



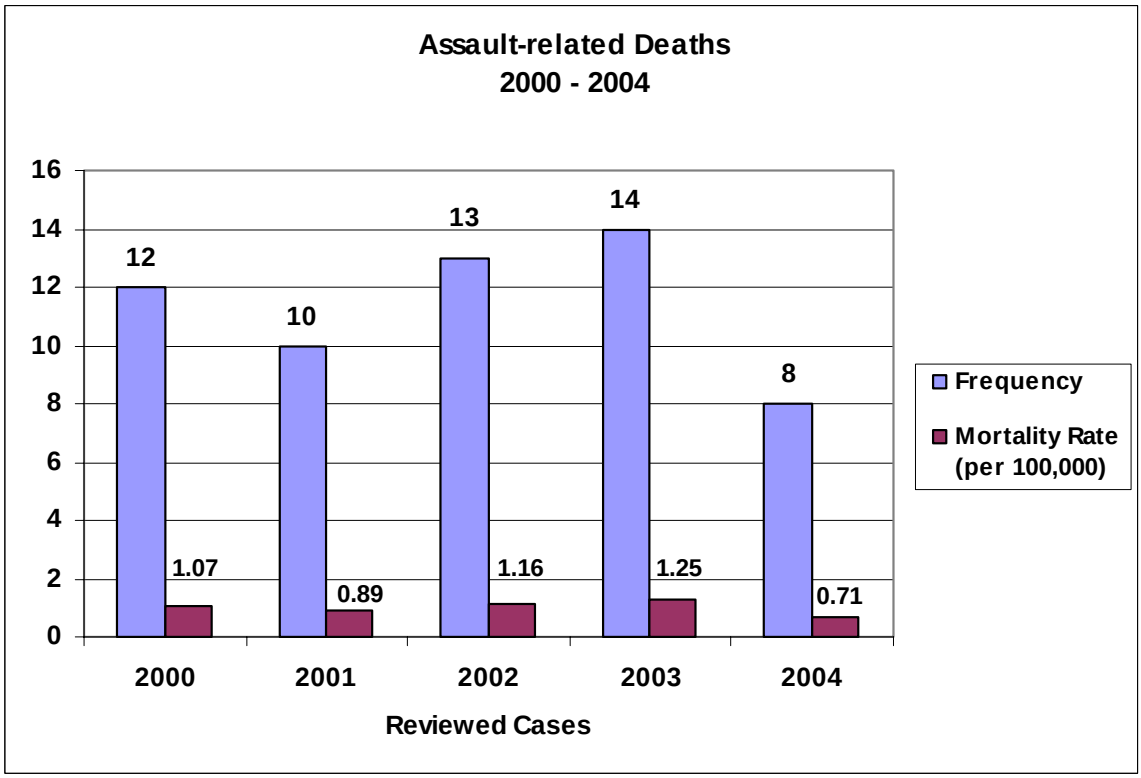
- With the exception of 2003, the suicide death rates are fairly consistent.



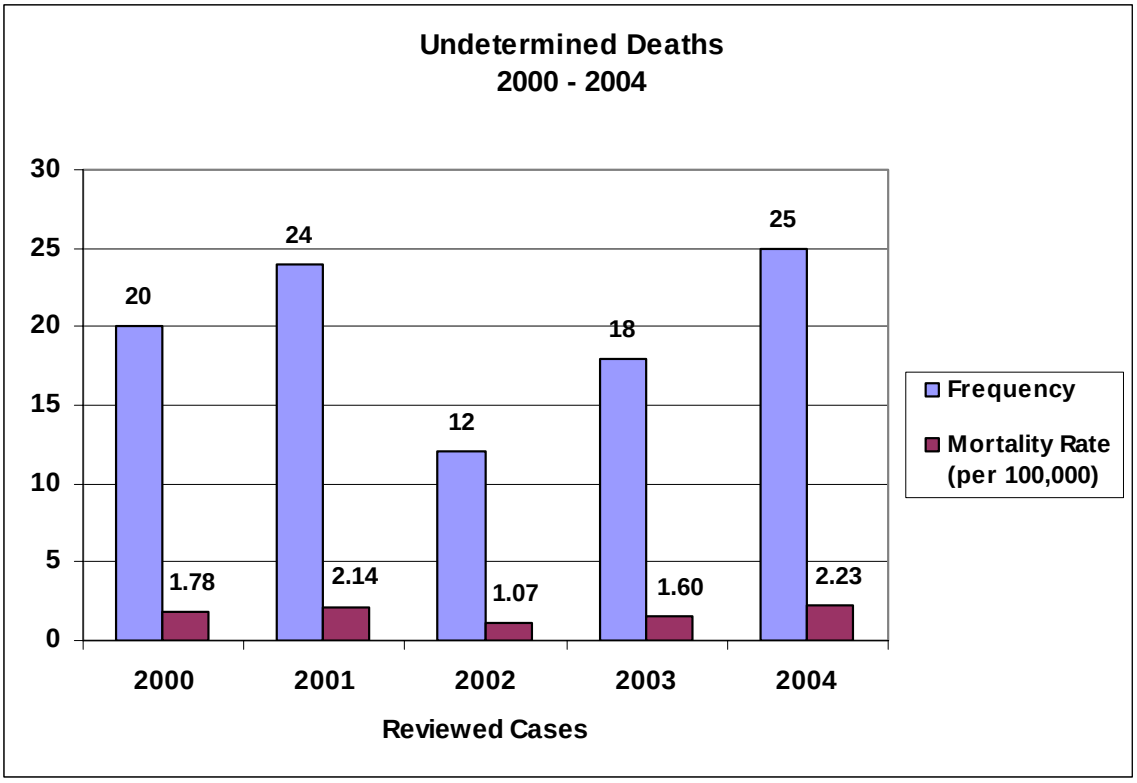
- There appears to be a possible spike in cases during 2002 and 2003, but these numbers are of insufficient size to document a trend.



