The Oklahoma

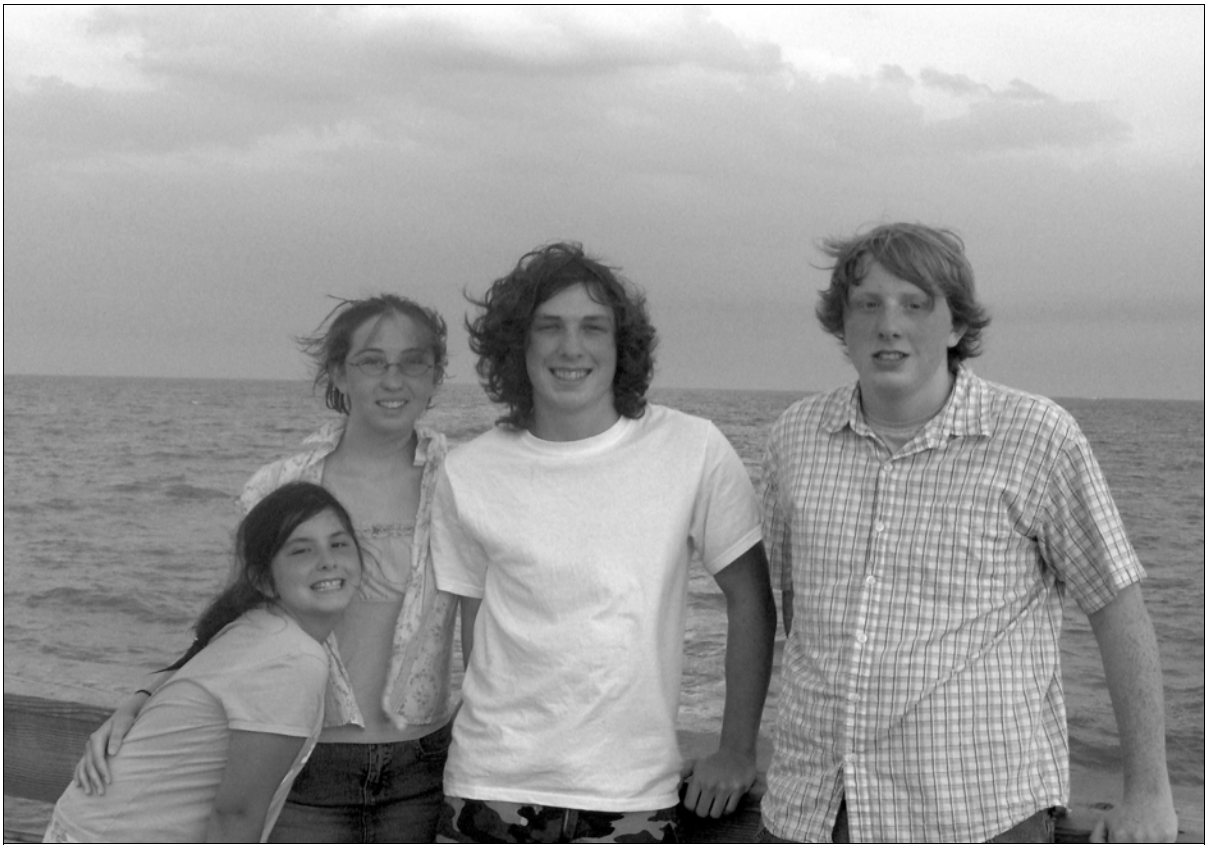
Child Death Review Board

2005 Annual Report

Containing information on cases reviewed and closed during the 2005 calendar year

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

Published November 2006



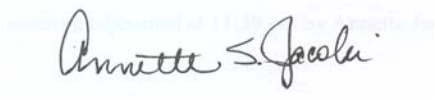
A message from the Chair of the Oklahoma Child Death Review Board

Every child death is difficult to comprehend. Regardless of whether a child dies from natural causes, an accident or intentional injuries, loved ones grieve. Often times, professionals such as first-responders, medical professionals, social service providers and law enforcement were involved. They, too, struggle with their emotions.

Since 1991, numerous individuals have served on the Oklahoma Child Death Review Board. Each person represents a profession or entity that is integrally involved with the welfare of children. Collectively the Board reviews the death of every child under the age of 18 with the purpose of determining if, with reasonable community or individual action, the death could have been prevented. During 2005, the Board reviewed and closed 409 child deaths.

Each of these deaths presented unique circumstances, yet many of the situations had a common thread – many were preventable. Car safety seats, life jackets, smoke detectors, helmets – each of these are an obvious tool in preventing deaths. One should add to this list, though, parent education regarding a variety of topics such as safe sleeping practices for infants, shaken baby syndrome, and graduated driver licenses for teens.

This annual report is dedicated to the children involved in the cases reviewed. The Child Death Review Board is privileged to learn about each child. It is our sincerest wish that with the knowledge gained from each review policies will be created, legislation will be passed and parents will hold their children closer to their hearts.



Annette Wisk Jacobi, J.D.
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.

Contact information: Oklahoma Child Death Review Board
PO Box 26901, RM 3B3406
Oklahoma City, OK 73190
Phone: (405) 271-8858
Fax: (405) 271-2931

Website: http://okcdrb.ouhsc.edu

The 2005 Oklahoma State Child Death Review Board Members

Organization	Member	Designees
Office of Child Abuse Prevention	*Annette Jacobi, JD; Chair*	
Oklahoma State Department of Health	*Mike Crutcher, MD, MPH*	*Carolyn Parks, MHR, RN; Vice-Chair*
Chief Child Abuse Examiner	*Robert Block, MD*	*Debbie Lowen, MD*
Post Adjudication Review Board	*Jay Scott Brown, MA*	*Buddy Faye Foster, JD*
OSDH, State Epidemiologist	*Brett Cauthen, MD, MPH*	*Rebecca Coffman, MPH, RN*
State Department of Mental Health and Substance Abuse Services	*Terry Cline, PhD*	*Julie Young, MA*
Office of Juvenile Affairs	*Richard DeLaughter*	*Donna Glandon, JD*
OSDH, Maternal and Child Health Service	*Suzanna Dooley, MS*	*Jim Marks*
Oklahoma Academy of Pediatrics	*Pilar Escobar, MD*	
Oklahoma Health Care Authority	*Michael Fogarty, JD*	*Lynn Mitchell, MD; Aimee Moore, RN*
Office of the Chief Medical Examiner	*Jeffery Gofton, MD*	*Sharon Asher*
Oklahoma Department of Human Services	*Howard Hendrick, JD, MBA*	*Esther Rider-Salem, MSW; Kathy Simms, MSW;*
Oklahoma Commission on Children and Youth	*Janice Hendryx, MSW*	*Chris Fiesel; Lisa Smith, MA*
Oklahoma Coalition Against Domestic Violence and Sexual Assault	*Evelyn Hibbs*	*Marcia Smith*
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*	
Oklahoma Osteopathic Association	*Julie Morrow, DO*	*Pam Ghezzi, DO*
National Association of Social Workers	*Keri Pierce, MSW*	
Oklahoma EMT Association	*Ray Simpson, REMT-PIRN*	*Jena Lu Simpson, CC-EMT-P*
OSDH, Injury Prevention Service	*Shelli Stevens-Stidham*	*Ruth Azeredo, DrPH*
Oklahoma District Attorney's Council	*Cathy Stocker, JD*	*Michael Fields, JD*
Children's Hospital of Oklahoma	*John Stuemky, MD*	*Amy Baum, MSW; Kathie Hatlelid, PA-C*
Cherokee Tribe of Oklahoma	*Kara Whitworth*	
Law Enforcement Representative	*Vacant*	

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
Submitted to the Oklahoma Commission on Children and Youth
May 2006

The following recommendations are based on the 409 cases reviewed and closed in calendar year 2005. Recommendations this year are based on deaths due to **motor vehicles, drowning, unsafe sleep practices, fires, and child abuse/neglect.**

Motor Vehicle Related Deaths
Key Findings

From the Board's inception, motor vehicle related fatalities have consistently been the leading cause of death among children 17 years of age and younger. There were a total of 115 cases (28.1% of 409) in 2005 involving motor vehicles. Of these:

- In 14 (12.2% of 115) cases the driver was cited for driving under the influence.
- Eleven (9.6% of 115) were pedestrians.
- Eighty-five (73.9% of 115) were traveling in a car/van/pickup/SUV.
- One (.9% of 115) was riding a bicycle—helmet use unknown.
- Drivers age 17 years and younger were involved in 35 (41.1% of 85) cases.
- Thirty (35.5% of the 85) were restrained.
- Seven (6.0% of 115) were riding All-Terrain Vehicles (ATVs), with the youngest six years of age and the oldest 15.
- Of the seven riding ATVs, six (85.7% of the seven) had no helmet and helmet use was unknown for the remaining case.
- Although exact numbers are unavailable at this time, the Board continues to be concerned about the number of motor vehicle collisions that occur with two or more teenage occupants.

Recommendations

- Mandatory sobriety testing of drivers in motor vehicle collisions resulting in a child fatality and/or a critical or serious injury to a child.
- Enforcement of child passenger safety restraint laws, which fines drivers transporting unrestrained children.
- Development and dissemination of a campaign that will promote the best practices related to booster seat usage.
- Provision of mandated universal driver education classes for all high school and career tech students.
- Passage of ATV legislation that contains elements requiring helmet use, prohibiting passengers, prohibiting drivers age 12 and under, and requiring ATV safety training.
- Enforcement of the Oklahoma Graduated Driver's License Law, which restricts the

number of multiple passengers younger than 21 (other than family).

- Court sanctions and/or education prevention programs, such as drunk driving victim impact 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.
- Promotion and establishment of funding for the Safe Kids Oklahoma Child Passenger Safety Program. This program includes: providing car seats for low-income families; providing training and car seats for **every** child care center in the state starting July 2006; providing, through a loaner program, car seats for special needs children; piloting a program for providing car beds for babies born prematurely; and the "Please Be Seated" program. This allows citizens the opportunity to send a card to Safe Kids with license plate information when a citizen has observed a child transported unrestrained. Safe Kids then contacts the family through a letter reminding them of the law and offering assistance for obtaining a car seat.
- Promotion and establishment of funding for the Safe Kids Oklahoma "Walk This Way" program which is aimed at reducing the number of child pedestrian injuries and fatalities.
- Promotion and establishment of funding for the Safe Kids Oklahoma bicycle safety program, which includes conducting bicycle safety rodeos and provides free helmets to groups who conduct bicycle safety education events utilizing Safe Kids curriculum.

