ALABAMA CHILD DEATH REVIEW SYSTEM REPORT

REPORT FOR COMPLETED 2008-2009 DATA

Learning from the Past to Protect the Future...

DEATHS AMONG CHILDREN IN ALABAMA

ALABAMA CHILD DEATH REVIEW SYSTEM

ANNUAL REPORT - 2008-2009 DATA

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A LETTER FROM THE STATE CHAIRMAN

March 1, 2013

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

Child Death Review (CDR) methodology began years ago with the systematic investigation of child abuse and neglect deaths and grew in scope to include other causes of death. In 1997, ACDRS was created under state law and is funded primarily by the Children First Trust Fund. ACDRS reviews the circumstances and underlying factors of all infant and child deaths in Alabama in order to identify those deaths which possibly could have been prevented. The findings of these reviews, as well as the recommendations drawn from them, are reported to state officials, state agencies, and to the general public. In addition to collecting and reporting data, ACDRS develops new literature and educational programs on many prevention topics including child passenger safety, teen driving, safe infant sleeping, and youth suicide. The data and related findings are used to make recommendations about policy changes at the state and local levels.

ACDRS consists of the State Office, Local CDR Teams throughout the state, and the State CDR Team. The State Office is responsible for program coordination and is instrumental in implementing strategies to make the public aware of ways to prevent future infant and child deaths. The Local CDR Teams are responsible for the in-depth analysis of individual cases assigned to them by the State Office and for making recommendations about how to prevent future infant and child deaths. The State CDR Team is a 28-member multidisciplinary team which meets quarterly and serves as an advisory board. Those involved with ACDRS at every level remain committed to the mission of preventing childhood injuries and fatalities in Alabama through education and public awareness.

This report presents new data collected and analyzed related to infant and child deaths in Alabama since adopting new procedures in 2008 as well as legacy data from ACDRS's first decade of operations. It includes multi-year analysis and illustrates some of the trends which are so important to our research, awareness efforts, and prevention activities. It also highlights some of the past successes, significant changes, current challenges, and future plans of ACDRS. We hope that you will find this information useful.

Sincerely,

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

Alabama Child Deaths

2008 – 2009

There were 1,719 children under the age of 18 who died in Alabama during the years 2008 and 2009. An examination of the deaths on a year-by-year basis reveals that in 2008 there were 923 deaths and in 2009 there were 796 child deaths in the state.

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

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

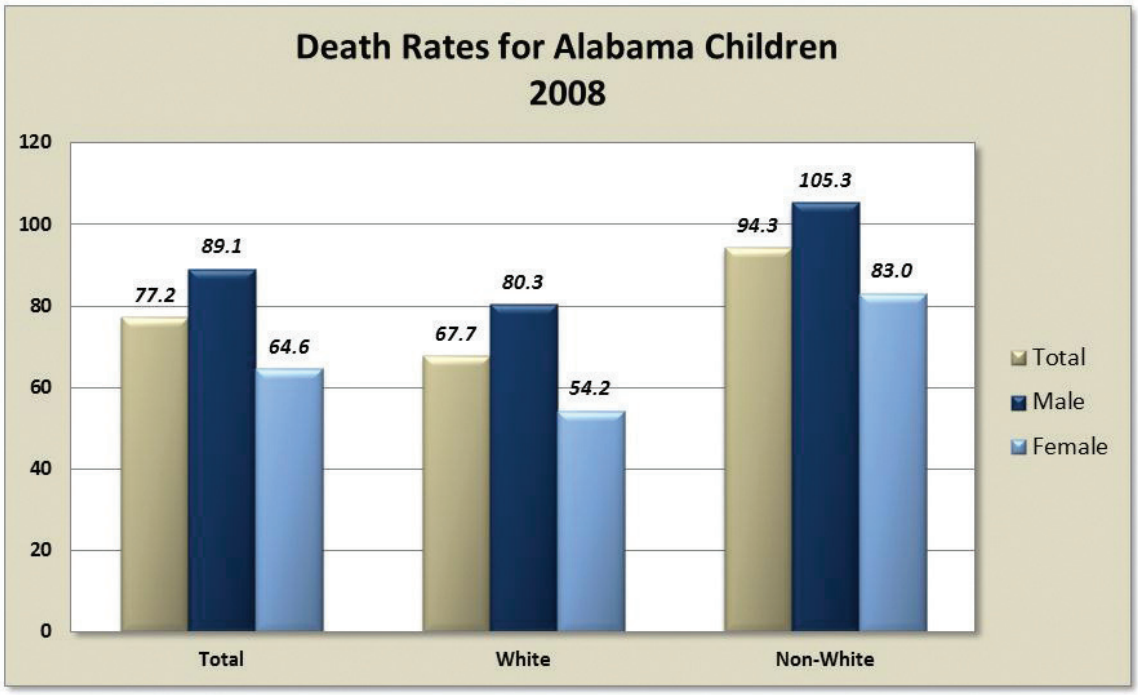
ACDRS was created by state law in 1997. What follows is a look at unexpected and unexplained child deaths in Alabama during 2008 and 2009.

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.

KEY FINDINGS

- There were 923 infant and child deaths (those under the age of 18) during 2008.
- The 2008 findings represent approximately 77.2 deaths per 100,000 children.*
- Of the deaths, 58 percent were male children.
- Of the deaths, 41 percent were non-white children.

- Below is a graph showing the total race-specific and gender-specific death rates (per 100,000 children) among children in Alabama in 2008. The graph allows for comparison of death rates among specific population groups.*

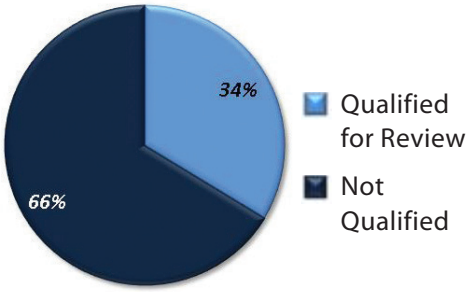


* Please note that race and/or gender information was unavailable for 56 deaths in 2008 which results in an underestimation in the death rates for 2008.

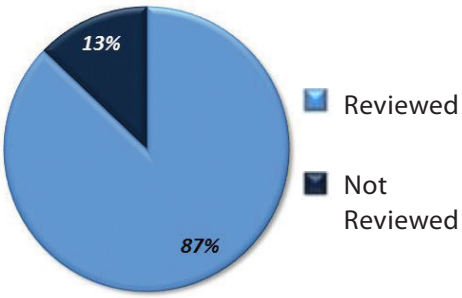
The data used for this portion of the report was provided by the Alabama Child Death Review System's Access Database.

KEY FINDINGS

- As the chart below indicates, of the 923 child deaths in Alabama in 2008, there were 311 deaths that year that qualified for review under the Alabama Child Death Review System.



- Of the deaths that qualified for review (311), the Local Child Death Review Teams reviewed and returned 271 reports (see chart below). There was a significant decrease in the percentage of reviewed deaths from 2007.