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

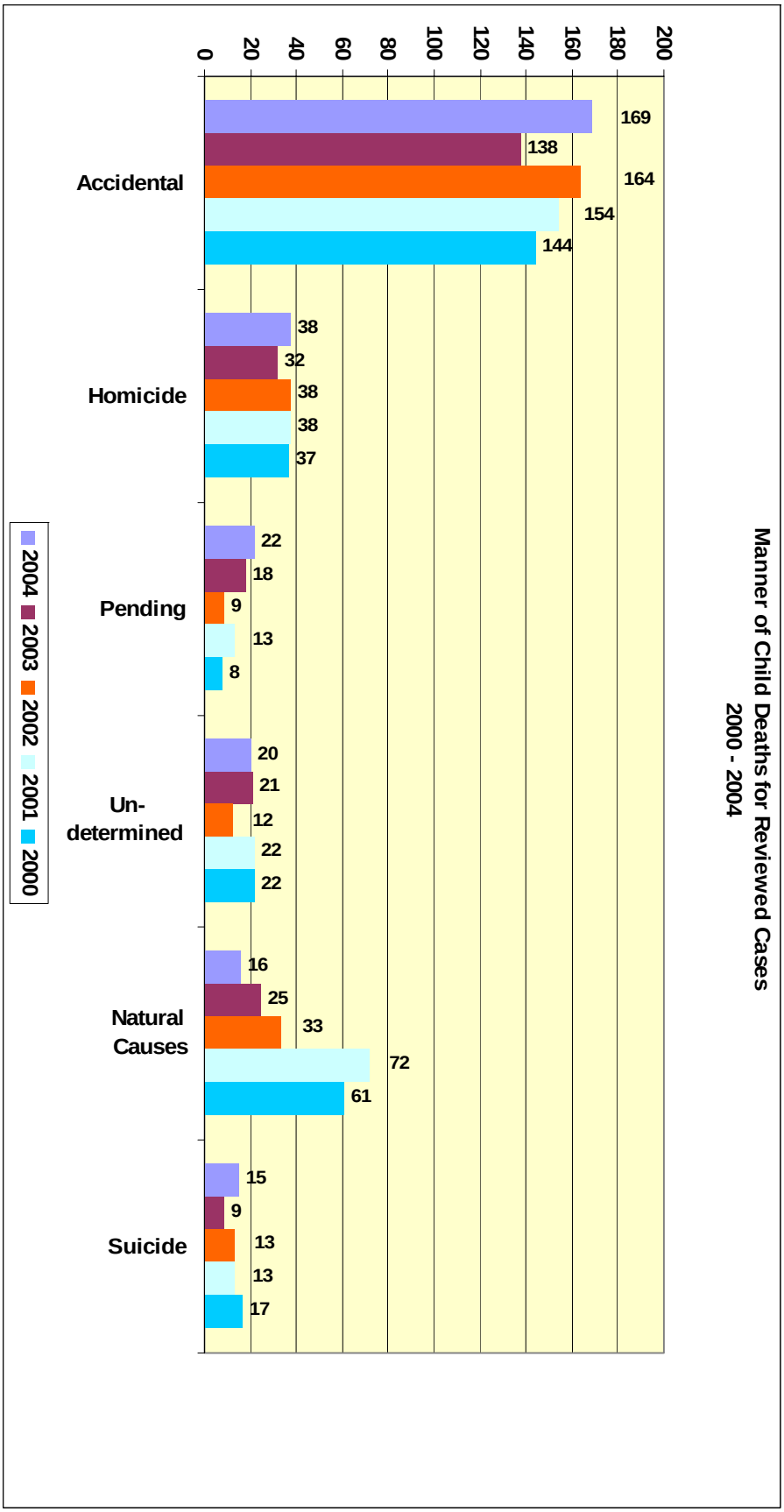


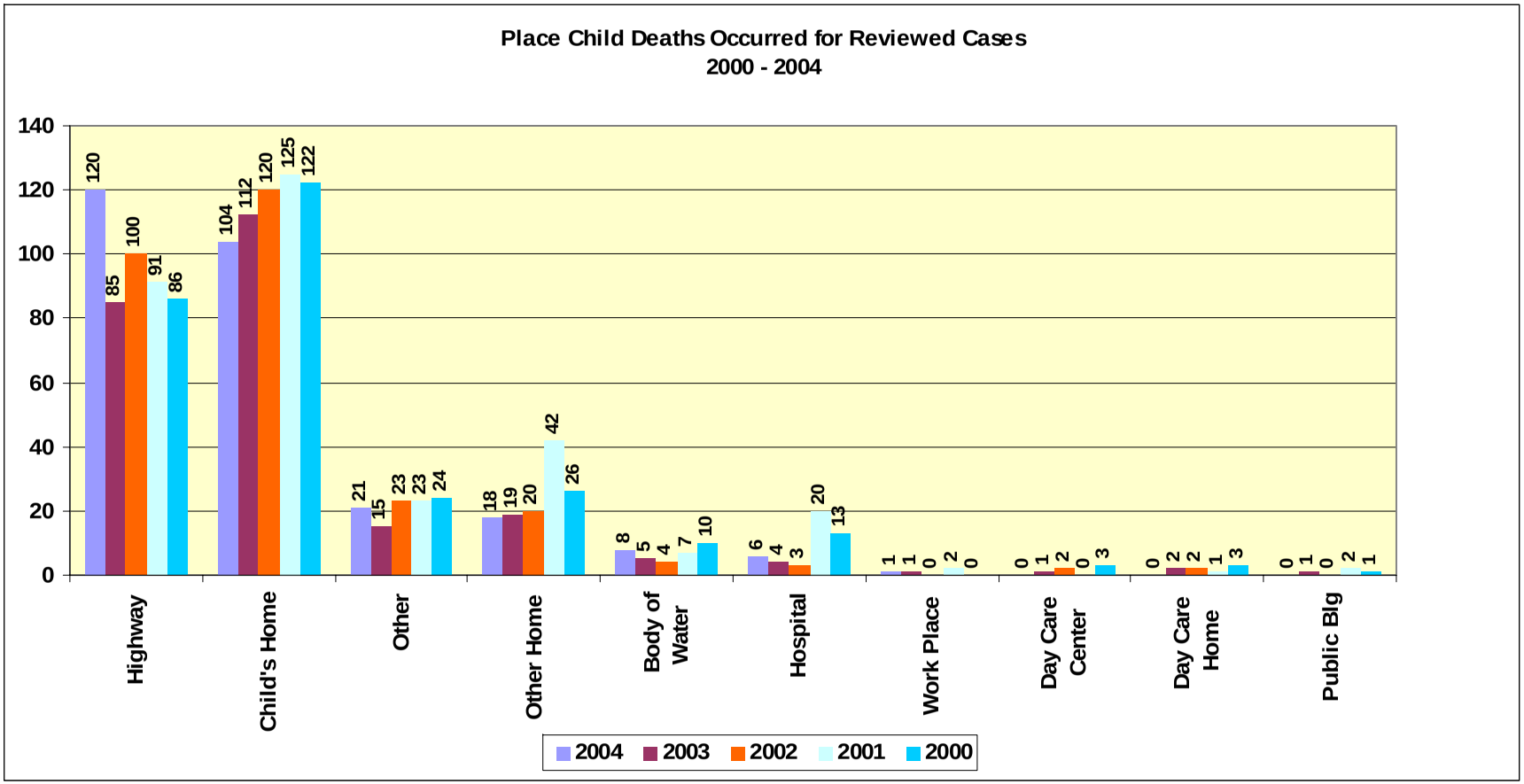
- Child assault-related deaths appear to be somewhat variable, much like adult assault-related deaths. However, the number of cases is of insufficient size to provide strong evidence for any implications.



- The number of undetermined deaths dropped in 2002 before rising in 2003 and 2004.

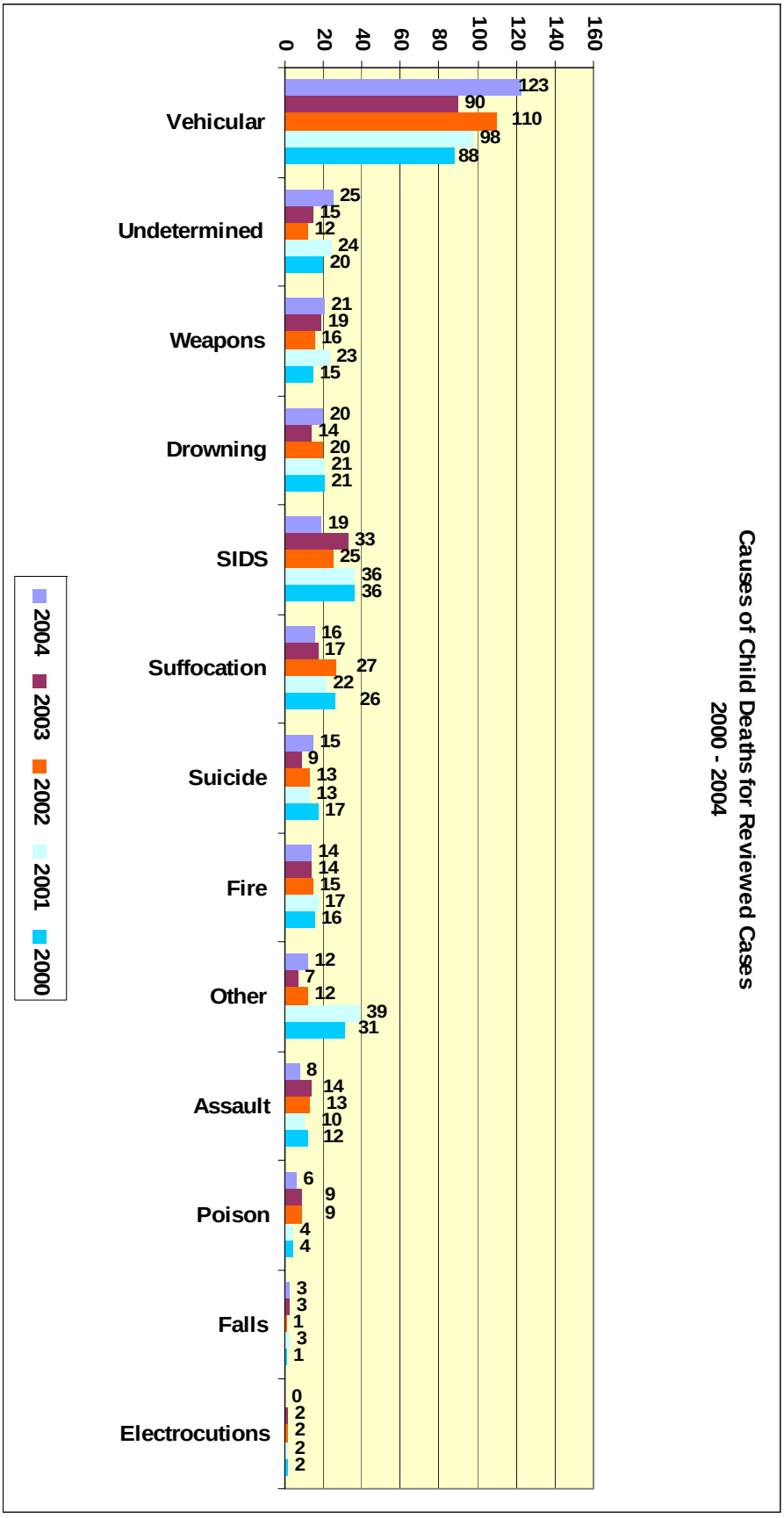
- While this chart does represent some fluctuation by year, the relative consistency seems more ascertainable.





