The Oklahoma

Child Death Review Board

2003 Annual Report

Containing information on cases reviewed during the 2003 calendar year

A program funded by and contracted through the
Oklahoma Commission on Children and Youth

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A message from the Chair of the Oklahoma Child Death Review Board

Reflected in these pages is the untold heartache of the premature loss of some of Oklahoma's children. However, through the dedicated efforts of a multitude of child advocates, great progress is being made to see that the tragedies of the past are not repeated in today's families.

The Oklahoma Child Death Review Board reviews the circumstances of the death of every child (not related to disease) under the age of 18 in Oklahoma. We search for trends and/or systems failures where changes in behavior, governmental policy or agency function can impact the future events contributing to the untimely death of a child.

This year has seen the expansion in the number of local review teams increasing the amount of expertise and time brought to each case. Alliances have been strengthened with organizations committed to the same goals, most notably the Oklahoma Safe Kids Coalition. Efforts have been undertaken to increase the dissemination of safe practices regarding children in many areas of concern including water safety, fire prevention, safe sleeping environments and automobile safety. We are exploring the feasibility of strengthening driver license laws for our teen drivers.

The Board is especially concerned with the rise in child fatalities related to the proliferation of methamphetamine use around the state. Substance abuse of all kinds greatly contributes to the endangerment of Oklahoma's children.

The data presented in this year's annual report provides statistical data based on child fatalities reviewed January 1, 2003, through December 31, 2003, together with the 2004 recommendations to enhance prevention strategies for reducing child fatalities. Due to the time required for accumulating all of the information pertaining to each case some deaths reviewed occurred in previous years.

A special thanks to our dedicated staff and to all those working on behalf of children.

Jay Scott Brown, M.A.
Chair, Oklahoma Child Death Review Board

The mission of the Oklahoma Child Death Review Board is to reduce the number of preventable deaths through a multidisciplinary approach to case review. Through case review, the Child Death Review Board collects statistical data and system failure information to develop recommendations to improve policies, procedures, and practices within and between the agencies that protect and serve the children of Oklahoma.

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The 2003 Oklahoma State Child Death Review Board Members

Organization	Member	Designees
Post Adjudication Review Board	*Jay Scott Brown, MA; Chair*	*Buddy Faye Foster, JD*
Oklahoma Osteopathic Association	*Julie Morrow, DO; Vice-Chair*	*Pam Ghezzi, DO*
Chief Child Abuse Examiner	*Robert Block, MD*	*Penny Grant, MD; Debbie Lowen, MD*
Oklahoma Psychological Association	*Linda Burks, PhD*	*Mary Beth Logue, PhD*
State Department of Mental Health and Substance Abuse Services	*Terry Cline, PhD*	*Julie Young*
Oklahoma State Department of Health	*Mike Crutcher, MD, MPH*	*Carolyn Parks, MHR, RN*
Office of Juvenile Affairs	*Richard DeLaughter*	*Donna Glandon, JD*
Oklahoma City Police Department	*Lt. Darla Dugan*	*Det. Audrey George*
Oklahoma Academy of Pediatrics	*Pilar Escobar, MD*	
Oklahoma Department of Human Services	*Howard Hendrick, JD, MBA*	*Kathy Simms, MSW; Esther Rider-Salem, MSW*
Oklahoma Commission on Children and Youth	*Janice Hendryx, MSW*	*Chris Fiesel; Lisa Smith*
Oklahoma Coalition Against Domestic Violence and Sexual Assault	*Evelyn Hibbs*	*Marcia Smith*
Office of Child Abuse Prevention	*Annette Jacobi, JD*	*Kara Wilbur, BSN, RN*
Office of the Chief Medical Examiner	*Fred Jordan, MD*	*Mary Anzalone, MD*
Oklahoma Bar Association	*Jennifer King, JD*	
Oklahoma State Bureau of Investigation	*DeWade Langley*	*David Page; Jack Dailey; Rick Zimmer*
Oklahoma Court Appointed Special Advocate	*Nadine McIntosh*	
OSDH, State Epidemiologist	*Joe Mallonee, MPH*	*Rebecca Coffman, MPH, RN*
OSDH, Injury Prevention Services	*Sue Mallonee, MPH, RN*	*Ruth Azeredo, DrPH*
OSDH, Maternal and Child Health Services	*Edd Rhoades, MD*	*Pat Saslow, MSN, ARNP; Peggy Byerly, MS*
Oklahoma EMT Association	*Ray Simpson, REMT-PIRN*	*Jena Lu Simpson, CC-EMT-P*
Oklahoma District Attorney's Council	*Richard Smothermon, JD*	*Pattye High, JD*
Children's Hospital of Oklahoma	*John Stuemky, MD*	*Amy Baum, MSW*
Cherokee Tribe of Oklahoma	*Kara Whitworth*	

Staff of the Oklahoma Child Death Review Board

Lisa P. Rhoades, Administrator

Ben A. Dunham, Case Manager

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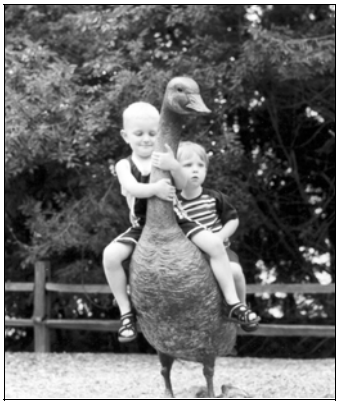
Cases Closed in 2003

The Oklahoma Child Death Review Board, along with its two local review teams, reviewed and closed 292 cases in 2003. It should be noted that this report contains information on cases reviewed and closed by the Board in calendar year 2003. These deaths did not necessarily occur in 2003 and do not include all of the deaths that occurred in Oklahoma in 2003.

As is the case every year, accidental deaths accounted for the greatest number of cases reviewed by the Board. Also as is the case every year, males accounted for more than half (65.1%) of the deaths reviewed. In fact, white males alone accounted for 44% of the deaths reviewed in 2003.

