

Alabama Child
Death Review System

Progress Report 2024

ACDRS

ALABAMA
CHILD DEATH
REVIEW SYSTEM

ALABAMA
PUBLIC
HEALTH

DEATHS AMONG CHILDREN IN ALABAMA ALABAMA CHILD DEATH REVIEW SYSTEM

Progress Report - 2024

Scott Harris, M.D., M.P.H.

State Health Officer

Michele Jones, M.S.

Chief of Staff

Jamey Durham, M.B.A.

Director

Bureau of Prevention, Promotion, and Support

Gloria Davis, L.M.S.W.

Director

Surveillance Branch

Spencer Avant, L.B.S.W.

Program Coordinator

Alabama Child Death Review System

Stuart Hoyle, M.P.H.

Epidemiologist

Surveillance Branch

Alabama Child Death Review System

The RSA Tower, Suite 960

201 Monroe Street, Montgomery, AL 36104

(334) 206-2085 • (334) 206-3723 (Fax)

alabamapublichealth.gov/cdr

Alabama Department of Public Health
Bureau of Prevention, Promotion, and Support
Surveillance Branch

This report is based on the most recent data available as of August 2025.

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Introduction

In 1997, Alabama enacted legislation creating the Alabama Child Death Review System (ACDRS) to review and identify unexplained or unexpected child deaths in Alabama with the purpose of developing strategies to prevent such deaths from occurring. ACDRS worked with 42 Local Child Death Review Teams (LCDRTs), the State Child Death Review Team (SCDRT), and the Alabama Department of Public Health (ADPH) Central Office staff to collect, review, consolidate, and utilize information on more than 2,490 child deaths since 2014. ACDRS's structure relies upon the time and effort volunteered by our team members throughout the state for in-depth reviews and prevention recommendations that provide the insight needed to prevent these deaths from continuing to occur. ADPH Central Office staff are grateful for each individual and organization that makes these efforts possible on behalf of Alabama's children.

In 2024, 710 children died in Alabama, based on a preliminary count of child deaths as of August 5, 2025*. This count is provisional and subject to change until the Centers for Disease Control and Prevention (CDC) finalizes the data. Every child's death is a tragedy, especially for the family and friends of the children lost. However, each death also serves as a powerful warning that other children remain at risk. To better understand how and why children die, the state tasks ACDRS with the following responsibilities: maintain statistics on child mortality; identify deaths that may result from abuse, neglect, or other preventable cases; and, from that information, develop and implement measures to help reduce the risk and incidence of future unexplained or unexpected child deaths in Alabama.

Child death reviews make a difference. Through death reviews, ACDRS has identified bodily force and weapon-related deaths, sleep-related and Sudden Unexpected Infant Death (SUID), and motor vehicle incidents as the leading causes of death for 2024. This report highlights the leading manners and causes of death for Alabama's children, significant risk factors burdening children, recommendations created by SCDRT to reduce preventable child deaths, and statewide initiatives that have been established due to the child death review process. ACDRS seeks to honor the memory of children who died in Alabama with this report. Hopefully, these efforts will lead to a better understanding of how Alabama can be a safer, healthier place for children.

Three Tiers of the Alabama Child Death Review System

A. ADPH Central Office Staff

For administrative and budgetary purposes, the State Child Death Review Office is located within ADPH, Bureau of Prevention, Promotion, and Support. The ACDRS Central Office consists of three staff members: an ACDRS Program Manager, a Program Coordinator, and an Epidemiologist. ADPH Central Office staff is responsible for sending death certificates, providing technical assistance, and overseeing the data review process of LCDRTs. ADPH Central Office staff also assist with developing prevention initiatives, public awareness campaigns, and special interest programs.

B. State Child Death Review Team

SCDRT is a multidisciplinary, multiagency review team, composed of 28 members, which are listed below and the first 7 of whom are ex officio members:

- The Jefferson County Coroner, Medical Examiner.
- The State Health Officer, who serves as Chair.
- One member appointed by the Alabama Sheriff's Association.
- The Director of the Alabama Department of Forensic Sciences.
- The Commissioner of the Alabama Department of Human Resources.
- The Commissioner of the Alabama Department of Mental Health.

**CDC Wonder, provisional data, as of 8/5/2025.*

- The Director of the Alabama Department of Public Safety.
- One pediatrician with expertise in Sudden Infant Death Syndrome (SIDS) appointed by the Alabama Chapter of the American Academy of Pediatrics.
- One health professional with expertise in child abuse and neglect appointed by ADPH.
- One family practice physician appointed by the Alabama Academy of Family Physicians.
- One pediatric pathologist appointed by the Alabama Department of Forensic Sciences.
- Eight private citizens appointed by the Governor.
- One member of the clergy appointed by the Governor.
- One representative of the Alabama Coroner's Association.
- One representative of the Alabama Network of Children's Advocacy Centers.
- One representative of the Alabama Sheriff's Association.
- One representative of the Alabama District Attorney's Association.
- One specialist in pediatric emergency medicine appointed by the Medical Association of the State of Alabama.
- One representative of the Alabama Association of Chiefs of Police.
- The Chair of the Senate Health Committee or his/her designee and the Chair of the House Health Committee or his/her designee.

SCDRT serves as an advisory board with quarterly meetings to:

- Identify factors that make a child at risk for injury or death.
- Collect and share information among State Team members and agencies that provide services to children and families or investigate child deaths.
- Suggest and recommend improving coordination of services and investigations to appropriate participating agencies.
- Identify trends relevant to unexpected/unexplained child injury and death.
- Review reports from local child death teams and, upon request of a local team, individual cases of child deaths.
- Provide training and written materials to local teams to assist them in carrying out their duties.
- Develop a protocol for child death investigations and revise the protocol as needed.
- Educate the public in Alabama regarding the incidence and causes of child injury and death and the public role in aiding in reducing the risk of such injuries and fatalities.
- Provide the Governor and the Legislature with an annual, written report including, but not limited to, SCDRT's findings and recommendations of each of its duties, and provide copies of such report to the public.

C. Local Child Death Review Teams

Currently, all 67 counties in Alabama are represented by one of 42 multidisciplinary LCDRTs based in each judicial circuit. The district attorneys within these judicial circuits are responsible for appointing a local coordinator and/or overseeing the child death review process for their circuit. Each Alabama county is included in an LCDRT jurisdiction.

The following individuals are LCDRT members:

- The county health officer.
- The director of the county Department of Human Resources.
- The county district attorney.
- The medical examiner.
- The local coroner.
- One investigator with a local sheriff's department who is familiar with homicide investigation.

- One investigator with a local police department who is familiar with homicide investigation.
- One pediatrician, or if no pediatrician is available, a primary care physician appointed by the county medical society.
- One representative from a local child advocacy center, should one exist.

The role of LCDRTs is to hold local review sessions that collect, review, consolidate, and report information regarding child death to the SCDRT and ADPH Central Office staff. By law, LCDRTs are required to meet at least annually. The purpose of these reviews is to decrease the incidence of unexpected or unexplained child injury and death by providing a better understanding of the circumstances surrounding each one. LCDRTs accomplish this purpose by completing the following tasks:

- The identification of factors that put a child at risk of injury or death.
- The dissemination of information among the agencies that provide services to children and families, or which investigate child deaths or provide services.
- The improvement of local investigations of unexpected/unexplained child deaths by participating agencies.
- The improvement of existing services and systems and assisting in establishing additional services and systems to fill gaps in the community.
- The identification of trends relevant to unexpected/unexplained child injury and death.
- The education of the local public regarding the incidence and causes of child injury and death and the public role in aiding and reducing the risk of such injuries and fatalities.

LCDRT reviews are essential in formulating recommendations that will modify risk factors at both local and state levels. Furthermore, LCDRT reviews of child deaths occurring in 2024 are the foundation for this report.

National Fatality Review Case Reporting System (NFR-CRS)

LCDRTs and ADPH use NFR-CRS as a database and data collection methodology to capture information regarding the circumstances surrounding each reviewed child’s death. This database serves as a case reporting tool that documents the often complex conversations, discussions, and report reviews that happen during the death review process. NFR-CRS also documents many descriptive aspects of the death, such as the child’s demographics, investigative actions, services provided or needed, risk factors, and LCDRT recommendations on how to prevent future child deaths in Alabama.

Alabama Child Death Review System Funding

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

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

Alabama Child Death Review System’s Prevention Initiatives

ACDRS has reviewed over 6,140 child deaths since 2000. Due to these reviews, educational programs and prevention initiatives such as the Teen Driver Safety Campaign, SUID Investigation (SUIDI) Team, the Booster Seat Advocacy Program, and the Healthy Start: Never Ever Shake a Baby Program have been developed.

A. SUID Training

To improve data quality and reduce sleep-related child deaths, ACDRS conducted Child Injury and Death Scene Reenactment and Scene Reconstruction Training sessions. Each session provided investigative protocols for law enforcement, Emergency Medical Services (EMS), district attorneys, medical examiners, coroners, and child protective services. ADPH social workers and nurses were also in attendance. Participants learned the skills necessary to conduct investigations: how to conduct witness interviews, how to perform doll reenactments, and how to develop narrative reports for forensic pathologists that will provide the foundation for a more accurate determination of the cause of injury and the person(s) responsible.

By completing the training, investigators were provided the necessary tools and knowledge to complete SUIDI accurately. Standardized reporting forms from CDC and SUIDI demonstration dolls were distributed to investigators as investigative tools. The provided training, materials, and tools were based on a nationally established CDC curriculum and aligned with CDC guidelines. These training and tools should improve infant death scene investigations, the accuracy of infant death diagnoses, and the overall usefulness of the information regarding infant deaths collected by ACDRS. Thorough and standardized investigations will assist ACDRS in obtaining better data. Better data will lead to improved and targeted prevention strategies statewide. More information about safe sleep practices for children and other educational materials can be found on the ADPH website, alabamapublichealth.gov, by searching for SUID and Safe Sleep.

In June of 2024, ACDRS assisted in a 2-day SUIDI training in Dothan, Alabama, with 26 attendees, including: law enforcement, social workers, crime scene technicians, child advocates, and emergency medical personnel. ACDRS provided doll reenactment kits for the training, which included: tactical bags, dolls, placed/found cards, 911 calls books, tape measures, and sanitizing items. The trainers for this training were at ACDRS' Train-the-Trainer session in Tuscaloosa, AL in 2023. ACDRS is looking forward to this new pool of trainers that can help conduct future SUIDI training throughout the state.

B. Car and Booster Seat Clinics

ADPH has Child Passenger Safety Technicians certified through Safe Kids to educate caregivers on properly installing their child's car seat. In addition to educating caregivers on proper installation, pregnant women and families receiving federal assistance are eligible to receive a car seat provided by ACDRS. In 2024, 217 seats were provided to eligible families, an increase from the 123 seats provided in 2023. More about this topic, information about state law, and links to informational materials can be found on the ADPH website, alabamapublichealth.gov, by searching for child restraints or car seats.