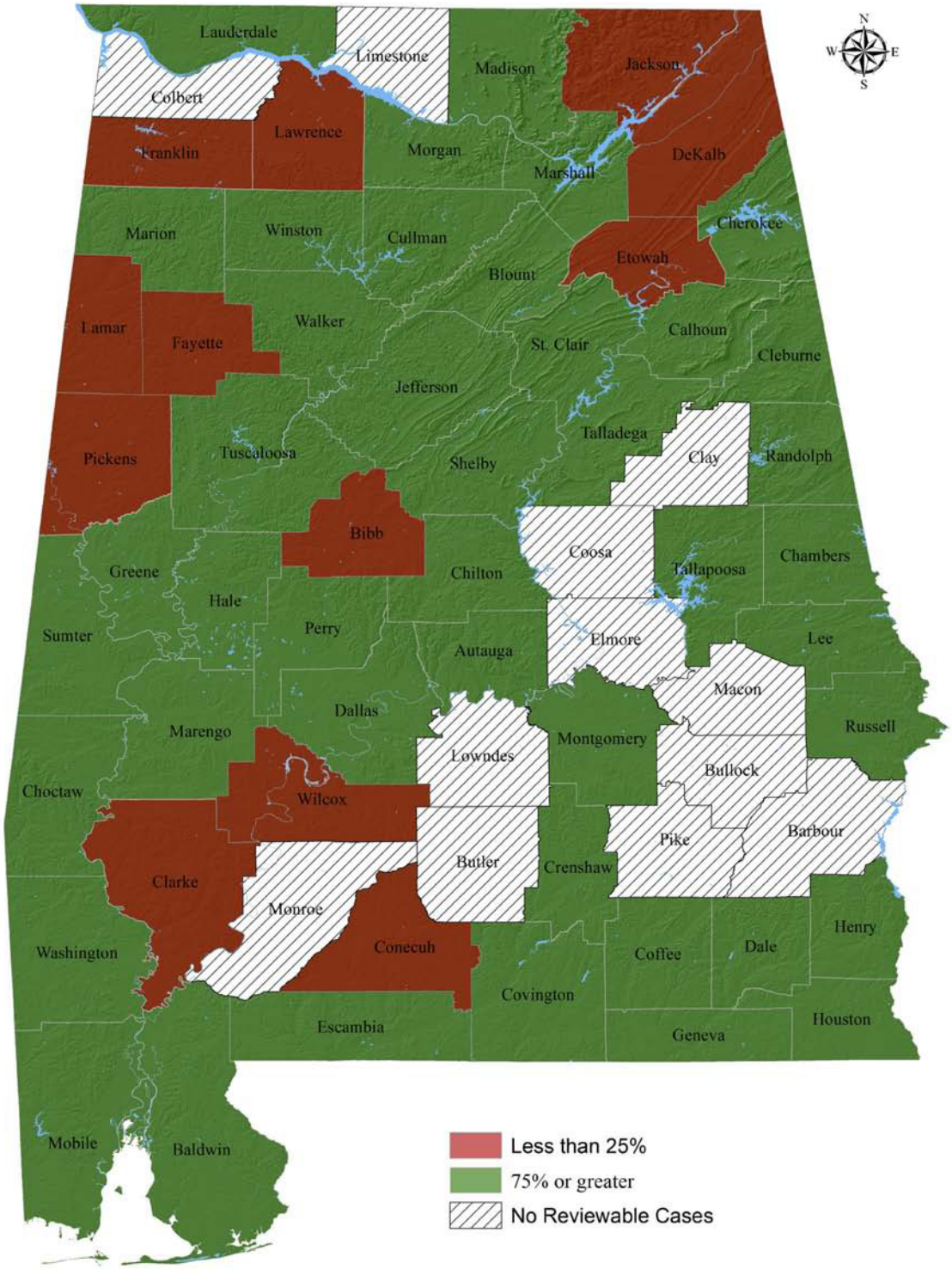


- In 2008, there were no significant race or gender differences in the proportion of cases reviewed compared to those cases not reviewed.

- There were no significant age group differences between those who were and those who were not reviewed.

AGE GROUP	*ALL*	*QUALIFIED*	*REVIEWED*	*QUALIFIED BUT NOT REVIEWED*
< 28 days	365	10	9	1
28 days – < 1 year	229	104	90	14
1 year – < 5 years	89	40	36	4
5 years – < 10 years	50	23	18	5
10 years – < 16 years	104	64	54	10
16 years – < 18 years	83	70	64	6

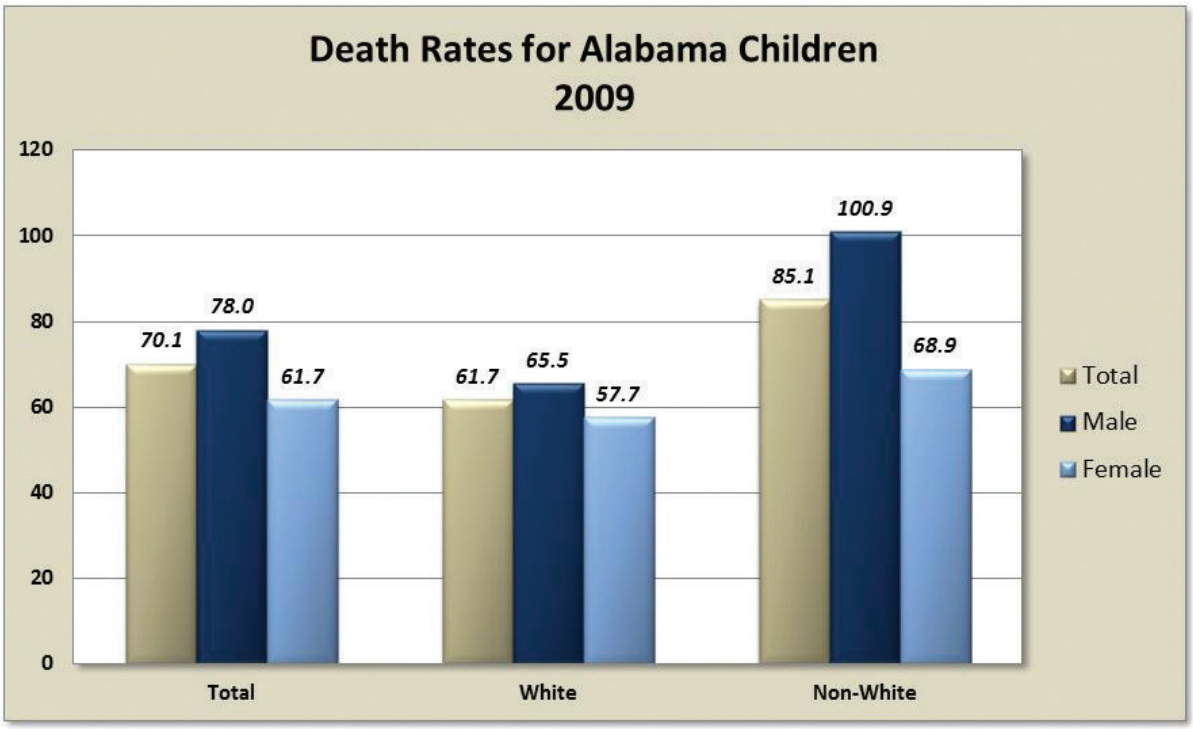
- There was a wide variety in the percentage of qualified cases that were reviewed and returned in 2008. The map below indicates the return rate for each Local Child Death Review Team. The goal is a 100 percent return rate.



KEY FINDINGS

- There were 797 infant and child deaths (those under the age of 18) during 2009.
- The 2009 findings represent approximately 70.1 deaths per 100,000 children.*
- Of the deaths, 56.5 percent were male children.
- Of the deaths, 42.8 percent were non-white children.

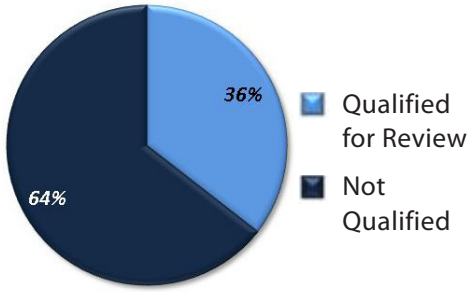
Below is a graph showing the total race-specific and gender-specific death rates (per 100,000 children) among children in Alabama in 2009. The graph allows for comparison of death rates among specific population groups.*



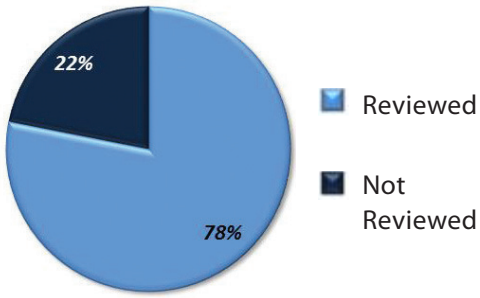
* Please note that race and/or gender information was unavailable for 10 deaths in 2009 which results in an underestimation in the death rates for 2009.

KEY FINDINGS

- As the chart below indicates, of the 797 child deaths in Alabama in 2009, there were 283 deaths that year that qualified for review under the Alabama Child Death Review System.



- Of the deaths that qualified for review (283), the Local Child Death Review Teams reviewed and returned 221 reports (see chart below). There was a significant decrease in the percentage of reviewed deaths from 2008.