Manner	Number	Percent
Accident	141	48.3%
Homicide	21	7.2%
Natural	85	29.1%
Suicide	17	5.8%
Undetermined	28	9.6%

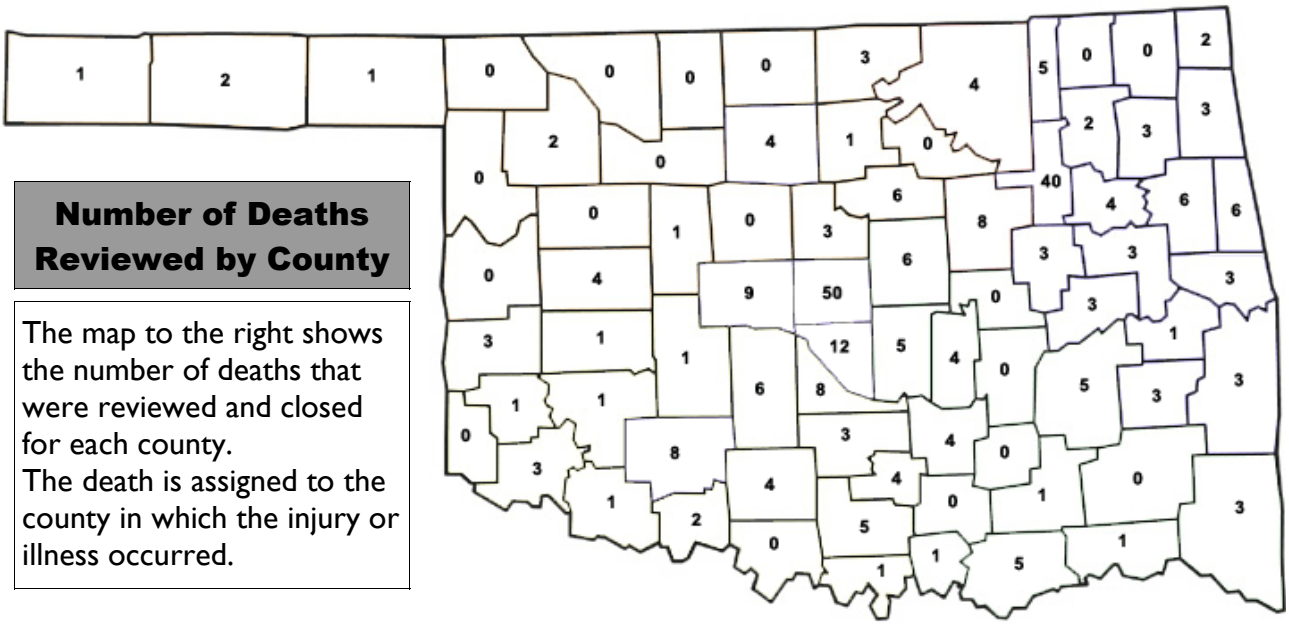


Race and Gender of All Cases Reviewed

African-American			
	Male	25	
	Female	13	
	Total	38	13.0%
American Indian			
	Male	17	
	Female	15	
	Total	32	11.0%
Pacific Islander			
	Male	0	
	Female	1	
	Total	1	0.3%
White			
	Male	129	
	Female	63	
	Total	192	65.8%
Hispanic			
	Male	14	
	Female	8	
	Total	22	7.5%
Other			
	Male	3	
	Female	2	
	Total	5	1.7%
Unknown			
	Male	2	
	Female	0	
	Total	2	0.7%

Number of Deaths Reviewed by County

The map to the right shows the number of deaths that were reviewed and closed for each county.
The death is assigned to the county in which the injury or illness occurred.



Accidents

There were 141 deaths due to accidents reviewed in 2003, with vehicle collisions still leading the category at 89 or 63.1 % (for more details on the deaths due to vehicles, please see page 8). Drownings were responsible for 20 or 14.2 % of the deaths ruled accidental (for more details on the deaths due to drowning, please see page 9). Deaths due to fire, rounded out the top three accidental causes of death with 11 or 7.8% (for more details on the deaths due to fire, please see page 11).

Race and Gender of Accident Victims

African-American			
	Male	6	
	Female	3	
	Unknown	0	
	Total	9	6.4%
American Indian			
	Male	6	
	Female	5	
	Unknown	0	
	Total	11	7.8%
Pacific Islander			
	Male	0	
	Female	1	
	Unknown	0	
	Total	1	0.7%
White			
	Male	70	
	Female	32	
	Unknown	0	
	Total	102	72.3%
Hispanic			
	Male	9	
	Female	3	
	Unknown	0	
	Total	12	8.5%
Other			
	Male	2	
	Female	2	
	Unknown	0	
	Total	4	2.8%
Unknown			
	Male	2	
	Female	0	
	Unknown	0	
	Total	2	1.4%

In October of 2003, the Centers for Disease Control issued a statement that deaths and injuries due to accidents and violent crime have reached epidemic levels in the United States and pose a threat to the nation's economic and social well-being. Officials stated injury is the top killer of Americans in the first four decades of life and costs the nation at least $260 billion in health care, lost productivity and other expenses each year. According to the CDC, most injuries could be prevented if legislators, health-care providers, religious leaders, teachers and parents joined a campaign to educate people at risk and cited the need to address the problem with the same urgency and same crisis mentality that other emerging public health threats are treated.

OKLAHOMA SAFE KIDS COALITION

(405) 271-5695

Gender of Accident Victims

Male	95	67.4%
Female	46	32.6%
Unknown	0	0.0%
		100.0%

Type of Accidents Reviewed

Type	Number
Vehicular	89
Drowning	20
Fire	11
Asphyxia/ Suffocation	5
Poisoning	5
Fall	3
Gun Related	2
Confinement	1
Sport Related	1
Electrocution	1
Other	3

Suicides

There were 17 suicides reviewed and closed in 2003, comprising 5.8% of all the deaths.

Youth Suicide Prevention Training was initiated in 2003 by the Oklahoma County Youth Suicide Prevention Council in cooperation with the Suicide Prevention Council. The training is for school personnel, students, and social service organizations in the community to help recognize the warning signs of suicide. The Oklahoma State Health Department is one of the coalition's working partners. The purpose of the training is to help participants develop local action plans for addressing youth suicide at the community level. Partner organizations include Teenline, CONTACT Crisis Helpline, Norman Alcohol Intervention Center, Oklahoma Department of Mental Health and Substance Abuse Services, Oklahoma City/County Health Department, State Department of Education, OSDH Maternal and Child Health Service, and the OSDH Family Health Services.

For more information about suicide prevention training, contact the OSDH, Child and Adolescent Health Division, Maternal and Child Health Service at 405/271-4471.