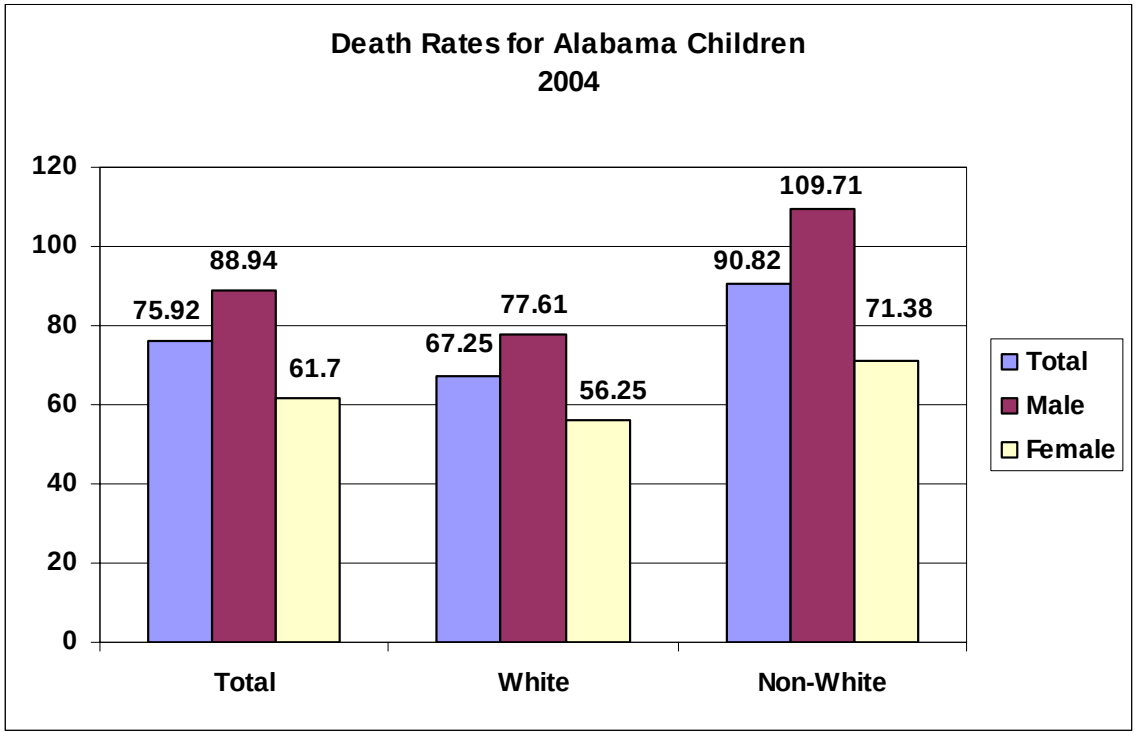
- There does seem to be fluctuation in some locales, such as the workplace, but deaths are relatively consistent in other locales. The workplace variability is likely due to the small number of deaths at such locations.

- There appears to be more consistency in causes of child deaths from year to year.

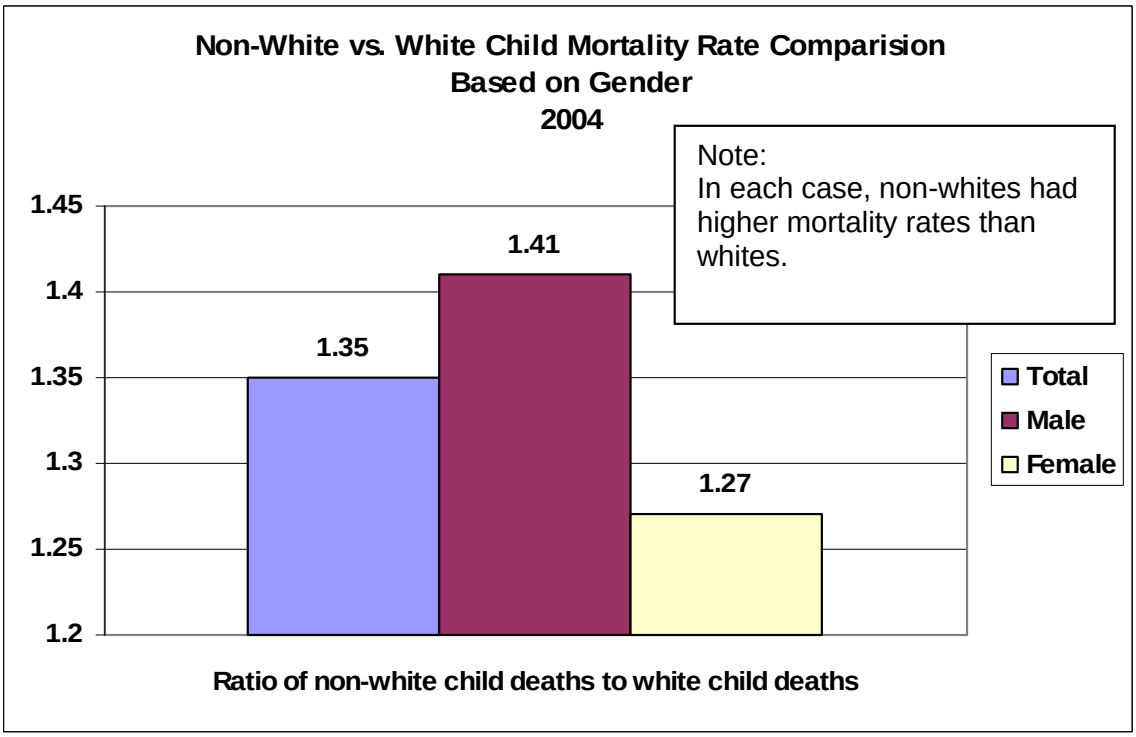


KEY FINDINGS

- There were 853 infant and child deaths (those under the age of 18) during 2004.
- The 2004 findings represent approximately 76 deaths per 100,000 children.
- Sixty percent of child deaths in 2004 were to male children.
- Forty-three percent of child deaths in 2004 were to non-white children.
- Below is a graph showing the total race-specific and gender-specific death rates (per 100,000 children) among children in Alabama in 2004. The graph allows for comparison of death rates among specific population groups:

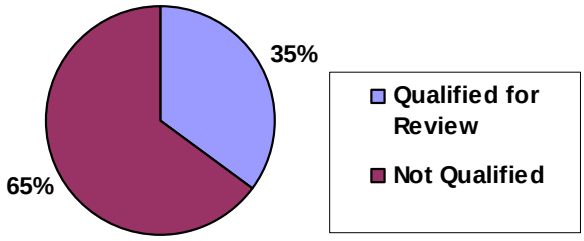


- Racial comparisons of the death rates of Alabama children are shown in the graph below. It should be noted that in each instance, non-whites have significantly higher rates ($p < .05$) than do whites (i.e. non-white males had a child morality rate 1.41 times greater than white males).

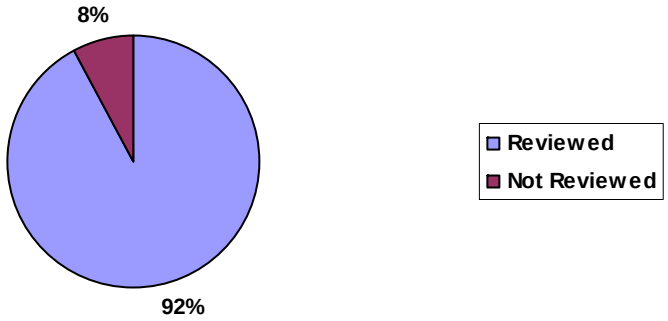


KEY FINDINGS

- As the chart below indicates, of the 853 child deaths in Alabama in 2004, there were 300 deaths that year that qualified for review under the Alabama Child Death Review System.