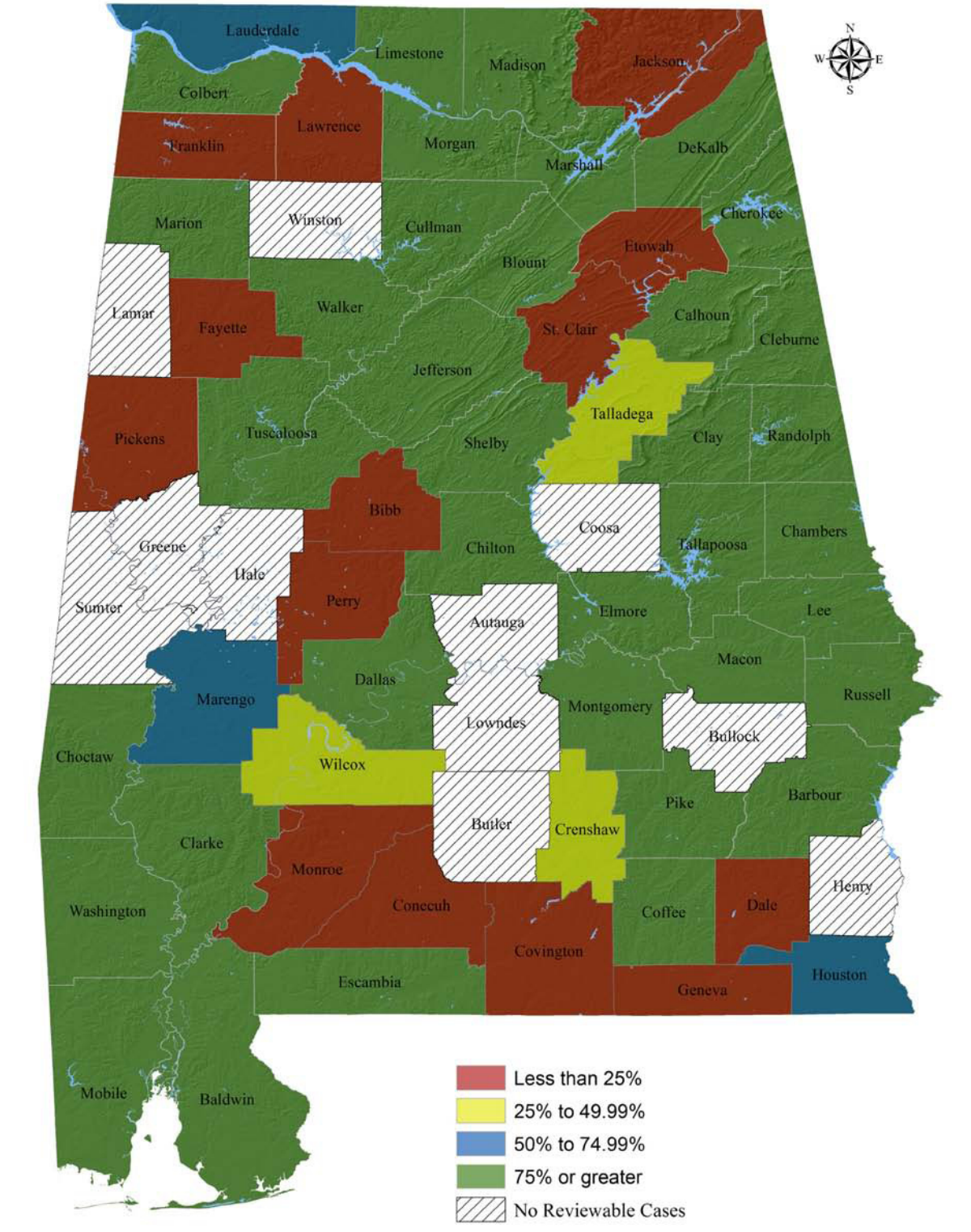


- In 2009, there were no significant race or gender differences in the proportion of cases reviewed compared to those cases not reviewed.

- There were no significant age group differences between those who were and those who were not reviewed.

AGE GROUP	*ALL*	*QUALIFIED*	*REVIEWED*	*QUALIFIED BUT NOT REVIEWED*
< 28 days	307	8	6	2
28 days – < 1 year	194	94	73	21
1 year – < 5 years	98	53	40	13
5 years – < 10 years	39	17	13	4
10 years – < 16 years	89	54	41	13
16 years – < 18 years	70	57	48	9

- There was a wide variety in the percentage of qualified cases that were reviewed and returned in 2009. The map below indicates the return rate for each Local Child Death Review Team. The goal is a 100 percent return rate.



2008-2009 CATEGORIES OF DEATH

KEY FINDINGS

- A total of 72 cases were reviewed in 2008.
- Sixteen of these deaths (22.2 percent) involved young drivers (those 16 years to 17 years of age).
- Three of these deaths (4.2 percent) involved underage drivers (those under the age of 16).
- Twelve of the deaths (16.7 percent) were listed as being due to an inexperienced driver.
- In 18 deaths (25 percent), lap and shoulder belts were present but not used. One death (1.4 percent) was the result of restraints not being used correctly.
- Additionally, 21 of these deaths (29.2 percent) were caused by speeding, 19 of these deaths (26.4 percent) were caused by reckless driving, and 10 deaths (13.9 percent) were caused by driver distraction.

KEY FINDINGS

- A total of 54 cases were reviewed in 2009.
- Eleven of these deaths (20.4 percent) involved young drivers (those 16 years to 17 years of age).
- Two of these deaths (3.7 percent) involved underage drivers (those under the age of 16).
- Eight of the deaths (14.8 percent) were caused by driver inexperience.
- For nine of these deaths (16.7 percent), lap and shoulder belts were present but not used.
- In two of the deaths (3.7 percent), child seats were present, but used incorrectly. In one death, a child seat was needed but was not present.
- Additionally, 14 of these deaths (25.9 percent) were caused by speeding, 12 of the deaths due to motor vehicle involvement (22.2 percent) were caused by reckless driving, and 6 deaths (11.1 percent) were caused by drug or alcohol use.

RECOMMENDATIONS

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

KEY FINDINGS

- Twenty-three suspected cases of Sudden Infant Death Syndrome (SIDS) were reviewed in 2008.
- The initial sleeping position of 21.7 percent of the babies whose deaths were reviewed is not known; however 8.7 percent were placed on their stomachs, which is a known risk factor for SIDS.
- Of those cases reviewed, eight infants (34.8 percent) were sleeping in adult beds and 21.7 percent were not sleeping alone. These numbers may not fully represent the situation given our lack of knowledge about the deaths in cases where the position of the infant was unknown.
- In nine of the reviewed cases (39.1 percent) the infant was exposed to second hand smoke. In six cases (26.1 percent), the infant was frequently exposed.

KEY FINDINGS

- Twenty-three suspected cases of Sudden Infant Death Syndrome (SIDS) were reviewed in 2009.
- Six infants (26.1 percent) were placed on their stomachs to sleep, which is a known risk factor for SIDS.
- Of those cases reviewed, 10 infants (43.5 percent) were sleeping in adult beds and five (21.7 percent) were not sleeping alone. These numbers may not fully represent the situation given our lack of knowledge about the deaths in cases where the position of the infant was unknown.
- In two of the reviewed cases (8.7 percent) the infant was exposed to second hand smoke. In six cases (26.1 percent), the infant's exposure to second hand smoke was unknown.

RECOMMENDATIONS

1. Increase public awareness about the dangers associated with infants sleeping with adults in adult beds.
2. Increase public awareness of the "Safe to Sleep" campaign and similar efforts.
3. Teach and promote the use of Alabama's Sudden Unexplained Infant Death Investigation (SUIDI) protocols.
4. Provide increased public education and encourage strict adherence to the American Academy of Pediatrics guidelines for preventing SIDS and reducing risks associated with infant sleeping environment.
5. Ensure that all child deaths in Alabama are reported to the appropriate authorities.
6. Help to ensure that forensic lab capacity is sufficient to meet the needs of the state.

KEY FINDINGS

- Twelve cases were reviewed in 2008.
- In three of these cases (25 percent), fire was the result of electrical wiring in the child's place of residence.
- Smoke alarms were absent in four cases (33.3 percent) of fire-related death. A smoke alarm was present in one case (8.3 percent).
- Five cases (41.7 percent) of fire-related death occurred in a trailer or mobile home. Five cases (41.7 percent) occurred in a single home.
- In three of the cases, the child died of burns, while nine cases (75 percent) of the fire-related deaths resulted from smoke inhalation.

KEY FINDINGS

- Eight cases were reviewed in 2009.
- In three of these cases (37.5 percent), fire was the result of electrical wiring in the child's place of residence.
- Smoke alarms were absent in six cases (75 percent) of fire-related death.
- One case (12.5 percent) occurred in a mobile home. Four cases (50 percent) occurred in a single home.
- In two of the cases, the child died of burns, while five (62.5 percent) of the fire-related deaths resulted from smoke inhalation.

RECOMMENDATIONS

1. Encourage enforcement of laws governing smoke detector installation, testing, and inspection in all homes, including new and used manufactured homes.
2. Support local fire departments in developing, expanding, and implementing fire education activities, particularly for elementary schools and child-care facilities.
3. Encourage community education efforts about the need for installation and periodic testing of smoke detectors in homes, businesses, and places of worship.
4. Encourage families to prepare, discuss, and practice a "Home Fire/Emergency Plan" for their households.

KEY FINDINGS

- Eighteen cases were reviewed in 2008.
- Thirteen of these deaths (72.2 percent) occurred in a swimming pool, hot tub or spa.
- Four of these deaths (22.2 percent) occurred in open water. Three deaths (16.7 percent) occurred in a river and one case occurred in a pond.
- Of the 18 drowning deaths, in 12 cases (66.7 percent) a flotation device was not being used.
- In nine of the cases (50 percent), it was reported that the child was unable to swim.

KEY FINDINGS

- Seventeen cases were reviewed in 2009.
- Six of these deaths (35.29 percent) occurred in a swimming pool, hot tub or spa.
- Seven of these deaths (41.18 percent) occurred in open water. Three deaths (17.7 percent) occurred in a river and two cases occurred in a pond.
- A personal flotation device was not being used during 12 of these cases (70.6 percent).
- In seven of the cases (41.2 percent), it was reported that the child was unable to swim.

RECOMMENDATIONS

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

KEY FINDINGS

- Twenty-two cases were reviewed in 2008.
- Eight cases of suffocation, five cases of strangulation, and two cases of choking were reviewed in 2008.
- In eight cases (36.4 percent), the suffocation was reported to be sleep-related (e.g. bedding, overlay, wedged). (Note: This is not a duplication of cases identified in the Sudden Infant Death Syndrome section.)
- Three of these victims (13.6 percent) were reported to be sleeping in an adult bed when the death occurred. Three deaths (13.6 percent) occurred while a child was sleeping on a couch.
- A belt caused the strangulation in two cases, while clothing caused one additional case of strangulation.

KEY FINDINGS

- Fifteen cases were reviewed in 2009.
- Four cases of suffocation and four cases of strangulation were reviewed in 2009.
- In four cases (26.7 percent), the suffocation was reported to be sleep-related (e.g. bedding, overlay, wedged). (Note: This is not a duplication of cases identified in the Sudden Infant Death Syndrome section.)
- Six of these victims (40 percent) were reported to be sleeping in an adult bed when the death occurred. Two deaths (13.3 percent) occurred while a child was sleeping on a couch.
- A belt caused the strangulation in two cases, while a rope or string caused two additional cases of strangulation.