The state of Connecticut made unprecedented headlines in 2003 when it convicted a mother of contributing to the suicide of her 12-year-old son who hanged himself after being picked on for months over his bad breath and body odor. She was found guilty of one count of risk of injury to a minor for creating a filthy home that prosecutors said prevented the boy from improving his hygiene. She faces up to 10 years in prison.

Race and Gender of Suicide Victims

African-American		
Male	0	
Female	1	
Unknown	0	
Total	1	5.9%
American Indian		
Male	3	
Female	0	
Unknown	0	
Total	3	17.6%
Pacific Islander		
Male	0	
Female	0	
Unknown	0	
Total	0	0.0%
White		
Male	8	
Female	4	
Unknown	0	
Total	12	70.6%
Hispanic		
Male	1	
Female	0	
Unknown	0	
Total	1	5.9%
Other		
Male	0	
Female	0	
Unknown	0	
Total	0	0.0%
Unknown		
Male	0	
Female	0	
Unknown	0	
Total	0	0.0%

Gender of Suicide Victims

Male	12	70.6%
Female	5	29.4%
Unknown	0	0.0%
		100%

Method	Number
Firearm	9
Asphyxia	8

Homicides

There were 21 homicides reviewed and closed by the Board in 2003. Please note that these 21 represent all homicides, not just those due to abuse and/or neglect.

Six (28.6%) of the homicides were perpetrated by acquaintances of the decedent. Four (19.0%) perpetrators were the biological mother, four (19.0%) were the biological father, and 4 (19.0%) were mother's boyfriend. One (4.8%) had no known perpetrator; one (4.8%) was the foster brother; and one (4.8%) was a step-parent.

In one case prosecutors were allowed to charge an individual with the death of his juvenile accomplice, as it occurred during the commission of a felony.

In 2003, the Oklahoma State Health Department announced it had received a five-year grant from the federal Centers for Disease Control and Prevention to develop an Oklahoma Violent Death Reporting System. This system will collect timely, complete, and accurate information about violent deaths to gain a better understanding of the circumstances and factors that affect violent deaths.

Race and Gender of Homicide Victims

African-American		
Male	6	
Female	0	
Unknown	0	
Total	6	28.6%
American Indian		
Male	4	
Female	2	
Unknown	0	
Total	6	28.6%
Pacific Islander		
Male	0	
Female	0	
Unknown	0	
Total	0	0.0%
White		
Male	6	
Female	2	
Unknown	0	
Total	8	38.1%
Hispanic		
Male	1	
Female	0	
Unknown	0	
Total	1	4.8%
Other		
Male	0	
Female	0	
Unknown	0	
Total	0	0.0%
Unknown		
Male	0	
Female	0	
Unknown	0	
Total	0	0.0%

Gender of Homicide of Victims

Male	17	81.0%
Female	4	19.0%
Unknown	0	0.0%
		100%

Prosecutorial Information

Charges filed — 16 (76.2%)
Of these sixteen, one (6.3%) was convicted in a jury trial; seven (44%) pled guilty and four (25%) still have trials pending.
Four (25%) involved juveniles and of these four, three were adjudicated delinquent and one was found non-delinquent.
Three (17.6%) cases had two persons charged in the death.

No charges—5 (23.8%)
Of these five, 1 (20%) committed suicide at the time of the decedent's death; 1 (20%) is unsolved; and 3 (60%) prosecutors declined charges (one accidental shooting, one self-defense, and one prosecutors believe there is not sufficient evidence to charge).

Cause of Death	Number
Gunshot	8
Struck	3
Cut/Stabbed	3
Shaken	2
Asphyxiated	1
Vehicular	1
Drowning	1
Exsanguination	1
Unknown	1

Undetermined

There were 28 undetermined deaths reviewed and closed by the Board in 2003. Twenty-five (89.3%) of the children were age 2 years or younger and 23 (82.1%) were age one year or younger, including 2 stillbirths. Maternal drug use was documented in both stillbirth deaths.

Of those age older than 2, one (3.6%) was 13 years of age with a history of thyroid problems and smoking cigarettes dipped in embalming fluid; one (3.6%) was 5 years of age and appeared at autopsy to have Fetal Alcohol Syndrome and malnutrition; and one (3.6%) was 3 years of age who had indications of inflicted trauma but also had a history of febrile seizures.

Race and Gender of Undetermined Victims

African-American			
	Male	4	
	Female	1	
	Unknown	0	
	Total	5	17.9%
American Indian			
	Male	2	
	Female	2	
	Unknown	0	
	Total	4	14.3%
Pacific Islander			
	Male	0	
	Female	0	
	Unknown	0	
	Total	0	0.0%
White			
	Male	11	
	Female	7	
	Unknown	0	
	Total	18	64.3%
Hispanic			
	Male	1	
	Female	0	
	Unknown	0	
	Total	1	3.6%
Other			
	Male	0	
	Female	0	
	Unknown	0	
	Total	0	0.0%
Unknown			
	Male	0	
	Female	0	
	Unknown	0	
	Total	0	0.0%

Gender of Undetermined Victims

Male	18	64.3%
Female	10	35.7%
Unknown	0	0.0%
		100%

Fifteen (53.6%) cases involved sleeping environments that could have contributed to the death. Of these 15, eight (53.3%) involved co-sleeping with one or more adults, so the possibility of death due to overlay could not be ruled out; five (33.3%) were found in a face-down position; five (33.3%) possibly had bed covers impeding breathing; 4 (26.7%) had a history of upper respiratory conditions; and one (6.7%) was sleeping in a baby swing.

Six (21.4%) of the undetermined cases had symptoms suspicious for trauma which could not be definitively substantiated. Only one (16.7%) of these suspicious for trauma resulted in any charges filed. In this case, the perpetrator was a kinship foster placement and was charged with injury to minor child and sentenced to thirty days jail time (with credit for the time served, which was 23 days) and court costs.

Natural Deaths - Reviewed

In 2003 the Oklahoma Child Death Review Board reviewed and closed 85 deaths that were ruled natural by a Medical Examiner or physician. Not all natural deaths are subject to a full review by the Board, but do undergo a death certificate review by a physician (see page 7). If the listed cause of death is unclear or unsatisfactory, the death certificate is flagged by the physician and a file is compiled for a full review. Additionally, some natural deaths are referred to the Child Death Review Board by both OKDHS and the Oklahoma State Department of Health. Those referrals receive a full review by the Board.