- Of the deaths that qualified for review (300), the Local Child Death Review Teams reviewed and returned 277 reports (see chart below). This compares to 89 percent reported for 2003.

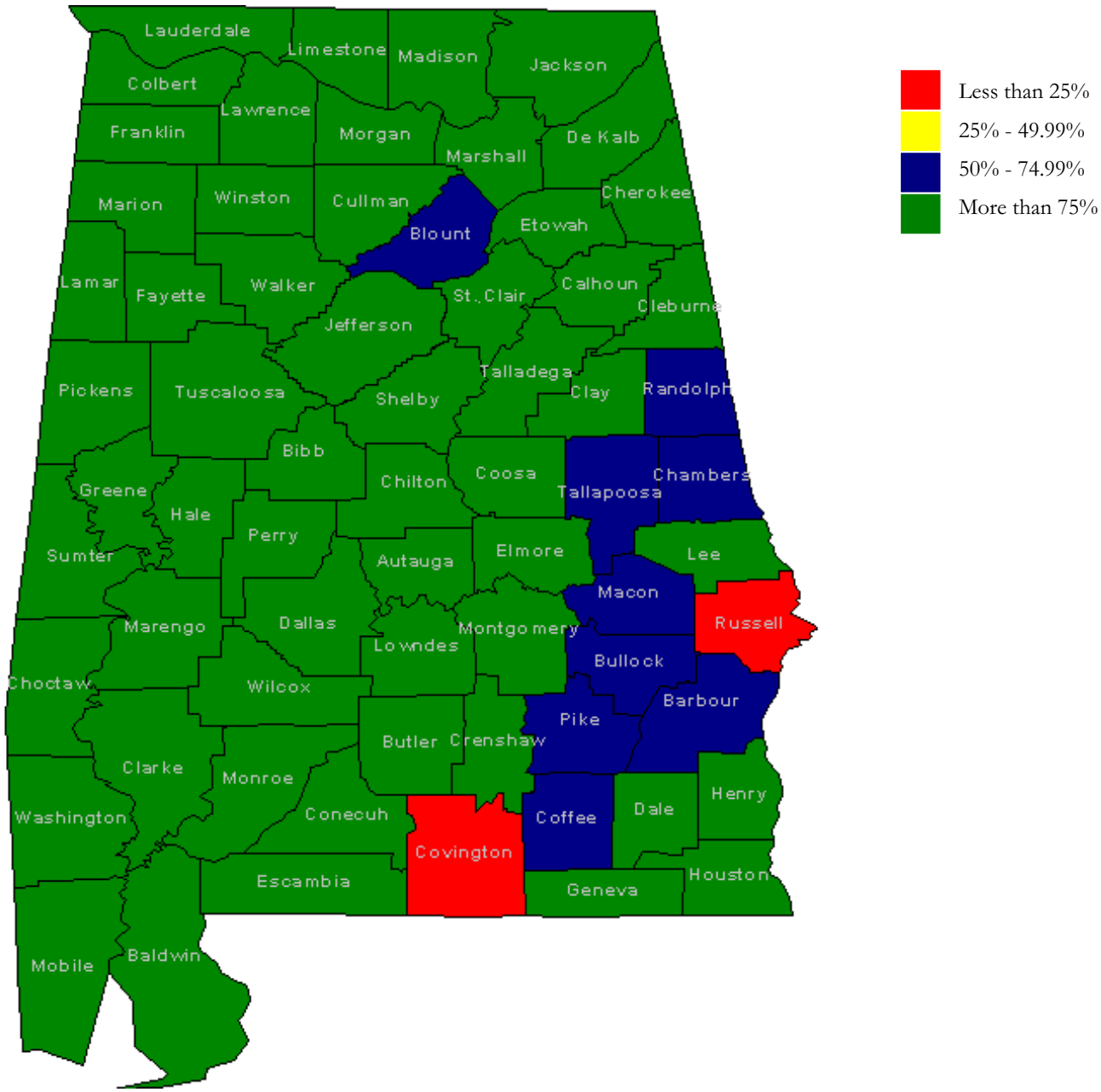


- In 2004, there were no significant race or gender differences in the proportion of cases reviewed compared to those cases not reviewed.

- While proportionately fewer neonates (those less than 28 days old) qualified for review in 2004 than did any other age category, there were no significant age group differences between those who were and those who were not reviewed.

AGE GROUP	*ALL*	*QUALIFIED*	*REVIEWED*	*NOT REVIEWED*
< 28 days	278	10	10	0
28 days - < 1 year	210	65	57	8
1 year - < 5 years	103	53	46	7
5 years - < 10 years	43	18	17	1
10 years - < 16 years	107	63	58	5
16 years - < 18 years	112	91	89	2

- There is a wide variety in the percentage of qualified cases that were reviewed and returned in 2004. The map below indicates the return rate for each Local Child Death Review Team. The goal is a 100 percent return rate.



KEY FINDINGS

- Nineteen suspected cases of Sudden Infant Death Syndrome (SIDS) were reviewed.
- We do not know the initial sleeping position of 42 percent of the babies whose deaths were reviewed; however, 26 percent were placed on their stomachs, which is a known risk factor for SIDS.
- Of those cases reviewed, 47 percent of infants were sleeping in adult beds and 58 percent were not sleeping alone. These numbers may not fully represent the situation given our lack of knowledge of the deaths in cases where the position of the infant was unknown.
- Only three of the reviewed cases involved families who did not smoke.
- Of all cases reviewed, at least six cases (32 percent) were classified as "rollover" deaths.

RECOMMENDATIONS

1. Increase public awareness about the dangers associated with infants sleeping with adults in adult beds.
2. Increase public awareness of "Back to Sleep" and "Babies Sleep Safest on Their Backs" programs.
3. Teach the use of standard protocols for the investigation of all unexpected and unexplained child deaths, including autopsy, scene investigation, and review of medical history.
4. Study the merits of mandating autopsies for all sudden and unexplained child deaths.
5. Develop and implement a program to train medical examiners and law enforcement personnel in the thorough investigation of child deaths.
6. Develop and implement a mechanism for notifying the appropriate medical examiner whenever a death certificate is received that shows SIDS as the cause of death, but for which no autopsy was done and/or the medical examiner had not been involved in the case.
7. Provide increased public education and encourage strict adherence to the 2005 American Academy of Pediatrics guidelines for preventing SIDS and reducing risks associated with infant sleeping environment.
8. Ensure that the death of every child in Alabama is reported to the appropriate medical examiner in accordance with the Alabama Child Death Review Systems Statute, Act #97-893.
9. Increase the number of forensic laboratories available in order to provide investigators with more timely information.
10. Require certification and training for everyone authorized to complete birth and death certificates in Alabama to include the use of standardized definitions.

KEY FINDINGS

- A total of 123 cases were reviewed in 2004.
- Thirty-one of these deaths (25 percent) were due to the fault of young drivers (those 16 years of age).
- Fourteen of these deaths (11 percent) were due to underage drivers (those under the age of 16).
- Fourteen of the deaths were listed as being due to an inexperienced driver.
- Forty-four of these deaths (36 percent) were the result of not using lap and shoulder belts or other appropriate safety restraints. Nine deaths (7 percent) were the result of restraints not being used correctly.
- Additionally, 66 of these deaths (53 percent) were due to reckless driving and/or speeding, with 21 of these deaths (17 percent) classified as reckless driving, 22 deaths (18 percent) classified as speeding, and 23 (19 percent) classified as both reckless driving and speeding.

RECOMMENDATIONS

1. Encourage the inclusion of information about the dangers of driving at high speeds and expand current education about reckless driving in driver education courses.
2. Encourage auto dealerships to provide point-of-sale information resources about proper installation and usage of child safety seats and booster seats when selling new or used vehicles.
3. Encourage new laws to better regulate children on All-Terrain Vehicles to include licensure and mandatory safety equipment.
4. Encourage legislation prohibiting the use of cell phones while driving for drivers under the age of 18 years.
5. Reinstate and restore funding for the “Alabama Child Passenger Safety Program.”
6. Adopt a policy of including multiple agencies in the development and implementation of all child safety interventions.