C. Healthy Start: Never Ever Shake a Baby

This prevention program targets one of the most serious forms of child abuse in children, Shaken Baby Syndrome (SBS). ACDRS funds The Family Center of Mobile to maintain a hospital based prevention program at the University of South Alabama Health Children's & Women's Hospital. The program focuses on reducing the stress of a new baby on the family and teaching parents how to calm a crying infant using Dr. Harvey Karp's "5S" method. Nearly all babies are shaken because of uncontrollable crying and the parent's frustration at their inability to calm the child. The program is offered directly to the patient while in the hospital, and the mother and other family members are encouraged to take the 30-minute class before leaving care. The class ends with the 8-minute video "Portrait of Promise," which details the devastating effects of SBS. Parents are asked to sign an affidavit stating they took the workshop and understand the dangers of shaking their child. They also promise to share the material provided with other caregivers for their new child. In 2024, the program served 556 families and 654 parents, an increase from 2023 when 319 families were served.

ACDRS continues to rely on SCDRT, LCDRTs, strategic partners, and the public to promote the program's mission. Although significant improvements have been made, ACDRS will continue to make strides that reduce child death through awareness, education, and prevention efforts.

2024 Recommendations to the Governor and Legislature

SCDRT recommends the following ongoing prevention strategies:

Statewide

- Use alternative channels such as social service agencies, houses of worship, and youth organizations to implement prevention education statewide.
- Improve media coverage on suicide prevention to encourage those who are vulnerable or at risk to seek help.
- Support annual suicide prevention education in schools to promote emotional well-being and connectedness among the entire school community.
- Encourage the safe storage of firearms by distributing gun locks as a safety precaution.
- Implement public education and awareness campaigns about the need for adult supervision around open bodies of water.

- Expand and mandate SUIDI training for EMS, law enforcement, coroners, and child protective services.
- Educate new parents regarding newborn and infant safety recommendations, such as safe sleep environments and car seat use/installation.
- Increase rural car seat distribution/education.
- Prevent co-sleeping through public education and awareness campaigns.

Build Partnerships to Serve Alabama’s Children and Families

- Establish a partnership with the Nurse-Family Partnership.
- Increase collaboration with the Alabama Suicide Prevention and Resources Coalition.

Educate, Enforce, and Improve Graduated Driver’s License (GDL) Policy

- Educate parents and law enforcement on GDL Law.
- Support further enhancement of the GDL by increasing night driving restrictions for teen drivers (10 p.m. - 5 a.m.).
- Include a questionnaire to determine knowledge of the GDL policy in the driver’s education exam.
- Implement a Statewide Teen Driver Safety Course for high school sophomores.

Cooperate and Collaborate for Legislative Action

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

Improve Public and Private Funding for Children’s Services

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

Create a Comprehensive Data System to Improve Prevention Initiatives

- Establish a standardized case management system for coroners and medical examiners.
- Increase collection and utilization of new sources of data.

Key Findings

In 2024, ACDRS reviews were completed for 223 child deaths, or 81.1 percent of the deaths eligible for review. Cases that meet the criteria for review are those involving deaths in Alabama of infants and children from live birth to less than 18 years of age whose deaths are considered unexpected or unexplained. Reviewed cases are categorized based on the manner and cause of death. The manner of death is classified based on the circumstances surrounding death. Cause of death refers to the primary underlying cause of death, which is the disease or injury/action initiating the sequence of events that led directly to death, or the circumstances of the accident or violence that produced the fatal injury. The five manners of death categories reviewed by ACDRS are accidents, homicides, suicides, undetermined manner, and pending/unknown manners of death.

Manner of Death Update for 2024

Reviews of qualifying deaths showed:

- Accidents (unintentional injury deaths) accounted for 90 reviewed deaths.
- Homicides accounted for 46 reviewed deaths.

- Suicides accounted for 36 reviewed deaths.
- Undetermined manner accounted for 46 reviewed deaths.
- Natural deaths accounted for less than 5 reviewed deaths.

Cause of Death Update for 2024

The circumstantial information in the following sections is not mutually exclusive of each other. A single death could involve a combination of circumstances listed below for each cause of death. Some data elements are unknown or undetermined based on information gathered from the death investigation systems within the state and available at the time of this report.

Bodily Force and Weapon-related Deaths

In 66 reviewed deaths, bodily force or a weapon was involved:

- In 61 (92.4 percent) reviewed weapon and assault cases, the child's death involved firearms.
- In 46 reviewed deaths, handguns were involved.

Motor Vehicle-related Incidents

In 46 reviewed deaths, the child was involved in a fatal vehicle-related incident:

- In 23 reviewed vehicle-related deaths, the child was a passenger.
- In 14 reviewed vehicle-related deaths, the child was the driver of the vehicle.
- In the remaining 9 reviewed vehicle-related deaths, the position of the child was unknown.
- In 11 reviewed vehicle-related deaths, reckless driving contributed to the event that caused death.
- In 10 reviewed vehicle-related deaths, speeding contributed to the event.
- In 18 reviewed vehicle-related deaths, a car was the vehicle involved in the event.
- In 8 reviewed vehicle-related deaths, a truck was the vehicle involved in the event.

Sleep-related Death and SUID

- In 35 reviewed deaths, the child was sleeping or in the sleep environment at the time of death.
- In 51 reviewed deaths, reviewers classified the incidents as SIDS or SUID, and in 32 of these deaths, the sleep environment was found to have contributed to death.
- In 40 reviewed sleep-related or SUID deaths, the child was not put down on a recommended sleep surface (such as a crib or bassinet).
- In 27 reviewed sleep-related deaths, the child was co-sleeping with an adult on the same sleep surface.

Additional External Causes of Death

Drowning

In 21 reviewed deaths, drowning was the cause of death:

- In less than 5 reviewed deaths, the child drowned in a source of open water.
- In 12 reviewed deaths, the child drowned in a pool or hot tub.

Suffocation

In 22 reviewed deaths, asphyxiation was the cause of death:

- Of these asphyxiation deaths, 9 were determined to be sleep-related deaths caused by various hazards in the sleep environment.
- In 11 asphyxiation deaths, the child hung themselves.

Fire, Burns, or Electrocution

In less than 5 reviewed deaths, fires were the cause of death:

- In all the reviewed deaths, the fire started in a single-family home.

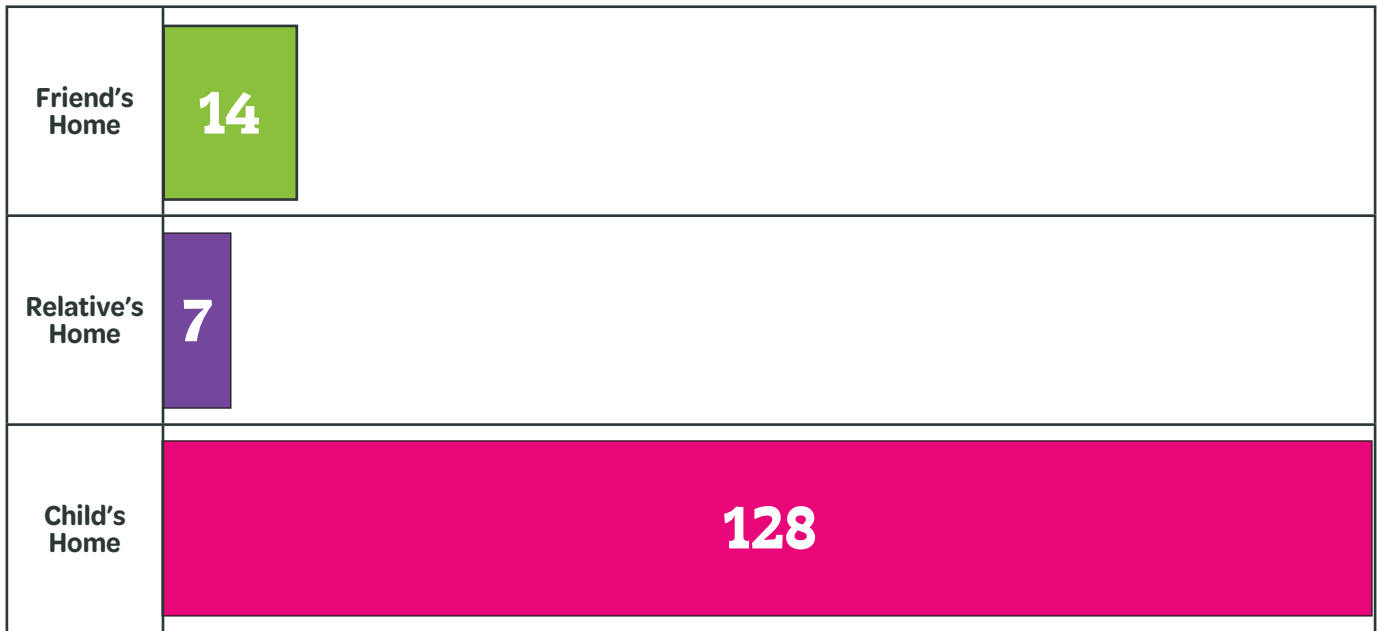
Poisoning or Overdose

In 9 reviewed deaths, poisoning or an overdose were the cause of death:

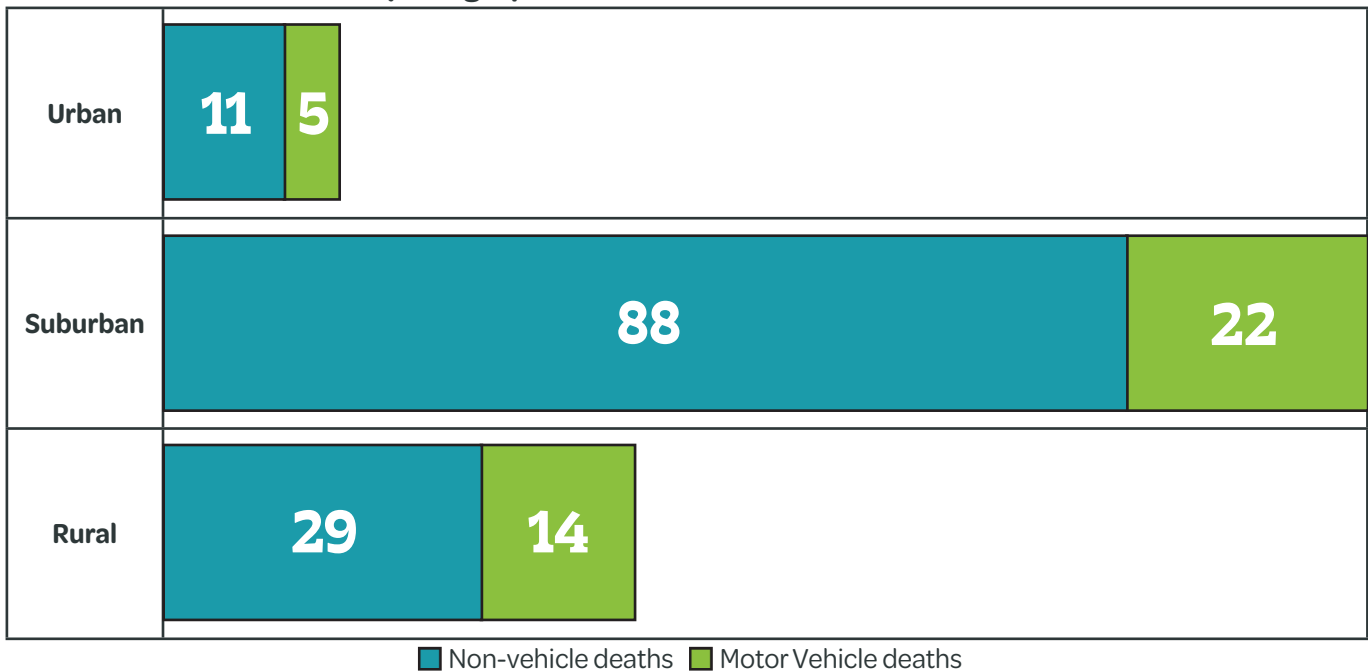
- Of these reviewed deaths, 8 were accidental poisonings.