Race and Gender of Natural Victims

African-American			
	Male	9	
	Female	8	
	Unknown	0	
	Total	17	20.0%
American Indian			
	Male	2	
	Female	6	
	Unknown	0	
	Total	8	9.4%
Pacific Islander			
	Male	0	
	Female	0	
	Unknown	0	
	Total	0	0.0%
White			
	Male	34	
	Female	18	
	Unknown	0	
	Total	52	61.2%
Hispanic			
	Male	2	
	Female	5	
	Unknown	0	
	Total	7	8.2%
Other			
	Male	1	
	Female	0	
	Unknown	0	
	Total	1	1.1%
Unknown			
	Male	0	
	Female	0	
	Unknown	0	
	Total	0	0.0%

A majority of the natural cases reviewed by the Board are the result of Sudden Infant Death Syndrome (SIDS). Forty-four of the cases reviewed were due to SIDS (see page 10).

Of the 35 cases not due to SIDS, nineteen (54.3%) were under a year old. Twenty-four (68.6%) of the 35 were under five years old.

The "other" category in the chart to the right included a Hantavirus case, a tularemia case (Rabbit Fever), a pertussis case, as well as several infections and a death due to "seizure disorder of unknown etiology".

Ten (28.6%) of the non-SIDS cases had applied for or were on Medicaid. In 13 (37.1%) of the non-SIDS cases the family had applied for or had received TANF assistance.

Gender of Natural Victims

Male	48	56.5%
Female	37	43.5%
Unknown	0	0.0%
		100%

Illnesses and Diseases Encountered in Death Cases

Illness/ Disease	Number
SIDS	44
Cardiac Condition	7
Septicemia	6
Pneumonia	3
Asthma	1
Congenital Condition	1
Cerebral Palsy	1
Cystic Fibrosis	1
Diabetes	1
Other	12
Unknown	2

Natural Deaths - Not Reviewed

Deaths due to natural processes are not reviewed as in-depth as other deaths, but instead are limited to a death certificate review by pediatricians on the Board. Any child whose cause of death appears to be unclear or to not match the normal disease process is then referred by the physician(s) to be reviewed fully. The death certificate review process findings in 2003 are as follows:

Prematurity	**92**
Congenital Conditions (Chart 1)	**49**
Cardiac Disease	**43**
Infectious Diseases (Chart 2)	**24**
Neoplastic Diseases (Chart 3)	**21**
Maternal Conditions	**18**
Brain Disease	**4**

Cerebral Palsy	**4**
Epilepsy	**2**
Low Birth Weight	**2**
Neurological Conditions	**2**
Liver Conditions	**1**
Seizure Disorders	**1**
Cause of Death Unclear	**2**

TOTAL —275

CHART 1

Congenital Conditions:	
Brain Malformations	3
Genetic Disorders	17
Metabolic Disorders	3
Renal Agenesis	6
Spinal Malformations	3
Not Otherwise Specified	17
TOTAL	49

CHART 2

Infectious Diseases:	
Brain Abscess	1
Bronchitis	1
Influenza	5
Meningitis	1
Pneumonia	7
Respiratory Sycynctial Virus	2
Rocky Mountain Spotted Fever	1
Sepsis	6
TOTAL	24

CHART 3

Neoplastic Diseases:	
Luekemia	7
Not Otherwise Specified	14
TOTAL	21

Vehicle Related Deaths

Traffic related fatalities accounted for 91 of the deaths reviewed by the Board. Speeding, lack of proper restraints, and drivers operating vehicles while impaired continued to be seen in high numbers in these deaths. In 32 of the cases (35.2%) a driver was cited for speeding. Thirty-six of the traffic fatality victims (39.6%) were not properly restrained. In 12 of the cases (13.2%) a driver was cited for driving under the influence.

Gender	Number	Percent
Male	54	59.3%
Female	37	40.7%

Of the five pedestrian/bicyclist deaths only two were under ten years old. Both were female.

Seven (7.7%) children died in ATV related accidents. Four (4.4%) died in motorcycle accidents.

Use of Seatbelts and Car Seats by Victims

Seatbelt/Car seat Use	Number	Percent
Properly Restrained	40	44.0%
Not Properly Restrained	36	39.6%
Unknown	10	11.0%
N/A	5	5.5%

Age of Driver of Decedent's Vehicle

Age	Number	Percent
<13	3	3.3%
13-15	4	4.4%
16	10	11.0%
17	23	25.3%
18	5	5.5%
19-21	4	4.4%
>21	28	30.8%
Unknown	1	1.1%
N/A	5	5.5%

Position of Decedent in Vehicle

Position	Number	Percent
Operator	33	36.3%
Front Passenger	17	18.7%
Rear Passenger	33	36.3%
Other	2	2.2%
Pedestrian/Bicycle	5	5.5%
Unknown	1	1.1%

Drownings

The Board reviewed and closed 21 drowning cases in 2003. Of these , 16 (76.2%) were white, three (14.3%) were of Hispanic descent, one (4.8%) was African American and one (4.8%) was American Indian. Nine (42.9%) were age 3 and under, three (14.3%) were 4 to 9 years of age, and nine (42.9%) were 10 years of age or older.

Gender	Number	Percent
Male	18	85.7%
Female	3	14.3%

Location of Drowning	Number	Percent
Natural Body of Water (i.e. creek, river, pond, lake)	9	42.9%
Private, Residential Pool	3	14.3%
Bathtub	3	14.3%
Public Swimming Area on Natural Body of Water	3	14.3%
Bucket	1	4.8%
Decorative Pond	1	4.8%
Public Swimming Pool	1	4.8%

Nine (42.9%) occurred during the months of June, July, and August. Eleven (52.4%) were investigated by OKDHS for abuse/neglect, with three (27.3%) having a confirmed finding.

One drowning occurred as a result of a car chase. The victim had gone down a road that had no warning sign that the road ended in a dead-end above a creek.

Another drowning occurred when teens were four-wheeling in a truck in a pasture and landed on a frozen pond. The victim was trapped under the ice.

The three deaths of Hispanic decent occurred at the same public swimming area of a natural body of water. Two were brothers who drowned at the same time. As a result, the water park increased the number of bi-lingual warning signs.

The Board believes all children could benefit from swimming lessons. Organizations such as the Red Cross, the YMCA and the YWCA offer swimming lessons as well as other safety courses. The Board urges anyone with children to contact one of these organizations to see what classes are available to them in their area.

