

The Oklahoma



Child Death Review Board

2004 Annual Report

Containing information on cases reviewed and closed during the 2004 calendar year

A statutorily established Board contracted through the
Oklahoma Commission on Children and Youth

Published January 2006



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

Although the loss of a child will forever leave a scar on the lives of their loved ones and the community as a whole, understanding the cause and contributing factors can prevent the tragedy from being repeated.

The dedicated efforts of the child advocates appointed to the Oklahoma Child Death Review Board have resulted in improvements in laws and practices designed to protect Oklahoma's children. The OCDRB 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.

Teasing out the multiple factors resulting in the death of a child can be challenging. For example, whereas drowning might be the manner of death, a lack of supervision by intoxicated parents might be the root cause. The more we learn about these interactions, the better our efforts will be at prevention.

On the Legislative front we have seen improvements in graduated driver's license, booster seat and car seat laws.

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. Oklahoma took a lead role in the nation by restricting access to *Pseudoephedrine*.

The information presented in this year's annual report provides statistical data based on child fatalities reviewed January 1, 2004, through December 31, 2004, together with the 2005 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.

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 2004 Oklahoma State Child Death Review Board Members

Organization	Member	Designees
<i>Post Adjudication Review Board</i>	<i>Jay Scott Brown, MA; Chair</i>	<i>Buddy Faye Foster, JD</i>
<i>Office of Child Abuse Prevention</i>	<i>Annette Jacobi, JD; Vice-Chair</i>	<i>Kara Wilbur, BSN, RN</i>
<i>Chief Child Abuse Examiner</i>	<i>Robert Block, MD</i>	<i>Penny Grant, MD; Debbie Lowen, MD</i>
<i>OSDH, State Epidemiologist</i>	<i>Kristy Bradley, DVM, MPH</i>	<i>Rebecca Coffman, MPH, RN</i>
<i>State Department of Mental Health and Substance Abuse Services</i>	<i>Terry Cline, PhD</i>	<i>Julie Young, MA</i>
<i>Oklahoma State Department of Health</i>	<i>Mike Crutcher, MD, MPH</i>	<i>Carolyn Parks, MHR, RN</i>
<i>Office of Juvenile Affairs</i>	<i>Richard DeLaughter</i>	<i>Donna Glandon, JD</i>
<i>OSDH, Maternal and Child Health Service</i>	<i>Suzanna Dooley</i>	
<i>Oklahoma City Police Department</i>	<i>Lt. Darla Dugan</i>	<i>Det. Audrey George</i>
<i>Oklahoma Academy of Pediatrics</i>	<i>Pilar Escobar, MD</i>	
<i>Oklahoma Health Care Authority</i>	<i>Michael Fogarty, JD</i>	<i>Lynn Mitchell, MD; Aimee Moore, RN</i>
<i>Office of the Chief Medical Examiner</i>	<i>Jeffery Gofton, MD</i>	<i>Sharon Asher</i>
<i>Oklahoma Department of Human Services</i>	<i>Howard Hendrick, JD, MBA</i>	<i>Esther Rider-Salem, MSW; Kathy Simms, MSW;</i>
<i>Oklahoma Commission on Children and Youth</i>	<i>Janice Hendryx, MSW</i>	<i>Chris Fiesel; Lisa Smith</i>
<i>Oklahoma Coalition Against Domestic Violence and Sexual Assault</i>	<i>Evelyn Hibbs</i>	<i>Marcia Smith</i>
<i>Oklahoma Bar Association</i>	<i>Jennifer King, JD</i>	
<i>Oklahoma State Bureau of Investigation</i>	<i>DeWade Langley</i>	<i>David Page; Jack Dailey; Rick Zimmer</i>
<i>Oklahoma Court Appointed Special Advocate</i>	<i>Nadine McIntosh</i>	
<i>Oklahoma Osteopathic Association</i>	<i>Julie Morrow, DO</i>	<i>Pam Ghezzi, DO</i>
<i>National Association of Social Workers</i>	<i>Keri Pierce, MSW</i>	
<i>Oklahoma EMT Association</i>	<i>Ray Simpson, REMT-PIRN</i>	<i>Jena Lu Simpson, CC-EMT-P</i>
<i>OSDH, Injury Prevention Service</i>	<i>Shelli Stevens-Stidham</i>	<i>Ruth Azeredo, DrPH</i>
<i>Oklahoma District Attorney's Council</i>	<i>Cathy Stocker, JD</i>	<i>Khristin Stubhar, JD</i>
<i>Children's Hospital of Oklahoma</i>	<i>John Stuemky, MD</i>	<i>Amy Baum, MSW; Kathie Hatlelid, PA-C</i>
<i>Cherokee Tribe of Oklahoma</i>	<i>Kara Whitworth</i>	

Staff of the Oklahoma Child Death Review Board

Lisa P. Rhoades, Administrator

Ben A. Dunham, Case Manager

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Recommendations

Oklahoma Child Death Review Board Recommendations As Submitted to the Oklahoma Commission on Children and Youth May 2005

The following recommendations are based upon the cases reviewed and closed in calendar year 2004. In the past, CDRB recommendations have addressed multiple manners and causes of death. This year, the Board has focused on deaths due to **motor vehicles, drowning, fire, natural causes, firearms, and child abuse/neglect.**

Motor Vehicle Related Deaths

Key Findings

From the Board's inception in 1993, motor vehicle related fatalities have consistently been the leading cause of unintentional deaths among children 17 years of age and younger. In 2004, the Board reviewed a **total** of 396 deaths. Of these, 120 (30.3%) involved motor vehicles. One hundred five (105) deaths were non-pedestrian related and of these, 43 (41%) were unrestrained. The driver was cited for driving under the influence in 13 (12.4%) cases. Drivers 17 years of age and younger were involved in 57 (54.3%) 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 in the vehicle.

Recommendations

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

- Passage of H.B. 1653, which strengthens Oklahoma's graduated drivers licensing system to include restrictions on teen drivers and the number of unlicensed and/or younger passengers allowed and the hours a teenager can drive on the road.
- 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.
- Passage of S.B. 799, which would increase the fines for drivers transporting unrestrained children to be comparable with fines for unrestrained drivers. This bill would also earmark the funding from that fine for child passenger safety education, administered through the Oklahoma Highway Safety Office.
- Court sanctions and/or education prevention programs, such as drunk driving victim's panels are strongly encouraged for first time and/or repeat offenders. Drug court, or a comparable drug and alcohol treatment program for repeat

Recommendations

offenders are also strongly encouraged.

- Provide mandated universal driver education classes for all high school and career technology students.

Drowning Deaths

Key Findings

In 2004 the Oklahoma Child Death Review Board reviewed 28 deaths caused by drowning. This represents 7.1% of the total deaths reviewed. Nineteen (67.9%) occurred in a natural body of water; four (14.3%) occurred in a residential pool or hot tub.

Recommendations

In order to reduce the number of deaths caused by drowning, the Board recommends:

- The State Department of Health's Injury Prevention Services Division should develop and distribute public service ads highlighting the dangers that flash-flooded natural bodies of water pose to curious children and adolescents.
- Continued distribution of the State Department of Health's Injury Prevention Services Division informational brochures on pool/hot tub safety.
- All pool/hot tub retailers in Oklahoma should be bound by law to distribute information on pool/hot tub safety to new pool/hot tub owners at the time of sale or installation of any new pool/hot tub.

Firearm Related Deaths

Key Findings

In 2004, the Board reviewed and closed 28 fatalities that were firearm related. This represents 7.1% of the total deaths reviewed.

Recommendations

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

- Mandatory reporting by health care providers to the appropriate law enforcement agency of any/all gunshot wounds; and, subsequent mandatory reporting by law enforcement agencies to the Injury Prevention Services, Oklahoma State Department of Health of all gunshot wounds for review.

(Continued on Next Page)

Recommendations

- 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 school aged children.
- Compliance with and enforcement of Bryar Wheeler Act.
- Continued support for Project Safe Child, a gunlock giveaway program based in the Lt. Governor's Office.

Natural Causes of Death

Key Findings

In 2004 the Oklahoma Child Death Review Board reviewed 91 (23.0%) deaths due to natural causes. Of those deaths, 73 (80.2%) children were under one year old.

Recommendations

In order to reduce the number of natural deaths, the Board recommends:

- Expanding the Oklahoma State Department of Health's Children First Program to cover all first time mothers and to extend the enrollment period to include mothers who do not enroll by the 28th week of pregnancy.
- Creation of prevention programs to include those not eligible for the Children's First program.
- Expand hospital educational programs to include information on available programs and newborn safety issues (i.e. safe sleeping issues) prior to discharge.

Fire Related Deaths

Key Findings

In 2004 the Oklahoma Child Death Review Board reviewed and closed 19 deaths caused by fires. This number represents 4.8% of the total deaths reviewed. In 13 (68.4%) cases, a working smoke detector was not present in the residence.

Recommendations

In order to reduce the number of fire related deaths, the Board recommends:

- Establishment of an educational/community outreach grant open to all fire departments in Oklahoma that would enable each department to engage in smoke detector giveaway/installation programs, and would also enable the departments to partner with the Oklahoma Safe Kids Coalition to provide juvenile cooking classes and home safety inspections.