KEY FINDINGS

- Fourteen cases were reviewed in 2004.
- In two of these cases, fires were the result of faulty wiring in the child's place of residence.
- In 10 of the cases (71 percent), it was not known whether the residence had a smoke alarm. In four of the cases (29 percent), there was no smoke alarm.
- Ten of the cases (71 percent) were deaths that occurred in mobile homes, while two cases (14 percent) occurred in brick-frame homes and one case (7 percent) occurred in a wood- and brick-mix home.

RECOMMENDATIONS

1. Encourage enforcement of laws governing smoke detector installation, testing, and inspection in all homes, including new and used manufactured homes.
2. Support local fire departments in developing, expanding, and implementing fire education activities, particularly for elementary schools and child care facilities.
3. Encourage community education efforts about the need for installation and periodic testing of smoke detectors in homes, businesses, and places of worship.
4. Explore the possibility of restricting cigarette retail sales to allow only "fire safe" cigarettes in Alabama.

DEATHS DUE TO DROWNING

KEY FINDINGS

- Twenty cases were reviewed in 2004.
- Six of these deaths (30 percent) occurred in swimming and/or wading pools.
- Eight of these deaths (40 percent) occurred in open water.
- Four deaths (20 percent) occurred in bath tubs.
- Of the 20 drowning deaths, 17 (85 percent) were reported as not wearing a flotation device.

RECOMMENDATIONS

1. Support public education and awareness campaigns about water safety. Place special emphasis on the need for constant adult supervision and focus on pools, bathtubs, and open bodies of water.
2. Encourage enforcement of ordinances regarding pool fencing and signage.
3. Persuade communities to seek ways to make swimming lessons and water safety classes more readily available to children and parents.
4. Encourage the use of flotation devices when swimming in open bodies of water.

KEY FINDINGS

- Sixteen cases were reviewed in 2004.
- At least five of these deaths (31 percent) were suspected to be the result of "rollovers" by an adult during a bed-sharing situation. (Note: This is not a duplication of rollovers identified in the Sudden Infant Death Syndrome section.)
- Six of these victims (38 percent) were reported to be sleeping in an adult bed when the death occurred.

RECOMMENDATIONS

1. Promote and encourage statewide education and awareness campaigns about safe sleeping practices and the dangers of bed sharing.
2. Promote and encourage parenting classes for new and, especially, young parents.
3. Provide increased public education and encourage strict adherence to the 2005 American Academy of Pediatrics guidelines for reducing risks associated with infant sleep environment.

KEY FINDINGS

- Twenty-one cases were reviewed in 2004.
- Eighteen of these deaths (86 percent) were the result of firearm use, with 16 deaths (76 percent) caused by handgun use and two deaths (10 percent) caused by rifle/shotgun use.
- The vast majority of these deaths, 17 (81 percent), were known to be due to an "intent to do harm."
- Only one child death (5 percent) reviewed in this category was reported to be the result of playing with firearms.
- Two of the 21 children (10 percent) were killed by a weapon being handled by a family member.

RECOMMENDATIONS

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

KEY FINDINGS

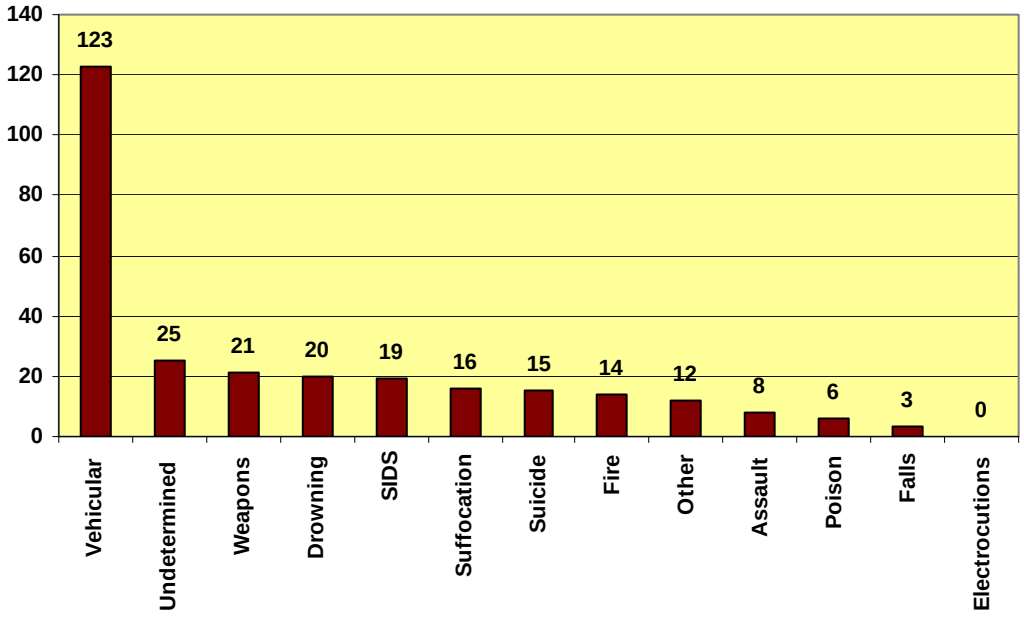
- Fifteen cases were reviewed in 2004.
- Eight of these deaths (53 percent) were reported as being unexpected.
- Six of these deaths (40 percent) were the result of hanging while nine deaths (60 percent) resulted from the use of firearms.

RECOMMENDATIONS

1. Support statewide efforts to examine issues surrounding adolescent suicide and develop plans for prevention.
2. Institute training for teachers about suicide risk assessment and referral resources.
3. Support a statewide education and awareness campaign aimed at parents and others about adolescent suicide risk assessment and assistance resources.
4. Support the Alabama Suicide Prevention Plan of 2004.
5. Encourage safe and secure storage of firearms.

REVIEWED CASES ONLY

- Motor Vehicle was the most often (44 percent) reviewed cause of child death in 2004.



POISON:

- Six cases were reviewed in 2004.
- Four of the poisoning cases reviewed (67 percent) resulted from illegal drug use.

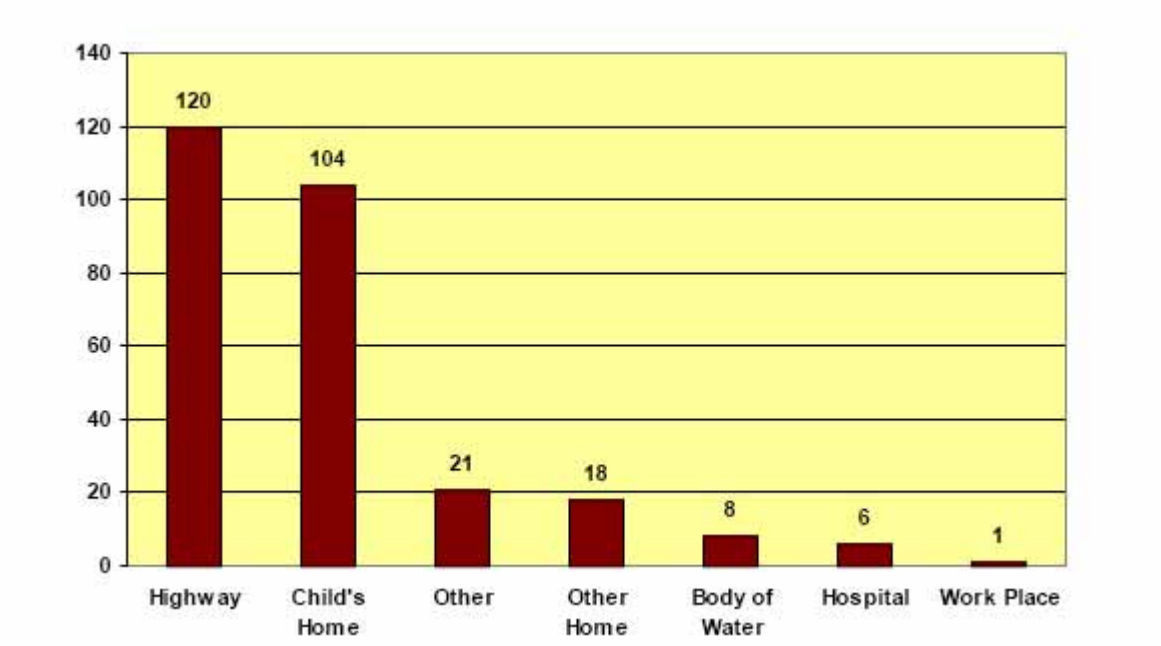
ASSAULT:

- Eight cases were reviewed in 2004.
- Of those, five deaths (63 percent) were caused by the use of hands and fists.
- Parents were responsible for two (25 percent) of the assault deaths.