Known Location of Death

Known Location of Child's Death - 2024 Non-vehicle Reviewed Deaths



Location of Child's Death by Geographic Area - 2024



Review Process and Timeline

Review Process

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

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

The ACDRS Central Office collects and analyzes information submitted by LCDRTs to answer requests for specific data and generate reports.

SCDRT meets quarterly to review the statewide data, consider LCDRT recommendations and performance, and conduct general ACDRS business. SCDRT acts on ACDRS issues through educational programs, informational publications, and other similar efforts.

Efforts to Increase Review Rates

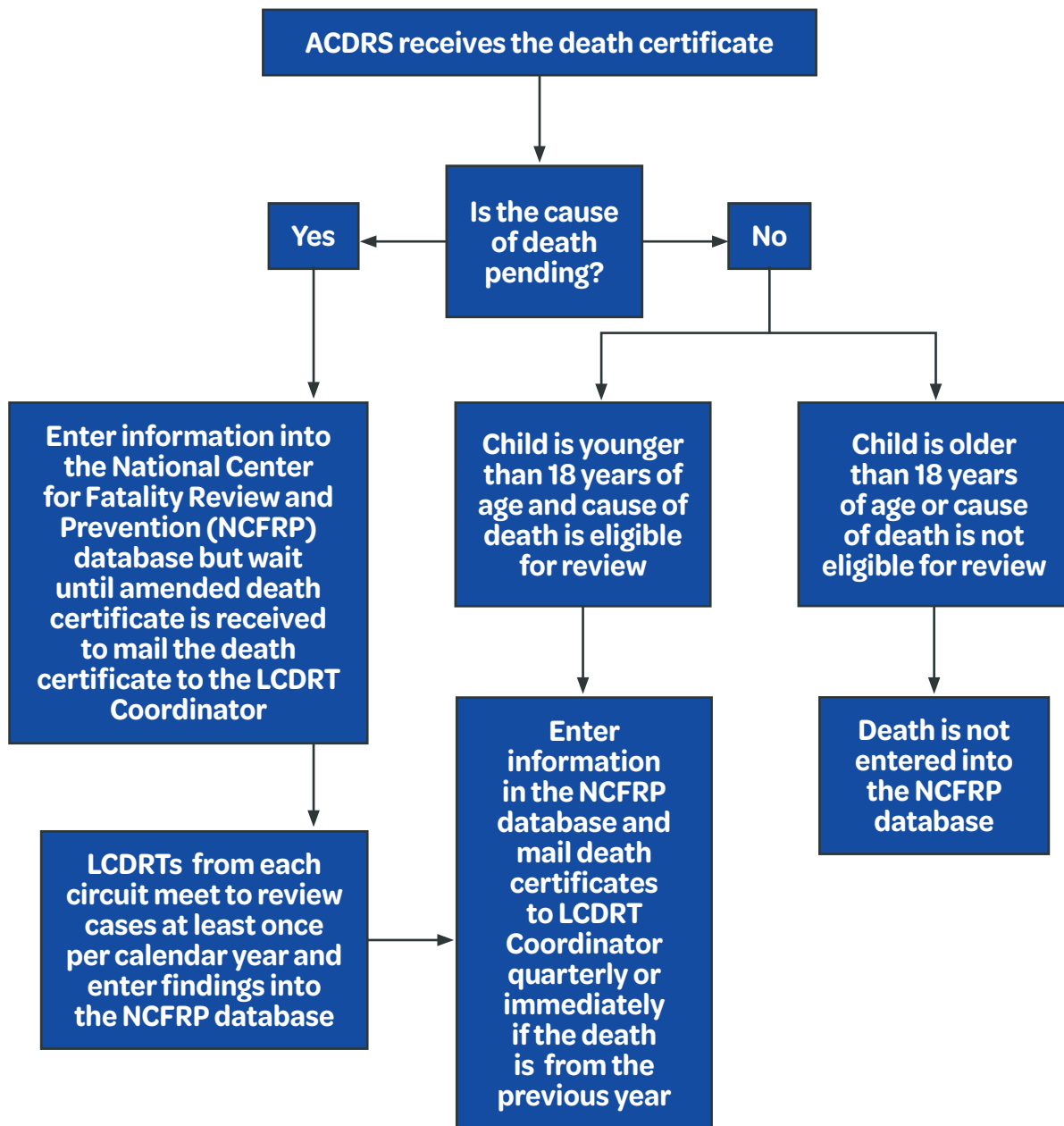
ACDRS Central Office staff:

- Maintain a constant flow of communication with local team coordinators.
- Attend local review team meetings and enter data when needed.
- Develop a tool that makes the review process more streamlined.
- Mail death certificates quarterly and encourage quarterly meetings.

Case Review Criteria

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

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

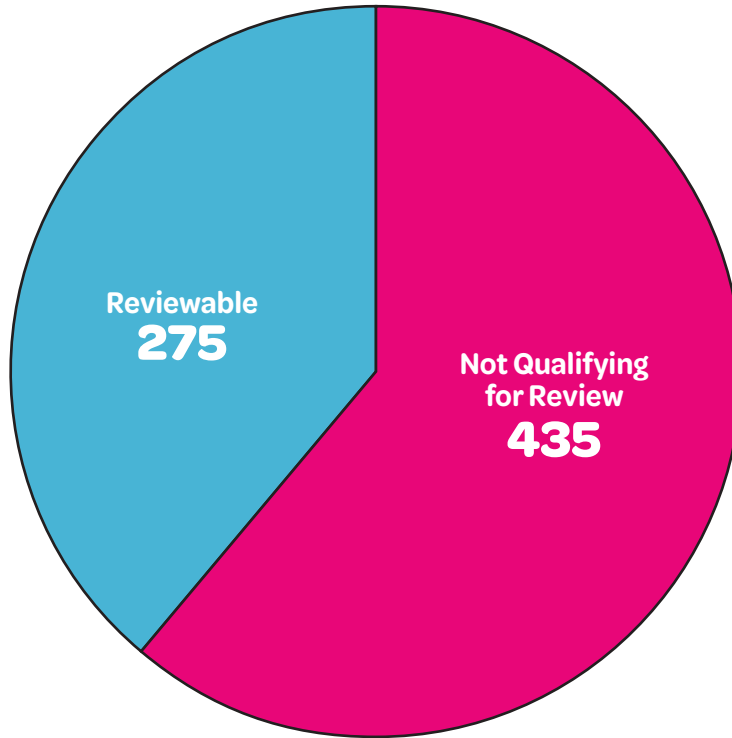


2024 Reviewed Child Deaths

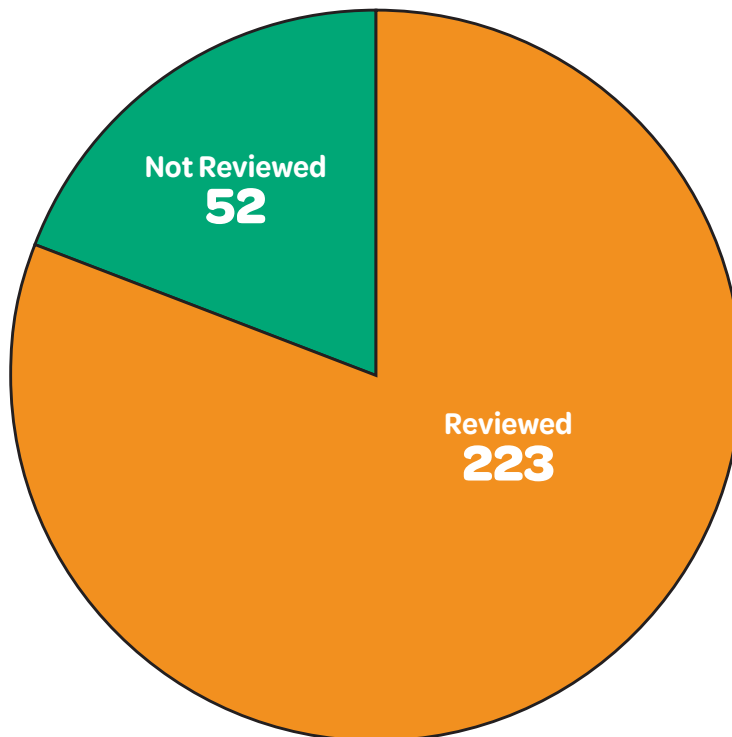
Local Child Death Review Team Success Rates

Based on a preliminary count, there were a total of 710 child deaths in Alabama during 2024,* and of these, 275 qualified for review under ACDRS guidelines. Of the qualified deaths, LCDRTs returned 223 completed reviews, or 81.1 percent.