Recommendations

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 2004, of a total of 396 deaths reviewed and closed by the Board, 48 (12.1%) were determined to be the result of child abuse/neglect by the Child Welfare division of the Oklahoma Department of Human Services. In 165 of the deaths (41.5% of the total), the family had previous experience with Child Welfare. Currently, Oklahoma's Child Welfare workers and supervisors carry an active caseload that is 2 to 3 times greater 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 in order to be in compliance with the recommended national standard issued by the Child Welfare League of America.
- Continued funding of the Oklahoma State Health Department's primary and secondary prevention programs.
- 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.



Activities of the Board

Board activities during the 2004 review year include:

- Supported amending O.S. 10 § 1150 in order to expand the scope of the two local teams and to allow for the creation of additional local teams. The existing teams began reviewing cases from additional counties and the groundwork for two more additional teams was initiated.
- Wrote eight letters of commendation to law enforcement agencies regarding well executed and documented scene investigations.
- Wrote nine letters to District Attorney's offices regarding the prosecutorial status of specific cases.
- Wrote ten letters to OKDHS regarding the safety of surviving siblings.
- Wrote two letters to the Office of the Chief Medical Examiner recommending the manner of death be amended.
- Wrote seven letters to law enforcement agencies recommending they amend their policies and procedures to include responding to the scene of an unresponsive child and/or increase the thoroughness of the investigation and/or keeping a written record of the scene investigation.
- Requested from OKDHS a copy of the treatment plan for two separate cases.



Activities of the Board

- Referred three cases to the Office of Juvenile Oversight, Oklahoma Commission on Children and Youth.
- Requested the Office of the Chief Medical Examiner perform toxicological studies in one case.
- Requested the policies and procedures for reporting unattended deaths to law enforcement and OKDHS from one hospital.
- Requested the policies and procedures for phone consultations from one hospital.
- Inquired from the District Attorney's Council information on expert witnesses and budget cuts.
- Wrote one attending physician recommending the cause of death be amended.
- Wrote one District Attorney regarding the state statutes and expressing Board's agreement with detective involved in case.
- Wrote two attending physicians requesting the submission of a death certificate.
- Initiated annual training for Board members, with an emphasis on confidentiality, the Open Meetings Act, and the case review process.
- Continued alliance with the Southeast Coalition on Child Fatalities.
- Initiated alliance with the Oklahoma Safe Kids Coalition for prevention of non-intentional injury.
- Initiated groundwork for prevention programs specific to safe sleeping environments, drowning prevention, and thermal injury prevention.
- Initiated alliance with Oklahoma Press Association for dissemination of contact information on the Oklahoma Child Death Review Board to media outlets across the state.



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Government Involvement

Five (1.3%) of the deaths reviewed and closed in 2004 were of children who died while in foster care. Of these, three were accidental deaths; one, a natural death and one death was ruled undetermined.

In 2004, the Oklahoma Child Death Review Board partnered with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) to determine the number of children who had received prior services through that agency. ODMHSAS determined that eight (2.0%) of the children whose deaths were reviewed and closed in 2004 had received state services from this department.

Many of the children whose deaths were reviewed and closed or the child's immediate family members had prior contact with the Oklahoma Department of Human Services (OKDHS). The chart below lists the number of children whose families' had received or applied for OKDHS services. The service listed may have been provided to the child who died or to another family member. Of the total deaths reviewed and closed, 113 (28.5%) had prior child welfare involvement before their death and forty-four (38.9%) of these were confirmed abuse and/or neglect. In 122 (30.8%) of the total cases reviewed, a sibling had prior contact with child welfare. Forty-eight (39.3%) of these cases were confirmed abuse and/or neglect.

The Office of Child Abuse Prevention, Oklahoma State Department of Health (OSDH), reported that none of the cases the Board reviewed and closed in 2004 had received services through that office. The Children's First program, also with the OSDH, found that 11 (2.8%) of the cases closed in 2004 had received services through its program. Two of the cases were actively receiving services at the time of death.



Number of Services Applied for or Received by Victim's Families Prior to Death Incident

Involvement	Number	Percent
TANF (Temporary Aid for Needy Families)	262	66.2%
Child Welfare	161	40.7%
Medical	133	33.8%
Child Support	126	31.8%
Food Stamps	115	29.0%
Child Care	64	16.2%
Emergency Assistance	20	5.1%
Disability	16	4.0%
Foster Care	5	1.3%

Accidents

Of the 396 cases reviewed and closed by the Board in 2004, 194 cases were determined to be accidental. Of these, motor vehicle fatalities was the highest cause of death at 120 or 61.9% (page 14). Drowning was second, with 25 deaths, or 12.9 % (page 15) and asphyxia/suffocation jumped ahead of fire-related deaths (page 18) this year at 17 or 8.8%. Of the 17 asphyxia/suffocation deaths, five (29.4) were bed sharing and were witnessed to have a body part covering them, three (17.5%) were noted to have breathing impeded by a

Race and Gender of Accident Victims			
African-American			
Male	8		
Female	8		
Unknown	0		
Total	16	8.2%	
American Indian			
Male	14		
Female	10		
Unknown	0		
Total	24	12.4%	
Pacific Islander			
Male	0		
Female	0		
Unknown	0		
Total	0	0.0%	
White			
Male	89		
Female	42		
Unknown	0		
Total	131	67.5%	
Hispanic			
Male	12		
Female	6		
Unknown	0		
Total	18	9.3%	
Other			
Male	3		
Female	1		
Unknown	0		
Total	4	2.1%	
Unknown			
Male	0		
Female	1		
Unknown	0		
Total	1	0.5%	

(11.8%) were wedged between the wall and the mattress, two (11.8%) choked on food, one (5.9%) tangled in rails of a bunk bed, one (5.9%) accidentally strangled with a dog leash on a swing set, one (5.9%) accidentally strangled by his shirt sleeve stuck on a sign post, one (5.9%) was pinned under a garage door, and one (5.9%) where the Medical Examiner was unsure if bed sharing contributed but ruled it an accident. Six (35.3%) of the 17 were less than two months of age.

The Injury Prevention Services of the Oklahoma State Health Department released the *Injury Free Oklahoma: Strategic Plan for Injury and Violence Prevention* in February of 2004 to address prevention of injuries, disability, and premature death during the first decade of the 21st century. A copy is available at: www.health.state.ok.us/program/injury/stateplan/Index.htm.

Type of Accidents Reviewed		
Type	Number	Percent
Vehicular	120	61.9%
Drowning	25	12.9%
Asphyxia/Suffocation	17	8.8%
Fire Related	13	6.7%
Poisoning/Overdose	8	4.1%
Firearm Related	5	2.6%
Other	6	3.1%

Suicides

Of the 396 deaths reviewed, 22 were suicides. This comprised 5.6% of all the deaths reviewed, with more than three times male compared to female deaths. In previous years, the methods utilized included only firearms and asphyxia; in 2004 poisoning/overdose and a pedestrian/train collision also appeared as mechanisms for suicide. Contributing factors for suicide included: substance abuse in six (27%), conflicts with boy/girlfriend in five (23%), conflicts with parent or “other” figure in four (18%), school problems in one (4.5%), and “unknown” in eight (36%). More than one contributing factor was present in six (27.3%). Ages of suicide victims ranged from 10 to 17 years (see table on page 25).

Race and Gender of Suicide Victims			
African-American			
Male	0		
Female	0		
Unknown	0		
Total	0	0.0%	
American Indian			
Male	2		
Female	0		
Unknown	0		
Total	2	9.1%	
Asian/Pacific Islander			
Male	0		
Female	1		
Unknown	0		
Total	1	4.5%	
White			
Male	14		
Female	4		
Unknown	0		
Total	18	81.8%	
Hispanic			
Male	1		
Female	0		
Unknown	0		
Total	1	4.5%	
Other			
Male	0		
Female	0		
Unknown	0		
Total	0	0.0%	
Unknown			
Male	0		
Female	0		
Unknown	0		
Total	0	0.0%	

In 2004, New Hampshire lawmakers initiated a prevention education policy based upon study of suicide notes left at the scene. Six of 10 New Hampshire teens who commit suicide leave behind a note, which is more than twice the national average of 20 to 30 percent. This study contributed to enactment of a law for better review of the development of a statewide plan for suicide prevention; coordinates the efforts of lawmakers, the state Board of Education, and the Youth Suicide Prevention Advisory Assembly; and calls for a school guidance counselor to be appointed to the Health Education Review Committee.

Gender of Suicide Victims		
Male	17	77.3%
Female	5	22.7%
Unknown	0	0.0%
		100%

Method	Number	Percent
Firearm	12	54.4%
Asphyxia	7	31.8%
Poisoning/ Overdose	2	9.1%
Vehicular (ped/train)	1	4.6%



Homicides

The Board reviewed and closed 38 homicide deaths in 2004. The deaths were evenly split between males and females with 19 each. Four youths (10.5%) were shot by police officers while engaged in a crime. All four shootings were ruled justifiable by a District Attorney's Office and no charges were filed against any of the officers. However, charges were filed in one case against the father and brother of a victim under a state

Race and Gender of Homicide Victims				
African-American				
Male	6			
Female	1			
Unknown	0			
Total	7	18.4%		
American Indian				
Male	3			
Female	3			
Unknown	0			
Total	6	15.8%		
Pacific Islander				
Male	1			
Female	0			
Unknown	0			
Total	1	2.6%		
White				
Male	7			
Female	13			
Unknown	0			
Total	20	52.6%		
Hispanic				
Male	1			
Female	2			
Unknown	0			
Total	3	7.9%		
Other				
Male	1			
Female	0			
Unknown	0			
Total	1	2.6%		
Unknown				
Male	0			
Female	0			
Unknown	0			
Total	0	0.0%		

statute that allows an individual to be charged with the death of another when the death occurs during the process of committing a felony. The family had been running from police after an armed robbery attempt.