Unsafe Sleep Practices

Key Findings

There were a total of 57 (13.9% of 409) deaths where unsafe sleeping practices contributed to the death. Of these:

- Thirty-six (63.2% of the 57) were ruled Unknown as to the manner of death, with the Medical Examiner stating unsafe sleep conditions might have contributed to the death.
- Five (8.7% of the 57) were ruled Accidental deaths due to overlay.
- Forty (9.8% of 409) deaths were classified as Sudden Infant Death Syndrome (SIDS). Of these 40, 20 (50% of 40) were sharing the same sleep surface with an adult or sibling, and 16 (40% of 40 and 28.1% of the 57) included the possibility of overlay. Regarding sleep position, six children were sleeping on their stomach, eight were sleeping on their side, and in 14 cases, sleep position was unknown.

Recommendations

- Require education about safe sleep practices to be included in child-birth preparation core curriculum.
- Require hospitals in Oklahoma to educate new parents about safe sleep practices prior to discharge from the hospital.

Recommendations

- Provide the Oklahoma State Department of Health (OSDH) with funding to create and distribute a "New Parent Kit" to all first time mothers who deliver in Oklahoma. A component of this kit would include educational information about safe sleep practices.
- Distribute cribs for low income families.
- Continue educational efforts regarding the safe sleep recommendations of the American Academy of Pediatrics through the OSDH SIDS program.

Drowning
Key Findings

In 2005 the Oklahoma Child Death Review Board reviewed 31 (7.7% of 409) deaths due to drowning. Of these:

- Fifteen (48.4% of the 31) occurred in a natural body of water.
- Seven (22.6%) occurred in a residential swimming pool and all seven were residents or visitors of the home where the pool was located.
- Three (9.7%) occurred in a bathtub.
- One (3.2%) occurred in a bucket.
- One (3.2%) occurred in a wading pool.
- Four (12.9%) occurred in an "other" place. These places included a hot tub, a municipal sewage lagoon, a hotel swimming pool, and an apartment complex swimming pool.
- Fifteen (48.4%) were three years of age or younger.
- Eight (25.8%) were five through 12 years of age.
- Eight (25.8%) were age 13 or older.
- Of the 15 occurring in a natural body of water: eight (53.3% of 15) were lakes, four (26.7%) were ponds, one (6.7%) was a river, one (6.7%) was a creek.

Recommendations

- 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.
- Promotion and establishment of funding for Safe Kids Oklahoma's water safety programs, which include the Wee Water Wahoo and Wacky Water Wahoo water safety training events and the Brittany Project, which provides loaner life jackets at Oklahoma Corps of Engineers lakes.
- The OSDH 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 OSDH Injury Prevention Services Division's informational brochures on pool/hot tub safety.

Recommendations

Fires

Key Findings

In 2005 the Oklahoma Child Death Review Board reviewed nine (2.2% or 409) deaths due to fires. Of these:

- Three (33.3% of 9) did not have a working smoke detector present in the residence.
- Three (33.3%) cases, investigators were unable to determine if a working smoke detector was present.

Recommendations

- Promotion and establishment of funding for Safe Kids Oklahoma's burn prevention programs, which includes the "Save-A-Life" smoke detector giveaway/installment programs, a fireworks safety campaign, a childcare providers burn education curriculum, a and "Change Your Battery" campaign.
- Fire departments to partner with the Safe Kids Oklahoma to provide juvenile cooking classes and home safety inspections.

Child Abuse and Neglect

Key Findings

n 2005, the Board reviewed and closed 42 (10.2% of 409) cases that were concluded by the Board to have been a result of child abuse and/or neglect. Nine (21.2% of the 42) had previous child welfare referrals, with two of these being confirmed. Currently, Oklahoma's child welfare workers and supervisors carry an active caseload that is two to three times greater than those recommended by the National Child Welfare League of America.

Recommendations

- Continued funding of the Oklahoma State Department of Health's primary and secondary prevention programs.
- Increase child abuse prevention services that serve families who do not qualify for the Children First's program, but have been considered to be high risk for abuse and/or neglect.
- 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.

Activities of the Board

Board activities during the 2005 review year included:

- Five inquiries to District Attorney's Offices regarding prosecution status on the alleged perpetrators.
- Requested one District Attorney's Office review a case for potential charges.
- Four letters to OKDHS/Child Welfare regarding sibling safety and/or placement of near death survivor(s).
- One letter to OKDHS/Child Welfare regarding Board's concern for high-risk family.
- One letter to OKDHS/Child Welfare requesting information regarding the services in which a family was involved.
- One letter to OKDHS regarding status of foster home.
- Seven letters to law enforcement agencies recommending a scene investigation be done on all child deaths and/or maintaining a written report when the agency does respond.
- Three letters to law enforcement inquiring if toxicology was drawn on driver's involved in fatalities.
- Four letters to law enforcement agencies recommending they add to their policies and procedures to contact the OKDHS/Child Welfare when conducting a scene investigation.
- Recommended one law enforcement agency open up an investigation into a child death.
- Commended two law enforcement agencies for the thoroughness of their scene investigation.
- Recommended three law enforcement agencies respond to Child Death Review Board requests.
- Advised one law enforcement agency that the Child Death Review Board did not agree with the findings of the Medical Examiner and requested an update on their investigation.
- Recommended one hospital include in its policies and procedures to notify the State Medical Examiner, law enforcement and OKDHS/Child Welfare of unattended deaths. (Hospital amended policies and procedures as a result of this recommendation.)
- Requested policies and procedures for "therapeutic misadventures" from one hospital.
- Four letters to the State Medical Examiner recommending manner and/or cause of death be amended.
- One letter to the State Medical Examiner recommending summary be amended.
- Two letters to physicians recommending they contact the State Medical Examiner for determining the manner and cause of death.
- One letter to a midwife requesting policies and procedures for prenatal care for clients.
- Entered into a Memorandum of Understanding with the Oklahoma State Health Department, Injury Prevention Services to provide the Oklahoma Violent Death Reporting System with child death data.
- Began collaboration with the Oklahoma State Health Department regarding safe sleep issues for infants.
- Collaborated with the Oklahoma Press Association on a poster containing Child Death Review Board contact information for distribution to newsrooms across Oklahoma.

Cases Closed in 2005

The Oklahoma Child Death Review Board and its four regional teams reviewed and closed 409 child fatality cases in calendar year 2005.
Four of the five manners* of death (Accident, Homicide, Suicide, and Unknown) are automatically reviewed by the Board. The remaining manner, Natural, is reviewed if it is a Sudden Infant Death Syndrome death or if it has been referred to the Board due to the fact that abuse and/or neglect is suspected as to have contributed to the death.

As always, please note that the year of review does not indicate the year of death. In other words, not all deaths that were reviewed in 2005, occurred in 2005.

Deaths Reviewed by the Board in 2005

Manner	Number	Percent
Accident	193	47.1%
Homicide	25	6.1%
Natural	101	24.7%
Suicide	23	5.6%
Unknown	67	16.4%

Accidents topped all manners of death, followed by deaths ruled Natural, and at third, were deaths ruled Unknown.

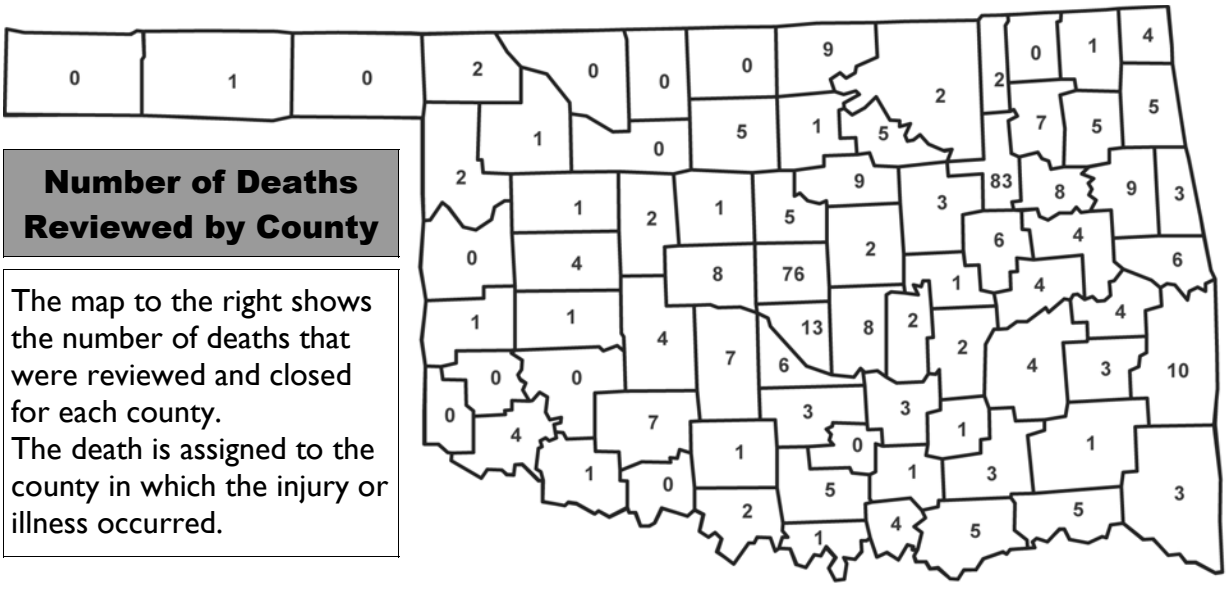
*Manner of death is determined by the Office of the Chief Medical Examiner.

Race and Gender of All Cases Reviewed

African-American			
	Male	29	
	Female	30	
	Total	59	14.4%
American Indian			
	Male	32	
	Female	17	
	Total	49	12.0%
Pacific Islander			
	Male	2	
	Female	2	
	Total	4	1.0%
White			
	Male	150	
	Female	103	
	Total	253	61.9%
Hispanic			
	Male	31	
	Female	6	
	Total	37	9.0%
Other			
	Male	5	
	Female	1	
	Total	6	1.5%
Unknown			
	Male	1	
	Female	0	
	Total	0	0.2%

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.



Government Involvement With Families

During the review process the Oklahoma Child Death Review Board collects information on state services applied for and/or being received by a family prior to the death of their child. The table below lists the state services the Oklahoma Child Death Review Board collects information on. **Please note that the information on this page concerns the families' involvement in state programs, the information on the next page concerns the deceased child's involvement in state programs.**

State aid had been applied for or was being provided to 322 (78.7%) of the families who lost a child reviewed by the Board in 2005. In over two-thirds (68.5%) of the cases closed by the Board in 2005, the family of the deceased had received TANF (Temporary Assistance for Needy Families) benefits from OKDHS at some point prior to the death event. In 185 of the cases (45.2%) the family had received TANF benefits within a year of the death.