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 2011 American Academy of Pediatrics guidelines for reducing risks associated with infant sleep environment.

KEY FINDINGS

- Forty-two cases were reviewed in 2008.
- Thirty-four of these deaths (80.9 percent) were the result of firearm use, with 19 deaths (45.2 percent) caused by handgun use and six deaths (14.3 percent) caused by rifle/shotgun use.
- Four deaths (9.5 percent) were caused by a sharp instrument.
- In 10 cases (23.8 percent), the use of the weapon at the time was for the commission of crime. In four cases, the weapon was used during an argument.
- Six of the deaths (14.3 percent) reviewed in this category were reported to be the result of playing with firearms.
- Six of the 41 children (14.3 percent) were killed by a weapon being handled by a family member.

KEY FINDINGS

- Thirty-one cases were reviewed in 2009.
- Twenty-six of these deaths (83.9 percent) were the result of firearm use, with 17 deaths (54.8 percent) caused by handgun use and seven deaths (22.6 percent) caused by rifle/shotgun use.
- Eight of the cases (25.8 percent) reviewed in this category were reported to be the result of playing with firearms. In two cases, the weapon was used during an argument.
- Three of the 31 children (9.7 percent) were killed by a weapon being handled by a family member.
- The firearm in four cases (12.9 percent) was stored in an unlocked cabinet. In one case, the firearm was stored under the mattress or pillow.

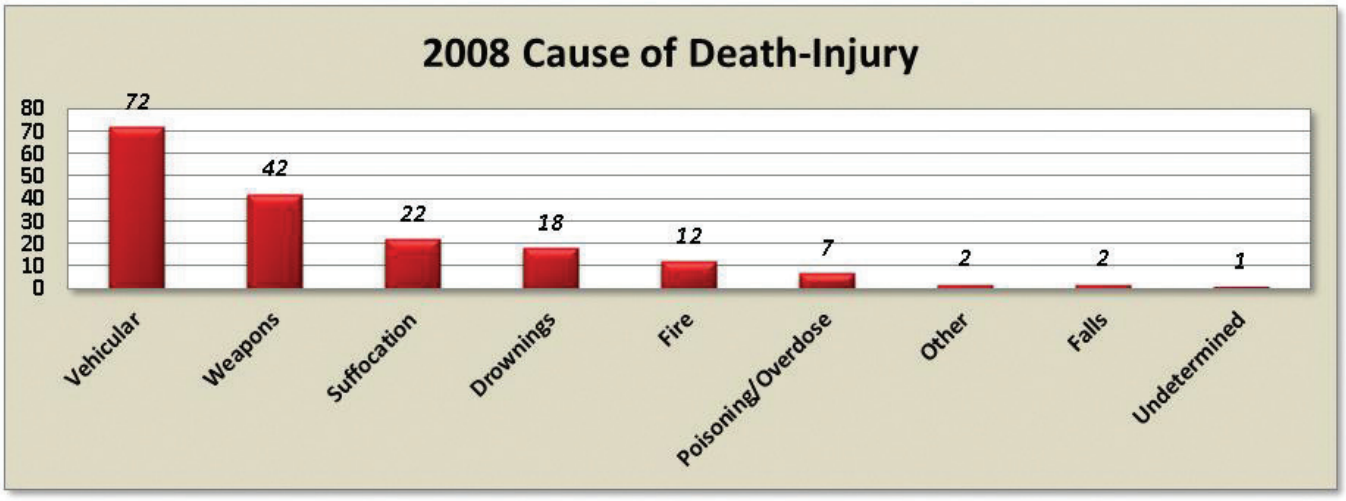
RECOMMENDATIONS

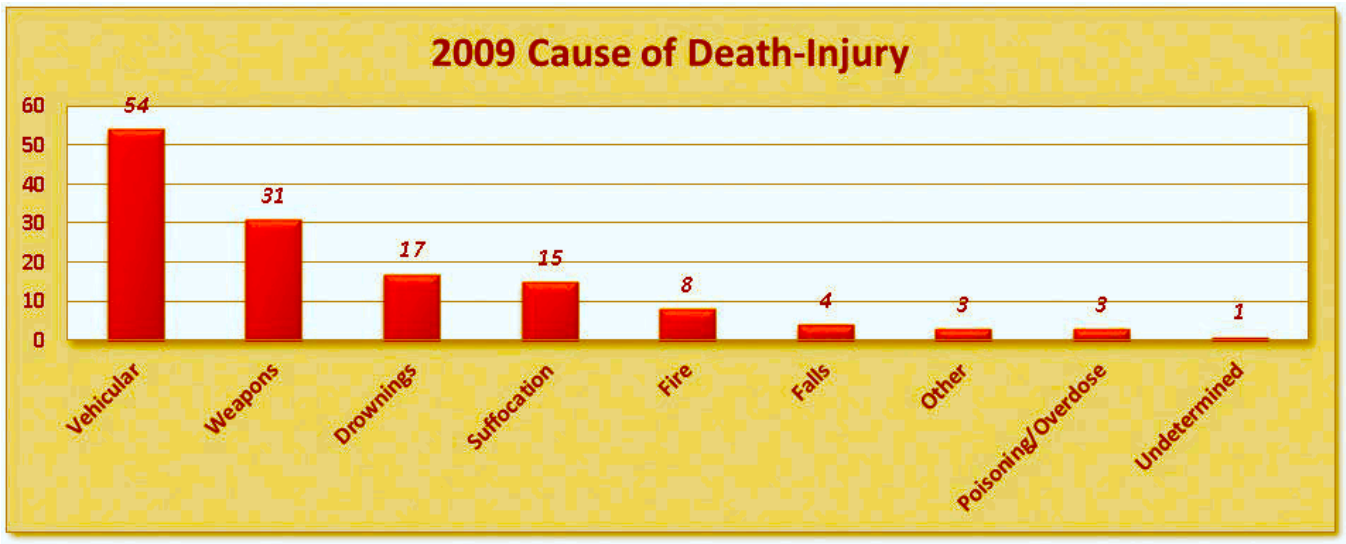
1. Encourage safe and secure storage of firearms.
2. Encourage gun safety education for children and parents.
3. Support crisis team and victim advocacy for children who witness violence.
4. Support after-school and evening education and recreation programs for high-risk youth.
5. Encourage community-based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

REVIEWED CASES ONLY

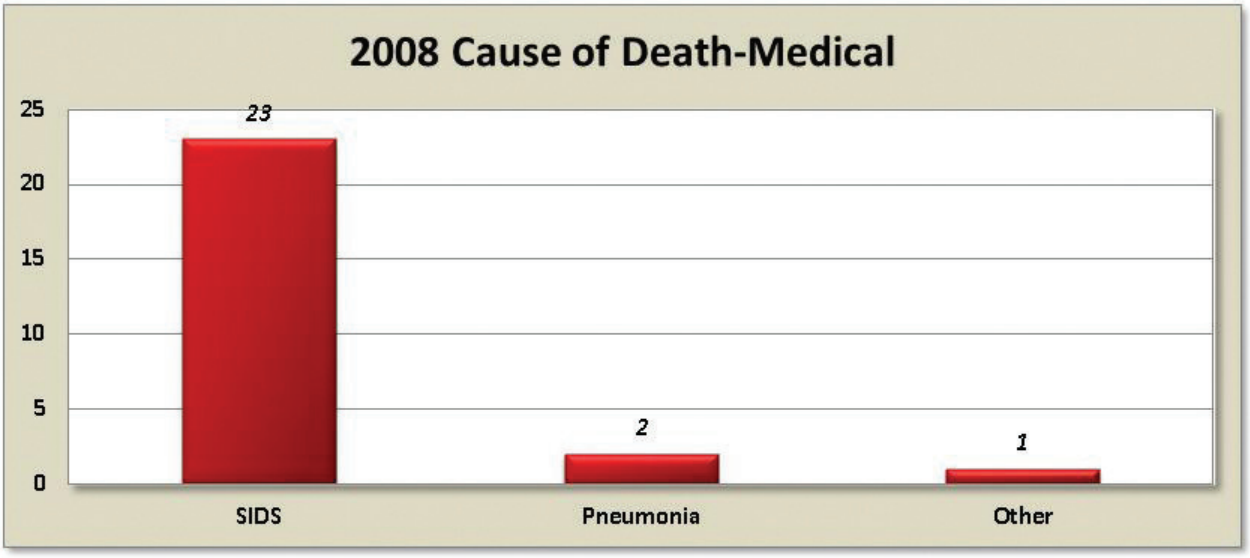
- Accident was the most frequently reviewed manner of death in 2008 (52 percent) and 2009 (46 percent).