The remaining perpetrators include:

- Biological mom-7 (18.5%)
- Biological dad-6 (15.8%)
- Parental paramour-5 (13.2%)
- Babysitter-2 (5.3%)
- Victim's ex-paramour-1 (2.6%)
- Unknown to decedent-1 (2.6%)
- Sibling-1 (2.6%)
- Other or Unknown-5 (13.2%)
- More than one perpetrator-1 (2.6%)

It should be noted that not all homicides are considered child abuse or neglect deaths because the perpetrator may not be the Person Responsible for the Child as defined in the state statute.

Gender of Homicide of Victims		
Male	19	50.0%
Female	19	50.0%
Unknown	0	0.0%
		100%

Cause of Death	Number	Per-cent
Struck	17	43.6%
Firearm Related	12	30.8%
Asphyxiation	2	5.3%
Shaken/Jerked	2	5.3%
Cut/Stabbed	1	2.6%
Drowning	1	2.6%
Fire/Arson	1	2.6%
Scalding	1	2.6%
Poisoning	1	2.6%

Prosecutorial Information
Charges filed — 24 (63.2%) Of these twenty-four, 7 (29.1%) convicted in jury trials; 7 (29.1%) plead guilty or <i>nolo contendere</i>; 6 (25.0%) have trials pending; 1 (4.2%) charges dismissed; 1 perpetrator shot while a fugitive; 1 was youthful offender so information unavailable; 1 ruled not guilty by reason of insanity. No charges filed — 14 (36.8%) Of these fourteen, 4 (28.7%) perpetrators are unknown; 3 (21.4%) were police shootings; 3 (21.4%) were deaths that occurred as an "accident" but still ruled 'homicide' by a Medical Examiner; 2 (14.3%) committed suicide before charges could be filed; 1 (7.1%) perpetrator fled the country (a warrant has been issued); and 1 (7.1%) was a stillborn whose mother's drug use contributed to the death but the D.A. declined charges.

Undetermined

After review and closure, the causes of 48 deaths (12.1%) were judged to be undetermined. Of these 48, 40 (83.3%) were determined by a Medical Examiner to be related to a sleeping environment that possibly contributed to the death. Of these 40, 33 (82.5%) cases were noted to have occurred while bed-sharing: 15 (45.5%) bed sharing with one other person; 11 (33.3%) bed-sharing with two other persons, six (18.2%) bed sharing with three others and one (3.0%) unknown (the result of conflicting reports from caregivers).

Race and Gender of Undetermined Victims

African-American			
Male	5		
Female	4		
Unknown	0		
Total	9	18.0%	
American Indian			
Male	3		
Female	6		
Unknown	0		
Total	9	18.0%	
Pacific Islander			
Male	0		
Female	0		
Unknown	0		
Total	0	0.0%	
White			
Male	16		
Female	11		
Unknown	0		
Total	27	54.0%	
Hispanic			
Male	4		
Female	0		
Unknown	0		
Total	4	8.0%	
Other			
Male	0		
Female	0		
Unknown	0		
Total	0	0.0%	
Unknown			
Male	0		
Female	1		
Unknown	0		
Total	1	2.0%	

Substance use/abuse was noted in four (8.3%) cases to have possibly contributed to the death; two having prenatal exposure to drugs and two associated with parental use at time of death.

Four (8.3%) cases were documented as having suspicious injuries at the time of death, none resulted in any charges being filed.

Gender of Undetermined Victims

Male	28	56.0%
Female	22	44.0%
Unknown	0	0.0%
		100%

In two (4.7%) cases charges were filed: 1) child neglect for deplorable living conditions-both parents charged and both received 5 year suspended sentences; and 2) second degree manslaughter on a mother who left the child unattended, wrapped tightly in bedclothes for an extended period of time. The mother was convicted and received a four year prison term plus fines.

In 2004, budgetary constraints prevented metabolic testing in at least five (10.4%) cases by the Office of the Chief Medical Examiner at the time of autopsy.

The Child Death Review Board, through the Oklahoma Commission on Children and Youth, was able to secure additional funding for the Office of the Chief Medical Examiner permitting continued metabolic testing on all child deaths.



Natural Deaths - Reviewed

The Board reviewed and closed 92 deaths resulting from natural causes in 2004. Not all natural deaths are subject to a full review by the Board. In these instances the death certificate is reviewed by a physician (see page 13).

Forty-seven (51.1%) of the natural death cases were the result of Sudden Infant Death Syndrome (SIDS) (page 17). Of the 45 remaining cases, 27 (60%) were under one year

of age and 36 (80%) were under five years of age.

The chart below lists the types of natural deaths reviewed and closed by the Board in 2004. The "Other Conditions" category included two deaths of unknown causes, a cerebral aneurysm, a brain herniation due to hypernatremia, a ruptured appendix, meconium aspiration, acute multi-organ dysfunction syndrome, a Prader-Willi case, a possible Reyes Syndrome case, a Streptococcus Type B case and a small bowel infarct with rupture.

Race and Gender of Natural Victims			
African-American			
Male	8		
Female	5		
Unknown	0		
Total	13	14.1%	
American Indian			
Male	4		
Female	8		
Unknown	0		
Total	12	13.0%	
Pacific Islander			
Male	0		
Female	0		
Unknown	0		
Total	0	0.0%	
White			
Male	35		
Female	24		
Unknown	0		
Total	59	64.1%	
Hispanic			
Male	3		
Female	2		
Unknown	0		
Total	5	5.4%	
Other			
Male	1		
Female	1		
Unknown	0		
Total	2	2.2%	
Unknown			
Male	0		
Female	1		
Unknown	0		
Total	1	1.1%	

Gender of Natural Victims		
Male	51	55.4%
Female	41	44.6%
Unknown	0	0.0%
		100%



Illnesses and Diseases Encountered in Natural Death Cases		
Illness/Disease	Number	Percent
SIDS	47	51.1%
Pneumonia	13	14.1%
Infectious Diseases	5	5.4%
Cardiac Disease	3	3.3%
Cerebral Palsy	2	2.2%
Other Conditions	13	14.1%
Unknown	9	9.8%



Natural Deaths - Not Reviewed

Deaths due to natural processes are not reviewed as extensively as are other deaths, but each death certificate is reviewed by a pediatric physician on the Board. Any child whose cause of death appears to be unclear or does not accord with the normal disease process is then referred by the physician for full review.

In 2004, such deaths were classified by the most immediate cause of death listed on the death certificate. Underlying conditions were only used to classify a death when the immediate cause of death was not listed. The death certificate review process findings in 2004 are as follows:

Cause of Death or Medical Condition	Number of Death Certificates Received	Percent
Prematurity	151	43.63
Congenital Disorder	70	20.2
Infectious Disease	47	13.6
Neurological Disorder	28	8.1
Neoplasm	24	6.9
Respiratory Disease	13	3.8
Cardiac Disease	8	2.3
Renal Disorder	2	0.6
Not Specified/Unclear	3	0.9
TOTAL	346	100.0

Vehicle Related Deaths

The Board reviewed and closed 121 deaths associated with motor vehicle injuries. This represents 62.7% of the accidental deaths and 30.6% of all deaths.

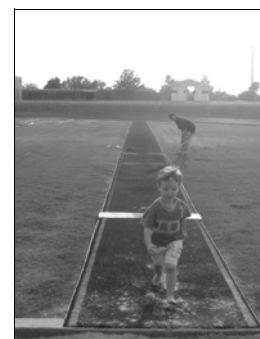
Gender	Number	Percent
Male	75	62.0%
Female	46	38.0%

Oklahoma made significant strides in 2004 in attempts to lower the number of traffic fatalities. Two laws that had been recommended by the Board for many years were enacted by the legislature. The first was the passage of a bill requiring the use of a booster or car seat for all children aged five years and younger. The previous requirement had been car/booster seat use for children ages three years and younger or weighing less than 60 pounds. Both the American Academy of Pediatrics and the National Highway Traffic and Safety Administration recommend booster seat use for children up to age eight, but similar measures failed to pass in the past and the legislature applied the bill to children ages five years and younger.

Use of Seatbelts and Car Seats by Victims

Seatbelt/Car seat Use	Number	Percent
Properly Restrained	43	35.8%
Not Properly Restrained	55	45.5%
Unknown	7	5.8%
Not Applicable	16	13.2%

Additional legislative action in 2004 included passage of a bill requiring that a teenager must have an instruction permit for six months before he/she can receive a driver's license. The law previously mandated that a teenager had to wait only 30 days before receiving a driver's license. The legislation also included the specification that an adult age 21 or older must be in the car if the teen driver only holds a driver's permit.



Age of Driver of Decedent's Vehicle

Age	Number	Percent
<13	4	3.3%
13-15	10	8.3%
16	20	16.5%
17	20	16.5%
18	12	9.9%
19-21	7	5.8%
>21	32	26.4%
N/A	16	13.2%

Activity of Decedent

Position	Number	Percent
Operator	39	32.2%
Front Passenger	36	29.8%
Rear Passenger	26	21.5%
Other	2	1.7%
Pedestrian/Bicycle	16	13.2%
Unknown	2	1.7%

Drownings

Of the 192 accidental deaths the Board reviewed and closed, 28 (14.6%) were caused by drowning. Of these 28, only one (3.6%) was reported to have had safeguards in place at the time of death, 22 (78.6%) were documented as not having safeguards in place and in five (17.8%) cases the Board was unable to determine whether or not safeguards were in place.