YMCA of Greater Oklahoma City
500 North Broadway, Suite 500
Oklahoma City, OK 73102
(405) 297-7777 Fax (405) 297-7718
www.ymcaokc.org

Firearm Related Deaths

The Board closed 19 cases in which a firearm was used. Handguns continue to be the weapon most used in firearm related deaths.

Manner	Number	Percent
Accident	2	10.5%
Homicide	8	42.1%
Suicide	9	47.4%

The Board strongly urges gun owners to practice safe storage techniques such as those suggested on the Project ChildSafe website (www.projectchildsafe.org).

Gender	Number	Percent
Male	14	73.7%
Female	5	26.3%

This website also lists agencies in Oklahoma where individuals can go to pick up free gun locks. In fiscal year 2003-2004 Lieutenant Governor Mary Fallin's office partnered with Project ChildSafe to give away over 300, 000 gun locks at over 400 locations in Oklahoma.

Type of Firearm	Number	Percent
Handgun	9	47.4%
Rifle	5	26.3%
Shotgun	4	21.1%
Unknown	1	5.3%

Sudden Infant Death Syndrome (SIDS)

The Board closed 44 cases due to Sudden Infant Death Syndrome (SIDS). Although public health campaigns have repeatedly stressed safe sleeping environments for infants, the Board still sees a high number of infants placed face down to sleep and a high number of infants co-sleeping with a parent or sibling.

Gender	Number	Percent
Male	25	56.8%
Female	19	43.2%

Age (in months)	Number	Percent
Less than 2	10	22.7%
2—6	29	65.9%
More than 6	5	11.4%

The Board is also troubled by a lack of proper documentation of the death scene by law enforcement. The chart to the right shows that nearly 30% of the cases did not have the sleeping position of the infant documented in the death investigation.

Sleeping Arrangement	Number	Percent
Alone	20	45.5%
With Adult	23	52.3%
With Sibling	1	2.3%

Position	Number	Percent
On Stomach	13	29.5%
On Back	13	29.5%
On Side	5	11.4%
Other	1	2.3%
Unknown	12	27.3%

For more information on SIDS and SIDS prevention contact:
Oklahoma State Department of Health
SIDS Program
(405) 271-4480

Fire Deaths

Of these 11 deaths, six (54.5%) did not have a working smoke alarm. Three were started by an unsupervised child playing with an ignitable source.

Gender	Number	Percent
Male	7	63.6%
Female	4	36.4%

During the National Fire Prevention Week (October 5-11, 2003), the Oklahoma City Fire Department, along with Batteries Plus, distributed 9-volt batteries and smoke alarms and educated consumers about smoke alarm safety. Home Depot also participated by donating 2,500 smoke alarms to the Oklahoma Safe Kids Coalition's Save-a Life program, a statewide smoke alarm distribution program. Fire departments across the sate, many of them volunteers, install the alarms in homes of low-income families with children at no cost. The store also conducted a safety fair including educational safety programs and fire trucks for children to explore.

Also in 2003, the Oklahoma State University Fire Service Training Program experienced nearly a 55% budget cut, leading to the suspension of 21 classes. This program is responsible for most of the training of the rural volunteer firefighters.

Abuse/Neglect Deaths

Twenty-nine of the cases closed by the Board in 2003 were due to maltreatment by a caretaker. In 22 (75.9%) of those cases an OKDHS investigation confirmed abuse or neglect allegations in regard to the death. Lack of proper supervision by the caretaker is the most frequent allegation confirmed by OKDHS in these cases.

To report child abuse or neglect in Oklahoma call:
1-800-522-3511

Manner of Death for Abuse/Neglect Victims

Manner	Number	Percent
Accident	12	41.4%
Homicide	12	41.4%
Natural	1	3.4%
Suicide	0	0.0%
Undetermined	4	13.8%

Gender of Abuse/Neglect Victims

Gender	Number	Percent
Male	19	65.5%
Female	10	34.5%

Age of Victims by Race

Age of African-American Victims

Age	Number	Percent
<1	22	57.9%
1	1	2.6%
2	2	5.3%
3	1	2.6%
4	0	0.0%
5	2	5.3%
6	0	0.0%
7	0	0.0%
8	0	0.0%
9	2	5.3%
10	3	7.9%
11	0	0.0%
12	0	0.0%
13	2	5.3%
14	1	2.6%
15	1	2.6%
16	1	2.9%
17	0	0.0%

Age of American Indian Victims

Age	Number	Percent
<1	12	37.5%
1	4	9.5%
2	0	0.0%
3	1	3.1%
4	1	3.1%
5	1	3.1%
6	0	0.0%
7	0	0.0%
8	0	0.0%
9	0	0.0%
10	0	0.0%
11	1	3.1%
12	1	3.1%
13	1	3.1%
14	0	0.0%
15	3	9.4%
16	5	15.6%
17	4	12.5%

Age of White Victims

Age	Number	Percent
<1	62	32.3%
1	12	6.3%
2	7	3.6%
3	5	2.6%
4	5	2.6%
5	2	1.0%
6	3	1.6%
7	3	1.6%
8	3	1.6%
9	6	3.1%
10	3	1.6%
11	5	2.6%
12	9	4.7%
13	4	2.1%
14	6	3.1%
15	14	7.3%
16	21	10.9%
17	22	11.5%