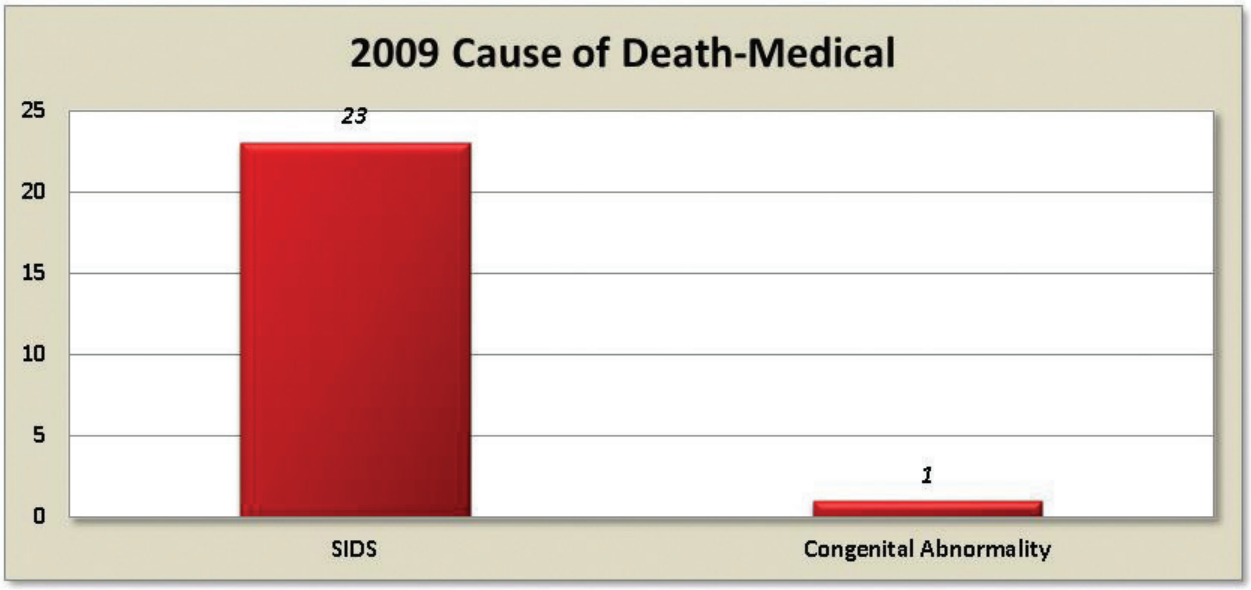
- Motor vehicle involvement was the most frequently reviewed cause of child death from an injury in 2008 (40 percent) and 2009 (40 percent).



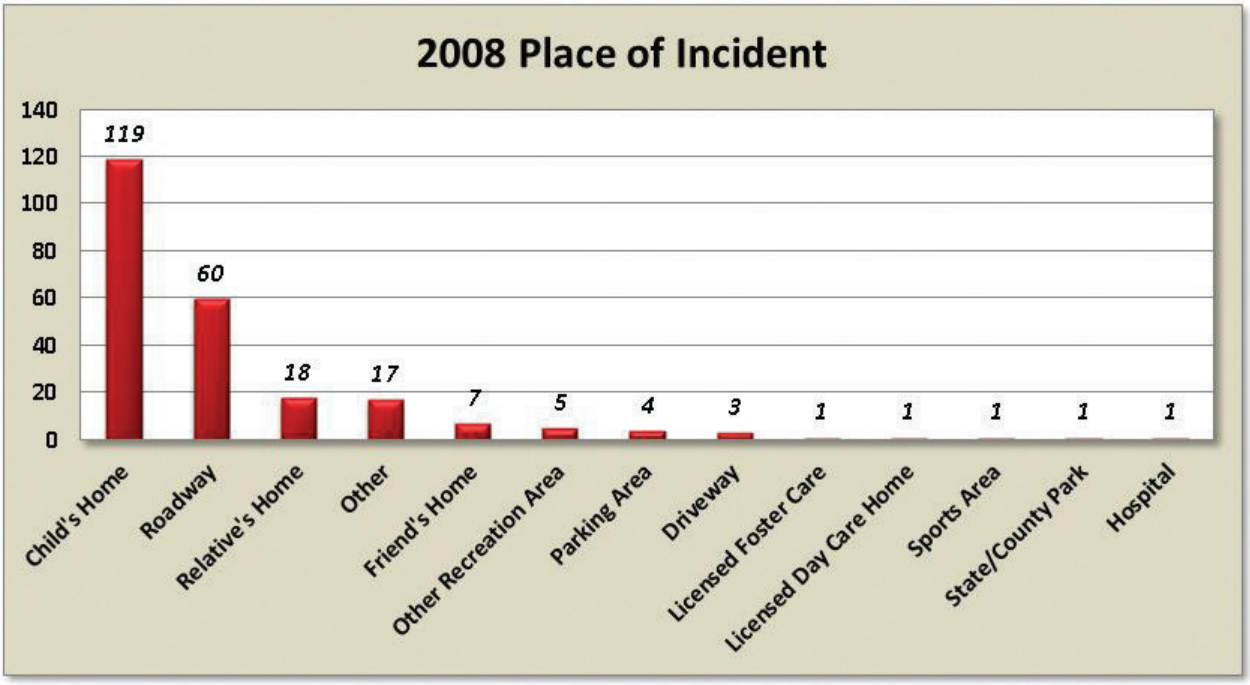


- SIDS was the most frequently reviewed case of child death from a medical cause in 2008 (88 percent) and 2009 (96 percent).

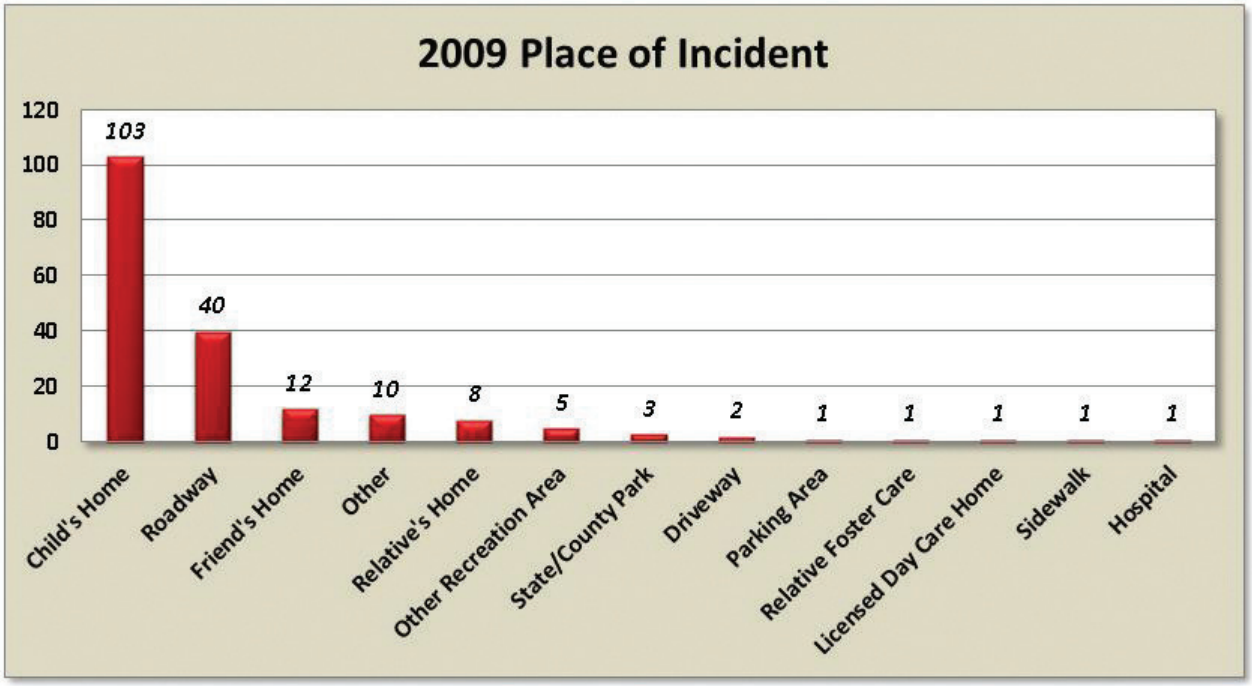




- In 2008, the child's home was the single most frequent place of incident (50 percent) followed by the roadway (25 percent).

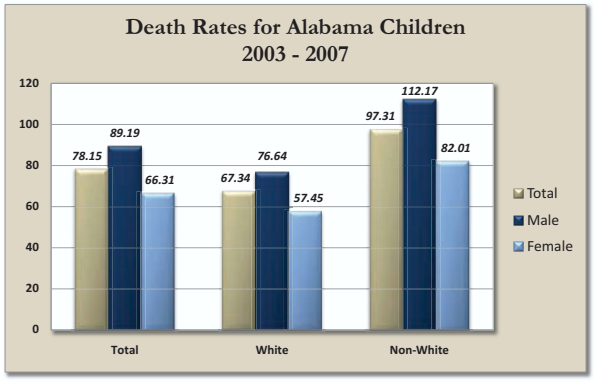


- In 2008, the child's home was the single most frequent place of incident (50 percent) followed by the roadway (25 percent).

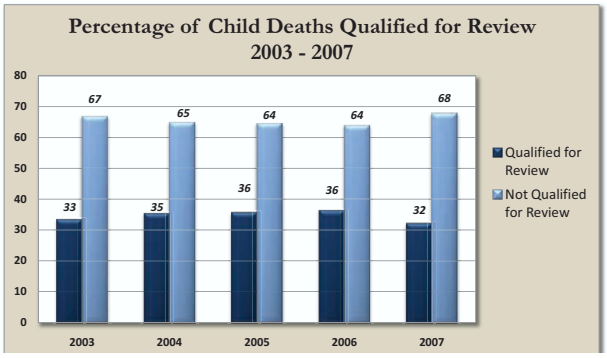


2003-2007
DATA FOR COMPARISION

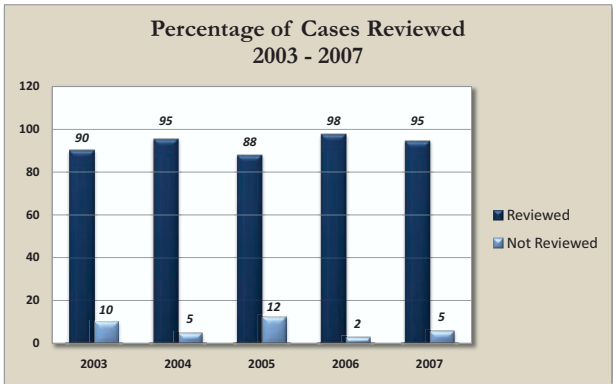
Below is a graph showing the total race-specific and gender-specific death rates (per 100,000 children) among children in Alabama from 2003 through 2007. This allows for comparison of death rates among specific population groups.



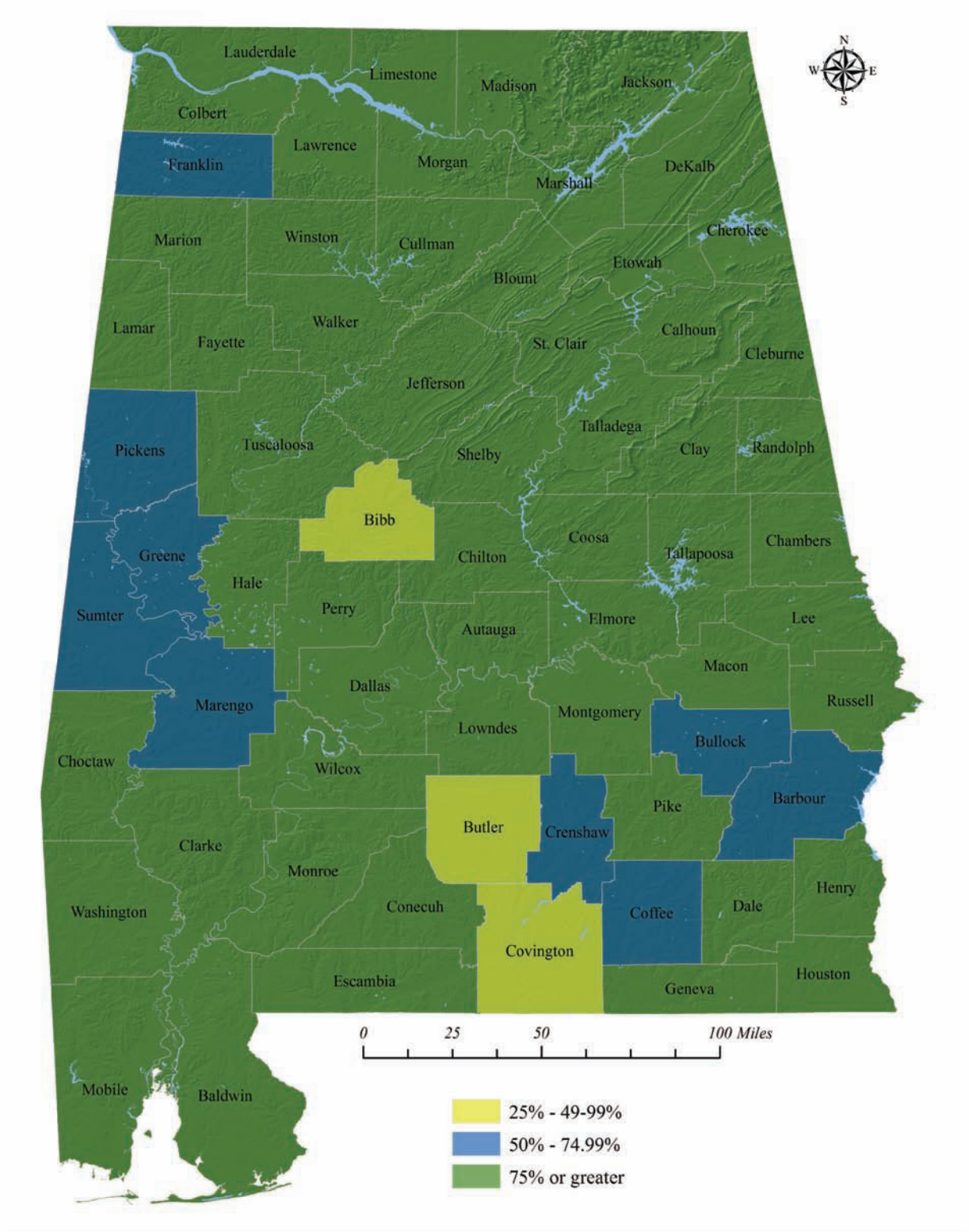
Of the 4,387 child deaths that occurred during the years 2003 through 2007, those that qualified for review under ACDRS totaled 1,512 (35 percent). The percentage of child deaths that have qualified for review has remained fairly constant over the five-year period.

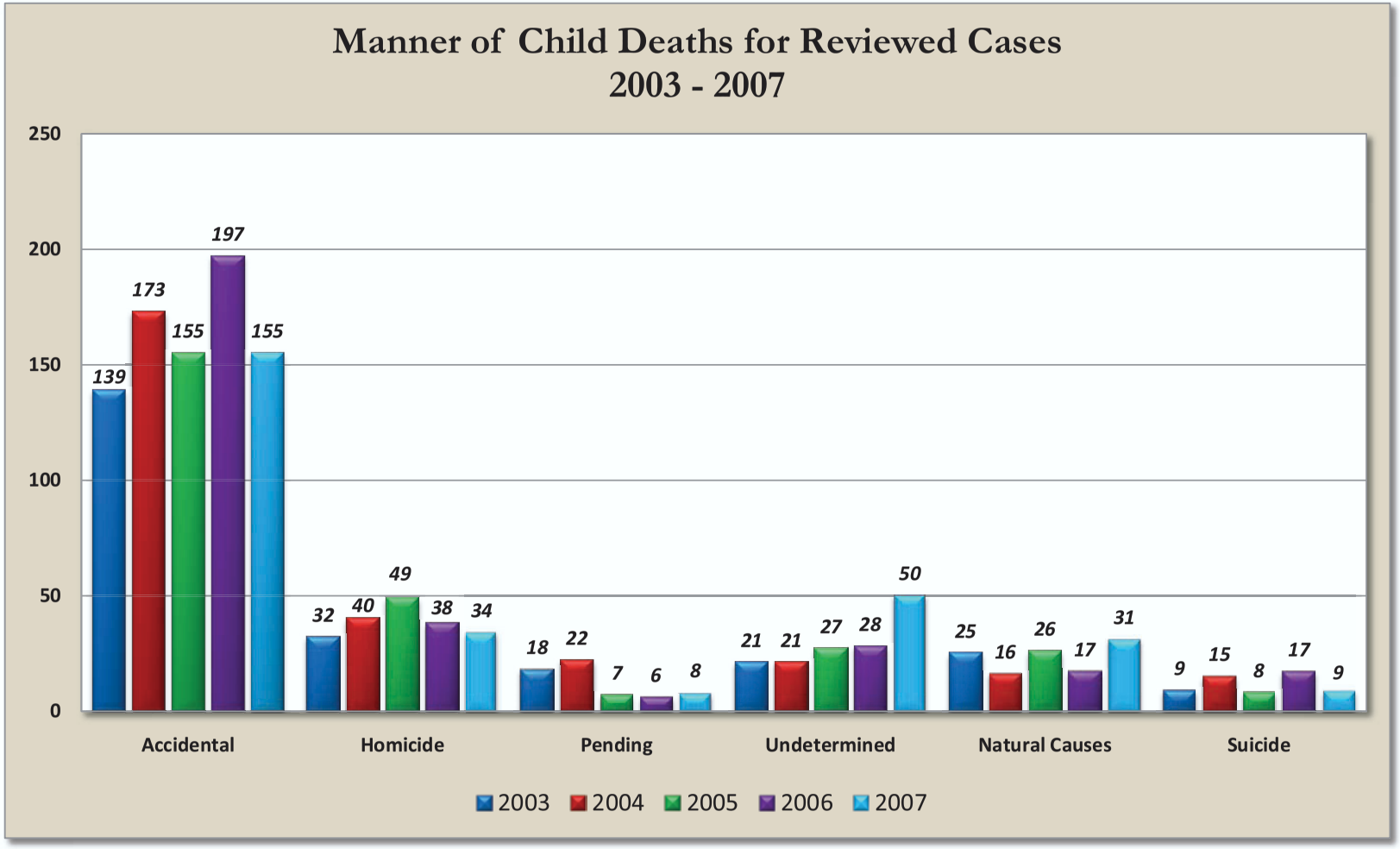


Of the total number of deaths that qualified for review during the years 2003 through 2007, the Local Child Death Review Teams reviewed and returned 1,408 cases (93.1 percent). The percentage of cases that qualified for review and were in fact reviewed has increased slightly over the five-year period.

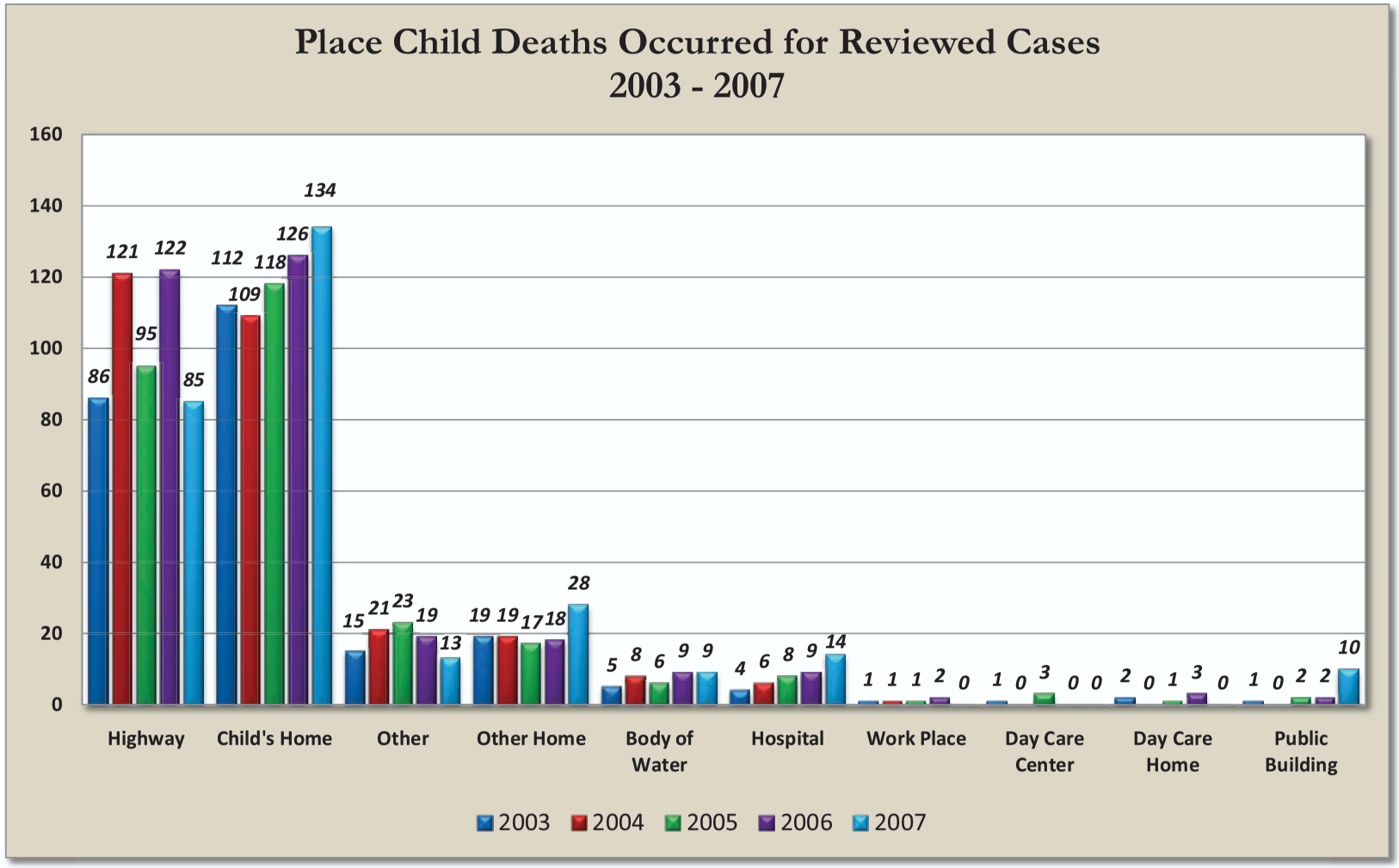


- The map below shows the case return rate of each Local Child Death Review Team for the years 2003 through 2007. While there are areas that can improve on the rate of review, all review teams should be commended for their efforts.

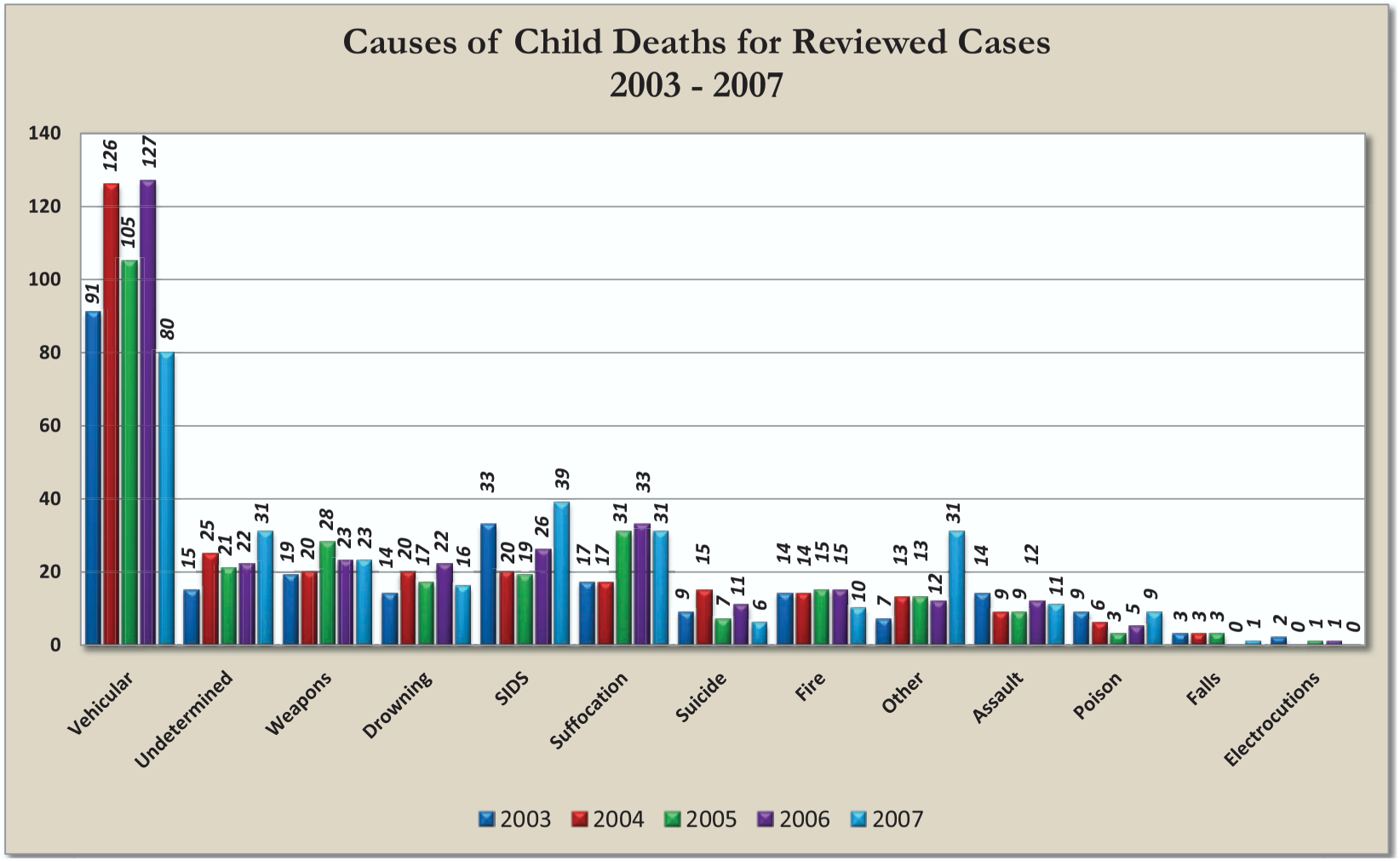




- The chart displays some fluctuation by year, although undetermined deaths show a slight increase while natural causes have decreased. This is possibly explained by reclassification of some child-related deaths.



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



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

ALABAMA CHILD DEATH REVIEW SYSTEM: THE NEXT CHAPTER

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Change is often essential to success and, sometimes, even to survival itself. The Alabama Child Death Review System (ACDRS) has experienced major changes in the past few years. Fortunately, along with those changes and the challenges associated with them, we have been presented with many exciting new opportunities as well.

Throughout its first decade of existence, ACDRS collected data using a proprietary system developed internally. Beginning with 2008 child death cases, ACDRS adopted a completely new data collection tool which is part of a standardized national CDR data collection system now used by most states in the nation. It is a secure and interactive web-based system provided cost-free to us through an agreement with the National MCH Center for Child Death Review. Our Local CDR Teams throughout the state are trained on the new system and contributing data to it now, but the transition was not an easy one. Everyone involved with ACDRS statewide had to be trained on and learn the new system and that led to delays and a temporary reduction in case completion rates. These challenges were not a surprise, but their magnitude was much greater than expected. In fact, this report has been delayed and now covers the first two years under the new system because of those transitional challenges. Our next report will likely also cover two calendar years and, by then, the system should be caught up from the system change. Once all is said and done, the new system should lead to more thorough reviews and more efficient and effective reporting.