Gender	Number	Percent
Male	22	78.6%
Female	6	21.4%

In 2004, the National SAFE KIDS campaign reported results of research conducted in conjunction with Johnson & Johnson that revealed that 88% of children who drown were under the supervision of another person, usually a family member. In this report, titled “Clear Danger: A National Study of Childhood Drowning and Related Attitudes and Behaviors”, the authors reviewed the circumstances of drowning deaths during 2000 and 2001 among 496 children using data from Child Death Review Teams in 17 states, including Oklahoma. SAFE KIDS also commissioned nationally representative surveys of parents of children 14 and under and children ages 8 through 12 to determine knowledge, attitudes and behaviors concerning water safety. Some of the results from the study include: 55% of parents said there are some circumstances where it is acceptable for a child to swim unsupervised; even when some parents say they are supervising, many are participating in a variety of distracting behaviors, including talking to others, reading, eating, and talking on the phone; nearly two-thirds (61%) of pool or spa-owning parents did not have isolation fencing around their pools or spas, and 43% had no self closing and self-latching gate. The report can be obtained at www.safekids.org.

Location of Drowning	Number	Percent
Natural Body of Water (i.e. creek, river, pond, lake)	19	67.9
Private, Residential Pool	4	14.3
Bathtub	2	7.1
Decorative Pond	2	7.1
Public Swimming Pool	1	3.6

The Consumer Product Safety Commission (CPSC) launched a prevention program in 2004 that included two public hearings to explore strategies to prevent drowning deaths, a video news release promoting pool safety, and CPSC field staff participated in local pool safety events.

The Oklahoma Safe Kids Coalition continues to conduct the Brittany Project (a life jacket loaner system at state and U.S.Army Corps of Engineer lakes) and the Wacky Water Wa-Hoo, an annual water safety and skills training for school children. New in 2004 was a Wee Wahoo water safety day that educated over 400 kindergarteners on water safety.

Firearm Related Deaths

Twenty-nine deaths involved firearms in 2004. As seen in the chart below, firearms were used in 12 (41.4%) homicide cases, 12 (41.4%) suicides and 5 (17.2%) were ruled “accidental” shootings.

The Project Child Safe program initiated by the Lt. Governor’s Office was expanded nationally in 2004 to include all 50 state and four U.S. territories. Oklahoma was the first state to conduct a statewide gun lock giveaway and the Lt. Governor suggested to program directors that national efforts on a might prove effective. The project distributed 304,000 free gun locks in Oklahoma in 2004 through the Oklahoma Association of Chiefs of Police, the Oklahoma Department of Wildlife Conservation and other law enforcement agencies. An additional component of the program included a traveling Project Safe Child bus which toured for 17 days distributing the locks across the state.

The state of Oklahoma earned a D– in gun safety in 2004 in the annual Brady Campaign to Prevent Gun Violence report card. The report also gave the state an A– for its juvenile possession law; A– for juvenile sale and transfer laws; an F in child access prevention, gun safety locks and safer design standards, background checks on secondary or gun show sales, and for not allowing cities and counties to pass gun laws; and a D– for its concealed handgun laws.

The city of Tulsa in 2004 was one of 15 cities targeted in the federal program ,Violent Crime Impact Teams, aimed specifically at gun law offenders. The Tulsa office received two new FBI agents to help address a rise in gun-related crime, as well as other violent crimes.

Gender	Number	Percent
Male	25	86.2%
Female	4	13.8%

Manner	Number	Percent
Accident	5	17.2%
Homicide	12	41.4%
Suicide	12	41.4%

Type of Firearm	Number	Percent
Handgun	20	69.0%
Rifle	6	20.7%
Shotgun	2	6.9%
Unknown	1	3.4%



Sudden Infant Death Syndrome (SIDS)

The Board reviewed and closed 47 deaths in 2004 ruled SIDS by a Medical Examiner, comprising 11.8% of all deaths reviewed and closed.

Two new studies appeared in 2004 hypothesizing why some babies succumb to SIDS. The first was from the University of Chicago and published in the journal *Neuron*. It examined how the brain regulates gasping for air under conditions of insufficient oxygen. Healthy mouse brain stem cells fired when deprived of oxygen, prompting gasping. Certain chemicals inhibited this response. Critics pointed out that it has not been proven that SIDS is directly related to intrinsic breathing problems or the failure to initiate a gasp. All agreed more research is needed.

In the second study conducted at Rush University in Chicago and published in *Pediatric Research*, researchers examined genes involved in the development of the autonomic nervous system, which controls breathing, heartbeat, and other involuntary functions. Genetic samples from 92 SIDS cases were compared to genetic material from 92 healthy one-year olds. Eleven different genetic mutations were found in 14 of the 92 SIDS cases, but only one mutation was found in two of the 92 healthy children. Seventy-one percent of the SIDS cases with the mutation were African-American and the two healthy babies that showed the same mutation were also African-American, giving strong support to the possibility of a genetic basis for at least some SIDS cases.



Gender	Number	Percent
Male	29	61.7%
Female	18	38.3%

Age (in months)	Number	Percent
Less than 2	13	27.7%
2—6	33	70.2%
More than 6	1	2.1%

Sleeping Position of Infant

Position	Number	Percent
On Stomach	17	36.2%
On Back	11	23.4%
On Side	5	10.6%
Other	0	0.0%
Unknown	14	29.8%

Sleeping Arrangement of Infant

Sleeping Arrangement	Number	Percent
Alone	25	53.2%
With Adult	19	40.4%
With Sibling	0	0.0%
Unknown	3	6.4%

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

Fire Deaths

Nineteen fire deaths were reviewed and closed by the Board in 2004. One was a homicide. It is important to note that three fires resulted in eight deaths (one set of two siblings and two separate sets of three siblings). One of these fires was ruled arson and the fire-starter was convicted of four counts of murder (the three children plus their mother) and sentenced to life without parole.

Gender	Number	Percent
Male	13	68.4%
Female	6	31.6%

In a historic move the state of New York passed legislation that required by June of 2004, all tobacco companies that sell cigarettes must certify that no more than 25 percent of the cigarettes sold could fail the ignition propensity test established by the American Society of Testing and Materials. The meaning of this is that cigarettes would be far less likely to start a fire if left unattended. Canada also passed a cigarette fire safety standard in 2004 becoming the first nation to pass such a standard. The Cigarette Fire Safety Act of 2004, similar to New York's law, died in congressional committee.

Age at Time of Death		
Age	Number	Percent
< 5	10	52.6%
5-10	5	26.3%
> 10	4	21.1%

In its 2004 publication *Injury Free Oklahoma*, the Oklahoma State Health Department's Injury Prevention Services listed fire-safe cigarettes as one of six prevention strategies for reducing the number of residential fire deaths. Included also was increased use of smoke alarms, increased use of residential sprinkler systems, fire/burn safety education; stricter flammability standards for clothing and other materials, and stricter building codes.



Age of Person Starting Fire		
Age	Number	Percent
< 5	1	5.3%
5-12	1	5.3%
13-18	0	0.0%
Over 18	7	36.8%
Unknown	10	52.6%

Working Smoke Detector Present		
Detector	Number	Percent
Yes	2	10.5%
No	13	68.4%
Unknown	4	21.0%

Abuse/Neglect Deaths

Forty-eight deaths caused by abuse and/or neglect were reviewed and closed by the Board. Of these, three separate fires accounted for eight deaths. Formal criminal charges were filed in 27 (56.3%) cases, with 21 successful convictions, four pending in the court system, one with charges dismissed, and one with charges filed but the perpetrator subsequently died. None of the five deaths due to natural causes resulted in any charges, even though two were considered neglect due to failure to seek medical attention. Two of the cases that did not result in charges included a parent who committed suicide before charges could be filed and a parent killed by police before charges could be filed. Twenty-two of the cases (45.8%) had a prior referral to child welfare; twelve of those referrals were confirmed.

Gender of Abuse/Neglect Victims

Gender	Number	Percent
Male	25	52.1%
Female	23	47.9%

Head trauma led the list of causes of abuse/neglect deaths, at 12 (25.5%). Multiple body trauma was next at nine cases or 19.1%: fire-8 (17.0%); asphyxia (including overlay): three (6.4%); medical conditions: three (6.4%), firearms: two (4.3%); possible overlay (Medical Examiner unable to definitively state overlay): two (4.3%), undetermined cause: two (4.3%); SIDS: two (4.3%); drowning: one (2.1%); electrocution: one (2.1%); thermal injury (non-fire): one (2.1%); and maternal drug use (methamphetamine): one (2.1%).

