

Children For Our Future



Alabama Child Death Review System
2001 Report



DEATHS AMONG CHILDREN IN ALABAMA FOR THE YEAR 2001

ALABAMA CHILD DEATH REVIEW SYSTEM
ANNUAL REPORT

EXECUTIVE SUMMARY

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STATE TEAM MEMBERS

As of April 15, 2004



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Justice Jean Brown
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March 15, 2004

It is difficult to think of anything more tragic than the needless, preventable death of a child. The Alabama Child Death Review System (ACDRS) was established by state law in 1997 to review child deaths in the State of Alabama with a focus on prevention. The state and local components of the ACDRS work together to analyze child death trends, identify preventable deaths, and implement prevention strategies. This report provides a brief overview of the ACDRS findings and recommendations for the year 2001.

Progress is being made in preventing child deaths, as several items in this report indicate. In just a few years of operation, the percentage of qualifying cases completed and returned by the local teams has improved from an initial rate of 64 percent to more than 81 percent for 2001. Meanwhile, the number of cases that qualified for ACDRS review has steadily decreased, from about 500 per year when the ACDRS began in 1998 to fewer than 350 in 2002 - a 30 percent decrease. In addition, Alabama has recently recorded significant declines in both child and infant mortality. While many factors have contributed to these declines, the ACDRS has been cited as a major contributor. We believe that our efforts in this regard have played a valuable part.

The ACDRS submitted a number of recommendations related to the prevention of child deaths to the Governor in September 2000 and again in March 2003. Those recommendations, along with the support and efforts of other like-minded agencies, have helped to improve day care standards, secure passage of a graduated driver's license law, improve child passenger safety requirements, and increase public awareness and education related to such issues as Sudden Infant Death Syndrome, Shaken Baby Syndrome, the "Back to Sleep" campaign, and safe infant/child bedding and co-sleeping practices. Still, there are other child-related issues that warrant our increased attention.

All child deaths in Alabama cannot be prevented and, accordingly, there is always room for further improvement. The ACDRS rate of case return must continue to improve, and all Local Child Death Review Teams must become active participants in this endeavor. Toward that end, this Annual Report identifies how each local team is performing. Better performance is a perpetual goal and we will implement a new evaluation protocol in the near future. In accordance with state law, we will submit a new set of recommendations to the Governor for his consideration in a continued effort to save the lives of infants and children. Our goal continues to be the protection of what we believe is Alabama's greatest resource - our children!

Sincerely,

A handwritten signature in black ink, appearing to read "D. Williamson", with a long horizontal flourish extending to the right.

Donald E. Williamson, MD
State Health Officer





There were 911 children under the age of 18 who died in Alabama in the year 2001. While each one of these deaths is a tragedy, especially to family and friends, each one also serves as a powerful warning that other children are at risk. To better understand how and why these children died in Alabama, the Child Death Review System has been empowered to maintain statistics on child mortality; to identify deaths that may be from abuse, neglect, or other preventable causes; and from that information develop and implement measures to aid in reducing the risk and incidence of future child injury and death in Alabama.

This report is a compilation of findings from Local Child Death Review Teams whose task is to: 1) identify factors that make a child at risk of injury or death; 2) share information among agencies that provide services to children and families or investigate child death; 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 injury and death; and 6) educate the local public about the causes of child injury and death while defining its role in helping to prevent such tragedies.

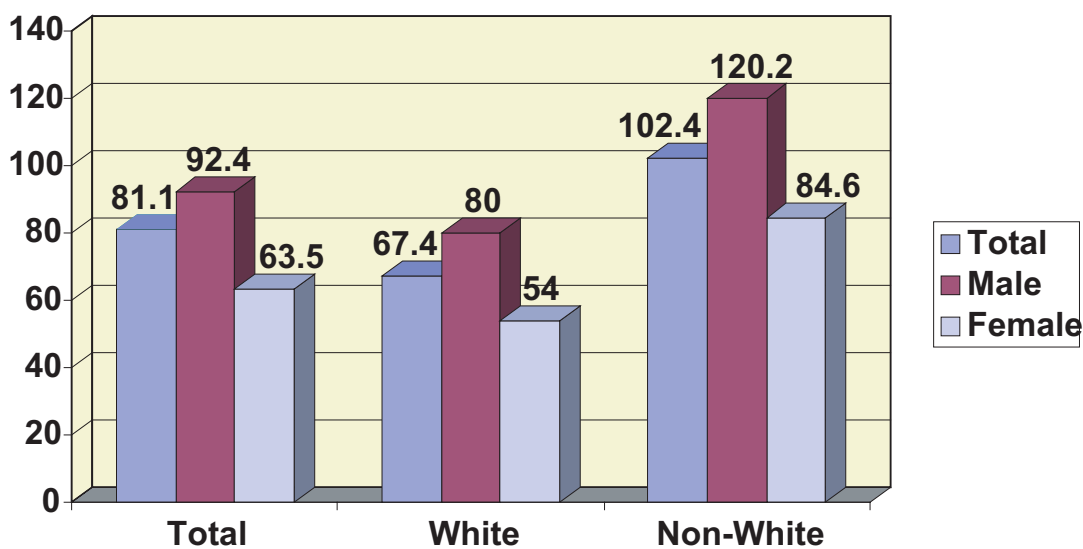
While this Executive Summary presents key findings from the local review teams and from data on Alabama child mortality, it also makes recommendations that can help prevent other deaths to our children. Thus, this report honors the memory of all those children who have died in Alabama. We hope that it leads to further understanding of how we can all make Alabama a safer and healthier place for children.



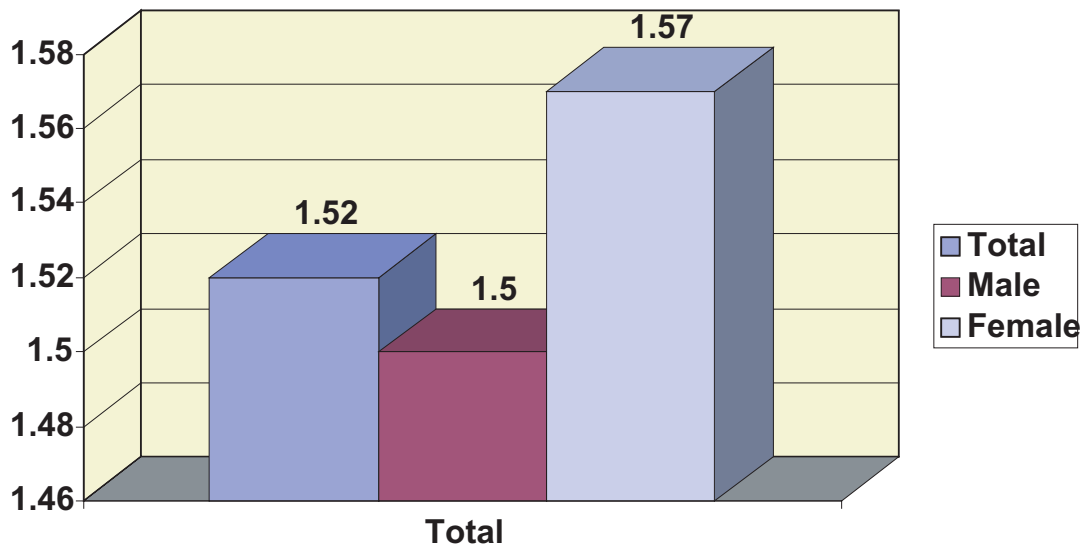


KEY FINDINGS

- * There were 911 deaths to children (i.e., those under the age of 18) during 2001.
- * This represents 81 deaths per 100,000 children.
- * Sixty percent of these deaths were to male children.
- * Fifty-five percent of these deaths were to white children.
- * Below is a graph showing the total, race-specific, and gender-specific death rates (per 100,000 children) among children in Alabama. This allows one to compare death rates while adjusting for population differences:



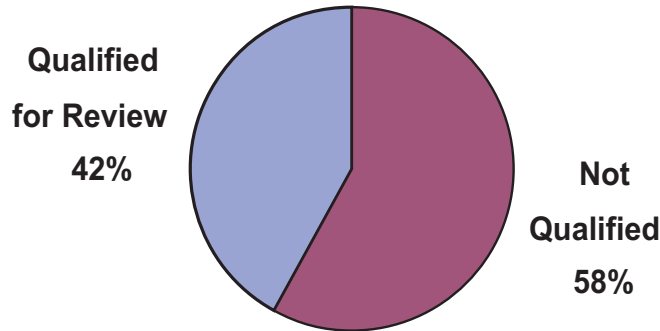
- * Racial comparisons of the above rates are shown in the graph below. It should be noted that in each instance, non-whites have significantly ($p < .05$) higher rates than do whites.



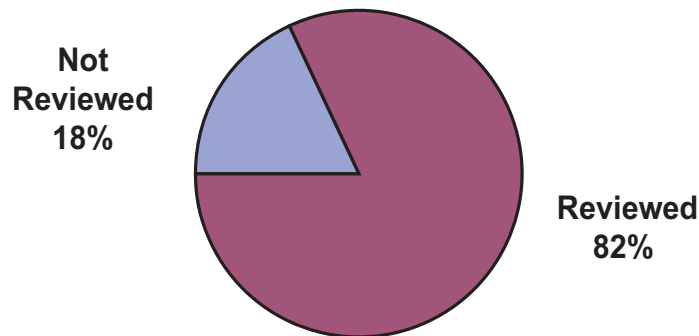


KEY FINDINGS

- As the chart below indicates, of the 911 child deaths in Alabama, there were 380 deaths during the year 2001 that qualified for review under the Alabama Child Death Review System.



- Of those deaths that qualified for review (380), the local review teams reviewed and returned 312 reports (see chart below).

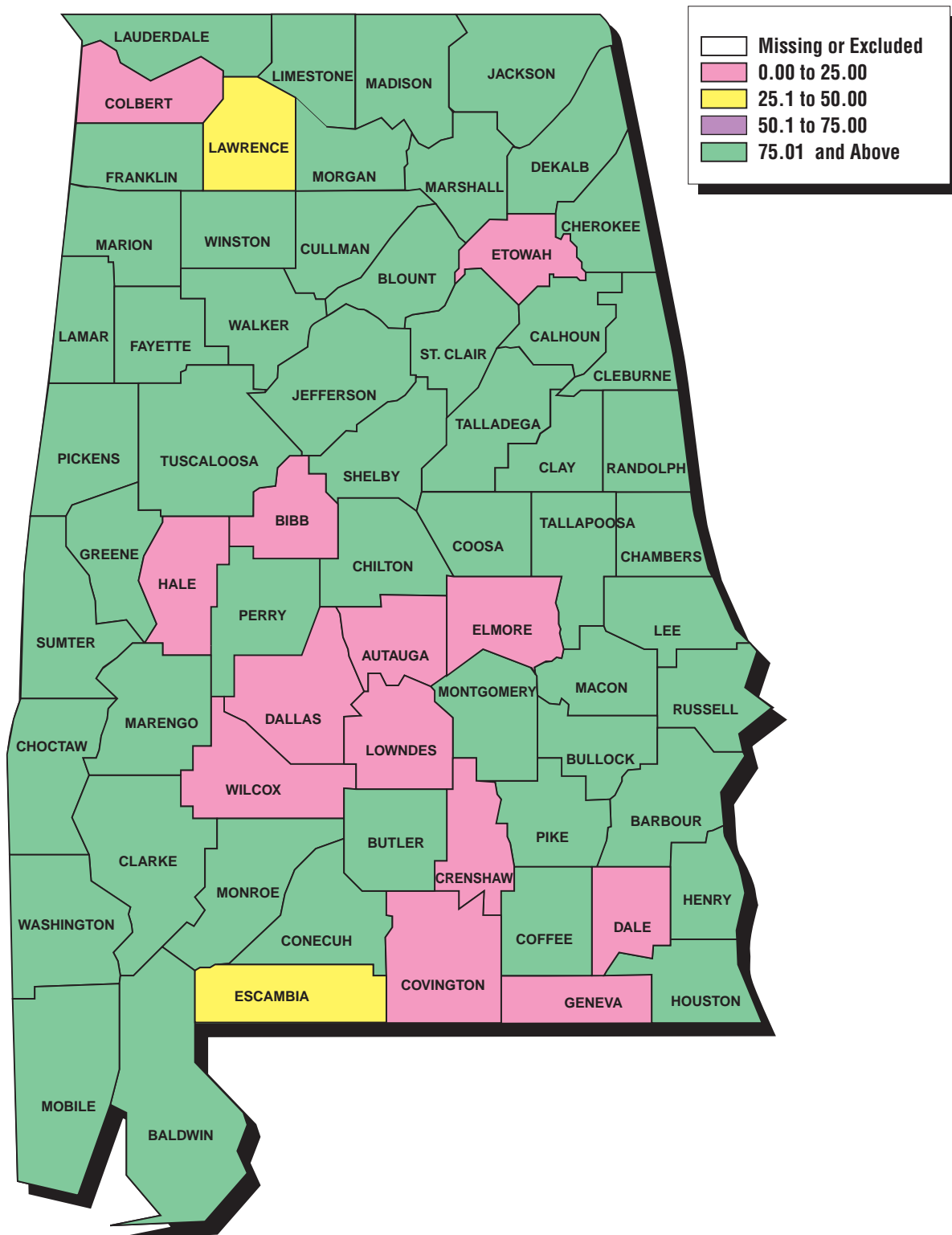


- There were no significant race or gender differences in the proportion of cases reviewed compared to those not reviewed.
- While proportionately fewer neonates (those less than 28 days old) qualified for review than did any other age category, there was no significant age group difference between those who were and those who were not reviewed.

AGE GROUP	ALL	QUALIFIED	REVIEWED	NOT REVIEWED
< 28 days	347	27	21	3
28 days - < 1 year	201	87	71	16
1 year - < 5 years	91	56	44	12
5 years - < 10 years	56	42	34	8
10 years - < 16 years	119	85	73	12
16 years - < 18 years	96	82	68	14



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





KEY FINDINGS

- Thirty-seven cases were reviewed.
- In only two cases were the infants known to be in a crib by themselves and put to sleep on their backs as is recommended.
- Of all the SIDS deaths reviewed, only six were known not to have a history of smoking in the household.

RECOMMENDATIONS

1. Teach the use of standard protocols for the investigation of all unexpected and unexplained child deaths, including autopsy, scene investigation, and review of medical history.
2. Study the merits of mandating autopsies for all sudden and unexplained deaths.
3. Develop and implement a program to train medical examiners and law enforcement personnel in the thorough investigation of child deaths.
4. Develop and implement a mechanism for notifying the appropriate medical examiner whenever a death certificate is received that shows SIDS as the cause of death, but for which no autopsy was done and/or the medical examiner had not been involved in the case.
5. Increase public awareness of “Back to Sleep” and “Babies Sleep Safest on their Backs” programs.



**KEY FINDINGS**

- Ninety-seven deaths were reviewed.
- Sixteen of these child deaths (17.02 percent) were due to young drivers (16 years of age) at fault.
- Thirteen child deaths (13.83 percent) in this category were due to underage driving (under the age of 16).
- In only 15.63 percent of these cases were safety restraints reported as being used correctly.
- Additionally, of these deaths involving motor vehicles, 19.59 percent were due to reckless driving or speeding.

RECOMMENDATIONS

1. Encourage the inclusion of information about the dangers of driving at high speeds on gravel roads or other poor road conditions and expand current education on reckless driving in driver's education courses.
2. Promote the adoption of legislation that would make it illegal under certain conditions to ride in the back of a pickup truck on public roads.
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 and encourage public education and safety training programs for child operators of ATVs.
5. Modify existing legislation to increase the child age requirement for seat restraints from "less than 5 years of age" to "less than 16 years of age."



**KEY FINDINGS**

- Seventeen deaths were reviewed.
- The largest number (47 percent) of fire-related deaths to children occurred to individuals who resided in wood-frame houses/buildings.
- None of the cases was known to have a smoke alarm in their residence or other place of death.

RECOMMENDATIONS

1. Encourage enforcement of laws governing smoke detector installation, testing, and inspection in new and used manufactured homes.
2. Support local fire departments in developing, expanding, and implementing fire education activities, particularly for elementary schools and other 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.



DROWNING



KEY FINDINGS

- Twenty-one deaths were reviewed.
- All of the children who drowned in open bodies of water were reported as **not** wearing a flotation device.