The Oklahoma Department of Human Services - Child Welfare Services had prior contact with 147 (35.9%) of the families that lost a child whose death was reviewed in 2005. Fifty-three (13.0%) of the families had contact within a year of the death.

Four (1.0%) of the deaths reviewed by the Board were in foster care at the time of death. All four died of natural causes including one that died of Sudden Infant Death Syndrome (SIDS). OKDHS did confirm an allegation of neglect against the foster care provider in one case.

Number of Families Applying for or Receiving Services Prior to Death Incident

Government Program	Within 1 year of Death	Within 5 years of Death	Anytime Prior to the Death
TANF (Temporary Aid for Needy Families)	185	211	280
Child Welfare	53	95	147
Child Support	85	110	145
Medical	12	49	125
Food Stamps	2	28	101
Child Care	0	1	41
Emergency Assistance	0	0	30
Disability	16	17	29
Foster Care	4	4	4

Government Involvement with Cases

The Child Death Review Board is currently working with several state agencies to identify services provided to children prior to their deaths. Those agencies are outlined below and the number of cases with previous involvement is noted.

The Children First program, administered by the Oklahoma State Department of Health (OSDH), is a community-based voluntary family resource program that offers home visitation to families expecting to deliver and/or parent their first child. Five (1.2%) of the cases closed in 2005 had previous involvement with the Children First program, including two cases that were actively involved in the program at the time of death.

The purpose of the Oklahoma Department of Human Services Child Welfare Services (OKDHS-CW) is to identify, treat, and prevent child abuse and neglect and ensure that reasonable efforts are made to maintain and protect children in their own home and when this is not feasible, CW seeks to provide a placement that meets the child's needs and arrange an alternative permanent placement as appropriate. Ninety-one (22.2%) of the deaths reviewed in 2005 had a previous referral on the deceased child to the OKDHS-CW for abuse and/or neglect. In 39 of those cases, the referral was confirmed by OKDHS-CW.

The Oklahoma State Department of Mental Health and Substance Abuse Services (ODMHSAS) provides mental health care ranging from community-based treatment to acute inpatient care and supports prevention programs to reduce the occurrence of substance abuse, violence, and other harmful behaviors among young people. Twelve (2.9%) cases closed in 2005 had previous ODMHSAS services; three had received services within 90 days of death.

The Office of Child Abuse Prevention (OCAP), administered by the Oklahoma State Department of Health, provides community based family resource and support services along with training to professionals regarding how to identify and report child maltreatment in an effort to prevent child abuse. Three (0.7%) of the cases closed in 2005 had previous OCAP involvement, including two who were actively involved at the time of death.

The Office of Juvenile Affairs (OJA) is the state agency assigned to provide court intake, rehabilitation, probation and parole supervision to delinquent youth. OJA had previous involvement with 13 (3.2%) of the cases closed in 2005., including eight that were involved with OJA at the time of their death. Three of those eight were in OJA custody at the time of death.

Number of Decedents with Previous Involvement in Selected State Programs

Agency	Number	Percent
Children First	5	1.2%
OKDHS - CW	91	22.2%
ODMHSAS	12	2.9%
Office of Child Abuse Prevention	3	0.7%
Office of Juvenile Affairs	13	3.2%

Accidents

Accidents topped all manners of death reviewed at 193, representing almost one-half of all deaths at 47.1%. Of these, 115 (59.6%) involved motor vehicles. A breakdown of the motor vehicle deaths may be found on page 15. The second cause of accidental deaths was drowning (page 16) at 31, or 16.1%. Rounding out the top three accidental causes of death was accidental asphyxiation/suffocation at 12, or 6.2%. Of these 12 accidental asphyxiation/suffocation deaths, five (41.7% of the 12) were infants who were bed sharing with at least one other person at the time of death. Two (16.7% of the 12) choked on food, one (8.3%) accidentally asphyxiated while playing with a rope, one (8.3%) accidentally was strangled in bunk-bed railing, one (8.3%) choked on a balloon, one (8.3%) asphyxiated while playing in a sand-pit, and one (8.3%) asphyxiated after becoming pinned between the crib and an apparatus placed on top to contain the child.

Oklahoma made strides in 2005 in improving its trauma-care system, including upgrading the priority rating system for hospital designation and the addition of a specialized helicopter for Medi-Flight of Oklahoma, to be used primarily for critically ill children and pregnant women.

Race and Gender of Accident Victims

African-American		
Male	11	
Female	14	
Unknown	0	
Total	25	12.9%
American Indian		
Male	11	
Female	11	
Unknown	0	
Total	22	11.4%
Asian/Pacific Islander		
Male	1	
Female	1	
Unknown	0	
Total	2	1.0%
White		
Male	73	
Female	50	
Unknown	0	
Total	123	63.7%
Hispanic		
Male	16	
Female	4	
Unknown	0	
Total	20	10.4%
Other		
Male	0	
Female	1	
Unknown	0	
Total	1	0.5%
Unknown		
Male	0	
Female	0	
Unknown	0	
Total	0	0.0%

Gender of Accident Victims

Male	112	58.0%
Female	81	42.0%
Unknown	0	0.0%
	193	100.0%

Type of Accidents Reviewed

Type	Number	Percent
Vehicular	115	59.6%
Drowning	31	16.1%
Asphyxia/ Suffocation	12	6.2%
Poisoning/Overdose	11	5.7%
Fire Related	8	4.1%
Firearm Related	2	1.0%
Electrocution	2	1.0%
Other	13	6.7%

The number of accidents in the chart above adds up to 194 due to one death listed as both a vehicular and a drowning death.

Suicides

Twenty-three suicides were reviewed and closed in 2005, comprising 5.6% of all deaths. As shown in the table below, the mechanism most used was asphyxiation, in almost two-thirds (65.2%) of the cases. Three (13.0%) cases were seeing a counselor at the time of death. Four (17.4%) had a prior attempt.

Contributing factors included: conflict with parents in 10 (43.5%), substance use/abuse in five (21.7%), mental health issues in four (17.4%), boyfriend/girlfriend problems in three (13.0%), school problems in three (13.0%), "other" problems in six (26.1) (includes dysfunctional family, missing dog, father had committed suicide, friend had committed suicide, unconfirmed boy/girlfriend problems, and unconfirmed mental health issues), and none or unknown problems in seven (30.4%).

Race and Gender of Suicide Victims

African-American			
	Male	1	
	Female	0	
	Unknown	0	
	Total	1	4.3%
American Indian			
	Male	3	
	Female	0	
	Unknown	0	
	Total	3	13.0%
Asian/Pacific Islander			
	Male	0	
	Female	0	
	Unknown	0	
	Total	0	0.0%
White			
	Male	10	
	Female	7	
	Unknown	0	
	Total	17	73.9%
Hispanic			
	Male	2	
	Female	0	
	Unknown	0	
	Total	2	8.7%
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	16	69.6%
Female	7	30.4%
Unknown	0	0.0%
	23	100%

Method of Suicide

Method	Number	Percent
Asphyxia	15	65.2%
Firearm	6	26.1%
Poisoning/ Overdose	2	8.7%

The Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services granted the Oklahoma Department of Mental Health and Substance Abuse Services $400,000 in 2005 for state-sponsored youth suicide prevention and early intervention programs. The state will receive this amount annually for three years.

One study published in 2005 indicated that simply asking a teenager about suicide did not make the teen more likely to contemplate or commit suicide, as has been feared among families and professionals alike. Authors speculated that bringing the subject up with a teenager may alleviate feelings of isolation the teen may be experiencing.

Homicides

Twenty-five homicide cases were reviewed and closed in 2005. This represents 6.1% of the total cases reviewed and closed in 2005. Homicide by firearm was the top mechanism at 10 cases, or 40.0%. Juveniles were identified as the perpetrator in six of the cases.

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 state statute.

Gender of Homicide of Victims

Male	18	72.0%
Female	7	28.0%
Unknown	0	0.0%
		100%

Race and Gender of Homicide Victims

African-American		
Male	5	
Female	3	
Unknown	0	
Total	8	32.0%
American Indian		
Male	1	
Female	0	
Unknown	0	
Total	1	4.0%
Asian/Pacific Islander		
Male	1	
Female	0	
Unknown	0	
Total	1	4.0%
White		
Male	9	
Female	3	
Unknown	0	
Total	12	48.0%
Hispanic		
Male	2	
Female	1	
Unknown	0	
Total	3	12.0%
Other		
Male	0	
Female	0	
Unknown	0	
Total	0	0.0%
Unknown		
Male	1	
Female	0	
Unknown	0	
Total	1	4.0%

Prosecutorial Information

In these 25 homicide cases, 24 suspects were identified. Fifteen of the suspects were convicted or pled guilty to a felony. Ten of these received either a life sentence or life without parole.

Four suspects are awaiting trial, one was found not guilty and one had charges dismissed. Three suspects were under 18 and no court information is available.

In three cases charges were not filed. In one of the cases the perpetrator committed suicide, in another case a suspect was never identified. The last case had many complicating factors.

Cause of Death in Homicide Cases

Cause of Death	Number	Percent
Firearm Related	10	40.0%
Struck/Shaken	8	32.0%
Cut/Stabbed	2	8.0%
Suffocation	1	4.0%
Poisoned	1	4.0%
Pushed into an Object	1	4.0%
Shot and Stabbed	1	4.0%
Pre-Natal Drug Exposure	1	4.0%

Perpetrators Identified

Perpetrator	Number
Other Juvenile	6
Biological Mother	4
Mother's Boyfriend	4
Biological Father	3
Adult Acquaintance	2
Father's Girlfriend	1
Babysitter	1
No Relationship	3
Unknown	1

Unknown

Of the 67 deaths reviewed where the Medical Examiner ruled the manner of death Unknown, 39 (58.2%) were found in unsafe sleeping environments that could have led to either accidental overlay or accidental asphyxiation. An additional four (6.0%) were infants found unresponsive in their own sleeping area with no indication from the scene investigation of either overlay or accidental asphyxiation.

Seven (10.4%) cases were considered suspicious. Of these seven, three were found with injuries including head trauma, one was found in fire debris with no soot found in mucosal passages nor any injuries to the body, one may have been purposely drowned by a biological parent, one the Medical Examiner was unable to tell if alive at birth, and one was found in a trash dumpster.