Age of Hispanic Victims

Age	Number
<1	6
1	2
2	1
3	1
4	1
8	1
13	1
14	3
16	2
17	2

Age of Other Victims

Age	Number
<1	1
1	1
5	1
10	2
14	1
17	1

Age of Asian Victims

Age	Number
12	1

Age of Victims by Manner

Age of All Victims

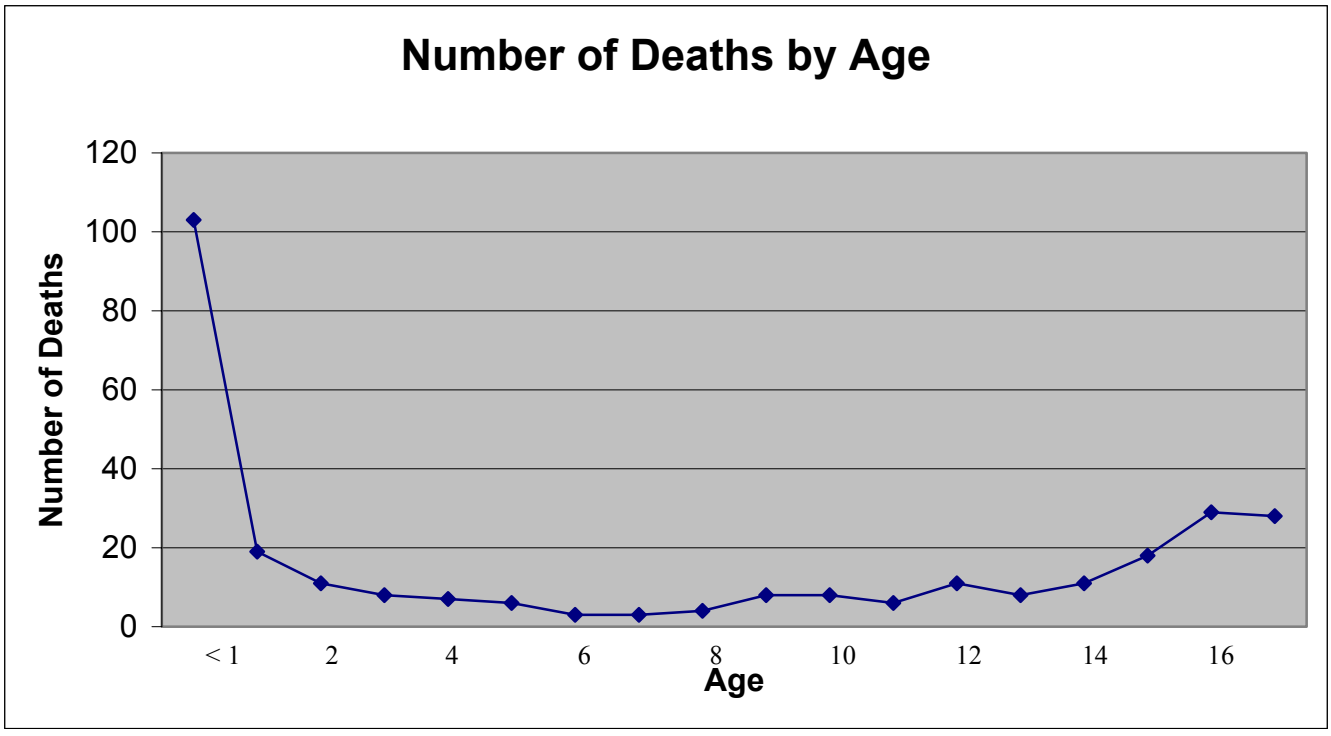
Age	Number	Percent
<1	104	35.6%
1	19	6.5%
2	11	3.8%
3	8	2.7%
4	7	2.4%
5	6	2.1%
6	3	1.0%
7	3	1.0%
8	4	1.4%
9	8	2.7%
10	8	2.7%
11	6	2.1%
12	11	3.8%
13	8	2.7%
14	11	3.8%
15	18	6.2%
16	29	9.9%
17	28	9.6%

Age of Accident Victims

Age	Number	Percent
<1	6	4.3%
1	12	8.5%
2	7	5.0%
3	6	4.3%
4	6	4.3%
5	3	2.1%
6	2	1.4%
7	3	2.1%
8	3	2.1%
9	7	5.0%
10	6	4.3%
11	5	3.5%
12	9	6.4%
13	5	3.5%
14	6	4.3%
15	13	9.2%
16	23	16.3%
17	19	13.5%

Age of Natural Victims

Age	Number	Percent
<1	70	82.4%
1	4	4.7%
2	1	1.2%
3	0	0.0%
4	0	0.0%
5	1	1.2%
6	0	0.0%
7	0	0.0%
8	1	1.2%
9	0	0.0%
10	1	1.2%
11	1	1.2%
12	1	1.2%
13	1	1.2%
14	0	0.0%
15	1	1.2%
16	1	1.2%
17	2	2.4%



Age of Victims by Manner (cont.)

Age of Homicide Victims

Age	Number	Percent
<1	6	28.6%
1	1	4.8%
2	2	9.5%
3	1	4.8%
4	0	0.0%
5	2	9.5%
6	1	4.8%
7	0	0.0%
8	0	0.0%
9	0	0.0%
10	1	4.8%
11	0	0.0%
12	0	0.0%
13	0	0.0%
14	0	0.0%
15	1	4.8%
16	2	9.5%
17	4	19.0%

Age of Suicide Victims

Age	Number	Percent
<1	0	0.0%
1	0	0.0%
2	0	0.0%
3	0	0.0%
4	0	0.0%
5	0	0.0%
6	0	0.0%
7	0	0.0%
8	0	0.0%
9	1	5.9%
10	0	0.0%
11	0	0.0%
12	1	5.9%
13	1	5.9%
14	5	29.4%
15	3	17.6%
16	3	17.6%
17	3	17.6%

Age of Undetermined Victims

Age	Number	Percent
<1	22	78.6%
1	2	7.1%
2	1	3.6%
3	1	3.6%
4	1	3.6%
5	0	0.0%
6	0	0.0%
7	0	2.8%
8	0	0.0%
9	0	0.0%
10	0	0.0%
11	0	0.0%
12	0	0.0%
13	1	3.6%
14	0	0.0%
15	0	0.0%
16	0	0.0%
17	0	0.0%

Lincoln/Pottawatomie Review Team

In 2003 the Lincoln/Pottawatomie Child Death Review Team closed 11 cases. The five natural deaths were all ruled Sudden Infant Death Syndrome (SIDS) by the Medical Examiner's office. In addition, one of the undetermined deaths was a possible SIDS death. That death was ruled undetermined instead of natural due to the fact that the parents were co-sleeping with the infant at the time of death. Two of the deaths that were ruled SIDS were also co-sleeping with parents. Two of the three accidental deaths were traffic related fatalities.

In 2004 the Lincoln/ Pottawatomie team's jurisdiction will expand to include all of the death cases in southeastern Oklahoma. This expansion will boost the teams average number of cases reviewed from 10-15 to around 60 per year.