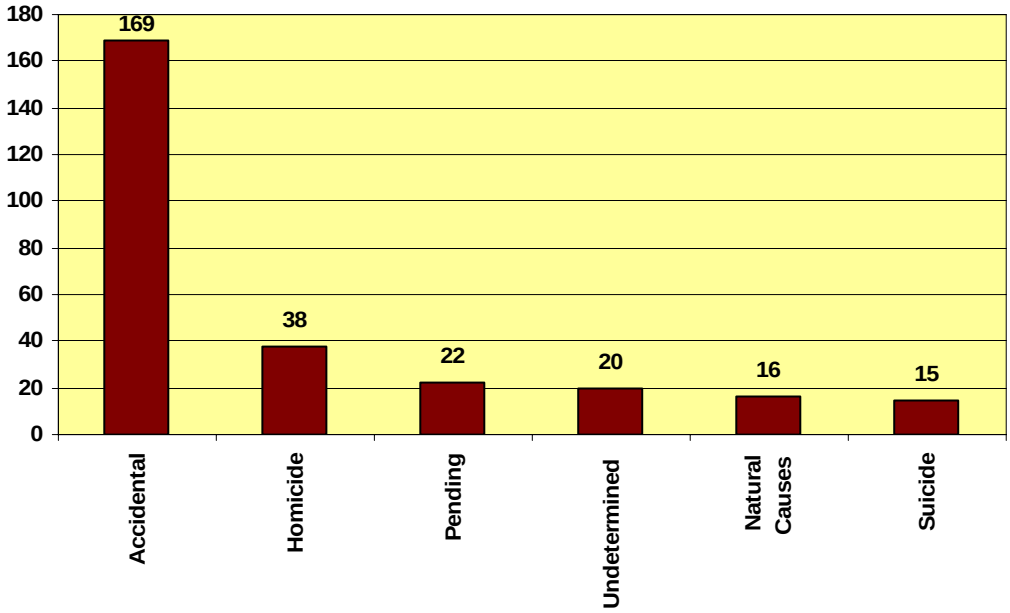
UNDETERMINED:

- Twenty-five cases were reviewed in 2004 in which the cause of death was undetermined.
- In 10 of the cases (40 percent), the infant was not sleeping alone.
- In two of the cases (8 percent), rollover was suspected.
- In 13 of the cases (52 percent), infants were found in an adult bed, an easy chair, or on the floor.

- The highway was the single most frequent place of death (42 percent), followed by the child's home (37 percent).



- Accident was the most frequent manner of death reviewed (169 cases or 60 percent).



The Alabama Child Death Review System (ACDRS) is a grass-roots program driven by local citizens for the express purpose of saving the lives of as many of Alabama's infants and children as possible. Our very effective State and Local Teams have contributed significantly to a reduction in preventable child deaths since the ACDRS began, and we continue to see great results from those efforts. We are delighted to report significant progress not only in our statistics, but in our special interest programs as well:

Expansion of the Cribs for Kids Program to Talladega County

The Cribs for Kids Program in Alabama is currently based in Montgomery. Cribs have been given to qualifying families in the Montgomery County area with the help of the Gift of Life Foundation. After experiencing success with the program there, the Gift of Life and the Alabama Child Death Review System decided to expand the program to other counties in the state. So far, Talladega County has been helpful in successfully distributing its first set of cribs. Escambia County will be next in helping to expand our efforts with the Cribs for Kids Program.

Initiation of the Booster Seat Advocacy Program

The Booster Seat Advocacy Program is a joint effort of the Alabama Child Death Review System, Children's Hospital Child Safety Institute, UAB Department of Pediatrics, and the Alabama Department of Public Health Injury Prevention Division. The program was initiated after the passage of the child restraint amendment in Alabama. Booster seats will be provided to families throughout Alabama to ensure that children are protected while riding in cars. Potential sites for distribution of the booster seats have been identified and funds necessary to carry out the mission of this program have been established.

Local Child Death Review Teams

The Alabama Child Death Review System is proud that all counties in Alabama now have a Local Child Death Review Team. This is an amazing goal that most other states with similar programs are striving to reach. Not only are the teams formed, but they are also meeting and reviewing cases at record rates. The ACDRS is happy to report a record 93 percent case review rate at its most recent Child Death Review State Team meeting. We are greatly pleased with the impressive efforts of our Local Teams.

Local Team Coordinator Training

The Local Team Coordinators participated in training that was made available at our 2006 Local Team Conference. Coordinators learned how to effectively coordinate and conduct Local Team meetings. The coordinators took the information they learned at the conference and applied it to their meetings. They have reported great success at Local Team meetings since attending the training.

We have highlighted only some of the successes that we are seeing. Many others are identified throughout this report. We recognize that every death is more than just a statistic to Alabama families and other fellow citizens. Every single infant and child death is a terrible personal tragedy. We are dedicated to reducing these tragedies as much as possible.

1. What is the ACDRS?

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

2. What is the "Mission" of the ACDRS?

- To understand how and why children die in Alabama in order to prevent future child deaths.

3. What is the primary focus of the ACDRS?

- The primary purpose of the ACDRS is prevention, not prosecution. This is done through statistical analysis, education and advocacy efforts, and local community involvement.
- "Preventability" refers to the ability of an individual or community to reasonably have done something to alter the conditions that led to the child's death, thereby preventing the child's death, or to reasonably do something now to reduce the likelihood of future similar deaths.

4. How is the ACDRS organized?

- The ACDRS is comprised of three major components:
  - The ACDRS **State Office** is located in the Alabama Department of Public Health, within the Children's Health Division of the Bureau of Family Health Services. There are three full-time staff members - Director, Assistant Director, and Administrative Assistant.
  - State Law requires each District Attorney to form at least one **Local Child Death Review Team (LCDRT)** in each Alabama Judicial Circuit. LCDRTs are multi-disciplinary and are required to meet at least once per year (most meet more frequently).
  - The **State Child Death Review Team (SCDRT)**, chaired by the State Health Officer (Director of the Alabama Department of Public Health), is also multi-disciplinary and meets quarterly. Its 28 members include various state agency directors and representatives, medical professionals, judicial and law-enforcement officials, state legislators, and private citizens appointed by the Governor.
- Because of these components the ACDRS considers itself a "system."

5. How is the ACDRS funded?

- Funding originates in Alabama's portion of the National Tobacco Settlement (NTS) through the Children First Trust Fund (CFTF).
- The amount equals ½ percent of the total CFTF portion of the NTS not to exceed $300,000.

6. What does the ACDRS do?

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

7. How does the ACDRS operate?

- The ACDRS State Office receives a copy of all death certificates issued to Alabama residents less than 18 years of age. Each certificate is reviewed to determine whether it meets the ACDRS review criteria. Copies of those certificates meeting the criteria are then mailed out to the LCDRT in the decedent's county of residence.
- The LCDRT reviews the individual cases and, based on its findings, completes the appropriate data collection forms and submits the information to the ACDRS State Office. The Local Team then takes action as allowed and/or required in the community to prevent additional deaths and makes recommendations to the State Team for state-wide consideration and action.
- The ACDRS State Office enters the information submitted by the LCDRT into a master database. The information in the database is then used to answer requests for specific data and to generate annual reports.
- The State Child Death Review Team meets quarterly to discuss Child Death Review (CDR) issues, review the State Office data, consider LCDRT recommendations and performance, and conduct general ACDRS business. The SCDRT makes periodic recommendations to the Governor and takes action on issues related to CDR (educational programs, informational publications and other efforts).