Manner of Death for Abuse/Neglect Victims

Manner	Number	Percent
Homicide	22	45.8%
Accident	15	31.3%
Undetermined	5	10.4%
Natural	5	10.4%
Suicide	1	2.1%

Perpetrator Information

Perpetrator	Number	Percent
Biological Mother	22	45.8%
Biological Father	9	18.8%
Parental Paramour	5	10.4%
Step-parent	3	6.3%
Other Family	3	6.3%
Sibling	2	4.2%
Babysitter	2	4.2%
Unknown	2	4.2%

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

Age of Victims by Race

Age of African-American Victims

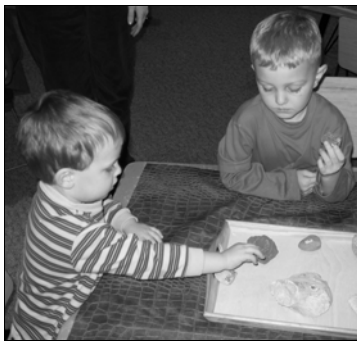
Age	Number	Percent
<1	22	48.8%
1	4	8.8%
2	1	2.2%
3	1	2.2%
4	2	4.4%
5	1	2.2%
6	0	0.0%
7	1	2.2%
8	0	0.0%
9	1	2.2%
10	1	2.2%
11	1	2.2%
12	0	0.0%
13	2	4.4%
14	2	4.4%
15	2	4.4%
16	1	2.2%
17	3	6.7%

Age of American Indian Victims

Age	Number	Percent
<1	23	43.4%
1	5	9.4%
2	4	7.5%
3	1	1.9%
4	1	1.9%
5	1	1.9%
6	3	5.7%
7	0	0.0%
8	0	0.0%
9	1	1.9%
10	0	0.0%
11	0	0.0%
12	0	0.0%
13	0	0.0%
14	2	3.8%
15	2	3.8%
16	5	9.4%
17	5	9.4%

Age of White Victims

Age	Number	Percent
<1	85	33.3%
1	10	3.9%
2	6	2.4%
3	12	4.7%
4	9	3.5%
5	6	2.4%
6	2	0.8%
7	5	2.0%
8	4	1.6%
9	8	3.1%
10	4	1.6%
11	9	3.5%
12	6	2.4%
13	7	2.8%
14	9	3.5%
15	20	7.9%
16	30	11.8%
17	23	9.1%



Age of Hispanic Victims

Age	Number
<1	10
1	4
2	3
3	2
4	1
5	1
13	1
15	3
16	4
17	2

Age of Other Victims

Age	Number
<1	2
3	1
6	1
13	1
17	2

Age of Unknown Race Victims

Age	Number
<1	1
3	1

Age of Asian Victims

Age	Number
<1	1
17	1

Age of Victims by Manner

Age of All Victims

Age	Number	Percent
<1	145	36.6%
1	23	5.8%
2	14	3.5%
3	18	4.5%
4	13	3.3%
5	9	2.3%
6	6	1.5%
7	6	1.5%
8	4	1.0%
9	10	2.5%
10	5	1.3%
11	10	2.5%
12	6	1.5%
13	11	2.8%
14	13	3.3%
15	27	6.8%
16	41	10.4%
17	35	8.8%

Age of Accident Victims

Age	Number	Percent
<1	16	8.2%
1	8	4.1%
2	7	3.6%
3	14	7.2%
4	12	6.2%
5	8	4.1%
6	6	3.1%
7	5	2.6%
8	4	2.1%
9	7	3.6%
10	4	2.1%
11	5	2.6%
12	5	2.6%
13	8	4.2%
14	7	3.6%
15	20	10.4%
16	31	16.1%
17	27	14.1%

Age of Natural Victims

Age	Number	Percent
<1	74	80.4%
1	4	4.3%
2	4	4.3%
3	1	1.1%
4	0	0.0%
5	1	1.1%
6	0	0.0%
7	1	1.1%
8	0	0.0%
9	2	2.2%
10	0	0.0%
11	3	3.3%
12	0	0.0%
13	1	1.1%
14	0	0.0%
15	0	0.0%
16	0	0.0%
17	1	1.1%



Age of Victims by Manner (cont.)

Age of Homicide Victims

Age	Number	Percent
<1	11	28.9%
1	6	15.4%
2	3	7.7%
3	3	7.7%
4	1	2.6%
5	0	0.0%
6	0	0.0%
7	0	0.0%
8	0	0.0%
9	1	2.6%
10	0	0.0%
11	0	0.0%
12	0	0.0%
13	2	5.1%
14	3	7.7%
15	4	10.3%
16	2	5.1%
17	2	5.1%

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	0	0.0%
10	1	4.5%
11	2	9.1%
12	1	4.5%
13	0	0.0%
14	3	13.6%
15	3	13.6%
16	7	31.8%
17	5	22.7%

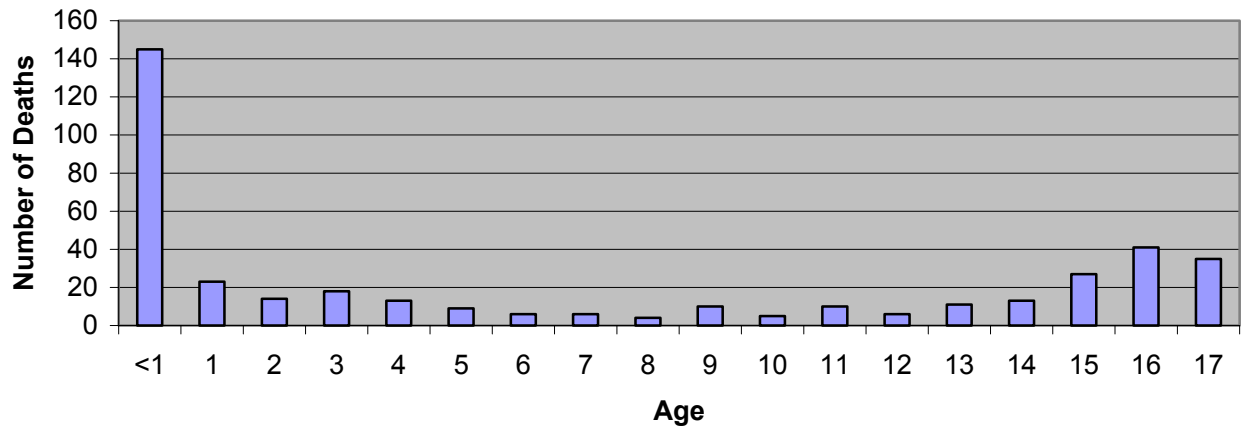
Age of Undetermined Victims

Age	Number	Percent
<1	44	88.0%
1	4	8.0%
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	0	0.0%
10	0	0.0%
11	0	0.0%
12	0	0.0%
13	0	0.0%
14	0	0.0%
15	0	0.0%
16	1	20.0%
17	0	0.0%