Three (4.5%) had prenatal drug exposure and died less than one day of age.

Two (3%) had siblings that had died either of SIDS or other unknown manner, with one of these being the third death to one mother.

Two (3%) had history of upper respiratory issues with recent hospitalizations.

Two (3%) were engaged in normal activity (wrestling with mother's boyfriend/ carrying groceries) when they became unresponsive.

One (1.5%) was a newborn delivered by a midwife whose parents' religion excluded seeking medical attention.

One (1.5%) died post surgical procedure.

One (1.5%) died either due to auto-erotic asphyxiation or purposeful asphyxiation.

One (1.5%) died of cardiac arrhythmia due to drug use that was either intentional or accidental.

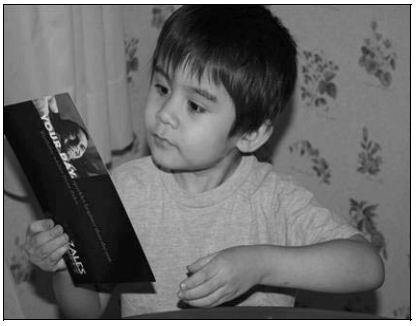
One (1.5%) had Down Syndrome and may have died due to cardiac malformation.

Race and Gender of Undetermined Victims

African-American		
Male	3	
Female	5	
Unknown	0	
Total	8	11.8%
American Indian		
Male	6	
Female	2	
Unknown	0	
Total	8	11.8%
Asian/Pacific Islander		
Male	0	
Female	1	
Unknown	0	
Total	1	1.5%
White		
Male	23	
Female	22	
Unknown	0	
Total	45	66.2%
Hispanic		
Male	4	
Female	1	
Unknown	0	
Total	5	7.4%
Other		
Male	0	
Female	1	
Unknown	0	
Total	1	1.5%
Unknown		
Male	0	
Female	0	
Unknown	0	
Total	0	0.0%

Gender of Undetermined Victims

Male	36	52.9%
Female	32	47.1%
Unknown	0	0.0%
	68	100%



Natural Deaths - Reviewed

There were 101 deaths reviewed and closed by the Board that were due to natural causes. These deaths represent 24.7% of the total deaths reviewed and closed in 2005. 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 14).

Forty (39.6%) of these deaths were due to Sudden Infant Death Syndrome (see page 18). Eighty (79.2%) were under the age of one, and 91(90.1%) were under the age of five.

Gender of Natural Victims

Male	65	64.0%
Female	36	36.0%
Unknown	0	0.0%
	101	100%

Race and Gender of Natural Victims

African-American		
Male	10	
Female	8	
Unknown	0	
Total	18	17.8%
American Indian		
Male	11	
Female	4	
Unknown	0	
Total	15	14.9%
Asian/Pacific Islander		
Male	1	
Female	0	
Unknown	0	
Total	1	1.0%
White		
Male	35	
Female	21	
Unknown	0	
Total	56	55.4%
Hispanic		
Male	7	
Female	0	
Unknown	0	
Total	7	6.9%
Other		
Male	1	
Female	3	
Unknown	0	
Total	4	4.0%
Unknown		
Male	0	
Female	0	
Unknown	0	
Total	0	0.0%

The chart below lists the types of natural deaths reviewed and closed by the Board in 2005. The "Other Conditions" category includes but is not limited to: gastroesophogeal reflux disease, inborn error of metabolism, colitis with sepsis, Joubert Syndrome, complications of siezure disorder, perforated ulcer, nemaline myopathy, myotonic dystrophy disorder, myocardial fibrosis, numerous infectious diseases, and numerous respiratory problems.

Illnesses and Diseases
Encountered in Natural Death Cases

Illness/Disease	Number	Percent
SIDS	40	39.6%
Pneumonia	13	12.9%
Cardiac Disease	5	5.0%
Cerebral Palsy	4	4.0%
Septicemia	3	3.0%
Other Conditions	26	25.7%
Unknown	10	9.9%

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.

These deaths are classified by the underlying condition that eventually led to the death of the child. The death certificate review process findings in 2005 are as follows:

Cause of Death or Medical Condition	Number of Death Certificates Received	Percent
Prematurity	166	46.4%
Congenital Disorder	84	23.5%
Infectious Disease	40	11.2%
Pulmonary Disorder	19	5.3%
Neurological Disorder	14	3.9%
Neoplasm	12	3.4%
Cardiac Disease	9	2.5%
Gastrointestinal Disorder	6	1.7%
Metabolic Disorder	4	1.1%
Diabetes	1	0.3%
Not Specified/Unclear	3	0.8%
TOTAL	358	100.0%

Vehicle Related Deaths

The Board reviewed and closed 115 vehicle related deaths in 2005. This represents 28.1% of all deaths and 59.6% of the accidental deaths.

Gender	Number	Percent
Male	64	55.7%
Female	51	44.3%

More improvements to legislation designed to decrease the number of vehicle related child fatalities were made in 2005 including: passage of Senate Bill 799, which raised the fine for violations of the state child restraint law and earmarked funding from the fines for child passenger safety education, as well as the passage of House Bill 1653, which imposes new restrictions on teenage driving. These restrictions include the prohibition of a teen driving with multiple passengers younger than 21 (other than family). If there is more than one passenger, there must be a licensed driver age 21 or older in the front seat or the passengers must be family. Additionally, teens are not allowed to drive between the hours of 11 p.m. and 5 a. m. except for driving to work, school, church, or if a licensed driver over 21 is seated next to the teen. The restrictions are removed after six months for teens who have had drivers education and one year for those who have not.

Vehicle of Decedent

Vehicle	Number	Percent
Car/Van/ SUV	85	73.9%
ATV	7	6.1%
Commercial Vehicle	3	2.6%
Personal Water Craft	2	1.7%
Bicycle	2	1.7%
Aircraft	1	0.9%
Pedestrian	11	9.6%
Other	4	3.5%

Age of Driver of Decedent's Vehicle

Age	Number	Percent
<13	3	2.6%
13-15	6	5.2%
16	18	15.7%
17	16	13.9%
18	5	4.3%
19-21	8	7.0%
>21	42	36.5%
N/A	13	11.3%
Unknown	4	3.5%

Use of Seatbelts and Car Seats by Victims

Seatbelt/Car seat Use	Number	Percent
Properly Restrained	29	25.2%
Not Properly Restrained	54	47.0%
Unknown	9	7.8%
Not Applicable	23	20.0%

Activity of Decedent

Position	Number	Percent
Operator	28	24.3%
Front Passenger	33	28.7%
Rear Passenger	37	32.2%
Pedestrian/Bicycle	13	11.3%
Unknown	4	3.5%

Drownings

Thirty-one (16.1%) of the 193 accidental deaths were attributed to drowning. Of these 31, only three (9.7%) were noted to have safeguards in place. Safeguards included appropriate adult supervision, wearing a life jacket, and perimeter fencing.

Gender	Number	Percent
Male	17	54.8%
Female	14	45.2%

Of the 15 occurring in a natural body of water, eight (53.3% of 15) were lakes, four (26.7%) were ponds, one (6.7%) was a river, and one (6.7%) was a creek.

Almost half of the drowning cases were under the age of three (15 or 48.4%). Eight (25.5%) were age five through 12 and another eight (25.5%) were age 13 or older.

Location of Drowning

Location	Number	Percent
Natural Body of Water (i.e. creek, river, pond, lake)	15	48.4%
Private, Residential Pool	7	22.6%
Bathtub	3	9.7%
Hot Tub	1	3.2%
Hotel Pool	1	3.2%
Apartment Pool	1	3.2%
Wading Pool	1	3.2%
Bucket	1	3.2%
Municipal Sewage Lagoon	1	3.2%

Despite the continuance of the Brittany Project of Safe Kids Oklahoma, many children are still observed to be swimming without life jackets. The Brittany Project is a life jacket loaner program that offers free use of children's life jackets at most lakes operated by the Oklahoma Department of Tourism, all Oklahoma lakes operated by the U.S. Army Corps of Engineers, and Quartz Mountain Nature Park.

Two cases in 2005 prompted a warning from officials regarding playing on frozen ponds, with a fire captain advising that there was no such thing as "safe" ice in Oklahoma.

If you do fall in:

- **Do not panic**
- **Hold onto the edge of the opening**
- **Pull up while kicking hard**
- **Once on top of the ice, roll to safe ground. Standing up concentrates weight in one small area, providing the opportunity to fall back through again.**

Firearm Related Deaths

Twenty deaths were reviewed and closed in 2005 that involved firearms. This represents 4.9% of the total number of deaths reviewed and closed in 2005. The majority of these were used in homicides (11 or 55.5%), as seen in the table below. For the one undetermined case, law enforcement as well as the Medical Examiner were unable to discern if the shooting occurred intentionally or unintentionally. Additionally, they were unable to determine if the wound was self-inflicted or inflicted by another.

The activity of the shooter is as follows: Six (30.0%) were purposefully committing suicide, five (25.0%) were noted as "other", three (15.0%) were victims of drive-by shootings, another three (15.0%) were unknown as to their activity, one (5.0%) was playing with a gun, one (5.0%) was accidentally shot when someone else was playing with a gun, and one (5.0%) was a victim of domestic violence.

Free gun safety kits, including gun locks, were given away in another statewide distribution program as a part of the National Project Childsafe, which originated in Oklahoma in 2000. The program is now funded by the U. S. Department of Justice and administered by the National Shooting Sports Foundation. Project Childsafe trucks traveled across the state with local retailers and city and county law enforcement agencies assisting in the distribution.

The Midwest City Police Department began a new program in 2005 in conjunction with the U. S. Bureau of Alcohol, Tobacco, and Firearms that allows them to electronically trace firearms and receive information in a more timely manner.

Gender of Firearm Victims

Gender	Number	Percent
Male	16	80.0%
Female	4	20.0%

Manner of Death for Firearm Victims

Manner	Number	Percent
Accident	2	10.0%
Homicide	11	55.0%
Suicide	6	30.0%
Undetermined	1	5.0%

Type of Firearm Used

Type of Firearm	Number	Percent
Handgun	8	40.0%
Rifle	4	20.0%
Shotgun	4	20.0%
Unknown	4	20.0%

Sudden Infant Death Syndrome (SIDS)

There were a total of 40 Sudden Infant Death Syndrome (SIDS) cases reviewed and closed in 2005. This represents 9.8% of the total number of deaths reviewed.

Less than half of these infants were sleeping alone, 18 or 45%. Less than half, 12 or 30%, were placed face-up to sleep despite the fact that the American Academy of Pediatrics has recommended for over 10 years that infants sleep alone and on their backs. In fact, the National Institute of Child Health and Human Development reported that in a survey, one-fifth of parents with an infant up to eight months of age reported their baby usually shared a bed with them. This was more than triple the percent ten years ago.

In September 2005, Dr. Mary Overpeck and other contributors reported the findings of a survey of 12 Child Death Review Teams (Oklahoma did not participate). The purpose of the survey was to determine the need for a national crib campaign. A total of 6,359 cases were reviewed by these 12 teams, with approximately 1/3 of these considered to be sleep-related deaths. Due to the nature of differing data collection of these teams, not all teams were able to answer all of the survey questions. Some of the findings included: 9 states (for a total of 1501 sleep-related deaths) reported that 23% of the sleep-related deaths occurred when children were sleeping in their own crib/ bassinette. Six states (for a total of 625 sleep-related deaths) reported that 75% were sleeping with at least one other person. The researchers were unable to determine: how often cribs were available but not used; reasons available cribs were not used; locations of deaths when cribs were not available; and whether the infant was either placed and/or found in prone (face-down) position in a crib.

Gender	Number	Percent
Male	28	70.0%
Female	12	30.0%

Age of Infant

Age (in months)	Number	Percent
Less than 2	15	37.5%
2—6	24	60.0%
More than 6	1	2.5%

Sleeping Position of Infant

Position	Number	Percent
On Stomach	6	15.0%
On Back	12	30.0%
On Side	8	20.0%
Other	0	0.0%
Unknown	14	35.0%

Sleeping Arrangement of Infant

Sleeping Arrangement	Number	Percent
Alone	18	45.0%
With Adult	18	45.0%
With Sibling	2	5.0%
Unknown	2	5.0%

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

Fire Related Deaths

Nine fire deaths were reviewed and closed by the Board in 2005. One fire resulted in three (33.3%) fatalities.

The activities of the fire starters included: one (11.1%) cooking and one (11.1%) playing with an ignition source. Only one (11.1%) was not applicable, as the fire started with a wood burning stove while the family slept. For the remaining cases, it is either unknown (3 or 33.3%) or noted to be "other" (3 or 33.3%). For the three cases with "other", there were smoldering cigarette butts in a trashcan, but it is unknown if the intention was to set a fire.

Gender of Fire Death Victims

Gender	Number	Percent
Male	5	55.6%
Female	4	44.4%

Age at Time of Death

Age	Number	Percent
< 5	6	66.7%
5-10	2	22.2%
> 10	1	11.1%

Age of Person Starting Fire

Age	Number	Percent
< 5	1	11.1%
5-12	1	11.1%
13-18	0	0.0%
Over 18	4	44.4%
Unknown	3	33.3%

Working Smoke Detector Present

Detector	Number	Percent
Yes	3	33.3%
No	3	33.3%
Unknown	3	33.3%

Fire Prevention Week was October 9-15 and many Oklahoma communities participated in some form. Two Oklahoma City Batteries Plus stores gave away safety equipment that included 9-volt batteries, smoke detectors, identification kits, and gun locks.
Edmond Fire Department hosted local events that included fire safety, as well as bicycle safety and other injury prevention topics.
Nationally, the theme for the Fire Prevention Association was candle safety, as candle fires have seen an increase nationally over the past 10 years.

Also in 2005, the National Fire Protection Agency advised that changing smoke alarm batteries may not be enough, as many alarms are older than the recommended replacement time period. They recommend replacing smoke alarms every 10 years.

Abuse/Neglect Deaths

The Oklahoma Child Death Review Board found that 42 of the deaths were related to abuse or neglect. Nearly half (45.2%) of these deaths were ruled accidental by the medical examiner.

Gender of Abuse/Neglect Victims

Gender	Number	Percent
Male	26	61.9%
Female	16	38.1%

Twenty-eight (66.7%) of these cases were confirmed by the Oklahoma Department of Human Services as abuse and/or neglect. Of the 14 cases determined by the Oklahoma Child Death Review Board to be related to abuse or neglect but not confirmed as abuse and/or neglect by OKDHS, nine were not investigated by OKDHS due to not meeting the criteria set forth by OKDHS to initiate an investigation. The nine not investigated included six traffic accidents where children were not properly secured, one traffic accident where the parent/driver was under the influence, one illegal abortion, and one drug-related stillbirth. The remaining five cases were investigated by OKDHS and abuse or neglect was **not** confirmed. Their findings included: two ruled "services recommended", two ruled "services not needed", and one ruled "failure to cooperate".

Nearly all of the victims (38 of the 42 or 90.5%) were under six-years-old. Twenty-seven (64.3%) of the deaths occurred to victims under the age of two-years-old.

Manner of Death for Abuse/Neglect Victims

Manner	Number	Percent
Accident	19	45.2%
Homicide	11	26.2%
Undetermined	8	19.0%
Natural	4	9.5%

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

Individuals Arrested for Child's Death

Perpetrator	Number	Percent
Biological Mother & Biological Father	4	9.5%
Biological Mother's Boyfriend	3	7.1%
Biological Mother	2	4.8%
Biological Father	2	4.8%
Biological Mother & Mother's Boyfriend	1	2.4%
Biological Father's Girlfriend	1	2.4%
Step-Brother	1	2.4%
Grandmother	1	2.4%
Driver of Vehicle	1	2.4%
No Arrest Made	26	61.9%

Age of Decedents by Race

Age of African-American Decedents

Age	Number	Percent
<1	22	37.9%
1	4	6.9%
2	3	5.2%
3	0	0.0%
4	2	3.4%
5	5	8.6%
6	1	1.7%
7	1	1.7%
8	2	3.4%
9	0	0.0%
10	2	3.4%
11	1	1.7%
12	3	5.2%
13	2	3.4%
14	0	0.0%
15	3	5.2%
16	5	8.6%
17	2	3.4%
Total	58	100.0%

Age of American Indian Decedents

Age	Number	Percent
<1	21	42.9%
1	3	6.1%
2	1	2.0%
3	3	6.1%
4	2	4.1%
5	1	4.1%
6	0	0.0%
7	0	0.0%
8	2	4.1%
9	2	4.1%
10	0	0.0%
11	0	0.0%
12	0	0.0%
13	2	4.1%
14	0	0.0%
15	2	4.1%
16	7	14.3%
17	3	6.1%
Total	49	100.0%

Age of White Decedents

Age	Number	Percent
<1	91	36.3%
1	22	8.8%
2	6	2.4%
3	7	2.8%
4	4	1.6%
5	6	2.4%
6	4	1.6%
7	4	1.6%
8	3	1.2%
9	1	0.4%
10	2	0.8%
11	5	2.0%
12	9	3.6%
13	4	1.6%
14	13	5.2%
15	21	8.4%
16	30	12.0%
17	19	7.6%
Total	251	100.0%

Age of Hispanic Decedents

Age	Number
<1	15
1	2
2	2
4	1
6	1
9	1
12	1
13	2
14	3
15	2
16	5
17	2
Total	37

Age of Other Decedents

Age	Number
<1	4
1	1
4	1
Total	6

Age of Unknown Race Decedents

Age	Number
<1	1

Age of Asian Decedents

Age	Number
<1	2
7	1
8	1
Total	4

Age of Decedents by Manner

Age of All Decedents

Age	Number	Percent
<1	157	38.4%
1	32	7.8%
2	13	3.2%
3	10	2.4%
4	10	2.4%
5	12	2.9%
6	6	1.5%
7	6	1.5%
8	8	2.0%
9	4	1.0%
10	4	1.0%
11	6	1.5%
12	13	3.2%
13	11	2.7%
14	16	3.9%
15	28	6.8%
16	47	11.5%
17	26	6.4%
Total	409	100.0%

Age of Accident Decedents

Age	Number	Percent
<1	14	7.3%
1	18	9.3%
2	10	5.2%
3	7	3.6%
4	9	4.7%
5	9	4.7%
6	6	3.1%
7	4	2.1%
8	7	3.6%
9	3	1.6%
10	4	2.1%
11	4	2.1%
12	10	5.2%
13	6	3.2%
14	6	3.2%
15	20	10.4%
16	36	18.7%
17	20	10.4%
Total	193	100.0%

Age of Natural Decedents

Age	Number	Percent
<1	80	80.0%
1	6	6.0%
2	1	1.0%
3	3	3.0%
4	0	0.0%
5	1	1.0%
6	0	0.0%
7	2	2.0%
8	1	1.0%
9	0	0.0%
10	0	0.0%
11	1	1.0%
12	2	2.0%
13	0	0.0%
14	1	1.0%
15	1	1.0%
16	1	1.0%
17	0	0.0%
Total	101	100.0%

Age of Decedents by Manner (cont.)

Age of Homicide Decedents

Age	Number	Percent
<1	4	16.0%
1	6	24.0%
2	2	8.0%
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	4.0%
10	0	0.0%
11	0	0.0%
12	0	0.0%
13	1	4.0%
14	3	12.0%
15	1	4.0%
16	4	16.0%
17	3	12.0%
Total	25	100.0%