Manner of Death for Lincoln/Pottawatomie Victims

Manner	Number
Accident	3
Homicide	1
Natural	5
Suicide	0
Undetermined	2

Gender of Lincoln/ Pottawatomie Victims

Gender	Number	Percent
Male	6	54.5%
Female	5	45.5%

Lincoln/Pottawatomie Child Death Review Team Members

Organization	Team Member	Designee
Community Representative	Kate McDonald Joyce; Chair	Mike Joyce
Unzner Center	Laura Allison; Vice-Chair	Sharon Trammell
Lincoln County OKDHS	David Burgess	
Pottawatomie County Sheriff's Office	Travis Caresia	Todd Hignite, Randy Willis
Judicial Representative	Glenn Dale Carter	
Pottawatomie County OKDHS	Christy Freeman	Carmen Hutchins
Youth and Family Resources Center	Susan Morris	Debbie Cathey
Medical Representative	Khanwal Obhrai, MD	Carolyn Parks
Pottawatomie County Health Department	Liz Petrin	Tonya Gifford James
District Attorney's Office	Richard Smotherman	Jeremiah Hagemeir

Muskogee Review Team

The Muskogee Child Death Review Team closed three cases in 2003. The accidental death was a traffic related fatality and the natural death was ruled Sudden Infant Death Syndrome (SIDS). Co-sleeping was noted in the SIDS death investigation.

Manner of Death for Muskogee Victims

Manner	Number
Accident	1
Homicide	0
Natural	1
Suicide	1
Undetermined	0

In 2004 the Muskogee team's jurisdiction will expand to include all of the death cases in eastern Oklahoma. This new Eastern Oklahoma Review Team expects to review around 80 cases per year.

Gender of Muskogee Victims

Gender	Number	Percent
Male	2	66.6%
Female	1	33.3%

Muskogee Child Death Review Team Members

Organization	Team Member	Designee
Medical Representative	Michael Stratton, DO; Chair	
Northeastern State University	Lillian Young, PhD; Vice-Chair	
CASA of Muskogee County	Pat Acebo	
Muskogee County Sheriff's Office	Tim Brown	Brenda Mace-Ellis, Darrin Smith
Muskogee County OKDHS	Theresa Buckmaster	Cathy Young
Oklahoma Coalition on Domestic Violence	Evelyn Hibbs	Gwin Lacrone
Muskogee County Children First Program	Linda Hitchye	
Kids Space	Betty Martin	
Muskogee County Council on Youth Services	Cindy Perkins	Daren Smith
Muskogee County Medical Examiner	Anna Randall, DO	
Green County Behavioral Health	Barbara Ross	
Muskogee County EMS	Carleen Morrison	
Muskogee County Health Department	Carol Weigel	
Muskogee Police Department	Todd Whitman	Shannon Humphrey
Muskogee County District Attorney's Office	Vacant	
Muskogee Public Schools	Vacant	

Near Death Cases Reviewed in 2003

The Child Death Review Board began reviewing near death cases in 2000. This is the first year the Board has released statistics on these cases. For a case to be reviewed by the Board as a near death incident the child must be admitted to the hospital in serious or critical condition due to alleged abuse and/or neglect . As with abuse/neglect deaths, lack of proper supervision is documented in the investigation in most of these cases.

Twenty-seven near death cases were reviewed by the Board in 2003. This is the only category where females outnumber males (51.9% to 48.1%). Biological parents are identified as the alleged perpetrators in most of these cases (55.5%).

Race of Near Death Cases

Race	Number	Percent
African-American	5	18.5%
American Indian	4	14.8%
Hispanic	1	3.7%
White	15	55.6%
Bi-racial	2	7.4%
Unknown	1	3.7%

Gender of Near Death Cases

Gender	Number	Percent
Male	13	48.1%
Female	14	51.9%

Injuries Inflicted in Near Death Cases

Injury	Number	Percent
Shaken	8	29.6%
Near Drowning	7	25.9%
Struck	4	14.8%
Suffocation/ Strangulation	2	7.4%
Poisoning/ Overdose	1	3.7%
Natural Illness	1	3.7%
Failure to Thrive	1	3.7%
Dog Attack	1	3.7%
Vehicular Collision	1	3.7%
Sexual Assault	1	3.7%

The Board believes increased funding to educational programs such as the state Health Department's Children First program could help in reducing the number of near death incidents occurring in Oklahoma.

Perpetrators in Near Death Cases

Perpetrator	Number
Father	8
Mother	7
Self	2
Step-father	2
Parent's Paramour	1
Foster Parent	1
Other Relative	1
Daycare Worker	1
Other	1
Unknown	3
None	4

Government Involvement

For several years the Child Death Review Board has tracked the level of prior involvement of the Oklahoma Department of Human Services with the families of with children who die in Oklahoma. Each year the statistics compiled from this tracking show that Oklahoma children in the lower socio-economic levels are more likely to die. Over half (52.7%) of the cases reviewed by the Board had applied for or received TANF assistance prior to death. Over a third (36.6%) of the cases had applied for or received medical assistance (Medicaid) prior to death. And roughly a quarter (25.7%) had applied for or received Food Stamps.

Three (1.0%) children died while in foster care in 2003. One was listed as an accidental drowning with supervision concerns noted. One was listed as a homicide with a juvenile charged with the crime. The last child was listed as a natural death with no areas of concern.

In eighty-eight of the cases (30.1%) the Oklahoma Department of Human services Child Welfare Division had involvement with the family prior to the victim's death.

This year the Board partnered with the Oklahoma State Health Department's Children First program to look at the number of enrollees in the program who die. Only one (0.3%) of the deaths reviewed by the Board in 2003 was enrolled in the Children First program. Additionally, this partnership has led to a notification system to let the Board immediately know when a Children First enrollee dies.

The Board hopes that in the future more state agencies such as, the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), Women Infant and Children Nutrition Supplement Program (WIC) and the Office of Juvenile Affairs (OJA), will help the Board track their involvement with children who die in Oklahoma.