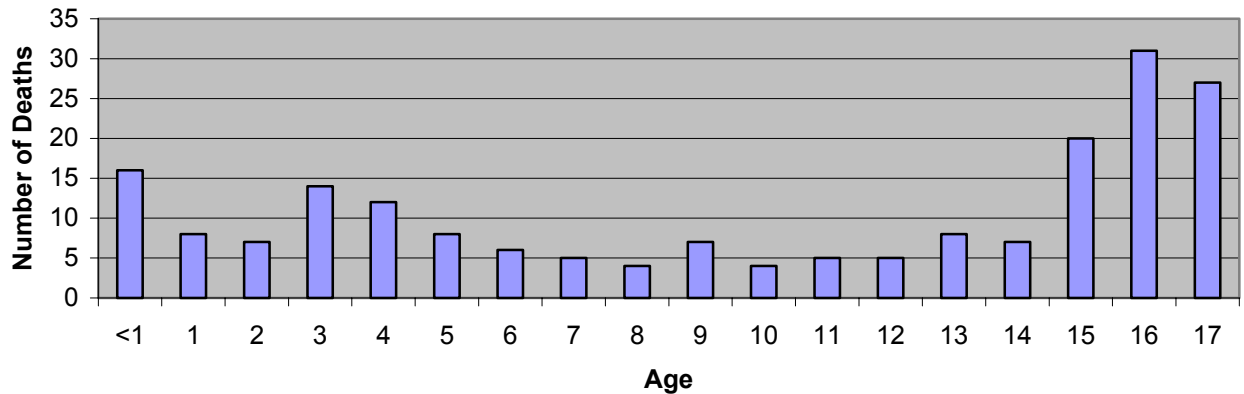


Age of Victims by Manner

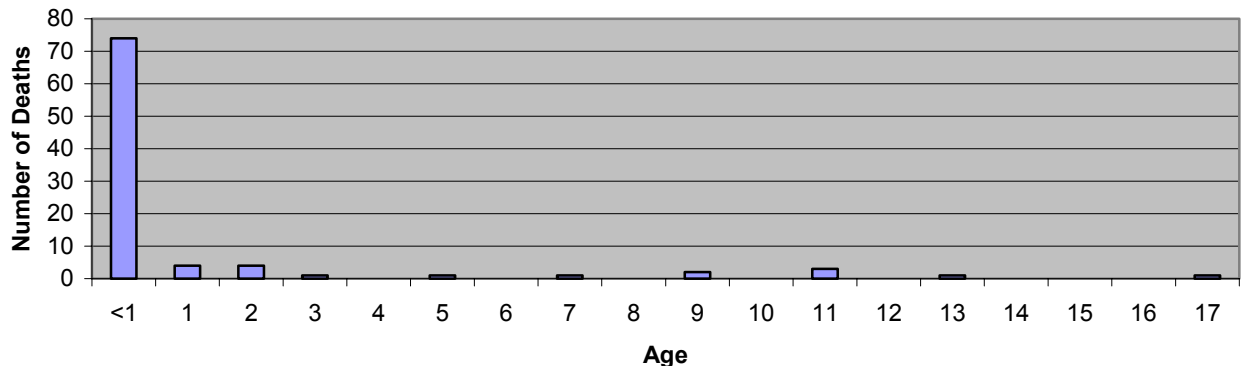
Total Number of Deaths by Age



Accidental Deaths by Age

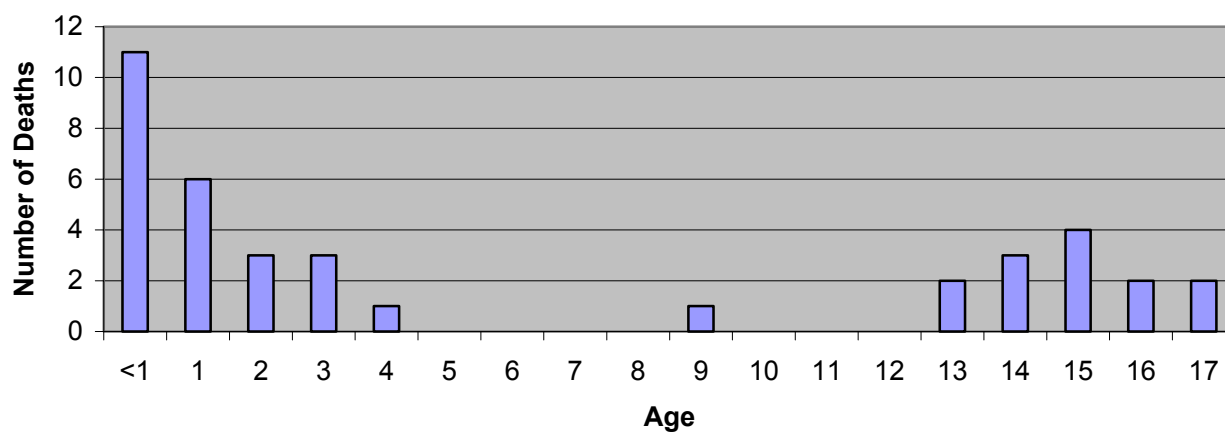


Natural Deaths by Age

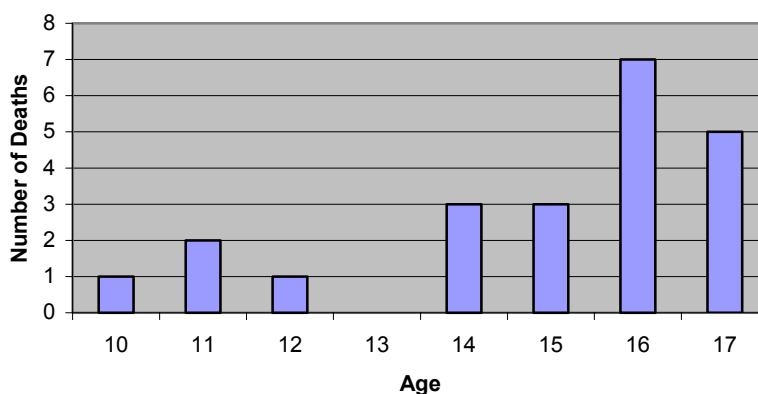


Age of Victims by Manner

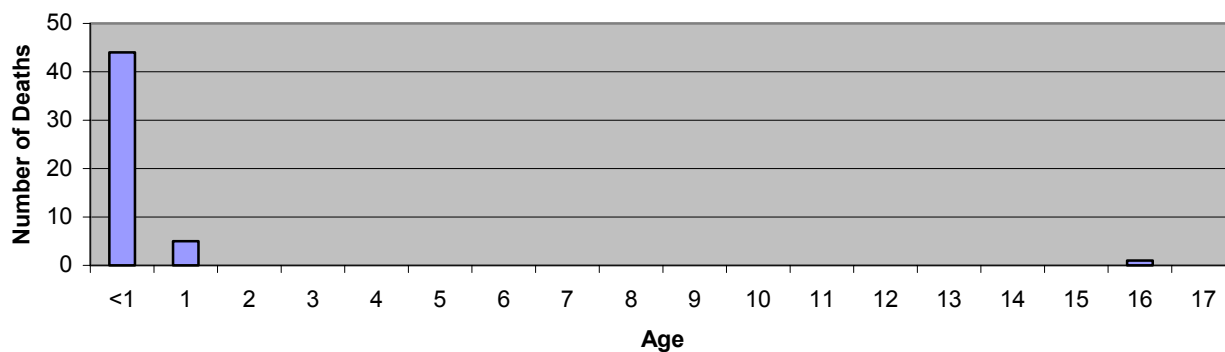
Homicide Deaths by Age



Suicide Deaths by Age

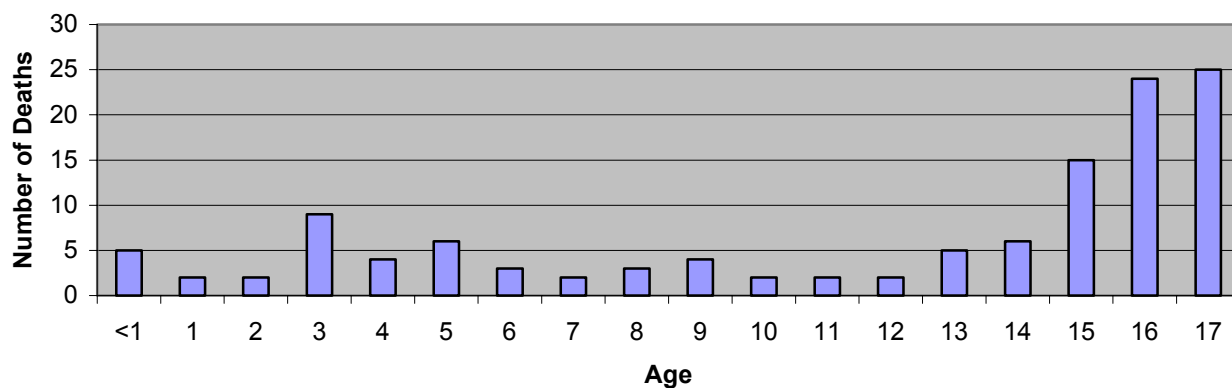


Undetermined Deaths by Age

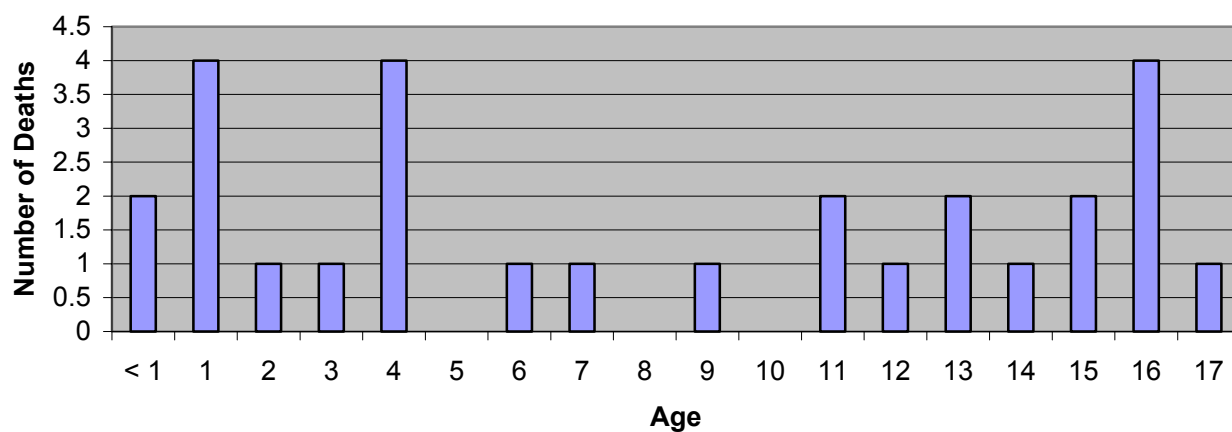


Age of Victims by Selected Causes

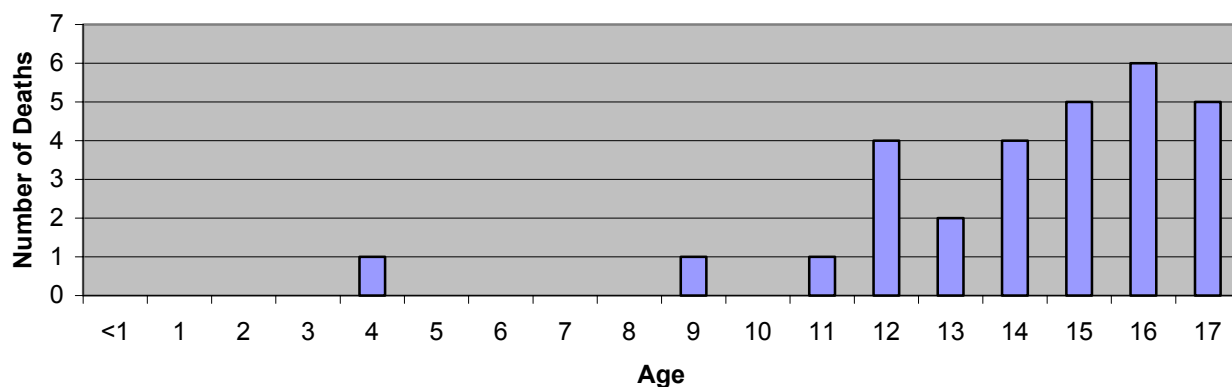
Vehicular Deaths by Age



Drowning Deaths by Age

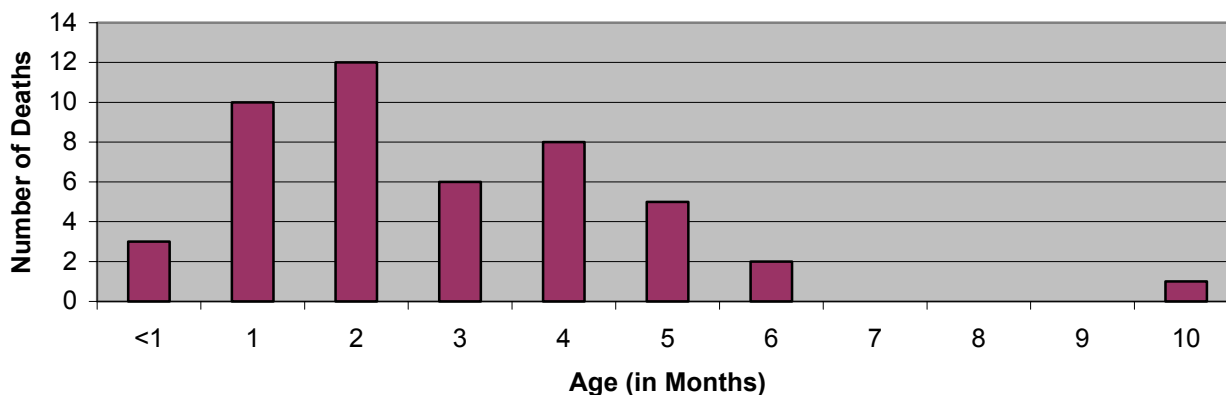


Firearm Deaths by Age

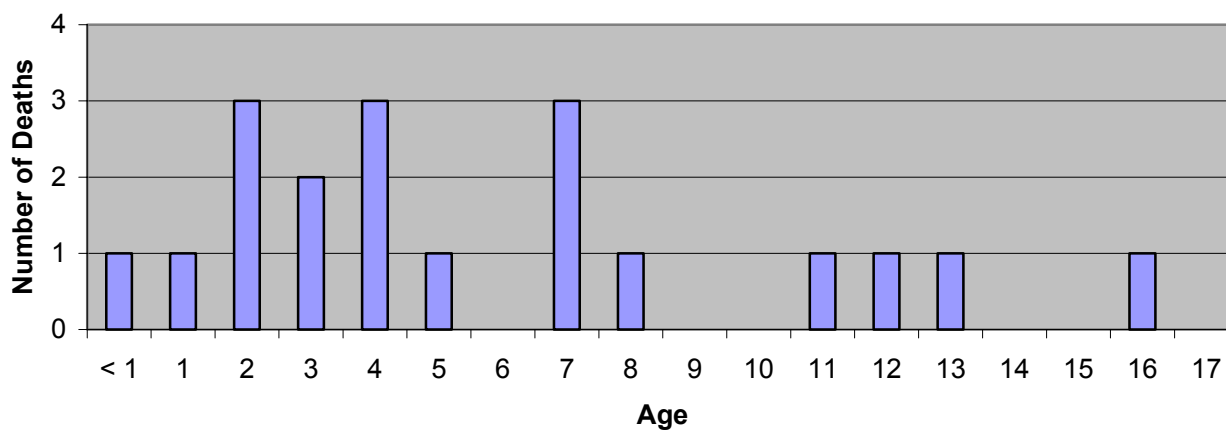


Age of Victims by Selected Causes

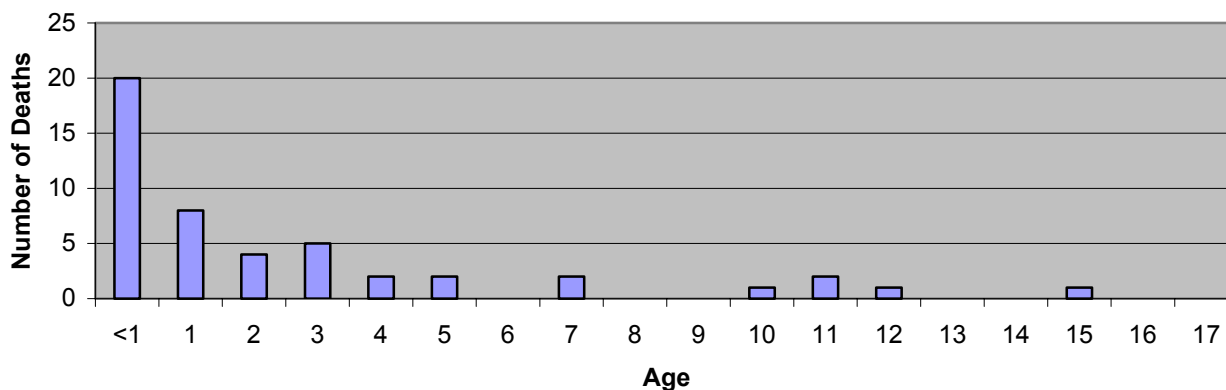
SIDS Deaths by Age



Fire Related Deaths by Age



Abuse/Neglect Deaths by Age



Lincoln/Pottawatomie Review Team

In 2004 the Lincoln/Pottawatomie Child Death Review Team met four times and reviewed and closed 13 cases. Additionally in 2004, legislation passed allowing the Lincoln/Pottawatomie Review Team to begin the process of expanding its coverage area to include counties in the southeast quadrant of Oklahoma. The team is now the Southeastern Oklahoma Regional Child Death Review Team (SE CDRT).

Gender of Lincoln/Pottawatomie Victims