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

- Deceased must be a resident of Alabama
- Deceased must be within the age range of birth to less than 18 years of age
- Deceased cause of death must be non-natural or Sudden Infant Death Syndrome

9. What are the ACDRS goals?

- All child deaths considered
- All eligible deaths reviewed
- High completion rate
- Meaningful research and recommendations
- Reduce preventable infant and child deaths in Alabama

10. What is Alabama's greatest resource?

OUR CHILDREN!!!

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

- An infant or child death occurs on September 1, 2004.
- Death certificate received at the ACDRS State Office on September 15, 2004. (The ACDRS State Office normally receives death certificates within 60 days of when they are issued.)
- Death certificate sent to the Local Child Death Review Team (LCDRT) on September 22, 2004. The ACDRS State Office continues to send additional death certificates that it receives to the Local Team within one to two weeks of receipt of the documents.
- The LCDRT meets to review this specific case and others on March 1, 2005. (By law, each Local Team is required to meet only once per calendar year.)
- The ACDRS State Office receives the last of the 2003 death certificates by July 2005.
- September 1, 2006, is the deadline by which the ACDRS State Office is to receive all 2004 cases that have been reviewed by LCDRTs.
- The ACDRS 2004 Annual Report is published and distributed before the end of 2007.

The Alabama Child Death Review System supported the following bills considered by the Alabama Legislature during the 2007 regular session:

- **Shaken Baby Syndrome Prevention Education:** This bill would require that hospitals make educational materials concerning Shaken Baby Syndrome available to parents of newborns. Supporters say this legislation could prevent injury and/or save the lives of many infants and toddlers. **(Did not pass)**

- **Increased Restrictions on Teen Drivers:** This bill included measures that placed further restrictions on teenagers and was strongly supported by the ACDRS. One of the provisions included prohibiting the use of cell phones by drivers under the age of 17. **(Did not pass)**

- **Tobacco Funds for the Child First Trust Fund:** This bill would provide continuing funds to the ACDRS. The funds would also be made available to other agencies that assist in protecting children, such as the Department of Children's Affairs, the Alabama Medicaid Agency, and the Department of Youth Services. (**Gov. Bob Riley has signed this legislation into law.)**

The Alabama Child Death Review System also supports these initiatives:

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

- **All-Terrain Vehicle Safety Education:** The ACDRS supports increased education of All-Terrain Vehicle safety education. The ACDRS supports an initiative that would introduce legislation requiring that helmets be worn while riding ATVs.

Nancy Wright, M.P.H.
Assistant Director, Injury Prevention Branch
Alabama Department of Public Health
Montgomery, Alabama

Injury is the leading cause of death in Alabama for children under the age of 18. However, this is just the tip of the iceberg. For every death, there are more than 40 hospitalizations and more than 1,000 hospital emergency department visits.

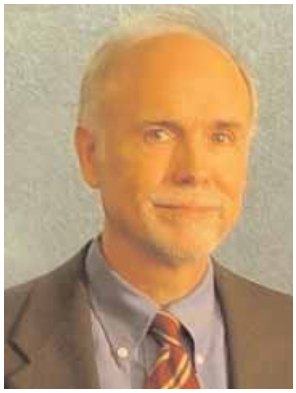
Injuries can be prevented; they are not accidents. The National Academy of Sciences states: "Injury is probably the most unrecognized major public health problem facing the nation today." Former U.S. Surgeon General C. Everett Koop, M.D., said: "If a disease were killing our children in the proportions that injuries are, people would be outraged and demand that this killer be stopped."

The mission of the Injury Prevention Branch within the Alabama Department of Public Health is to reduce disability and death from unintentional and intentional injury through coordination and implementation of health promotion and education programs and special events. Unintentional injuries include motor vehicle crashes, drowning, poisoning, falls, and fire-related deaths. Intentional injuries include suicide, sexual assault, and domestic violence. Our branch strives to reach the community - parents and children - and teach them how to protect themselves from injury. The use of bicycle helmets, appropriate car seats, seat belts, smoke alarms, pre-planned fire escape routes, bullying programs, and violence education can reduce injuries and deaths in our community.

The Alabama Child Death Review Teams are in Alabama's communities and witness the deaths that are associated with unintentional and intentional injury. It makes sense that the Injury Prevention Branch and Child Death Review Teams work together to get the word out about the actions we can take to protect our children and youth and prevent these deaths. Together with Child Death Review Team members, we have made presentations to schools, shared educational materials and distributed these materials in Alabama's communities. As partners, the Injury Prevention Branch and Child Death Review Teams are sharing their knowledge and experience in an effort to prevent unnecessary deaths of Alabama children.

It is my hope that by lending our voice through community education efforts to reduce child deaths, we will strengthen the program and succeed.

BOOSTER SEAT ADVOCATE PROGRAM



William King, Ph.D., Director
Southeast Regional Child Safety Institute
Children's Hospital
Birmingham, Alabama

A recent series of observational surveys on booster seat use for Alabama children ages 4 years to 8 years provided a startling contrast to the reported usage of child restraint seats (92 percent reported in 2005, 88 percent in 2006). The booster seat use surveys conducted at various elementary schools statewide reported a low of 21.6 percent and a high of 38.5 percent, significantly lower than the overall car seat usage that is reported each year. Nationally, booster seat use is recognized as the new frontier for child passenger safety improvement. Indeed, this is the case for Alabama child passengers.

The recent passage of the Child Restraint Amendment in Alabama provides an opportunity for both enhanced enforcement and enhanced educational efforts. The state should use these opportunities to improve awareness of parents, law enforcement personnel, and elementary school systems about the importance of booster seat use for children 4 years to 8 years of age. Whenever possible, educational activities should be collaborative and networked with existing state and local agencies that actively advocate for child safety and welfare.

The proposed Booster Seat Advocate Program represents a novel approach to improving booster seat use in Alabama. This project will be statewide in scope and will utilize several important intervention strategies: 1) collaboration and networking with existing local area Child Death Review Team members and agencies; 2) targeting educational efforts to Child Death Review Team reporting areas; 3) identifying local area "booster seat advocates" to lead the local project; 4) providing certified child passenger safety (CPS) technician and/or instructor support to local advocates; 5) providing funding support to local area advocates to establish booster seat educational programs; and 6) providing process and outcome evaluation support to develop improved local booster seat programs and to identify changes in local area booster seat use.

The Booster Seat Advocate program will provide limited funding for each local area site. In total, 10 sites will be identified and selected for implementation. Each site will use its funding for the following activities: 1) travel related to the identification and recruitment of the local area advocates; 2) travel related to scheduling and providing a one-hour child passenger safety educational event or health fair event; 3) travel reimbursement for the assigned CPS technician/instructor educator; and 4) basic supplies required to support the local area Booster Seat Advocate Program.

Each site advocate will sponsor a booster seat awareness event, during which the CPS technician/instructor will provide an educational program and/or assist with a car seat check-up event. This event will emphasize the importance of the use of booster seats. Additionally, written educational materials will be provided. These educational or check-up events will be promoted to parents, school officials, child care providers, law enforcement personnel, and others. Advocates will also coordinate the recruitment of local area members and stimulate agency and business sponsorships to support the Booster Seat Advocate Program.

The use of local area Child Death Review Team members as advocates will serve to augment effective community collaboration and to garner local support. The local advocates will assist in providing education, service (booster seat fitting and acquisition support) and an understanding of Alabama's child restraint legislation. Thus, the Booster Seat Advocate Program is multi-interventional, focused on areas of need and utilizing an existing network of professionals who actively work on behalf of child safety and well-being.

The overall coordination of these efforts will include members of the State Child Death Review Team, Children's Hospital Child Safety Institute, the Healthy Child Care Alabama Program, the University of Alabama at Birmingham Department of Pediatrics, and the Alabama Department of Public Health Injury Prevention Division. Technical expertise and assistance will be provided by Children's Hospital and the Healthy Child Care Alabama nurse car seat technicians.

You will be contacted by one of our child passenger safety specialists to assist in your event coordination and planning.

Jannah M. Bailey, Executive Director
Child Protect
Montgomery, Alabama

The 19th Circuit Child Death Review Teams cover the counties of Autauga, Elmore, and Chilton. Child Protect, the children's advocacy center, coordinates the meetings for the three counties. Each county has its own team, and team members include state troopers and other law enforcement personnel, the county coroner, employees from the Alabama Department of Public Health and the Alabama Department of Human Resources, prosecutors, the medical examiner, and a forensic scientist. The teams meet twice a year in an effort to keep current with and to try and prevent unnecessary child deaths in the counties.