Child Deaths Qualifying for Review, 2024



Qualifying Child Deaths Reviewed, 2024



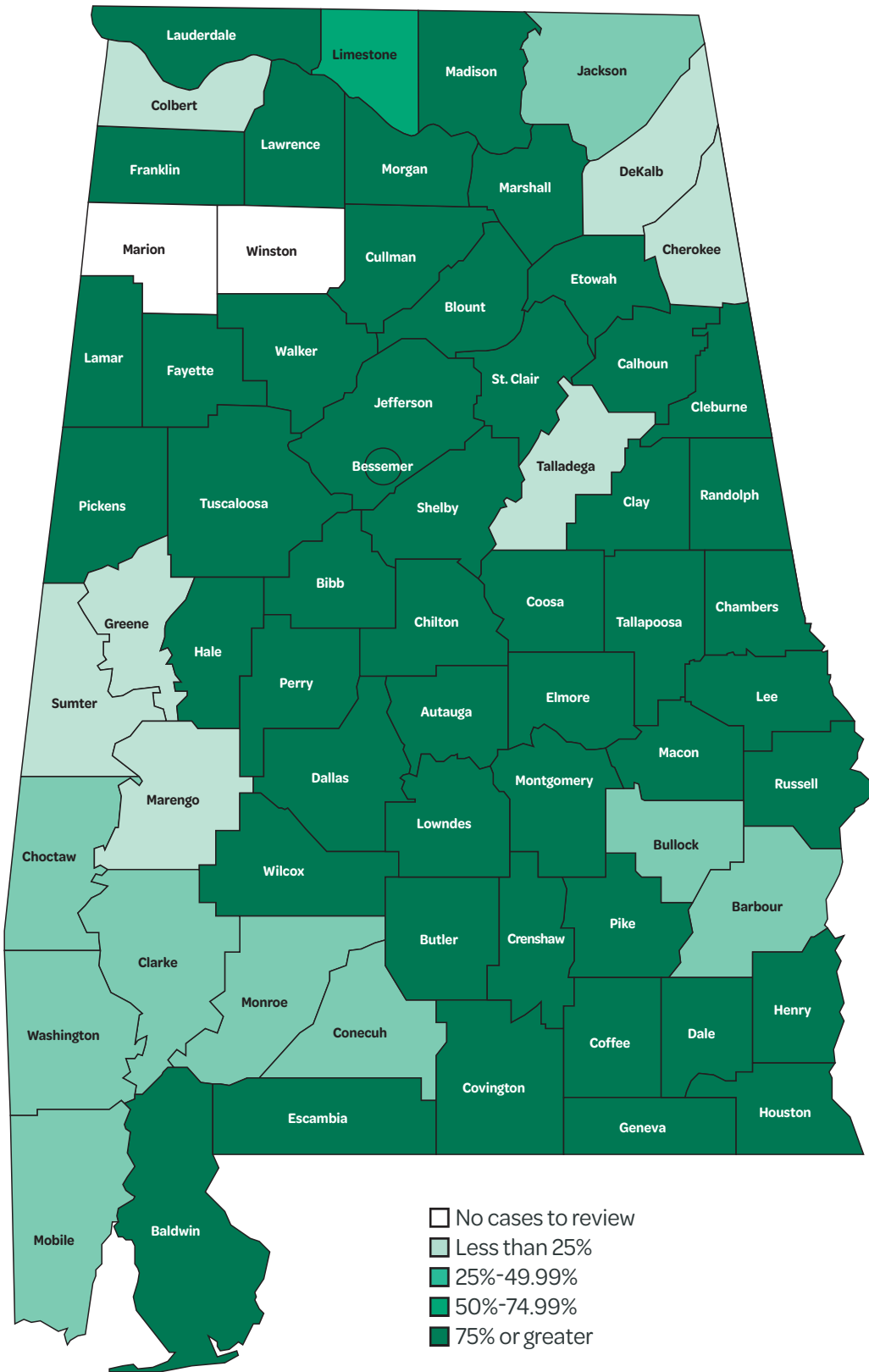
*CDC Wonder, provisional data, as of 8/5/2025.

LCDRT Recognition

The ACDRS goal is for each LCDRT to have a 100 percent case completion rate. The table below recognizes the outstanding efforts of many LCDRTs that achieved this goal. Unfortunately, pending death certificates often prevent LCDRTs from reaching 100 percent completion, as the death is difficult to review without the official cause and manner.

2024 LCDRT Recognition		Completion (%)
Team 2	Butler, Crenshaw, and Lowndes	100.00
Team 4	Bibb, Dallas, Hale, Perry, and Wilcox	100.00
Team 5	Chambers, Macon, Tallapoosa, and Randolph	100.00
Team 6	Tuscaloosa	100.00
Team 7	Calhoun and Cleburne	100.00
Team 8	Morgan	100.00
Team 10A	Jefferson	100.00
Team 10B	Bessemer	100.00
Team 11	Lauderdale	100.00
Team 12	Coffee and Pike	100.00
Team 14	Walker	100.00
Team 15	Montgomery	100.00
Team 16	Etowah	100.00
Team 18	Shelby	100.00
Team 19	Autauga, Chilton, and Elmore	100.00
Team 20	Henry and Houston	100.00
Team 21	Escambia	100.00
Team 22	Covington	100.00
Team 23	Madison	100.00
Team 24	Fayette, Lamar, and Pickens	100.00
Team 26	Russell	100.00
Team 27	Marshall	100.00
Team 28	Baldwin	100.00
Team 30	St. Clair	100.00
Team 32	Cullman	100.00
Team 33	Dale and Geneva	100.00
Team 34	Franklin	100.00
Team 36	Lawrence	100.00
Team 37	Lee	100.00
Team 40	Clay and Coosa	100.00
Team 41	Blount	100.00

2024 Review Completion Rate by County



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

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

Alabama Child Death Trend Rates from 2013 to 2023*

Trends in Rate of Death by Manner and Race

As the following graphs indicate, African American and Caucasian children suffer from a disproportionately higher rate of death depending on their manner of death. African American children usually suffer a much higher rate of death from homicide, and Caucasian children generally suffer a slightly higher rate of suicide. Regarding accidental manners of death, African American and Caucasian rates of death vary from year to year.

In the following graphs of race and manner of death, certain races and ethnicities were excluded due to extremely small counts of related deaths, which triggered ACDRS' internal suppression rules. This measure preserves the confidentiality of the data collected by ACDRS.

The rates depicted in the following graphs are calculated by dividing the number of an affected population, such as child deaths, by the total number of children in Alabama and then multiplying by 100,000 to normalize the calculation and allow easy comparisons between different races and ethnicities. The following calculation is used to determine rates.

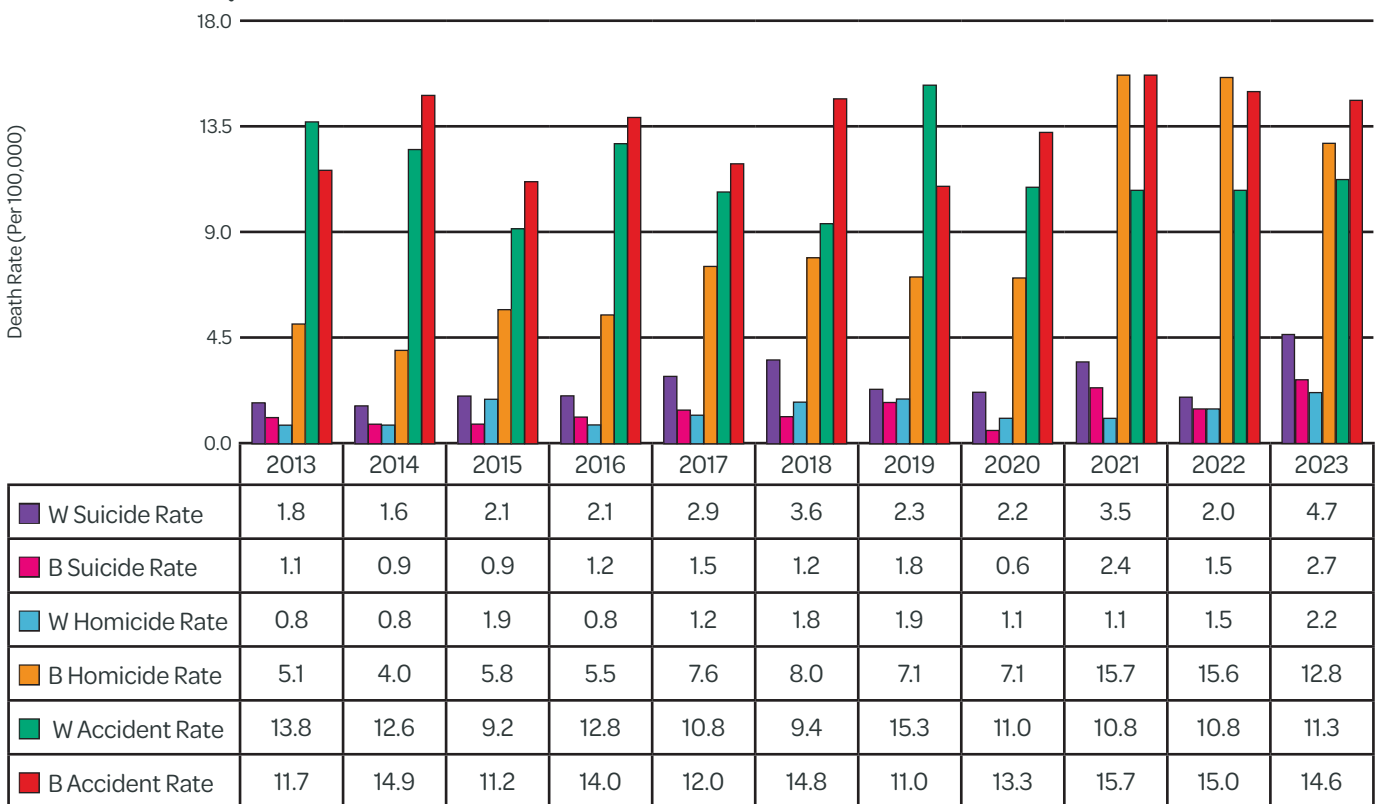
$$(\# \text{ Child Deaths} / \text{Total \# of Children in Alabama}) \times 100,000 = \text{Rate}$$

An example of a rate calculation:

$$(48 \text{ African American Accidental Deaths} / 327,818 \text{ African American Children in Alabama}) \times 100,000 = 14.6 \text{ African American Accidental Child Deaths per } 100,000 \text{ in } 2023$$

National and statewide population statistics have not been finalized and released for 2024 at the time of this report. As such, rates of death for 2024 will be included in future reports.

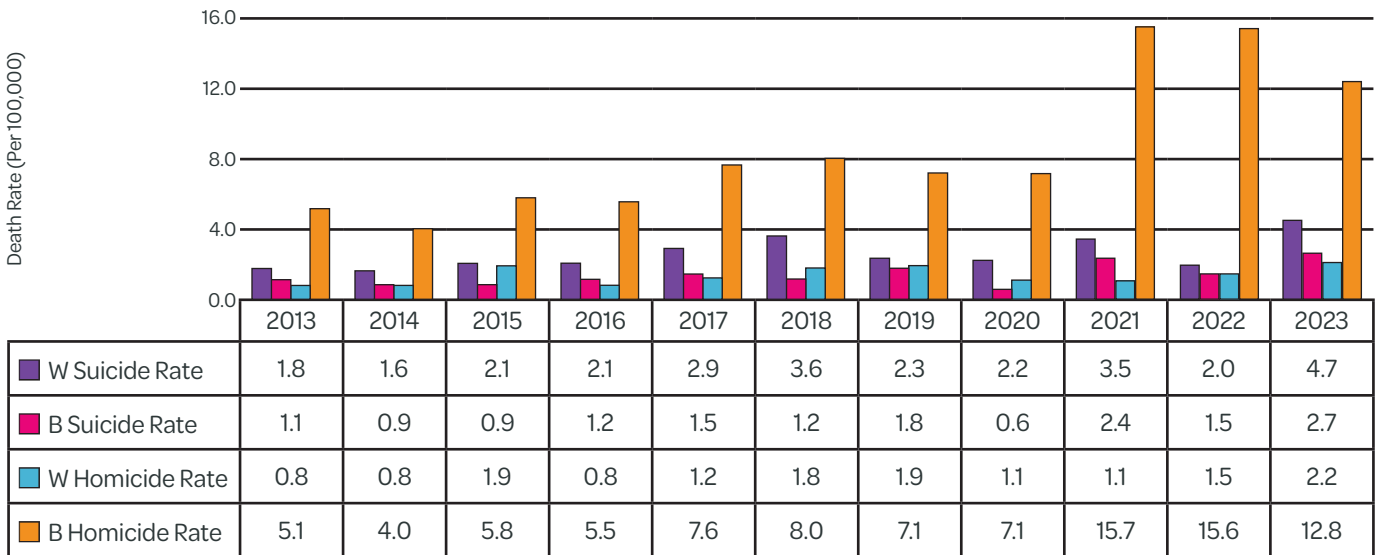
Rate of Death by Manner and Race, 2013-2023^



*ADPH Center for Health Statistics as of August 2025.

^CDC WONDER. Causes of death are pulled from death certificates and are based on the following International Classification of Diseases (ICD-10) codes: accidental causes of death from V01 to X59, suicide causes of death from X60 to X84, and homicide causes of death from X85 to Y09.

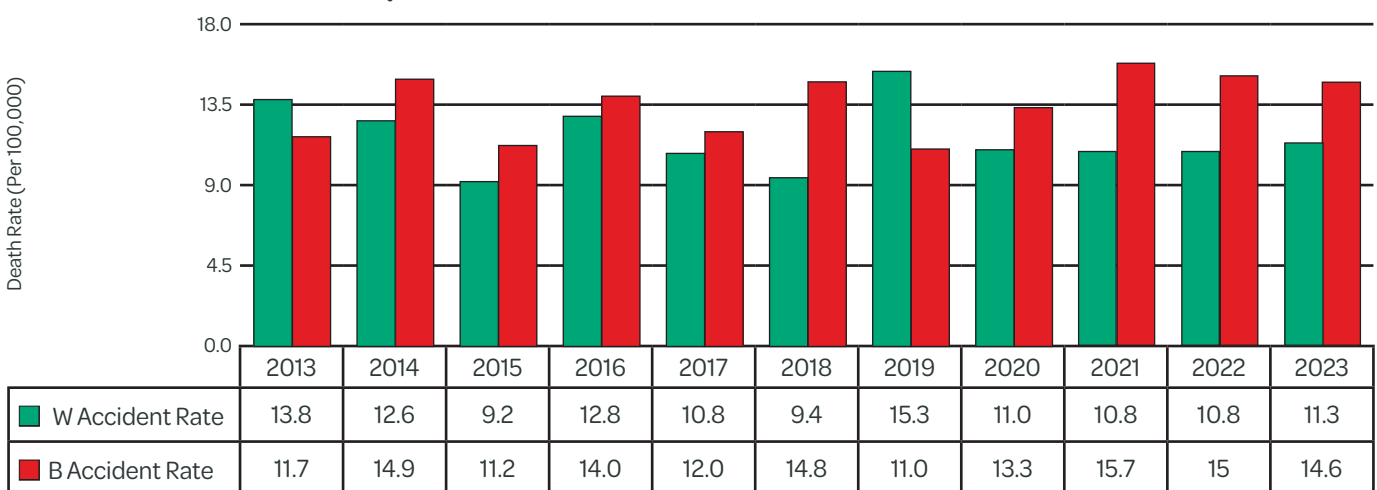
Rate of Death by Violent Manner and Race, 2013-2023[^]



As shown in the preceding graph, African American children suffer a significantly larger rate of death from homicide, and Caucasian children suffer a higher rate of suicide. The rate of homicide in African American children is drastically higher than that of Caucasian children and has significantly increased since 2020 and the COVID-19 pandemic. During the years since 2020, the rate of homicide for African American children has more than doubled, though a decrease in homicide rates was seen in 2023. A steady increase in the rate of homicide within the population of Caucasian children has occurred since 2020. However, the variability of homicide rates among Caucasian children was not as substantial as the variability of homicide rates among African American children.

The rate of suicide for Caucasian children has varied the last 4 years, as shown in the preceding graph. Sizable increases in Caucasian suicide rates were seen in 2021 and 2023, with a large decrease in rates during 2022. Among African American children, suicide rates increased each year from 2016 to 2019, but declined in 2020. However, African American children's rate of suicide has shown the same variability seen in Caucasian children over the last several years.

Rate of Accidental Death by Race, 2013-2023[^]



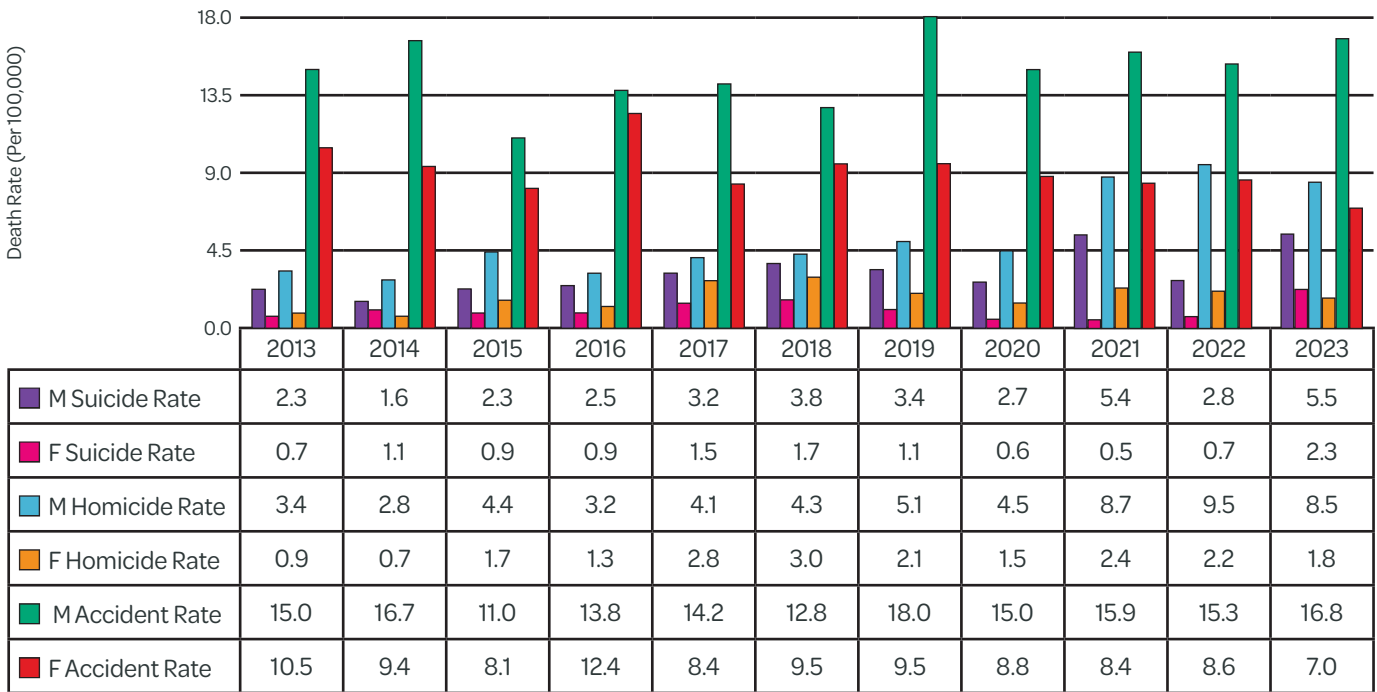
As the preceding graph indicates, African American and Caucasian children often suffer from differing rates of accidental death depending on the year. Accidental death rates among children typically surpass rates of death for violent manners. However, in 2021, the accident rate (15.7) for African American children was equal to the homicide rate (15.7), and in 2022, the homicide rate (15.6) was higher than the accident rate (15). Though accident rates based on race fluctuate from year to year, since 2020, the rates of death for African American children have routinely been higher than Caucasian rates.

[^]CDC WONDER. Causes of death are pulled from death certificates and are based on ICD-10 codes: accidental causes of death from V01 to X59, suicide causes of death from X60 to X84, and homicide causes of death from X85 to Y09.

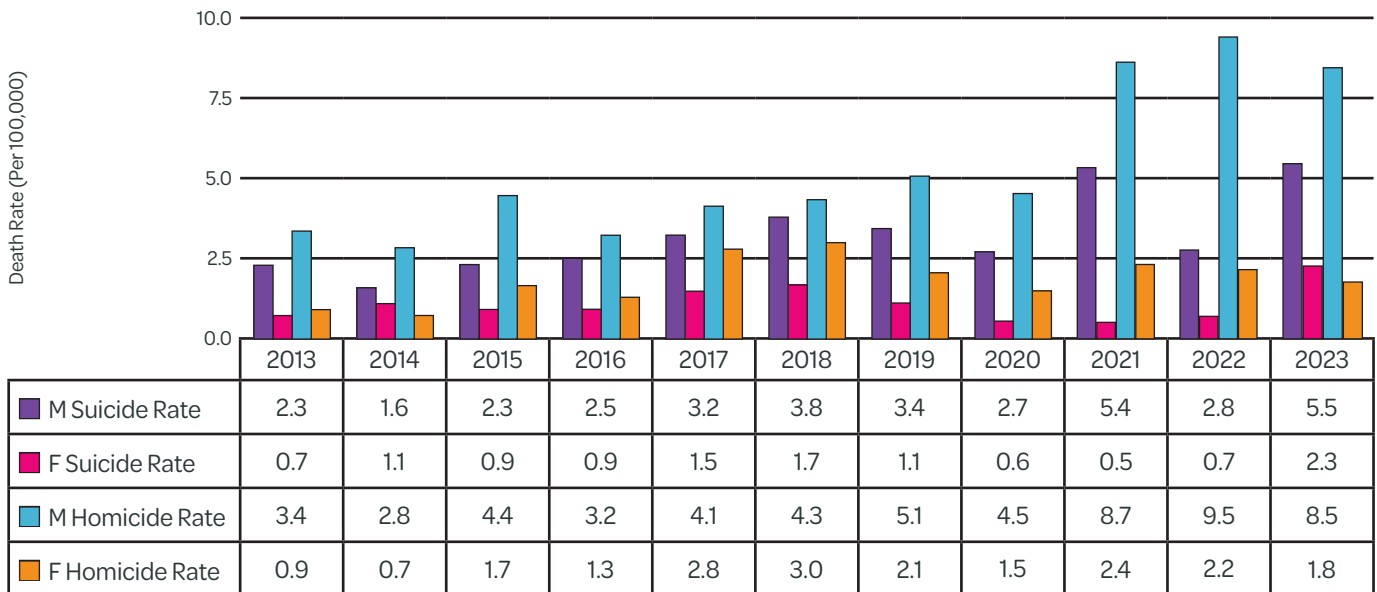
Trends in Rate of Death by Manner and Gender

Male children have historically had a higher rate of death for both accidental and violent manners than female children. This higher rate of death persists through all 11 years included in the three following graphs.

Rate of Death by Manner and Gender, 2013-2023[^]



Rate of Death by Violent Manner and Gender, 2013-2023[^]

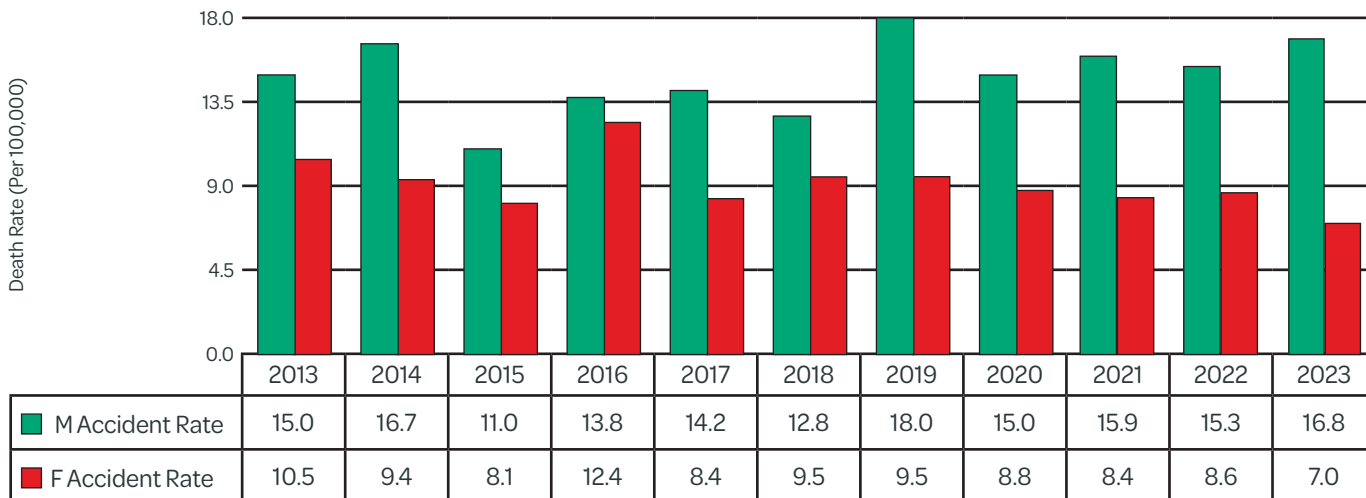


As shown in the preceding graph, male children typically suffer a significantly higher rate of death from homicide and suicide than female children. From 2014 to 2018, the rate of suicide for male children increased annually. Since 2020, the rate of male children's suicide has varied from year to year, but a large increase in male children's suicide can be seen in 2021 and 2023. Male children's homicide rates have drastically increased since 2020, when rates were already increasing nearly every year. During 2021 and 2023, the homicide rates for male children nearly doubled from the rate during 2020, and more than doubled during 2022.

[^]CDC WONDER. Causes of death are pulled from death certificates and are based on the following ICD-10 codes: accidental causes of death from V01 to X59, suicide causes of death from X60 to X84, and homicide causes of death from X85 to Y09.

Female children’s suicide rates and homicide rates stayed relatively similar without the drastic changes as seen in male children. Female children’s rates of suicide have been lower than female children’s rates of homicide since 2015. Suicide rates among female children had decreased before 2022, but the rate of suicide more than doubled in 2023. Female children’s homicide rates have flattened since 2019, with small increases and decreases in rates over the last 5 years on the preceding graph.

Rate of Accidental Death by Gender, 2013-2023[^]



As shown in the preceding graph, male children have historically suffered from a higher rate of accidental death than female children. No large changes in rate of accidental child death were observed in 2021 and 2022. However, a decrease in accident rate was seen for female children in 2023, continuing a decreasing rate trend since 2019. Conversely, an increase in accident rate was seen for male children in 2023, continuing an increasing rate trend since 2020.

Manner of Death Summary – 2024 Reviewed Deaths

Manner of death is a determination of the broad classification of death and is typically made by a coroner, medical examiner, police, or other official. The distinction between manner and cause of death is that cause is a specific disease, injury, or other mechanism of death, whereas manner is primarily a legal determination.

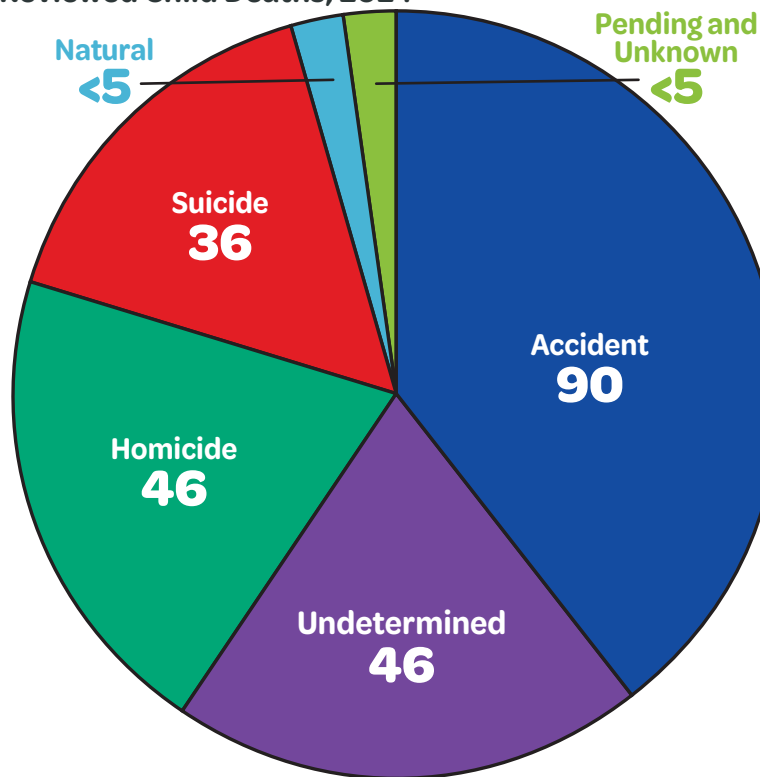
For the purposes of this report, manner of death refers to 1 of the 6 general categories of death listed on the Alabama Death Certificate. The six categories are:

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

As information was collected, unclassified manners of death not currently marked as an official manner are included as “other” manners of death. This manner of death may contain natural deaths that do not generally qualify for inclusion in ACDRS as they have not been classified or reviewed at the time of this report.

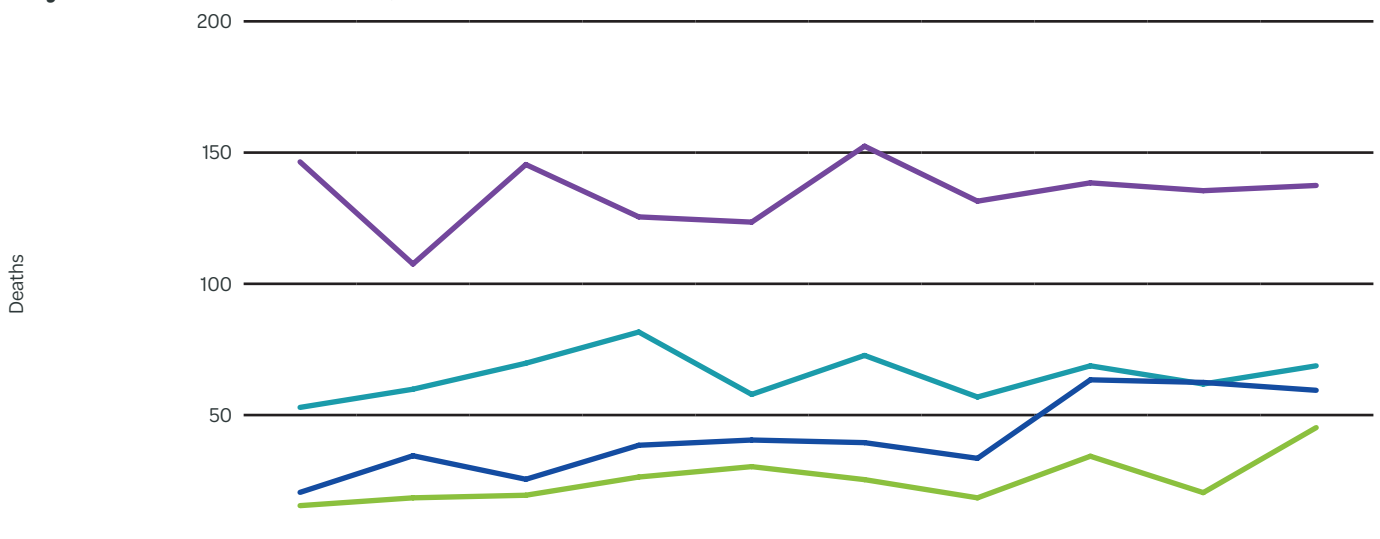
[^]CDC WONDER. Causes of death are pulled from death certificates and are based on the following ICD-10 codes: accidental causes of death from V01 to X59, suicide causes of death from X60 to X84, and homicide causes of death from X85 to Y09.

Manner of Death for Reviewed Child Deaths, 2024



The following graph shows the trend of Alabama child deaths for the listed manners of death from 2014 to 2023. National and statewide population statistics have not been finalized and released for 2024 at the time of this report. As such, rates of death for 2024 will be included in future reports.

Major Child Death Manners, 2014-2023[^]



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
— Suicide	15	18	19	26	30	25	18	34	20	45
— Homicide	20	34	25	38	40	39	33	63	62	59
— All Accidental	145	106	144	124	122	151	130	137	134	136
— All Undetermined	52	59	69	81	57	72	56	68	61	68

[^]CDC WONDER. Causes of death are pulled from death certificates and are based on the following ICD-10 codes: suicide causes of death from X60 to X84, homicide causes of death from X85 to Y09, accidental causes of death from V01 to X59, and undetermined causes of death from R99 and Y10-Y34.

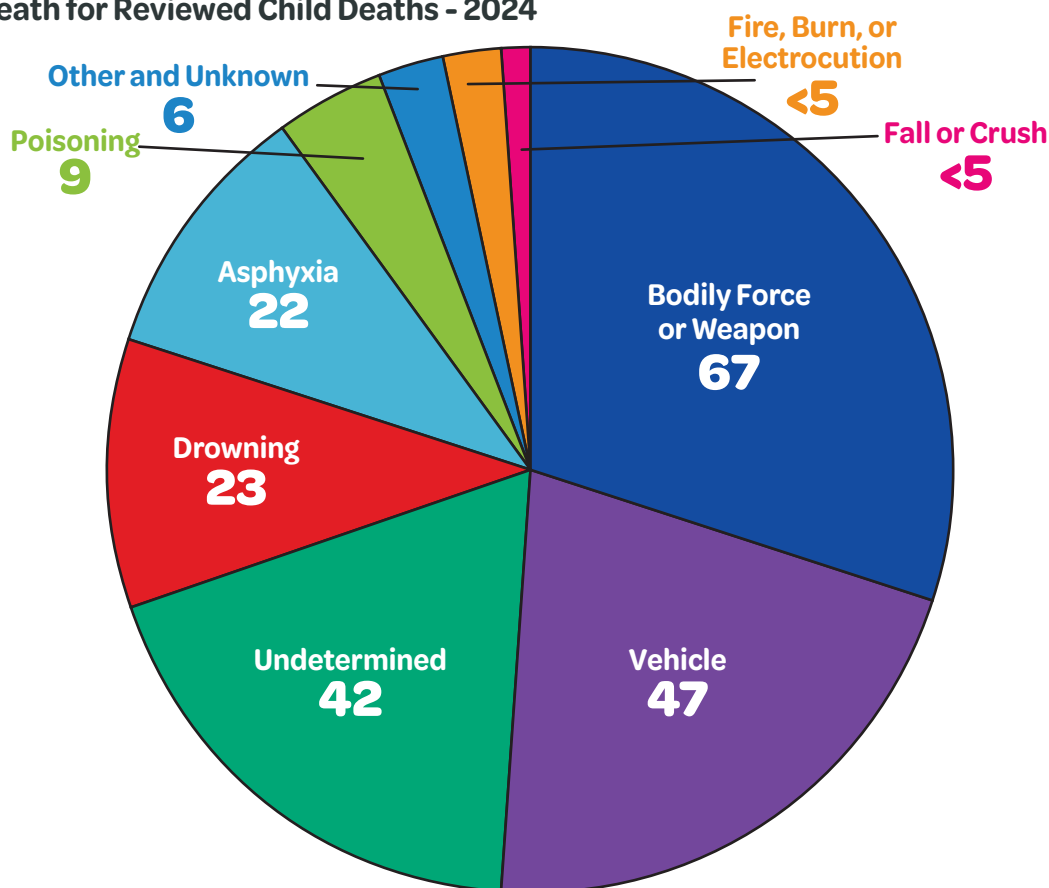
Cause of Death Summary – 2024 Reviewed Deaths

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

In 2024, the three most frequently reviewed known causes of death due to injury were:

1. Bodily force or Weapon-related causes (67 deaths).
2. Undetermined - Sleep-related and SUID causes (51 deaths).
3. Vehicle-related causes (47 deaths).

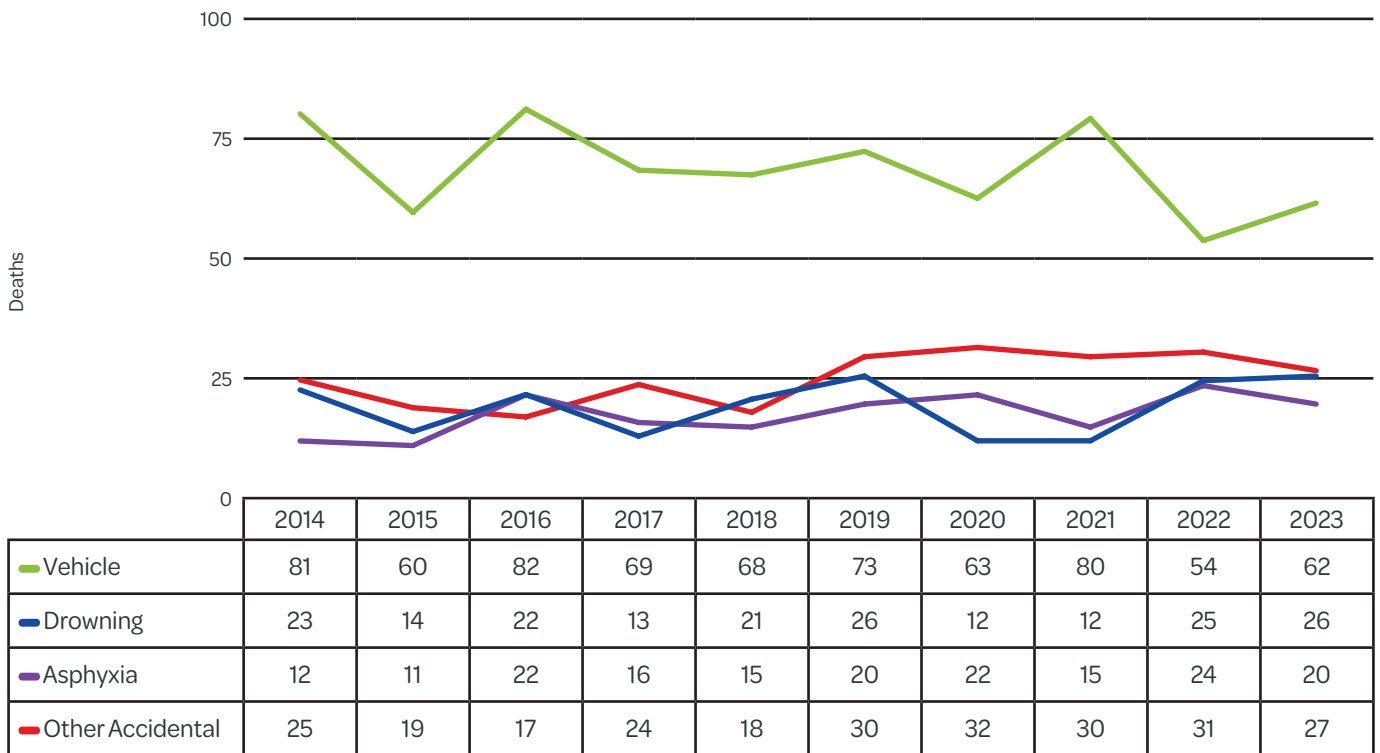
Cause of Death for Reviewed Child Deaths - 2024



Sleep-related causes of deaths are included in the pie chart above as a part of the undetermined and accidental asphyxiation causes of death.

The following graph shows the major accidental causes of death for Alabama children over the period from 2014 to 2023. National and statewide population statistics have not been finalized and released for 2024 at the time of this report.

Major Accidental Child Death Causes, 2014-2023[^]



Review of Common Causes of Child Death in Alabama

A. Bodily Force and Weapon-related Deaths

This category includes deaths due to physical force caused by another person and weapon related injuries, either accidentally or intentionally inflicted. Bodily force encompasses all physical force caused by another person against a child and includes, but is not limited to, hitting, kicking, throwing, dropping, or pushing. Types of weapons include, but are not limited to, firearms, sharp or blunt instruments, and explosive devices. The use of bodily force or weapons in this category may be determined to be self-injury; the result of violence, such as gang-related activity; the result of aggressive behavior, such as bullying or a heated argument; or accidental, as in cases of a child playing with a weapon or showing it to friends.

During 2024, there were 67 reviewed deaths caused by bodily force or weapon-related incidents among children in Alabama.

Cause of Death Details:

- In 61 (92.4 percent) reviewed bodily force or weapon-related cases, the child's death involved a firearm.
- In 46 of reviewed firearm deaths, a handgun was involved.
- In 7 reviewed deaths, a long gun, such as a shotgun, hunting rifle, or assault rifle, was involved.

Circumstances of Death Details:

- In 23 reviewed deaths, the child caused injury to themselves with a firearm. These deaths include both accidental and intentional harm.
- In 23 reviewed deaths, the firearm causing the child's injury was used in the commission of a crime.
- In 7 reviewed deaths, the child was injured in a drive-by shooting.
- In 6 reviewed deaths, the child was injured in an act of child abuse.
- In less than 5 reviewed deaths, the child was playing with a firearm when the injury occurred.

[^]CDC WONDER. Causes of death are based on the following ICD-10 codes: vehicle (ground) cause of death from V01 to V89, drowning causes of death from W65 to W74, asphyxia causes of death from W75 to W84, and other accidental causes from W00 to W64, W85 to W99, and X10 to X59.

Storage and Ownership of the Firearm Causing Injury:

- In 12 reviewed deaths, the firearm was loaded when the child obtained possession of the weapon.
- In 5 reviewed deaths, the firearm was locked up, but the child managed to gain access to it.
- In 19 reviewed deaths, the firearm was not kept locked away from the child.
- In 16 reviewed deaths, the owner of the firearm was a caregiver, a parent, or a direct family member of the child who died.
- In 8 reviewed deaths, the owner of the firearm was a friend or acquaintance of the child.
- In 6 reviewed deaths, the owner of the firearm was an extended family member of the child who died.
- In 6 reviewed deaths, the owner of the firearm was a stranger to the child who died.

Homicides and Suicides

During 2024, there were 46 reviewed homicides:

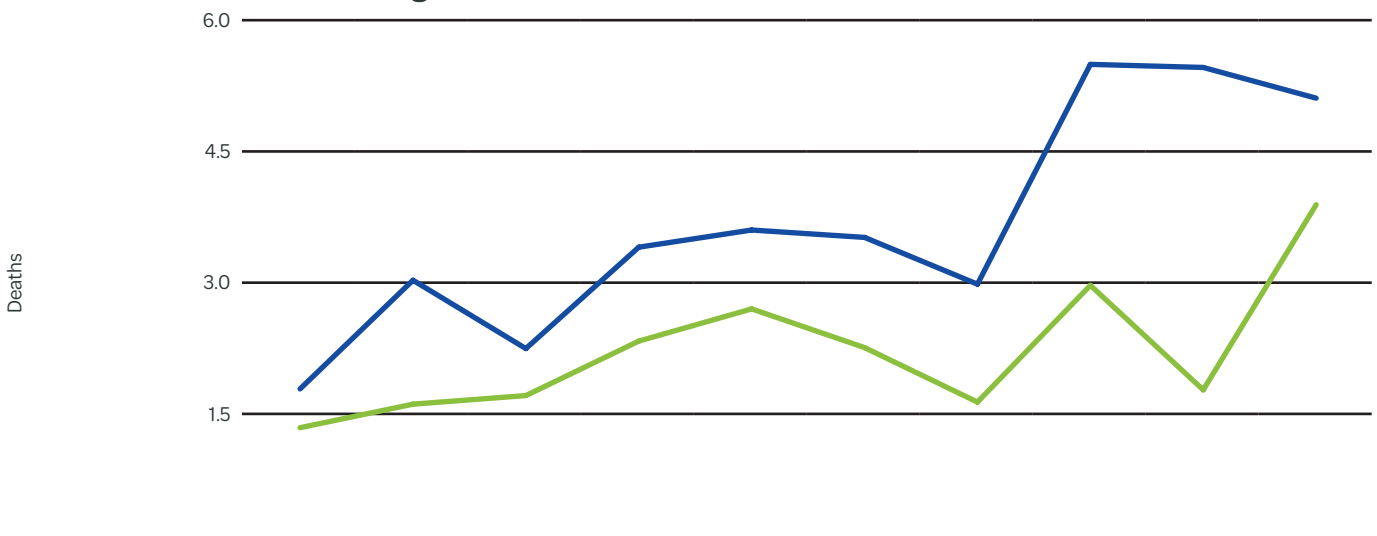
- In 37 reviewed deaths, a firearm was used, and of those deaths, 26 involved the use of a handgun.

During 2024, there were 36 reviewed suicides:

- In 23 reviewed suicides among children, a firearm was involved.
 - o In 19 reviewed deaths, a handgun was involved.
 - o In 13 reviewed deaths, the firearm was owned by the child’s caregiver.
 - o In 7 of these deaths, the firearm was not kept locked away from the child.
- In 11 reviewed suicides, the child died from asphyxiation.
 - o In 10 of these asphyxiation deaths, the child hung themselves.

As shown in the following graph, the homicide rate among children declined from 2018 to 2020. However, during 2021, a significant spike in homicide and suicide rates occurred. Homicide rates in children then began to slowly decrease during 2022 and 2023. The suicide rate among children decreased in 2022, but then increased to more than double the rate seen in 2022 during 2023. National and statewide population statistics have not been finalized and released for 2024 at the time of this report.

Rate of Violent Deaths Among Children, 2014-2023[^]



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Rate - Suicide	1.35	1.63	1.73	2.37	2.75	2.30	1.66	3.03	1.80	3.98
Rate - Homicide	1.81	3.08	2.28	3.47	3.67	3.58	3.04	5.61	5.58	5.22

[^]Causes of death are pulled from death certificates and are based on the following ICD-10 codes: suicide causes of death from X60 to X84, and homicide causes of death from X85 to Y09. Population counts gathered from CDC WONDER - <https://wonder.cdc.gov/ucd-icd10>.

B. SUID and Sleep-related Deaths

Sleep-related deaths are deaths that can be attributed to specific causes or factors in the sleep environment after investigation and are distinct from sudden infant deaths such as SIDS and SUID, which cannot be attributed to any established cause or contributing factor. These deaths typically occur in children under 12 months of age and are commonly classified as undetermined manners of death. This is due to the difficulty of establishing convincing contexts of injury for such sleep-related deaths. These deaths may be attributed to improper sleep surfaces, co-sleeping, toys or other objects in the sleep environment, and other hazards that could affect the child's health.

SUID and Sleep-related Deaths

For 2024, there were 35 reviewed sleep-related deaths and 51 reviewed SUID (32 of which sleep environment contributed).

Sleep-related deaths and SUID are not mutually exclusive or mutually inclusive in the following counts, and there is significant overlap. For example, the 32 SUID that the sleep environment contributed to are included in the 35 sleep-related death count. Furthermore, many SUID are determined to have sleep-related connections without a specific cause of death. However, not all SUID are sleep-related deaths and not all sleep-related deaths are SUID.

Manner of Death - Sleep-related:

- In 26 reviewed deaths, the manner of death was undetermined.
- In 9 reviewed deaths, the manner of death was accidental.

Cause of Death - Sleep-related:

- In 9 reviewed deaths, the cause of death was unintentional asphyxia.
- For the remaining 26 reviewed deaths, the cause of death was undetermined, unknown, or other.

SUID and Sleep-related Deaths - Sleep Surface:

- In 8 sleep-related or SUID, the child was sleeping on a recommended sleep surface (such as a crib or bassinet).
- In 36 reviewed sleep-related or SUID, the child was sleeping on an unrecommended sleep surface (such as an adult bed or couch).
- In 27 reviewed sleep-related or SUID, the child was sleeping on an adult bed.

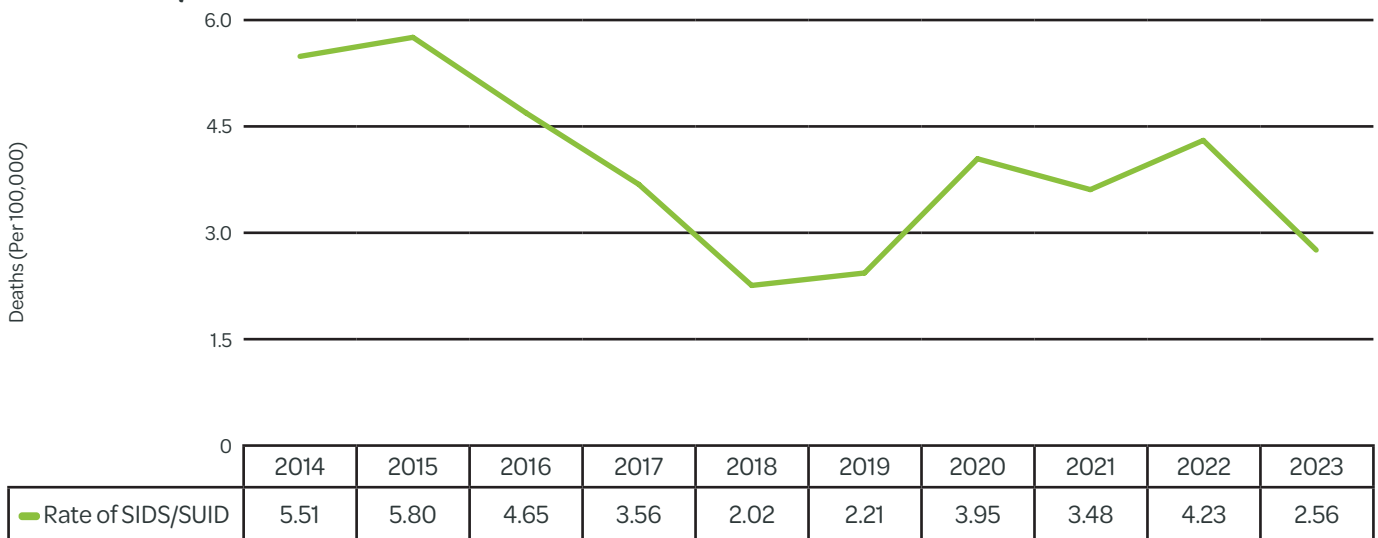
Sleep-related Deaths - Co-Sleeping:

- In 22 reviewed sleep-related deaths, the child was co-sleeping with only an adult(s) on the same sleep surface.
- In less than 5 reviewed sleep-related deaths, the child was co-sleeping with an adult(s) and another child(ren) on the same sleep surface.

ACDRS has strived to increase the proper use of SIDS and SUID classifications and has worked with coroners, medical examiners, law enforcement, and others within Alabama to educate people about classifying death in this use. Only through the proper classification of these types of death can an accurate view of the burden that SIDS and SUID place on Alabama children be measured and addressed.

As shown in the following graph, the rate of SIDS and SUID is variable but appears to be decreasing over time. This variability could be due to difficulties in defining a cause of child death that is characterized by being sudden, unexpected, and to a certain degree unexplainable. Some stability has occurred in the rate of SIDS and SUID, specifically between 2020 and 2022, with rates between 3.5 and 4.2 per 100,000. This could be a result of SUIDI training conducted with death investigation organizations around Alabama, and other attempts to standardize this cause of death in the state. National and statewide population statistics have not been finalized and released for 2024 at the time of this report.

Rate of SIDS/SUID - 2014 to 2023[^]



C. Vehicle-related Deaths

This category includes all deaths occurring in children who are drivers, passengers, pedestrians, or occupants of all forms of vehicles, including bicycles, motorcycles, all-terrain vehicles (ATVs), trains, etc. The manner of death is usually accidental but can also include suicides or homicides. Some of the following circumstances may not be mutually exclusive and may be used to describe a single vehicular fatality.

Vehicle-related Deaths

For 2024, there were 47 reviewed deaths from motor vehicle-related incidents.

Child Position in or Around the Vehicle:

- In 23 reviewed deaths, the child was a passenger.
 - In 6 reviewed deaths where the child was a passenger, the child was sitting in the front seat of the vehicle.
 - In 10 reviewed deaths where the child was the passenger, the child's biological parent was driving during the fatal event.
- In 14 reviewed deaths, the child was the driver of the vehicle.
- In 9 reviewed deaths, the child was a pedestrian or riding a bicycle at the time of the event.
- In 5 reviewed vehicle-related deaths, the child was a pedestrian struck by a vehicle.

Most motor vehicle-related deaths occurred in passenger cars, with trucks and sport utility vehicle (SUVs) incidents resulting in fewer child deaths. Passenger car incidents resulted in 18 child deaths, followed by 8 deaths in trucks, and 5 deaths occurring in SUVs.

Circumstances Contributing to the Vehicle-related Incident

Driver Behavior:

- In 11 reviewed vehicle-related deaths, reckless driving contributed to the event that caused death.
- In 10 reviewed vehicle-related deaths, speeding contributed to the event.
- In 7 reviewed vehicle-related deaths, carelessness or inattention contributed to the event.
- In 6 reviewed vehicle-related deaths, alcohol use contributed to the event.
- In 5 reviewed vehicle-related deaths, drug use contributed to the event.

Fatal Event and Driving Conditions:

- In 18 reviewed vehicle-related deaths, a car the child was in was the vehicle involved in the event.
- In 8 reviewed vehicle-related deaths, a truck the child was in was the vehicle involved in the event.

[^]Causes of death are pulled from death certificates and are based on the following ICD-10 codes: SIDS, SUID, and other ill-defined causes of death R95. Population counts gathered from CDC WONDER - <https://wonder.cdc.gov/ucd-icd10>.

- In 5 reviewed deaths, the vehicle backed over a child causing the fatal event.
- In 5 reviewed deaths, distracted driving contributed to the fatal event.

Seatbelt and Other Restraint Use:

- In 29 (63 percent) reviewed vehicle-related deaths, a proper restraint was not used for the child at the time of the event.
- In 7 reviewed vehicle-related deaths, a proper restraint was in use at the time of the event.

For the remaining reviewed deaths, source documents did not report restraint use for the child(ren) involved.

As shown in the following graph, the rate of child death from vehicle-related incidents has been on a gradual downward trend since 2016. With statewide initiatives such as free car seat distribution, safe driving practices, and outreach, ACDRS hopes to further reduce the number of fatal child vehicle accidents in the state. National and statewide population statistics have not been finalized and released for 2024 at the time of this report.

Rate of Ground Vehicle-related Child Death - 2014 to 2023[^]



[^]Causes of death are pulled from death certificates and are based on the following ICD-10 codes: vehicle-related (ground) causes of death from V01 to V89. Population counts gathered from CDC WONDER - <https://wonder.cdc.gov/ucd-icd10>.

State Child Death Review Team Members

Scott Harris, M.D., M.P.H.

State Health Officer/Chair
Alabama Department of Public Health

Gregory Davis, M.D.

Coroner/Medical Examiner
Jefferson County

Sheriff Jimmy Lambert

Alabama Sheriff's Association

Angelo Della Manna

Director
Alabama Department of Forensic Sciences

Nancy Buckner

Commissioner
Alabama Department of Human Resources

Kimberly Boswell

Commissioner
Alabama Department of Mental Health

Colonel Jonathan Archer

Director
Alabama Department of Public Safety

Marsha Raulerson, M.D., FAAP

Alabama Academy of Pediatrics Appointee

Candice Dye, M.D.

Alabama Department of Public Health Appointee

Max Capouano, M.D

Alabama Academy of Family Physicians Appointee

David Rydzewski, M.D.

Alabama Department of Forensic Sciences Appointee

Bruce Wilson

Alabama Coroners Association Appointee

Lynn Bius

Alabama Network of Children's Advocacy Centers Appointee

Sheriff Bill Franklin

Alabama Sheriff's Association Appointee

Bob Wilters

Alabama District Attorney's Association Appointee

Shaundra Blakemore, M.D.

Pediatric Emergency Medicine Specialist
Medical Association of the State of Alabama Appointee

Chief Justin Lovvorn

Alabama Association of Chiefs of Police Appointee

Representative Paul Lee

Chair
House Health Committee

Senator Jim McClendon

Chair
Senate Health Committee

LaBeatrix Tatum

Clergy
Governor Appointee

Crys Fuller

Private Citizen
Governor Appointee

David Peebles

Private Citizen
Governor Appointee

Kristin Byrd

Private Citizen
Governor Appointee

Dr. Jennifer McCain

Private Citizen
Governor Appointee

Tonita Phipps

Private Citizen
Governor Appointee

Tim Davis

Private Citizen
Governor Appointee

Bob Hinds

Private Citizen
Governor Appointee