Gender	Number	Percent
Male	7	53.8%
Female	6	46.2%

Four (57.1%) of the accidental deaths closed by the SE CDRT were vehicle related. Two of the four vehicle related deaths involved alcohol. Two (28.6%) accidents were caused by drowning and one (14.3%) was a fire related death.

The three natural deaths consisted of two with a medical illness and one SIDS death. In the SIDS death, the infant had been sleeping alone on his back.

Manner of Death for Lincoln/Pottawatomie Victims

Manner	Number	Percent
Accident	7	53.8%
Homicide	0	0.0%
Natural	3	23.1%
Suicide	1	7.7%
Undetermined	2	15.4%

The suicide death was committed using a firearm. Both of the undetermined deaths

Lincoln/Pottawatomie Child Death Review Team Members

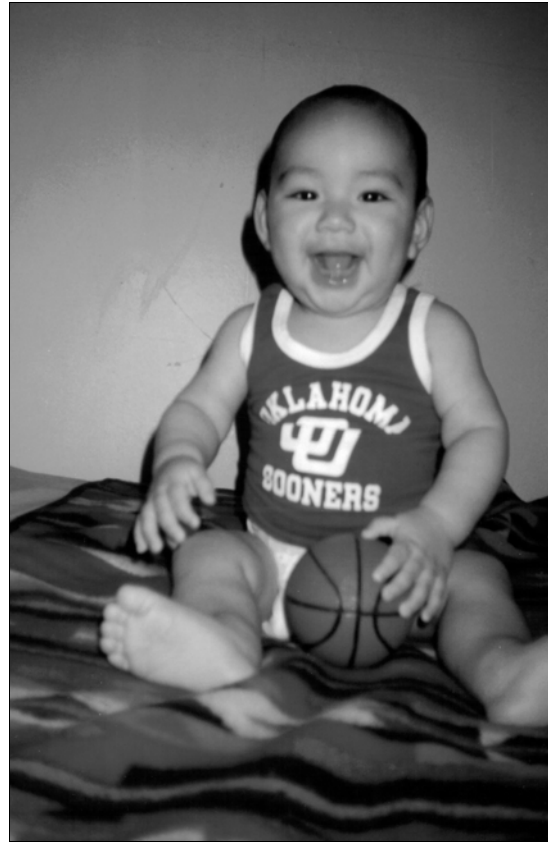
Organization	Team Member	Designee
Community Representative	Kate McDonald Joyce; Chair	Mike Joyce
Unzner Centre	Laura Allison; Vice-Chair	Sharon Trammell
Judicial Representative	Judge Glenn Dale Carter (Ret.)	
Pottawatomie County Sheriff's Office	Todd Hignite	Randy Willis
Oklahoma Department of Human Services	Carmen Hutchins	
Youth and Family Resources Center	Susan Morris	Debbie Cathey
Medical Representative	Kelly Neher	Joye Byrum
State CDRB Representative	Carolyn Parks	
Pottawatomie County Health Department	Liz Petrin	Tonya Gifford James
District Attorney's Office	Richard Smotherman, JD	Melissa Estes, JD