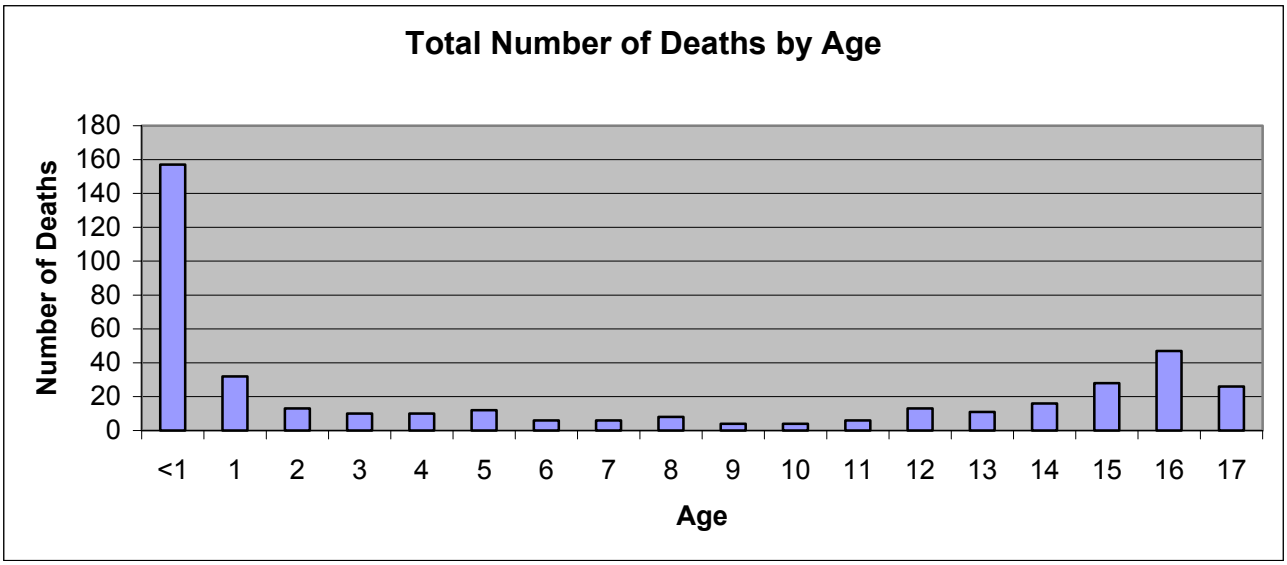
Age of Suicide Decedents

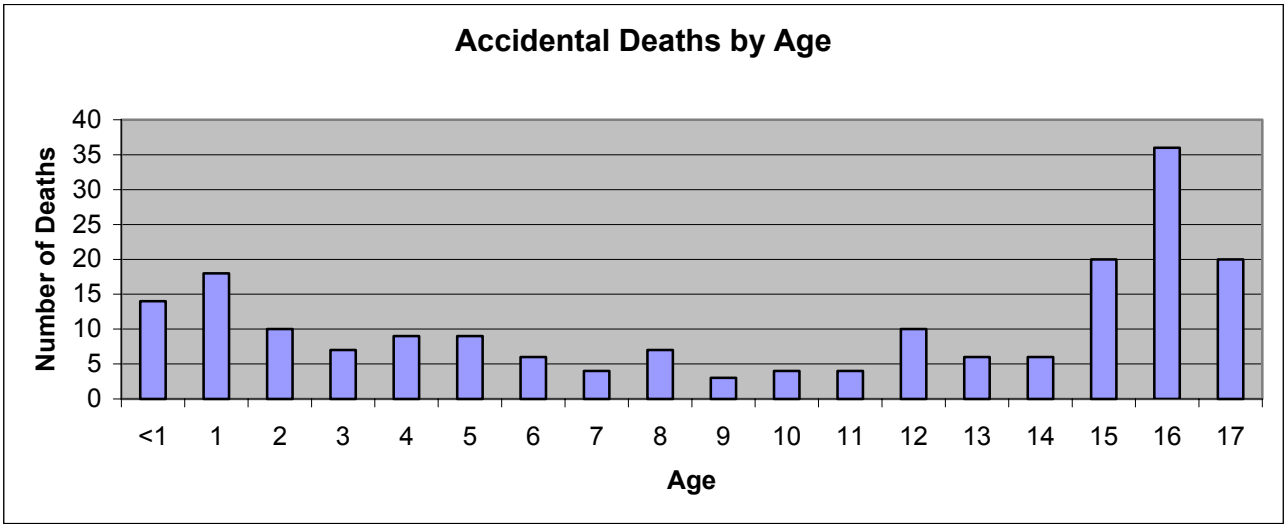
Age	Number	Percent
<1	0	0.0%
1	0	0.0%
2	0	0.0%
3	0	0.0%
4	0	0.0%
5	0	0.0%
6	0	0.0%
7	0	0.0%
8	0	0.0%
9	0	0.0%
10	0	0.0%
11	0	0.0%
12	1	4.3%
13	4	17.4%
14	5	21.7%
15	6	26.1%
16	4	17.4%
17	3	13.0%
Total	23	100.0%

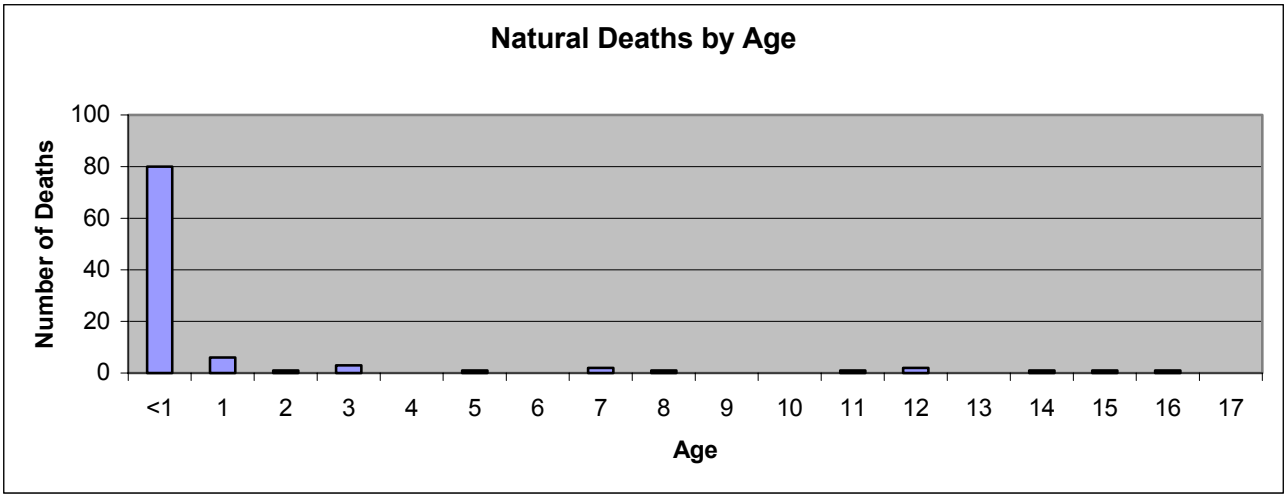
Age of Undetermined Decedents

Age	Number	Percent
<1	59	88.1%
1	2	3.0%
2	0	0.0%
3	0	0.0%
4	1	1.5%
5	2	3.0%
6	0	0.0%
7	0	0.0%
8	0	0.0%
9	0	0.0%
10	0	0.0%
11	1	1.5%
12	0	0.0%
13	0	0.0%
14	1	1.5%
15	0	0.0%
16	2	3.0%
17	0	0.0%
Total	67	100.0%

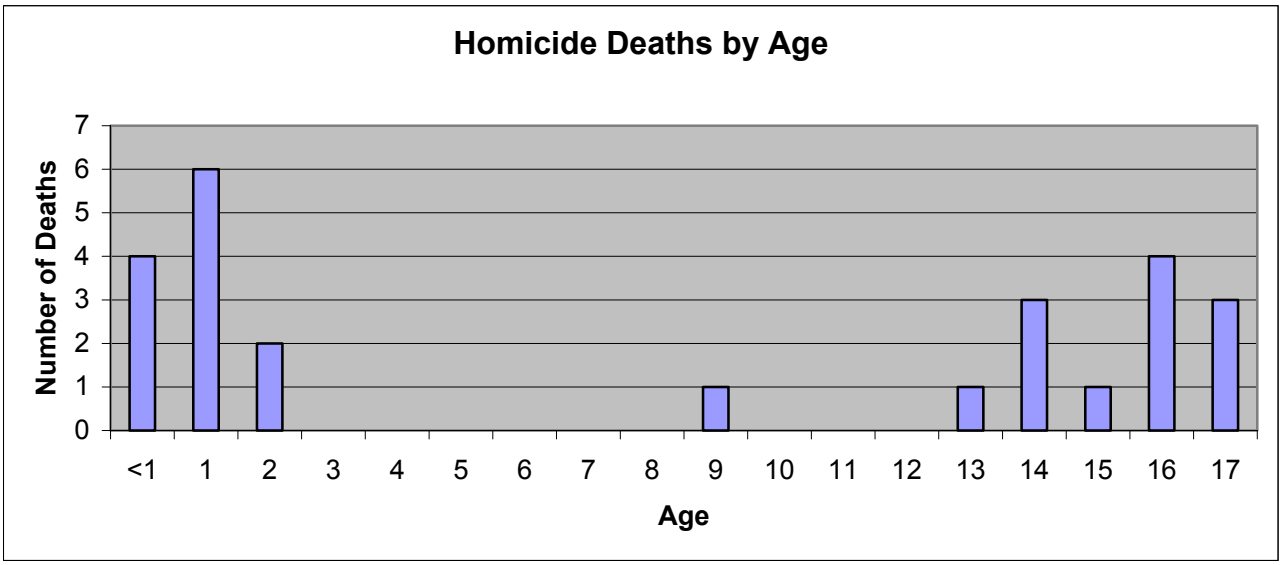
Age of Decedents by Manner

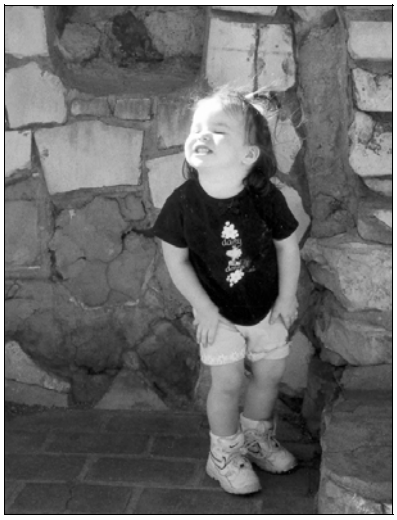


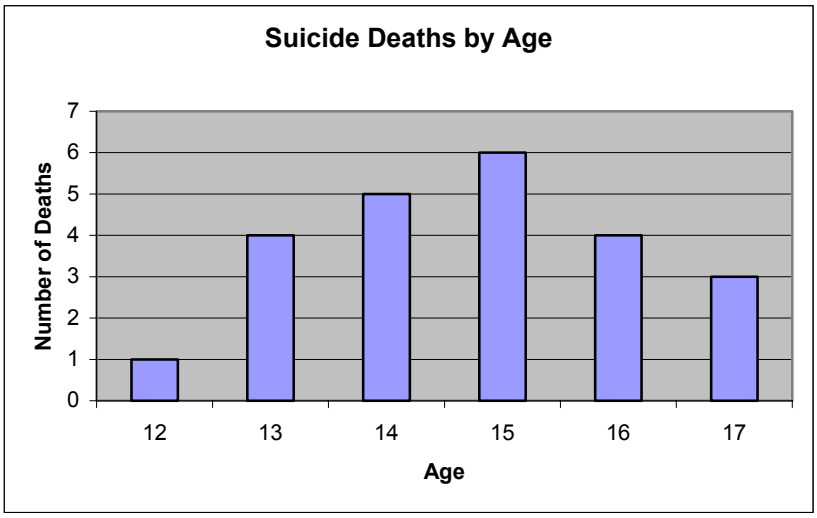


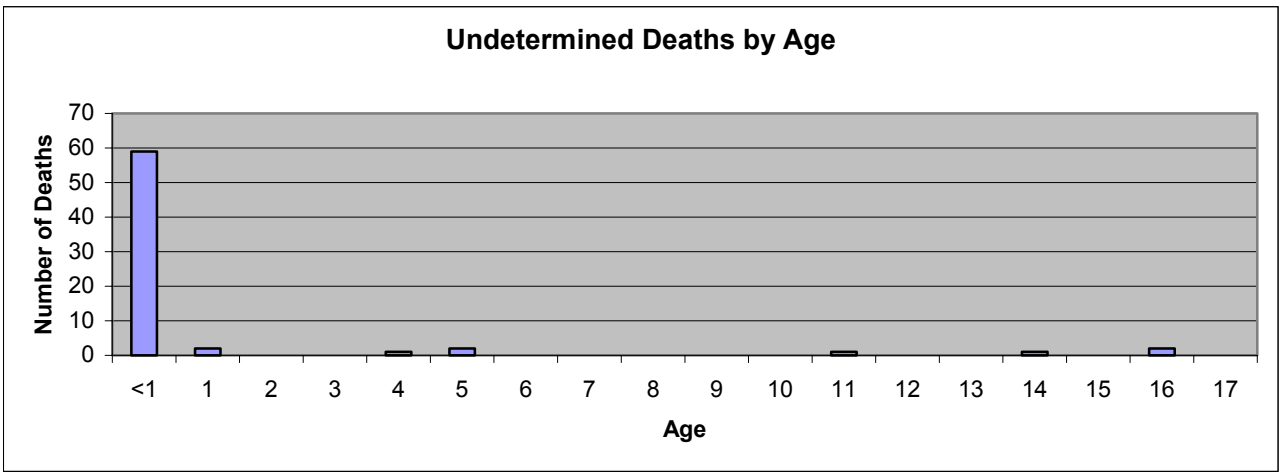


Age of Decedents by Manner

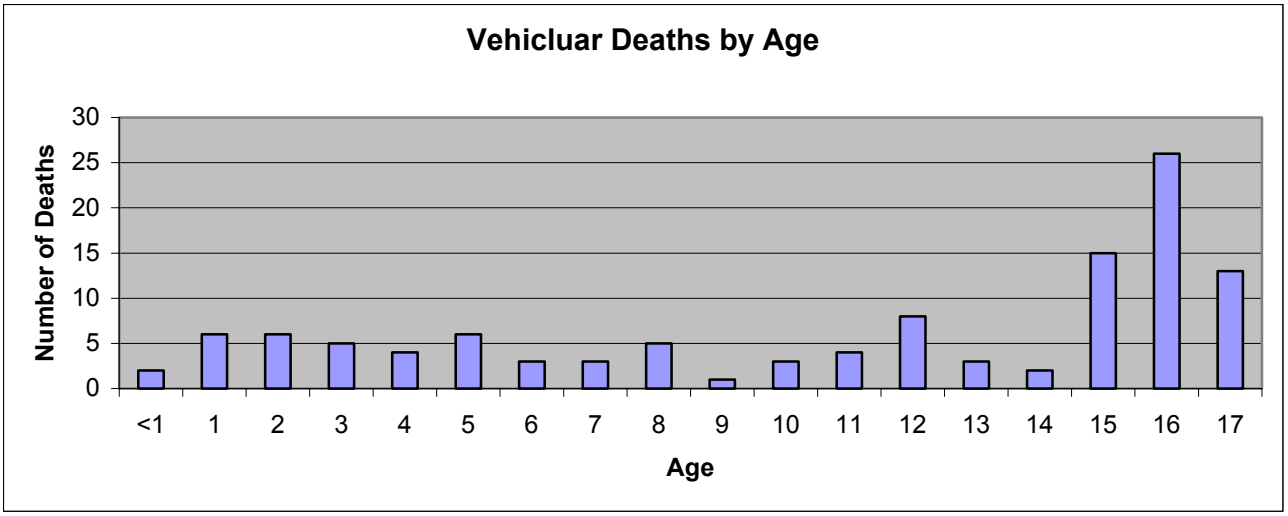


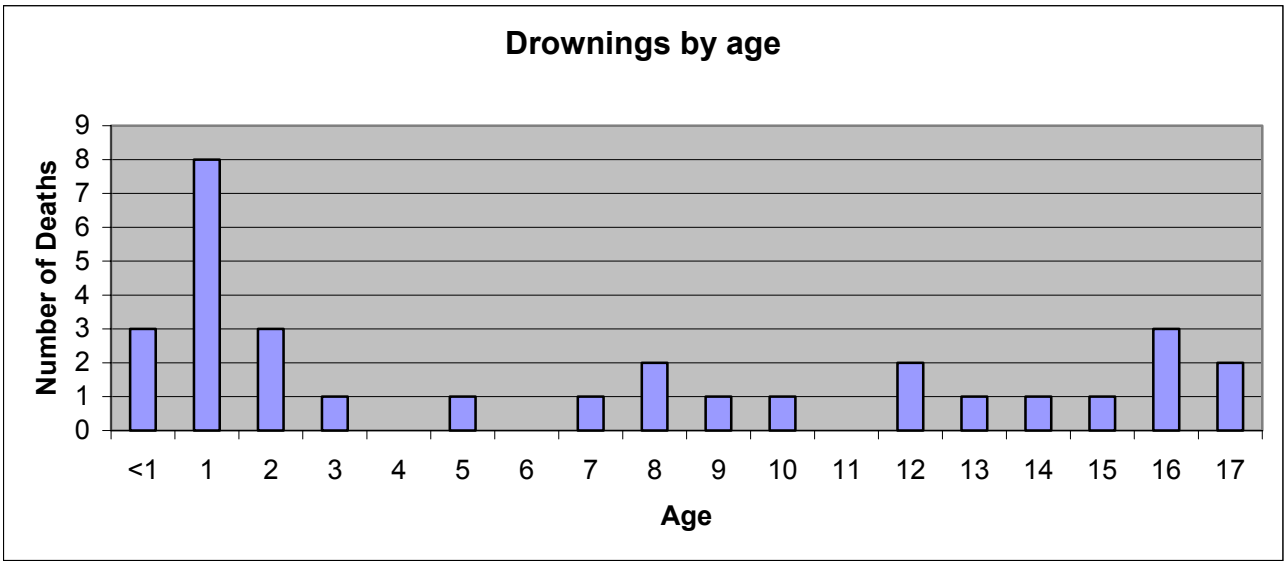


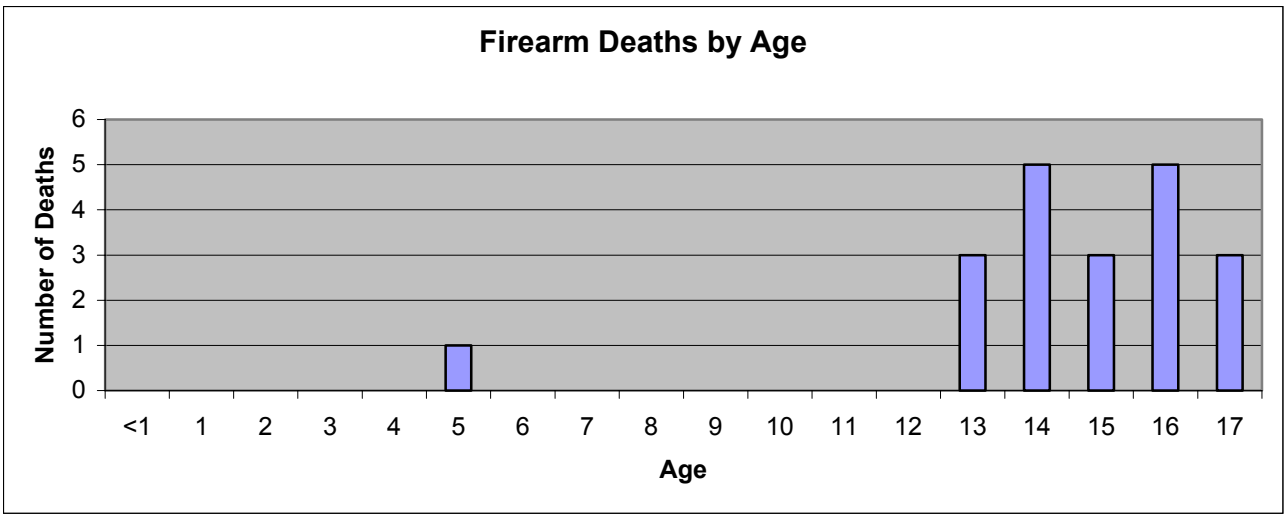




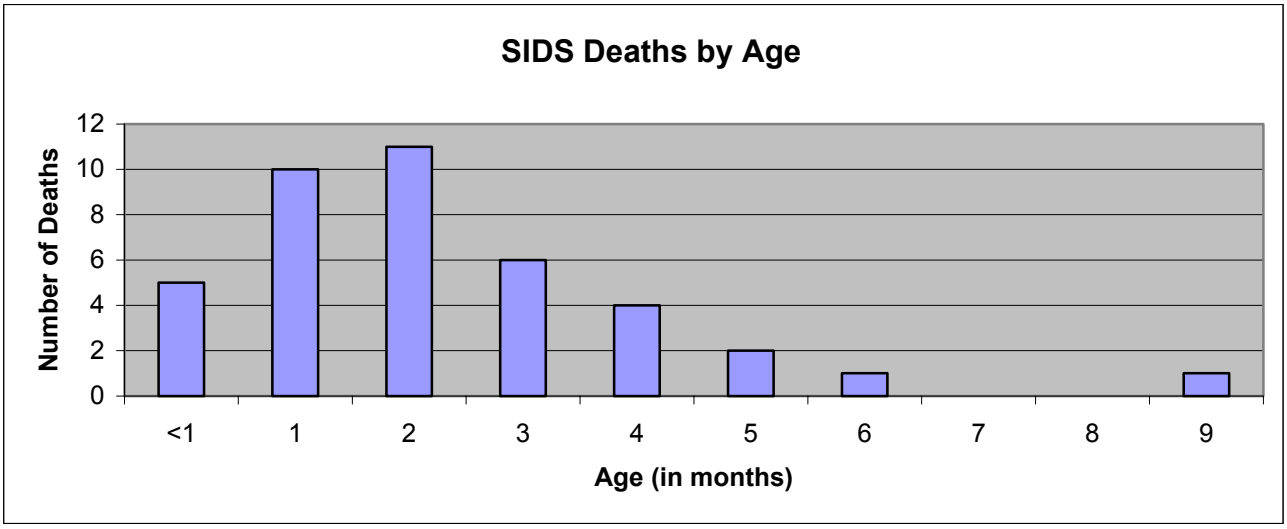
Age of Decedents by Selected Causes

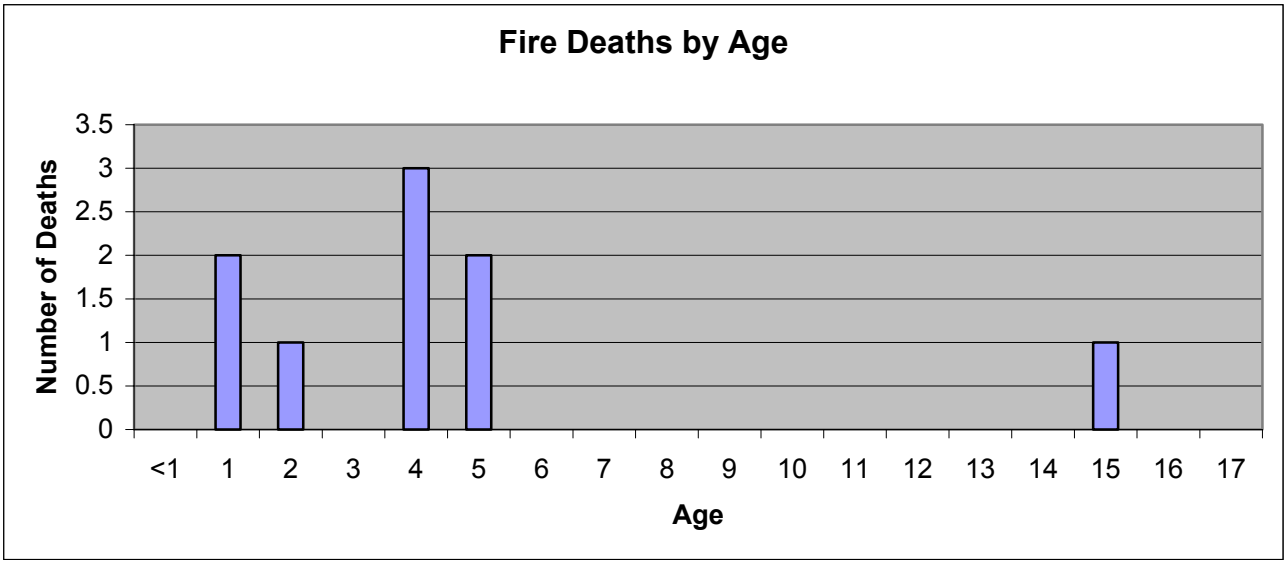


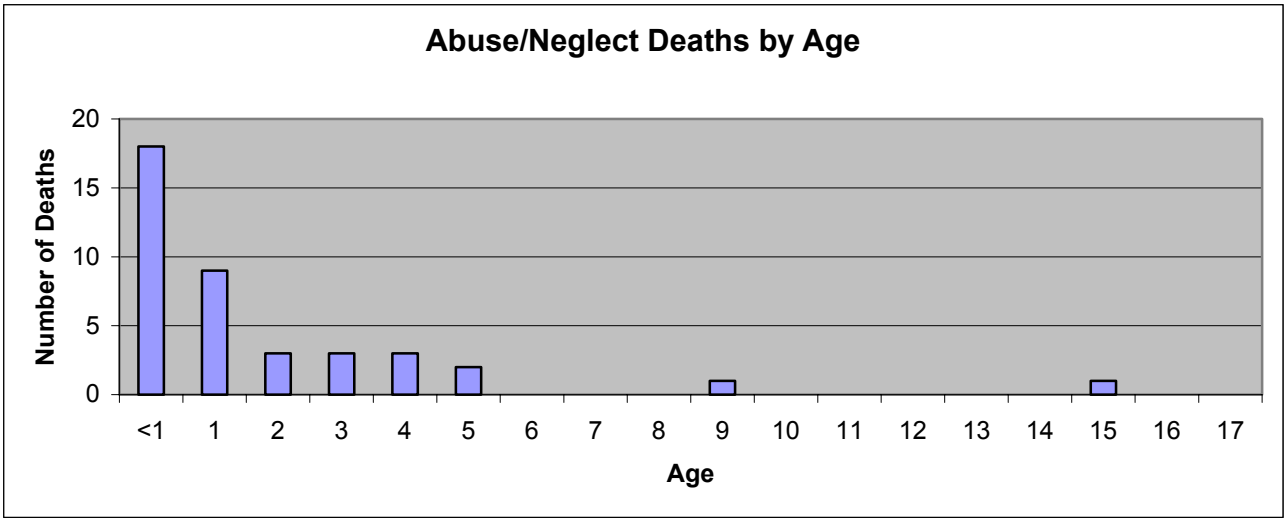




Age of Decedents by Selected Causes





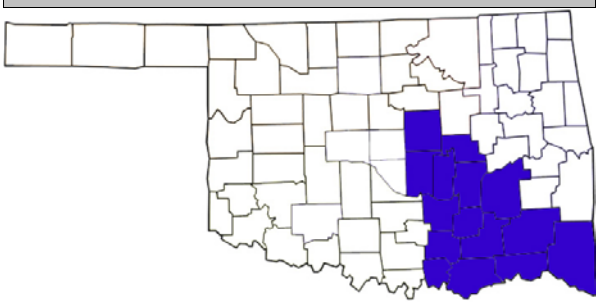


Regional Review Teams

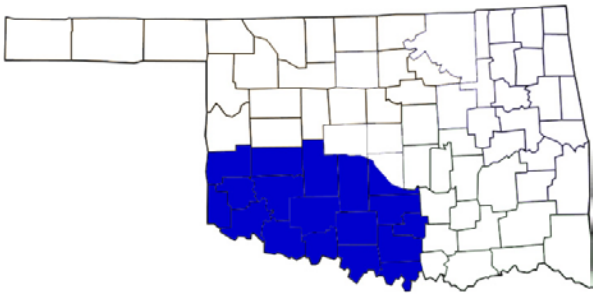
Calendar year 2005 marked the first full year of review by the four regional teams that had expanded in the latter half of 2004. Combined, the teams reviewed 177 (43.3%) of the 409 cases reviewed and closed in 2005. There are plans to expand the number of regional teams to five, to include a team for the northwestern quadrant of the state. Currently the state board reviews the deaths that occur in those counties.

Counties of the Eastern Oklahoma Regional Child Death Review Team

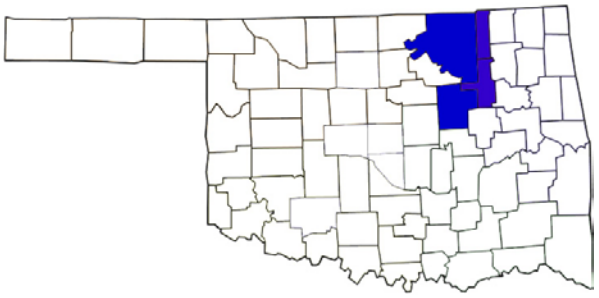
Counties of the Southeastern Oklahoma Regional Child Death Review Team



Counties of the Southwestern Oklahoma Regional Child Death Review Team



Counties of the Tulsa Regional Child Death Review Team



Eastern Review Team

The Eastern Oklahoma Regional Review Team closed 47 cases in 2005. Twenty-nine of the deaths were traffic related. Four of the accidental deaths were the result of drowning. Two were crushed under objects, one child asphyxiated and one child was struck by lightening.

Manner of Death for Eastern Oklahoma Victims

Manner	Number	Percent
Accident	38	80.9%
Homicide	0	0.0%
Natural	6	12.8%
Suicide	0	0.0%
Undetermined	3	6.4%

Gender of Eastern Oklahoma Victims

Gender	Number	Percent
Male	29	61.7%
Female	18	38.3%

Three of the natural deaths were due to SIDS. One of the deaths was due to pneumonia, one was due to complications of cerebral palsy and one was due to myotonic dystrophy disorder.