Services Victims' Families Applied for and/or receiving Prior to Death Incident

Involvement	Number	Percent
TANF	154	52.7%
Medical	106	36.3%
Child Welfare	88	30.1%
Child Support	79	27.1%
Food Stamps	75	25.7%
Child Care	54	18.5%
Emergency Assistance	14	4.8%
Disability	8	2.7%
Foster Care	3	1.0%

Helpful Numbers

Child Abuse Reporting Hotline	1-800-522-3511
CONTACT Crisis Helpline	1-800-784-2433
Office of the Chief Medical Examiner	(405) 239-7141
Oklahoma Coalition Against Domestic Violence and Sexual Assault	(405) 524-0700
Oklahoma Commission on Children and Youth	1-866-335-9288
Oklahoma Health Care Authority	(405) 522-7300
Oklahoma Mental Health and Substance Abuse Services	(405) 522-3908
Oklahoma Office of Juvenile Affairs	(405) 530-2800
Oklahoma SAFE KIDS Coalition	(405) 271-5695
Oklahoma State Department of Education	(405) 521-3301
Oklahoma State Department of Health	(405) 271-5600
Acute Disease Prevention	(405) 271-4060
Acute Injury Prevention	(405) 271-3430
Adolescent Health Program	(405) 271-4471
Child Abuse Prevention	(405) 271-7611
Children First Program	(405) 271-7612
Dental Health Services	(405) 271-5502
SoonerStart	(405) 271-6617
Sudden Infant Death (SIDS) Program	(405) 271-4480
Vital Records	(405) 271-4040
WIC	1-888-655-2942
Oklahoma State House of Representatives	(405) 521-2711
Oklahoma State Senate	(405) 524-0126
Oklahoma Department of Human Services	(405) 521-3646
SAFELINE	1-800-522-7233
TEENLINE	1-800-522-TEEN

Actions of the Board

Board actions during the 2003 review year are listed below:

- Assisted the Office of the State Medical Examiner in acquiring funds to reinstate metabolic testing for unattended child deaths.
- Recommended the Oklahoma State Health Department pursue the expansion of newborn metabolic testing statewide.
- Commended law enforcement agencies for a well-executed and documented scene investigation in three unrelated cases.
- Commended a Child Welfare worker for a well-executed and documented child death investigation.
- Recommended the Office of Juvenile Affairs implement a previous recommendation made regarding a perpetrator in state custody.
- Wrote five letters to various law enforcement agencies recommending they amend or adhere to the agencies policies and procedures regarding conducting thorough scene investigations, and/or documentation of such, for unattended child deaths.
- Invited the Oklahoma Health Care Authority to further discuss its policies and procedures.
- Consulted with a Sheriff's Office on one case.
- Recommended one law enforcement agency amend its policies and procedures to include rabies testing in unusual animal events.
- Wrote ten letters to OKDHS regarding the safety of surviving siblings.
- Wrote two letters to OKDHS regarding specifics of two family safety plans.
- Wrote seven letters to District Attorney's offices regarding the prosecutorial status of their cases.
- Requested further explanation from an attending physician regarding a child death.
- Recommended two hospitals amend or adhere to policies and procedures for notification of an unattended child death to law enforcement, Child Welfare, and the Medical Examiner.
- Requested the Office of the Chief Medical Examiner change the manner of death in two separate cases.
- Requested, from the Office of the Chief Medical Examiner, further explanation of findings in two separate cases.

Recommendations

Oklahoma Child Death Review Board Recommendations Submitted to the Oklahoma Commission on Children and Youth May 2004

Motor Vehicle Related Deaths

Key Findings

From the Board's inception, motor vehicle related fatalities have consistently been the leading cause of unintentional death among children 17 years of age and younger. In 2003, the Board reviewed a total of 292 deaths: of these, 89 (30.5%) involved motor vehicles. Eighty-six were non-pedestrian related and of these, 46 (53.5%) were unrestrained. The driver was cited for driving under the influence in 11 (12%) cases. Drivers aged 17 years and younger were involved in 40 (46.5%) cases. Although exact numbers are unavailable at this time, the Board is extremely concerned about the number of motor vehicle collisions that occur with two or more teenaged occupants.

Recommendations

In order to reduce the number of motor vehicle related fatalities, the Oklahoma Child Death Review Board recommends:

- Strengthening Oklahoma's graduated drivers licensing system to include restrictions on teen drivers and the number of unlicensed and/or younger passengers allowed.
- Mandatory field sobriety testing of drivers in motor vehicle accidents resulting in a child fatality and/or a critical or serious injury to a child.
- Increasing fines for drivers transporting unrestrained children to be comparable with fines for unrestrained drivers.
- Court sanctions and/or education prevention programs, such as drunk driving victim's panels should be strongly encouraged for first time and/or repeat offenders. Drug court, or a comparable drug and alcohol treatment program for repeat offenders should also be strongly encouraged.
- Provide mandated universal driver education classes for all high school and career tech students.

Firearm Related Deaths

Key Findings

In 2003, the Board reviewed and closed 18 fatalities that were firearm related. This represents 6.2% of the total deaths reviewed.

Recommendations

In order to reduce the number of firearm related fatalities, the Oklahoma Child Death Review Board recommends:

- Mandatory reporting by health care providers to the appropriate law enforcement agency of

Recommendations

any/all gunshot wounds. Subsequently, mandatory reporting by law enforcement agencies to the Injury Prevention Services, Oklahoma State Department of Health of all gunshot wounds for review.

- Mandatory field sobriety testing of all individuals present during a firearm related fatality.
- Development of gun safety and avoidance programs, including implementation plans, with a particular emphasis on elementary aged children.
- Identification of secure visitation drop-off locations for the safe exchange of children in cases where the court has ordered visitation and a caregiver/parent has expressed to the court a concern over safety.

Child Abuse/Neglect Deaths

Key Findings

Reduction of child abuse/neglect deaths has remained a primary goal for the Oklahoma CDRB since its inception. In 2003 the Board reviewed and closed 29 (9.9% of the total number reviewed and closed) cases that were concluded by the Board to have been a result of child abuse/neglect: 22 (75.9%) of these were also ruled abuse/neglect by the Oklahoma Department of Human Services, Child Welfare. Additionally, 11 (37.9%) had previous child welfare involvement. Currently, Oklahoma's child welfare workers and supervisors carry an active caseload that is 2 to 3 times great than those recommended nationally by the Child Welfare League of America.

Recommendations

In order to reduce the number of deaths due to child abuse/neglect, the Oklahoma Child Death Review Board recommends:

- Provide the Oklahoma Department of Human Services with funding to hire additional child welfare staff to be in compliance with the recommended national standard issued by the Child Welfare League of America.
- Continue to fund the Oklahoma State Health Department's primary and secondary prevention programs (i.e. Children First, Child Guidance, Office of Child Abuse Prevention Programs, Oklahoma Parents as Teachers, and Safe Families).
- Increase child abuse prevention services that serve families that do not qualify for Children First but have been considered to be at high risk for abuse/neglect.

Acknowledgements

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The Police Departments and County Sheriffs' Offices of Oklahoma

Department of Public Safety
Office of the Chief Medical Examiner
Oklahoma Commission on Children and Youth
Oklahoma Department of Human Services
Oklahoma State Bureau of Investigation
OSDH Vital Statistics

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