As the coordinator of the teams for the past several years, I have seen team members' level of interest, responsibility, and support increase dramatically. It is rare now that a member is not able to attend a team meeting. Team members have come to realize the importance of the meetings, that these gatherings can literally save the life of a child.

The subject matter of the meetings - the death of children - is no doubt difficult to sit through, particularly when the deaths have to be discussed in detail. Still, the outcomes of these meetings directly impact communities and can help prevent unnecessary deaths of children. Most of the deaths are accidental and, therefore, preventable. There is always much discussion as to what we as a team can do to help educate and inform communities about how to prevent these heartbreaking accidents.

Being proactive as a group is how the team members go from their meetings back out into the community, where they continue to advocate for children - informing parents of the dangers of sleeping with their babies, reminding parents that younger children should always wear helmets when riding bicycles or All-Terrain Vehicles, and insisting that parents put their children in proper restraints when traveling in cars.

The Child Death Review Teams in the 19th Circuit are making a difference in the lives of children, not just in the particular counties they serve but throughout the entire state of Alabama.

Jan McDuff, Chair
Child Death Review Team
Shelby County

Close your eyes and imagine that a child you know has died in a car accident. Now imagine that you have the opportunity to sit on a team with other well-qualified professionals who together can possibly change the outcome for another child. Chances are you would jump at this opportunity if you were able to change the outcome for even one child. This is one of the many goals of Child Death Review Teams.

The Shelby County Child Death Review Team investigates the deaths of all children under the age of 18 that live in the county. If a child resides in Shelby County but dies in another county, the report and investigation are forwarded to our Child Death Review Team.

Our team has had success in reviewing numerous cases and trying to make a difference in the lives of children. When there was an increase in Sudden Infant Death Syndrome (SIDS) in the county, team members put their heads together and prepared and distributed pamphlets that warned new mothers about the dangers associated with placing their infants on their stomachs to sleep.

Our team has also had success in increasing helmet usage by young adults who ride motorcycles and All-Terrain Vehicles. Once again, the team prepared pamphlets, this time for local motorcycle dealers to distribute with every motorcycle or ATV sold to a family with a child or children. The shop owners were more than happy to comply knowing that they may help save the life of a child.

Our team recently participated in the preparation, lobbying for and passage of what is now the *Brantley Law*. This law affords an unborn child the same rights as any other person. In the past, if a mother chose to smoke crack and her unborn child became addicted, prosecutors would have had to wait until the baby was born before they could try to have the mother charged with abuse. Under the *Brantley Law*, the mother can be charged as soon as there is knowledge of drugs in the unborn child's system. Another example: If a drunk driver hits a car driven by a pregnant woman and injures the pregnant woman, the drunk driver could be charged with assaulting not only the woman but her unborn child as well. Should the unborn child be lost as a result of the accident, the drunk driver could be charged with manslaughter.

Our team is also available to help other Child Death Review Teams. Some municipalities do not have the capability to handle a sophisticated crime scene and might need to call in another jurisdiction. Some municipalities might have a small crime scene and may not think they need to call a larger police department for assistance. This is where we may be able to help. Sometimes additional assistance can have a tremendous impact on the outcome of the case, whether or not charges are filed.

Our team's objective is simple: To make a difference in the lives of children.

A ROUND TUIT

Cathy Pinion, Executive Director
CARE House, Inc.
Baldwin County Child Advocacy Center

When I was a child, there was a popular novelty item that was used as a motivational tool - a small, wooden disc with the word "tuit" imprinted on it. My mother gave one to me and each of my siblings and told us to keep a tuit with us at all times. She explained that people often put off doing important things, saying they will do them when they get around to it. "Now," she said, "you don't have an excuse. You will always have 'a round tuit.' "

I have long since lost my "round tuit," but the message has not been lost on me. In this fast-paced, multi-tasking world, it is far too easy to put things off. Not that we are lazy, or that something is not important. We are just overwhelmed with many important things in our lives. Sometimes we work on the tasks that will result in instant awards because they give us that good "sense of accomplishment." We intend to do the other things, too, and we will - as soon as we get "around to it."

The Child Death Review Team meeting is probably one of those things we would never get around to if there were not deadlines for reviewing cases. The meetings are difficult, and the rewards are not immediately known. Sometimes it is hard to get the entire team together since everyone has so much on their plates already. But however unpleasant this task is, it is by far one of the most important. When we go through this process, we discover many things - trends, the need for public information and education and other tools - that help us put together prevention programs that may save another child from the same fate. No, we cannot prevent all accidents, and prevention programs will not reach all citizens. But there are some things we can do that may make a difference.

Recently, our team wrote a letter to Toyota Motor Corporation to point out that one of the company's television commercials sends a dangerous message to children. The commercial shows a father telling his son that the boy's tree house is finished. The child, meanwhile, is sitting in a Toyota mini-van watching videos and playing with another child. The boy asks, "Does it have leather seats … a DVD player … a stereo sound system?" The father looks bewildered as he answers, "No." The child responds: "We're good here." Granted, the children are cute and we may be amused at the father's forlorn look. But I hear a message saying that it is all right (and even good) for a child to play in an unattended vehicle. I believe that this is an unintended message, but children watching the commercial would not necessarily understand that Toyota is just trying to sell a luxury van. Some children might decide to use the family vehicle as a play house. How many deaths of children in unattended vehicles (hyperthermia, choked by automatic window, gear slipping, etc.) do we hear about each year?

So, we wrote a letter. So, that was last year and we have not had any response from Toyota (and, sadly, the commercial still airs). Still, we will continue to look at all the different ways that we can be proactive. I do not know what will come of this situation, but I do know that we have a responsibility to at least try and make changes. We are not ultimately responsible if manufacturers, retailers and others do not make changes, but we are responsible to our children to do the best we can with what we know we need to do.

Sometimes in life, we do not see dramatic results. Sometimes, we do not see results at all. But we must keep on keeping on nonetheless. We do what we are called to do, and we do it to the best of our ability. None of us are serving as team members for money or prestige. We have been called upon to protect our children. That is what keeps our team going. I believe we are making a difference and some day we may hear testimony or see statistics that show we are making a difference. In the meantime, we will continue to pull out our round tuits, roll up our sleeves, and press on. Why? For the sake of our children.

- **Cases That Meet the Criteria for Review** - These are cases involving the deaths of Alabama resident infants and children from birth to less than 18 years of age whose deaths are considered unexpected or unexplained.

- **Cause of Death** - As used in this report, the term "cause of death" refers to the underlying cause of death. The underlying cause of death is the disease or injury/action initiating the sequence of events that leads directly to death, or the circumstances of the accident or violence that produced the fatal injury.

- **Reviewed Cases** - This term includes those cases that were reviewed by a Local Child Death Review Team and added to the Alabama Child Death Review System database.

- **Manner of Death** - This is one of six general categories (Accident, Homicide, Suicide, Undetermined Circumstances, Pending Investigation, or Natural Causes) that is found in Item #49 on an Alabama Death Certificate.

- **Natural Causes** - A manner or cause of death by other than external means (the expected outcome of a disease, birth defect, or congenital anomaly). The ACDRS normally will not review such cases. However, many cases in which the cause of death is initially classified as "Pending" or "Undetermined/Unknown" are later discovered to have been death by "Natural Causes." This is why there are so many in this category included in the data. Sudden Infant Death Syndrome (SIDS) is considered a natural cause of death, but Local Child Death Review Teams are required by law to review all SIDS deaths.

- **Residential Institutions** - As used in this report, this is a term used to identify a place of death. Included in this classification are hospitals and emergency rooms. The number of deaths that occur in this category is usually fairly high because frequently victims survive long enough to reach the hospital, but not much longer. This does not necessarily mean that hospitals are dangerous places, but it does show that hospitals face frequent life or death situations.

- **Unexpected/Unexplained** - In referring to a child's death, this category includes all deaths which, prior to investigation, appear possibly to have been caused by trauma, suspicious or obscure circumstances, child abuse or neglect, other agents, or SIDS.

CALENDAR OF EVENTS

KEY DATES

- **September 1, 2007** - Deadline for completion of calendar year 2005 cases
- **September 20, 2007** - State Team Meeting
- **November 15, 2007** - State Team Meeting

...We are all part of the solution

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