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

FOR IMMEDIATE RELEASE

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Positive trends in reducing preventable childhood deaths which have been seen over the past few years in Alabama continued in 2002. A total of 896 children under the age of 18 died in the state during 2002, the latest year for which data are available. Of this number, 335 deaths were considered preventable, which qualified them for Alabama Child Death Review System review. This is down from 380 preventable deaths in 2001 and marks a 33 percent decrease in preventable deaths since ACDRS began in 1997.

This and other information on child deaths can be found in the latest annual report of the Alabama Child Death Review System, 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 all infant and child deaths 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 stated, "The death of even one child represents a tragedy for the child's family, the community and our entire state. Our goal is simple yet very important: fewer child deaths in Alabama."

Among the key findings are that 57 percent of deaths were to male children, 42 percent of these deaths were to black children. Thirty-two percent of infants who died were placed on their stomachs, a practice which is a known risk factor for Sudden Infant Death Syndrome.

The Alabama Child Death Review System's 2002 annual report includes additional recommendations related to preventing child deaths. These are in the areas of preventing SIDS; motor vehicle crashes; fire, drowning, suffocation, firearm/weapons, suicide and others. Recommended actions for emphasis are as follows:

• The importance of safe infant sleeping practices, especially to increase public awareness of "Back to Sleep" and "Babies Sleep Safest on Their Backs" programs and increase awareness of the dangers associated with infants sleeping with adults in adult beds.

• Encourage the inclusion of information about the dangers of driving at high speeds and expand current education about reckless driving in driver's education courses.

• Encourage enforcement of laws governing smoke detector installation, testing and inspection in all homes, including all manufactured homes; support fire education activities; and encourage community education efforts about the need for installation and testing of smoke detectors.

• Support public education and awareness campaigns about water safety with a special emphasis on the need for constant adult supervision and a focus on pools, bathtubs and open bodies of water; encourage enforcement of ordinances regarding pool fencing and signage; and encourage use of floatation devices when swimming in open bodies of water.

• Encourage youth and parent gun safety education; support crisis team and victim advocacy for children who witness violence; encourage community-based violence prevention programs; and encourage safe and secure storage of firearms.

• Support statewide efforts to examine all issues surrounding adolescent suicide and develop plans for prevention; institute training for teachers about suicide risk assessment and referral resources; support a statewide education and awareness campaign aimed at parents and others about adolescent suicide risk assessment and assistance resources.

The latest and previous annual reports of the Alabama Child Death Review System, other publications and 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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