In 2011, ACDRS experienced an even bigger change when it was relocated within ADPH, both physically and administratively. ACDRS, which had been located within ADPH's Bureau of Family Health Services since its creation, was organizationally moved to the Bureau of Health Promotion and Chronic Disease. At the same time the position of ACDRS Director was combined with the position of the Director of the Injury Prevention Branch. Both of these moves made strategic and administrative sense, because ACDRS has always worked very closely with Health Promotion staff on outreach and education materials and the Injury Prevention programs on issues of mutual interest. As positive as these moves and changes eventually were, it was still a difficult and challenging time for the programs and for all staff involved. In the end, however, this has led to new and better collaborations and combined efforts that seem to have benefited all programs involved.

ACDRS now continues in its second decade of operation, having been challenged by all of these changes but undeterred in its mission to protect Alabama's children. We have faced those programmatic changes above while experiencing the common challenges faced by most agencies and programs these days with regard to reduced budgets and economic concerns, demographic and political shifts, and sweeping governmental reforms at all levels. But along with all of these challenges we have discovered new opportunities to pursue our goals. We will continue to strive to "learn from the past to protect the future" in our daily work and it is our sincere hope that Alabama's families will benefit from our efforts.

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

- An infant or child death occurs on September 1, 2012.
- The death certificate is received at ACDRS State Office by November 1, 2012, barring delays. Delays sometime result in certificates being received several months after the death.
- The case is assigned to the appropriate Local Child Death Review Team (LCDRT) by November 15, 2012.
- The LCDRT meets to review this specific case and others during 2013 and/or 2014. (By law, each Local Team is required to meet only once per calendar year and all information necessary to the review process may not be available for several months after the death.)
- The ACDRS State Office receives the last of the 2012 death certificates by July 2013.
- April 1, 2015, is the deadline by which the ACDRS State Office is to receive all 2012 cases that have been reviewed and completed by LCDRTs.
- The ACDRS Annual Report on 2012 Data is published during 2015.

ALABAMA CHILD DEATH REVIEW SYSTEM: SUCCESSES

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

Local Child Death Review Teams

The Alabama Child Death Review System has a Local Child Death Review Team (LCDRT) in every Judicial Circuit in the state. These teams continue to meet and review child death cases that occurred within their jurisdictions. Following the delays and challenges related to the transition between data collection systems, most Teams are now entering current data into the new national online collection system and case completion rates are beginning to approach past levels. We should again soon see the standard-setting levels that we experienced before retiring the old system thanks to the impressive efforts of our Local Teams.

ACDRS Training

In the past, ACDRS has conducted statewide training every other year, in even-numbered years. After conducting smaller regionalized trainings in 2010, ACDRS returned to a three day statewide training conference in 2012. The 2012 conference was held in July in Birmingham and culminated with a quarterly State CDR Team meeting. The conference was well-attended and well-received.

Teen Driving Safety Campaign

In 2010, ACDRS began a multifaceted campaign to promote teen driving safety that continues today. We introduced a new website (www.acdrs.org/teendriving) and a new brochure, Surviving Teen Driving, both of which have been well-received. We also conducted a media campaign, promoting both of these new resources, which was publicly commended by the U.S. Secretary of Transportation. Vehicular deaths continue to be the leading cause of preventable child deaths in Alabama and safe teen driving, along with proper child passenger restraint and ATV safety, remains a primary issue of concern for ACDRS.

Alabama SUIDI Team

The CDC has established standardized tools and protocols for Sudden Unexplained Infant Death Investigation (SUIDI) which have been adopted nationwide. The ACDRS Director is proud to chair the Alabama SUIDI Team which has been codified as a sub-committee of the State CDR Team. The Team has developed a formal SUIDI training course for Alabama which is now required for all Coroners, Deputy Coroners, and certain law enforcement investigators. On-site training has been conducted for many groups of first responders statewide, and most of the state's Coroners and Deputy Coroners received the training at their annual conference. A distance learning approach will be employed for most future trainings. The dissemination of this important information should greatly improve infant death scene investigations, the accuracy of infant death diagnoses, and the overall usefulness of the information ACDRS collects regarding infant deaths.

The Alabama Cribs for Kids Program

The Cribs for Kids Program in Alabama began in Montgomery as a pilot program. Cribs, along with personal instruction regarding safe infant sleeping, have been provided to many qualifying families in the Montgomery County area with the help of the Gift of Life Foundation. After the success of the initial program there, Gift of Life and ACDRS expanded the program to other counties in the state. Jefferson, Mobile, and Escambia Counties now have similar programs in place and we hope to expand our efforts with the Cribs for Kids Program to Madison and other Alabama counties in the future.

Child Passenger Safety Efforts

The Booster Seat Advocacy Program is a joint effort of ACDRS, Children's Hospital Child Safety Institute, UAB Department of Pediatrics, and the Alabama Department of Public Health's Injury Prevention Branch. The program was initiated after the passage of the enhanced child restraint amendment in Alabama. Booster seats are provided to families throughout Alabama to ensure that children who are too large for infant seats but too small to be adequately protected by seat belts alone are protected while riding in passenger vehicles. ACDRS Central Office staff are all also trained Child Passenger Safety (CPS) Technicians and routinely conduct local CPS clinics in conjunction with other partners.

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 the incidence of these tragedies as much as possible.

ALABAMA CHILD DEATH REVIEW SYSTEM
FREQUENTLY ASKED QUESTIONS

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

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

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

4. **How is ACDRS organized?**
   - The ACDRS **State Office** is located in the Alabama Department of Public Health, within the Behavioral Health Division of the Bureau of Health Promotion and Chronic Disease. There are three full-time staff members as well as part time support staff.
   - 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 ACDRS considers itself a "system."

5. How is ACDRS funded?

- Funding originates in Alabama's portion of the National Tobacco Settlement (NTS) through the Children First Trust Fund (CFTF).
- The amount equals one half of 1 percent of the total CFTF portion of the NTS not to exceed $300,000.
- The Alabama Medicaid Agency now also provides some supplemental funding to ACDRS through a reimbursement agreement. These funds are used solely for education and outreach efforts.

6. What does ACDRS do?

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

7. How does ACDRS operate?

- The ACDRS State Office receives a copy of all death certificates issued in Alabama for decedents less than 18 years of age. Each certificate is reviewed to determine whether it meets ACDRS review criteria. Cases meeting the criteria are then assigned to the appropriate LCDRT on a case-by-case basis.
- The LCDRT reviews the individual cases and, based upon its findings, completes the appropriate data collection forms and submits the information to the ACDRS State Office. The Local Team then takes action as allowed and/or required in the community to prevent additional deaths and makes recommendations to the State Team for consideration and action.
- The ACDRS State Office collects and analyzes the information submitted by the LCDRTs. This information is used to answer requests for specific data and to generate reports.
- The State Child Death Review Team meets quarterly to discuss Child Death Review (CDR) issues, review the statewide data, consider LCDRT recommendations and performance, and conduct general ACDRS business. The SCDRT makes periodic recommendations to the Governor and takes action on issues related to CDR (educational programs, informational publications, and other efforts).
- All formal recommendations and prevention efforts are evidence-based and goal-oriented.

8. What is included within ACDRS case review criteria?

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

9. What are ACDRS goals?

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

DEFINITIONS

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

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

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

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

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

- **Residential Institutions –** As used in this report, this is a term that identifies a place of death. Included in this classification are hospitals and emergency rooms. The number of deaths that occur in this category is usually fairly high because frequently victims survive long enough to reach the hospital, but then expire there.

- **Sudden Infant Death Syndrome (SIDS) –** This is a very specific type of SUID (see below) in infants from one month to 1 year old in which all external contributing causes are eliminated through complete autopsy and toxicology, review of the clinical history, and thorough death scene investigation.

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

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

ALABAMA STATE CHILD DEATH REVIEW TEAM RECOMMENDATIONS TO THE GOVERNOR

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

The State Child Death Review Team recommends:

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

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

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

Enhancements to and stricter enforcement of child passenger restraint laws

Establishment of a minimum age to operate ATVs

Safety training requirements for ATV operators

Prohibition of passengers from open truck beds on public roads

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

The State Child Death Review Team recommends:

A comprehensive statewide safe infant sleep awareness and education campaign

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

KEY DATES FOR 2014

- **January 16** State CDR Team Meeting
- **March 16-22** National Poison Prevention Week
- **April** National Child Abuse Prevention Month
- **April 1** Deadline for Submission of all Calendar Year 2011 Case Reviews
- **April 17** State CDR Team Meeting
- **July 17** State CDR Team Meeting
- **September** National Infant Mortality Awareness Month
- **September 8-12** National Suicide Prevention Week
- **September 14 -20** Child Passenger Safety Week
- **October** National SIDS Awareness Month
- **October 5-11** National Fire Prevention Week
- **October 16** State CDR Team Meeting
- **October 14-20** National Teen Driver Safety Week

...We are all part of the solution

ADPH

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