Lincoln/Pottawatomie Review Team

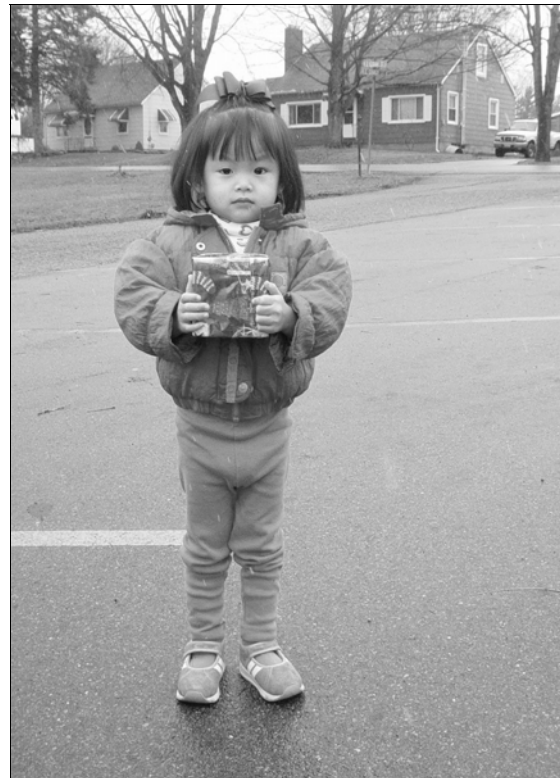
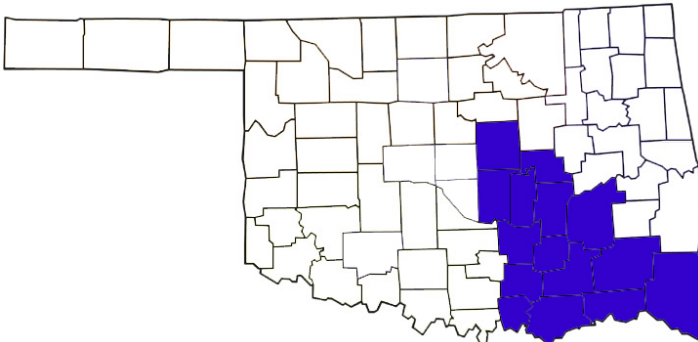
were infants and in both cases the Medical Examiner noted unsafe sleeping arrangements and stated that overlay could not be ruled out.

In September of 2004 the Bryan County OKDHS Child Welfare Unit met with the Bryan County Health Department and Sooner Start professionals to discuss the high incidence of child deaths in that county. Although a majority of those deaths were ruled SIDS, parental bed sharing was noted in most of the cases. A coalition was formed to educate professionals, the public and the judicial system on the risks of bed sharing.

Other notable child safety programs in the region include the Pottawatomie County Sheriff's Office continued participation in the Project ChildSafe gunlock giveaway program. In addition every year the Shawnee Fire Department attends the Shawnee Mall Safety Fair to provide information on smoke detectors. Forms are available at the safety fair to apply for a free smoke detector from the fire department. For individuals who live within the city limits, the Shawnee Fire Department will make arrangements to install the detector in the household.



Counties of the Southeastern Oklahoma Regional Child Death Review Team



Muskogee Review Team

In 2004 the Muskogee Child death Review Team met four times and closed 10 cases. As a result of legislation, the Muskogee Team expanded its coverage area. The

Gender of Muskogee Victims

Gender	Number	Percent
Male	4	40.0%
Female	6	60.0%

Manner of Death for Muskogee Victims

Manner	Number	Percent
Accident	5	50%
Homicide	1	10%
Natural	3	30%
Suicide	0	0%
Undetermined	1	10%

Muskogee Child Death Review Team, now known as the Eastern Oklahoma

Regional Child Death Review Team (E CDRT), is responsible for reviewing all the deaths that occur in the eastern/northeastern counties of Oklahoma.

Three (60%) of the five accidental death were

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	
Cherokee Nation Mental Health	Misty Boyd, PhD	
Muskogee County Sheriff's Office	Tim Brown	Darrin Smith
Muskogee County OKDHS	Theresa Buckmaster	Cathy Young
Oklahoma Coalition on Domestic Violence	Evelyn Hibbs	Gwyn LaCrone
Muskogee County Children First Program	Linda Hitcheye	
Muskogee County District Attorney's Office	John David Luton, JD	Kristin Littlefield, JD
Muskogee County Regional Hospital	Sheila McMahan	
Kids Space	Betty Martin	Kimberly Sharp
Muskogee County EMS	Rebecca Smith	Carlene Morrison
Muskogee County Council on Youth Services	Cindy Perkins	Darren Smith
Muskogee County Medical Examiner	Anna Randall, DO	
Muskogee Police Department	John Toles	Shannon Humphrey
Muskogee County Health Department	Carol Weigel	
Muskogee Public Schools	Debbie Winburn	

Muskogee Review Team



vehicle related. The other two accidental deaths consisted of one (20%) drowning and one (20%) accidental suffocation. The one homicide was committed with a firearm.

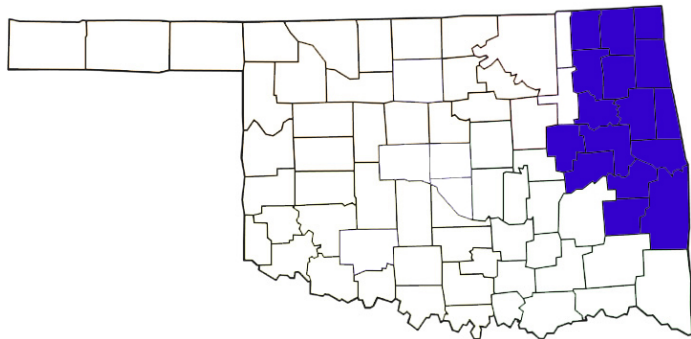
The undetermined case involved an infant with suspicious injuries.

Of the three natural deaths, one had a medical illness and two were ruled SIDS. In both cases, the baby was sleeping alone at the time of death, one face down, the other on his side.

Dr. Lillian Young, an Eastern Oklahoma Regional Child Death Review Team member and a college professor at Northeastern State University, annually makes presentations to students pursuing teaching degrees. Her presentations cover teachers' responsibilities regarding suspected child abuse. Dr. Young also makes presentations to students concerning Shaken Baby Syndrome.



Counties of the Eastern Oklahoma Regional Child Death Review Team



Near Death Cases Reviewed in 2004

The Oklahoma Child Death Review Board reviewed and closed 23 near death cases in 2004. In order 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 ruled by a physician.

Gender of Near Death Cases

Gender	Number	Percent
Male	16	69.6%
Female	7	30.4%

Of the 23 cases reviewed and closed, 15 (65.2%) were confirmed by OKDHS as abuse and/or neglect. Of these 15, four (26.7%) were confirmed abuse, nine (60.0%) were confirmed neglect, and two (13.3%) were both abuse and neglect.

Fourteen (60.9%) of the near death children had experienced prior abuse/neglect investigations on them (ten or 71.4% of these confirmed) and ten (43.4%) cases had siblings with a prior abuse and/or neglect referral (six or 60% of these confirmed). Twenty-one (91.3%) cases had families who had applied for and/or received OKDHS services.

Race of Near Death Cases

Race	Number	Percent
African-American	4	17.4%
American Indian	4	17.4%
Hispanic	2	8.7%
White	13	56.5%

Near death cases tend to require more time to collect records and review the case than do the death cases. Most of the near death cases reviewed in 2004 were from incidents that occurred in 2003 (17 cases), four occurred in 2004, one occurred in 2001 and one occurred in 2000.

Abuse/Neglect Allegations Confirmed Against:

Perpetrator	Number
Biological Mother	4
Biological Father	3
Both	4
Biological Mom & Step-father	2
Biological Mom & Boyfriend	1



Injuries in Near Death Cases

Injury	Number	Percent
Shaken	4	17.4%
Near Drowning	4	17.4%
Fall	4	17.4%
Poisoning/Overdose	4	17.4%
Vehicular	3	13.0%
Scalded	1	4.3%
Firearm	1	4.3%
Unknown	2	8.7%

Helpful Numbers

Child Abuse Reporting Hotline	1-800-522-3511
Heartline 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 or 606-4900 (in OKC)
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 Service	(405) 271-4060
Adolescent Health Program	(405) 271-4480
Child Abuse Prevention	(405) 271-7611
Children First Program	(405) 271-7612
Dental Health Services	(405) 271-5502
Injury Prevention Service	(405) 271-3430
SoonerStart	(405) 271-6617
Sudden Infant Death (SIDS) Program	(405) 271-4471
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

National Resources



NATIONAL MCH CENTER FOR CHILD DEATH REVIEW

KEEPING KIDS ALIVE



In August of 2004 the National MCH Center for Child Death Review out of Michigan held a symposium in St. Louis, Missouri showcasing the value of inter-disciplinary coordination and collaboration in child death investigations. Participants from 31 states and 3 foreign countries attended the symposium.



The National Center for Child Death Review provides guidance and review tools not only for established child death review teams, but also assists states interested in starting child death review teams. More information on the National Center for Child Death Review can be found at: www.childdeathreview.org.



NCFR

THE NATIONAL CENTER ON CHILD FATALITY REVIEW

The National Center on Child Fatality Review of California also provides guidance, assistance and tools to states with child death review boards and to states interested in creating a child death review board. Additionally, the National Center on Child Fatality Review publishes a newsletter, Unified Response, to spotlight the accomplishments of state child death review boards. Information on the National Center on Child Fatality Review can be found online at: www.ican-ncfr.org.

Acknowledgements

The Oklahoma Child Death Review Board would like to thank the following agencies for their help in gathering information for this report.

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

This publication, printed in January 2006 by the University of Oklahoma Health Sciences Center printing office, is issued by the Oklahoma Child Death Review Board. Five hundred (500) were printed at a cost of \$1775. Copies have been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries.