NEWS RELEASE
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Alabama Child Death Review System annual report records progress in decreasing child deaths

FOR IMMEDIATE RELEASE

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The Alabama Child Death Review System has published its latest annual report which contains child death data. The system was created by law in 1997 to review all unexplained or unexpected child deaths in Alabama. Its mission is to identify which child deaths can be prevented and to take steps to prevent similar deaths in the future.

Each judicial circuit in Alabama has at least one local child death review team, and every district attorney in Alabama is required to form a local team that meets at least once a year. Local teams review every infant and child death that meet the system's review criteria. Findings are submitted to the state office and then further reviewed by the State Child Death Review Team.

Local teams look for hazardous situations in communities and work to change them. The state team analyzes child deaths, educates the public, makes recommendations to elected officials, and helps recommend and support legislation. The state team, which meets quarterly, is made up of 28 individuals and includes state agency directors and representatives; medical, legal and law-enforcement professionals, legislators and private citizens appointed by the governor.

Dr. Donald Williamson, state health officer, chairs the State Child Death Review Team. He commented, "If anything is more tragic than the death of a child, it's a needless child death which could have been prevented. While Alabama remains in the lower third of the U.S. in preventable child mortality, I am happy to report progress is being made in protecting what we believe is Alabama's greatest resource--our children."

Alabama has experienced a 30 percent drop in the number of child deaths that meet the standards needed for review since the system was created. The number of cases that qualified for review has steadily decreased from about 500 per year when the system began in 1998 to fewer than 350 in 2002.

Linda Tilley, director of VOICES for Alabama's children, added, "The creation of the Child Death Review Teams is one of the most important and cost effective ways we have in this state to keep children safe. The statewide team examines preventable patterns that cause child death and promotes policies for changing those patterns."

Recommendations made by the system and the support of like-minded agencies and individuals have led to significant improvements in a number of areas. These include improved day care standards, passage of a graduated driver's license law, improved child passenger safety requirements and increased 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.

The Alabama Child Death Review System's 2001 annual report includes additional recommendations related to preventing child deaths including the following:

• Enhanced child death investigation training

• The importance of safe infant sleeping practices

• The need for proper and consistent use of smoke and carbon monoxide detectors in homes

• Improvements in child passenger safety, especially related to all-terrain vehicles, passengers riding in open truck beds and enhancements to child safety restraint laws.

All of the Alabama Child Death Review System annual reports, as well as other publications and much more information about the program are available online by visiting the system's Web site at www.adph.org/cdr. Printed copies may also be obtained by contacting Tarina Moores, Alabama Childhood Death Review System, Bureau of Family Health Services, at (334) 206-2953, tmoores@adph.state.al.us.

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