RECOMMENDATIONS

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



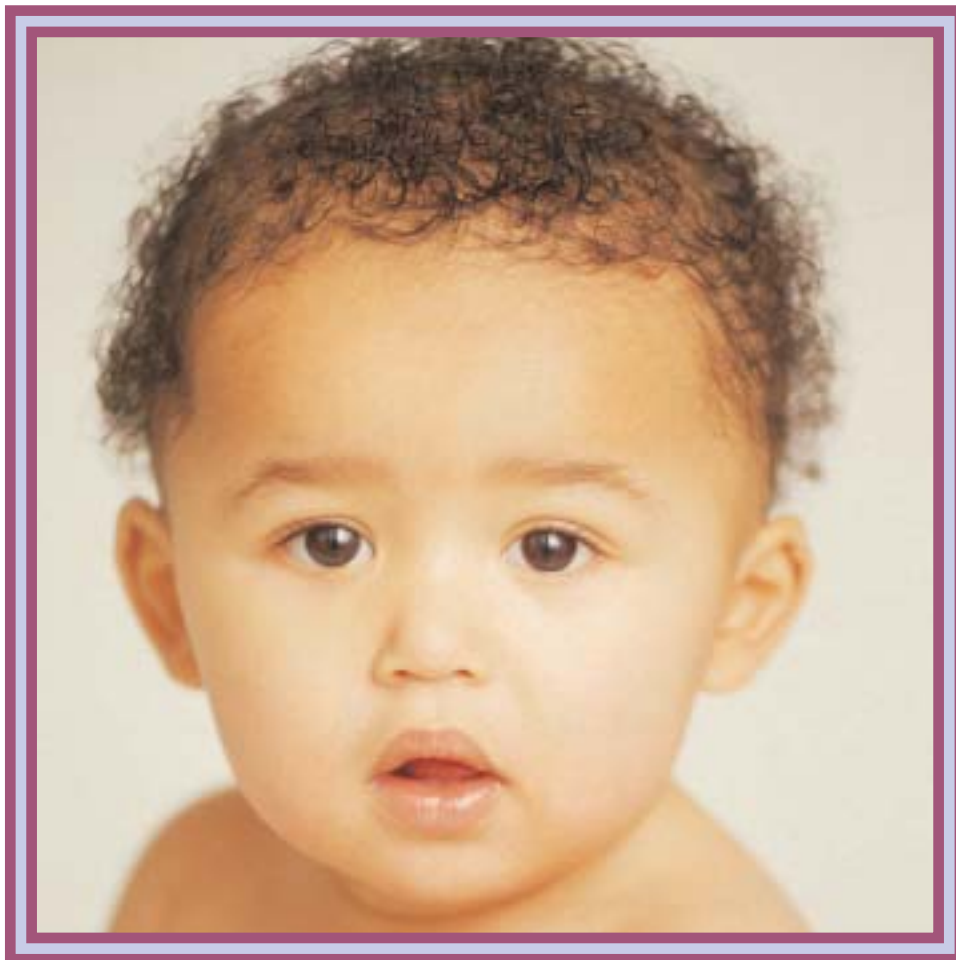


KEY FINDINGS

- Twenty cases were reviewed.
- Fourteen percent of these deaths to children due to suffocation were considered intentional.
- Another 43 percent of the deaths were considered unintentional “roll over” by an adult.

RECOMMENDATIONS

1. Promote and encourage statewide education and awareness campaigns about safe bedding practices and the dangers of co-sleeping.
2. Promote and encourage parenting classes for new and, especially, young parents.





KEY FINDINGS

- Twenty-three cases were reviewed.
- Fifty-two percent of these deaths to children were known to be the result of handgun use.
- The vast majority (61 percent) of these deaths were known to be due to an “intent to do harm.”
- Only four child deaths reviewed in this category were reported as the result of playing with firearms.

RECOMMENDATIONS

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





KEY FINDINGS

- Fourteen cases were reviewed.
- Five (35.71 percent) of these deaths were reported as being completely unexpected.
- Most (64.29 percent) were classified as use of firearms, followed by hanging (28.57 percent).

RECOMMENDATIONS

1. Support statewide efforts to examine all of the issues surrounding adolescent suicide and develop plans for prevention.
2. Institute training for teachers about suicide risk assessment and referral resources.
3. Support a statewide education and awareness campaign aimed at parents and others about suicide risk assessment and assistance resources.

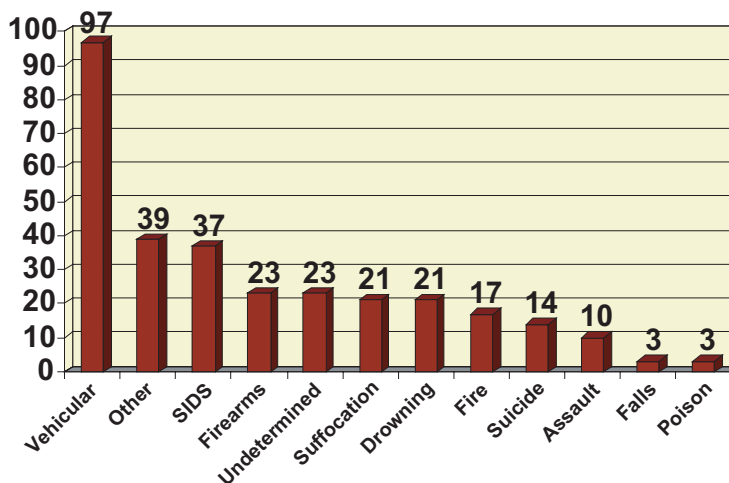


OTHER FINDINGS

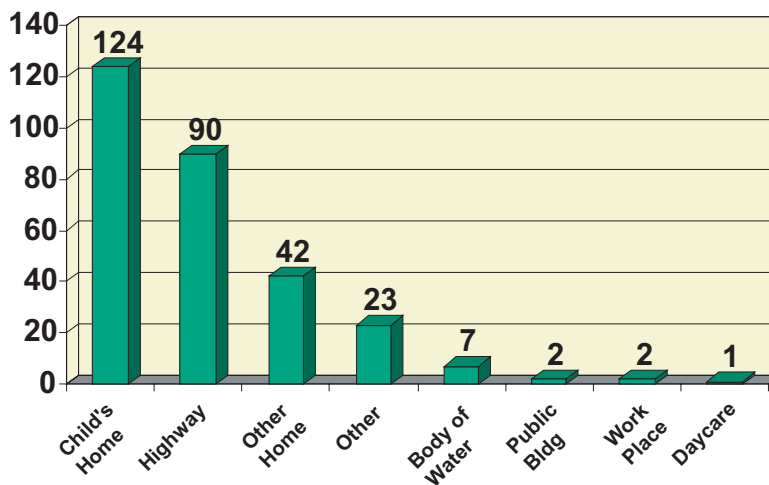


REVIEWED CASES ONLY

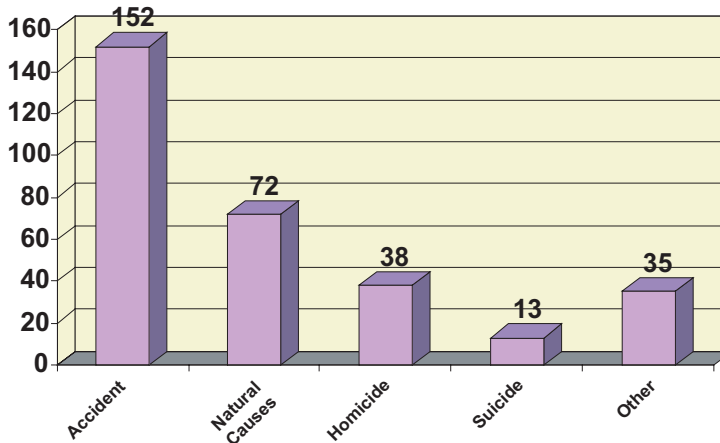
- Motor Vehicle was the most often (31 percent) reviewed cause of child death.



- As can be seen from the graph below, the single most frequent place of death (40 percent) was the child's home.



- Accident was the most frequent (152) manner of death reviewed.



POISON:



- Four cases were reviewed.
- Of those, one (25 percent) was the result of illicit drugs and three (75 percent) were the result of prescriptive medication.

FALLS:

- Three cases were reviewed.
- Of those, two (66.67 percent) were from natural elevation.

ELECTROCUTIONS:

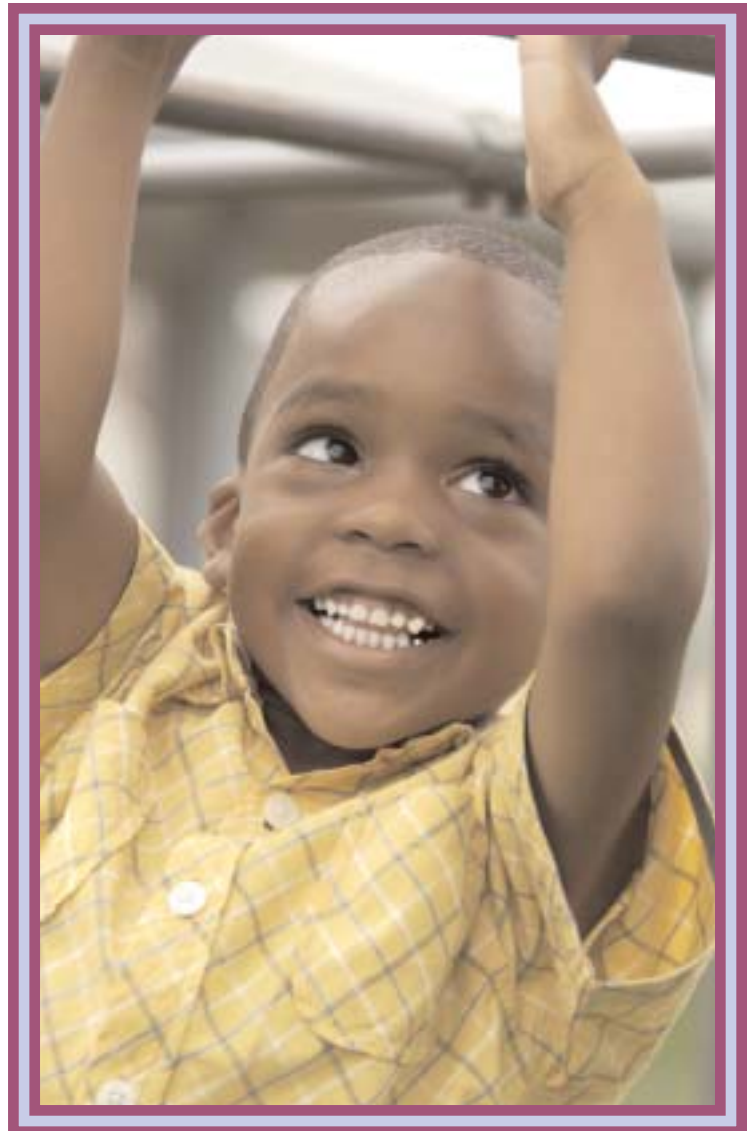
- Two cases were reviewed.
- Of those, one was the result of lightning.

ASSAULTS:

- Ten cases were reviewed.
- Of those, four (40 percent) were by hands and fists, followed by blunt instrument, other, and unknown at two each (20 percent each).

UNDETERMINED:

- Twenty-three cases were reviewed.





The Alabama Child Death Review System (ACDRS) is making a difference in the lives of Alabama's children. ACDRS data, as published in our first-ever Annual Report, showed that in both calendar years (CYs) 1998 and 1999, there were approximately 500 infant/child deaths per year that met our criteria for case review. New data shows that since 1999, the number of infant and child deaths that have met our review criteria has steadily decreased each year to a low of 349 in 2002. While the ACDRS cannot take credit for all of this decrease, it has been publicly recognized as a significant contributor to these improved numbers.

The ACDRS's second Annual Report, containing final review data for CY 2000, was published in March of 2003. It was distributed to the Governor and the State Legislature, as well as to more than 300 other citizens and agencies in Alabama and around the country. This 2001 Annual Report continues a state legal requirement that will provide annual progress reports on the outcomes achieved through the ACDRS.

In addition to hosting the regular quarterly meetings of the State Child Death Review Team (SCDRT), the ACDRS also formed and hosted meetings of the new Child Death Investigation Task Force (CDITF). The CDITF was charged with the duty of developing new/improved training curricula for death scene investigators. The Task Force developed both an addendum to the curriculum taught to new recruits at the state's police academies, and a specific in-service course for experienced investigators. Both of these have been implemented, well received, and are currently being taught.

Many new people are serving on the SCDRT and on Local Child Death Review Teams (LCDRTs) statewide. Accordingly, the ACDRS plans to hold a training conference during 2004 to make sure everyone involved understands the purpose, mission, procedures, and operations of the ACDRS. This conference is now scheduled for August 2004.

Finally, the operational efficiency of the ACDRS continued to improve in 2003. The ACDRS website (www.adph.org/cdr) has much more useful content, including downloadable and printable versions of all our Annual Reports, ACDRS Publications (such as our new "Safety for Sleeping Babies" brochures in English and Spanish and our "Back to Sleep" reminder posters), and the Investigative Assessment Tool developed by the CDITF. More LCDRTs are utilizing the online data submission forms and total case completion is up to a high of greater than 83 percent of all cases assigned (compared to 60 percent in the first year of operation). We expect to improve data collection and case completion even further in the coming year.

The ACDRS submitted its second official set of recommendations to the Governor in March 2003. These recommendations, along with the first set submitted in September 2000, have been taken very seriously and have helped to further efforts both within and outside of Public Health. Examples of specific recommendations and related actions and outcomes include:

- Recommendations to improve the quality and, particularly, the safety of day care settings in Alabama led to the adoption of new minimum standards, including: Training related to "Back to Sleep," safe bedding practices, CPR, and first aid; on-site safety assessment of play areas and playground equipment; periodic "spot checks" for hazardous conditions that can lead to immediate closure; and more stringent licensing and

accountability requirements. The ACDRS, in cooperation with other Alabama Department of Public Health programs, recently developed a “Back to Sleep” reminder poster for statewide distribution to day care settings.



- Recommendations for statewide public education and general injury prevention awareness campaigns in several areas led to such efforts in the areas of Shaken Baby Syndrome, “Back to Sleep,” and Child Passenger Safety. The ACDRS also is working closely and sharing statistical data with the Alabama Injury Advisory Council.
- The recommendation for the development and subsequent passage of legislation supporting graduated driver’s licenses was adopted, and such legislation was passed into state law and took effect Oct. 1, 2002.
- The recommendation that all professionals responsible for child death investigations in Alabama receive training in a standardized set of protocols has led to the development of the CDITF. Under the ACDRS/SCDRT guidance, the CDITF has revised the entry-level death investigation curriculum and developed an in-service course for experienced officers. The revised curriculum is already being taught to cadets at the various Alabama law enforcement academies, and the in-service course is now being offered at various locations throughout the state. An optional Child Death Investigation Assessment Tool and a set of related guidelines also were developed in conjunction with the above courses.
- The recommendation for further statewide public education and awareness programs related to the dangers of co-sleeping with an infant led the ACDRS to develop the “Safety for Sleeping Babies” brochure, which has been offered to delivery hospitals, perinatal professionals, and health/medical associations statewide.

Recognizing that infant and child deaths are very different from an investigative stand point from adult death investigations, and in an effort to improve our ability to investigate infant/child deaths, the March 2004 recommendations to the Governor will include a recommendation that all potential infant/child death investigators be encouraged to attend the new “Infant/Child Death Investigators In-Service Course.”

Other recommendations, which as yet have not had an opportunity to be acted upon, include new legislative restrictions upon child ATV operation and child transport in truck beds; new consideration for safety signage, fencing, and floatation device usage related to children swimming in public and private pools and recreation areas; and the importance of smoke and carbon monoxide alarms, particularly in mobile homes. These recommendations have resulted in large part from the recommendations and activities of the LCDRTs. They routinely report changes to community investigation procedures and prevention activities and, occasionally, re-open criminal investigations as a result of their case reviews. The ACDRS counts all of these recommendation-related actions, in their various forms, as evidence of program successes. The ACDRS will continue to develop recommendations for the Governor as needed and advocate for action on existing recommendations.

As reported earlier, the number of preventable infant and child deaths in Alabama has been reduced. Additionally, the ACDRS is proud to have been cited by VOICES for Alabama's Children and the Center for Health Statistics as a contributor to Alabama's recent child and infant mortality decreases. It is our hope that through continuing ACDRS activities, including our recommendations, these numbers will continue to decrease.



Fewer preventable child deaths in Alabama - that has been the result of ACDRS activities and their subsequent effects on state and local communities. This is the goal and continuing mission of the ACDRS.





The following is a fictionalized account of a child death in Alabama and is intended to illustrate how the state's Child Death Review System works. This account is not based upon any actual incident, but it is indicative of the types of cases reviewed by the Alabama Child Death Review System (ACDRS) and a case similar to this could be encountered by any of the more than 50 Local Child Death Review Teams (LCDRTs) across the state.

Baby John Doe was born prematurely. Weighing less than a full-term infant, he spent time in the hospital's Neonatal Intensive Care Unit. A little over a month later, he was home with his parents and, although suffering from a cold, was otherwise a healthy baby.

After an 11 p.m. feeding one night, Baby Doe's mother fell asleep with him in her bed, surrounded by soft pillows and covers. She awoke to find that he was not breathing. She called for an ambulance. Paramedics arrived and attempted unsuccessfully to revive the infant.

Law enforcement officials were summoned to the house. Investigators from the Homicide Division examined the bed where Baby Doe had died, noting the covers and pillows, as well as the position of the infant. They took pictures. An autopsy was conducted by the Medical Examiner, and a death certificate was issued and forwarded to the Alabama Department of Public Health in Montgomery.

Upon receipt of the death certificate, the Department of Public Health issued a copy of it to the Director, ACDRS. The Director and his staff then examined the case to determine if it met the criteria for a local team case review. The Baby Doe case did meet the criteria of an unexplained/unexpected child death. Therefore, copies of Baby John Doe's birth and death certificates and the appropriate data collection forms were sent to the members of the local review team in the city where Baby Doe lived for a complete case review.

Local Child Death Review Teams (LCDRT) in Alabama are designated by state law and typically include representatives from various local governmental offices and agencies, including the District Attorney's and Medical Examiner's offices, the Department of Human Resources, the Homicide Division and Juvenile Court. Forensic pediatricians and officials from area hospitals and schools are also involved.

After receiving copies of Baby Doe's birth and death certificates, members of the LCDRT in the county where he resided scoured their records and files for information they might have related to the infant's life and death that could prove helpful during their inquiry. Team members brought this information with them to their next regular meeting.

At the meeting, team members discussed the incidents surrounding Baby Doe's death and determined what additional information was needed to pinpoint a cause of death. They gathered this information, discussed and analyzed the circumstances, and then recorded their findings about Baby Doe's death on the primary ACDRS data collection form (CORE Module). A separate module titled "Cause of Death - Undetermined" sought information about the position of the infant at the time of discovery, the position in which the infant was put to sleep, whether the infant was sleeping alone, and whether "positional asphyxiation" was suspected. The LCDRT's aim during the review was to ensure that the team understood what happened to Baby Doe and to look for ways that the local community might prevent the next occurrence of a similar death.

The LCDRT then forwarded the information to the State Child Death Review Team (SCDRT), along with recommendations about how Baby Doe’s death, and similar deaths, might be prevented in the future. (The SCDRT assembles, analyzes, and distributes all the data and recommendations from all Local Teams. This information is used to publish an Annual Report, develop specific recommendations for the Governor’s consideration, and to take steps, as appropriate, to reduce the number of preventable infant and child deaths in Alabama.)



While the above example is very abbreviated and leaves out many specific details, it is intended as a summary to give the reader a general understanding of the flow of information in a child death case and the methodology employed by the LCDRTs in reviewing such cases. The Alabama Child Death Review System is mandated by state law and is, therefore, not an optional program. Every District Attorney in Alabama is required to form a Local Child Death Review Team to serve every citizen and every county in our State.



DEFINITIONS



- **Cases That Meet the Criteria for Review-** These are cases involving the deaths of Alabama resident infants and children from birth to less than 18 years of age whose deaths are considered unexpected/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) falls into this category. The ACDRS normally will not review such cases. However, many cases in which the cause of death is initially classified as “Pending” or “Undetermined/Unknown” are later discovered to have been death by “Natural Causes.” This is why there are so many in this category included in our data. Sudden Infant Death Syndrome (SIDS) is considered a natural cause death, but our teams are required by law to review all SIDS deaths.
- **Residential Institutions-** As used in this report, this is a term used to identify a place of death. Included in this classification are hospitals/emergency rooms. The number of deaths that occur in this category is usually fairly high because frequently victims survive long enough to reach the hospital, but not much longer. This does not necessarily mean that hospitals are dangerous places, but it does show that hospitals face frequent life or death situations.
- **Unexpected/Unexplained-** In referring to a child’s death, this category includes all deaths which, prior to investigation, appear possibly to have been caused by trauma, suspicious or obscure circumstances, child abuse or neglect, other agents, or SIDS.



...we're all part of the solution



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Informational materials
in alternative formats
will be made available
upon request.