Eastern Oklahoma 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
Kids Space	Betty Martin	Kimberly Sharp, Walter Davis
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 Regional Hospital (ER)	Sheila Villines	
Muskogee County Health Department	Carol Weigel	
Muskogee Public Schools	Debbie Winburn	

Southeastern Review Team

The Southeastern Oklahoma Regional Review Team closed 31 cases in 2005. Of the nineteen deaths ruled accident by the medical examiner, 14 were traffic related. Two were accidental asphyxiation deaths, one was an overdose, one child died in a fire and one was electrocuted. This group includes eight children under the age of five; seven cases between the age of five and 15 years old, and four cases 16 years of age or older.

Gender of Southeastern Oklahoma Victims

Gender	Number	Percent
Male	20	64.5%
Female	11	35.5%

Of the six undetermined deaths, five occurred under unsafe sleeping conditions including two placed to sleep face down, two positional asphyxias and one possible overlay. The remaining undetermined case was an infant exposed to illegal drugs in utero.

Manner of Death for Southeastern Oklahoma Victims

Manner	Number	Percent
Accident	19	61.3%
Homicide	1	3.2%
Natural	3	9.7%
Suicide	2	6.5%
Undetermined	6	19.4%

Both of the suicidal deaths were due to hanging. All of the natural deaths were ruled SIDS by the medical examiner.

The one homicide case was an infant shaken by his biological father. The father was tried and convicted for the death.

Southeastern Oklahoma 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	Aubree Holsapple
Medical Representative	Kelly Neher	Joye Byrum
State CDRB Representative	Carolyn Parks	
Pottawatomie County Health Department	Liz Petrin	
District Attorney's Office	Richard Smotherman, JD	Melissa Estes, JD

Southwestern Review Team

The Southwestern Oklahoma Regional Review Team reviewed and closed 16 deaths in 2005.

Gender of Southwestern Oklahoma Victims

Gender	Number	Percent
Male	8	50.0%
Female	8	50.0%

As was the case with all of the teams, accidents accounted for a majority of the deaths reviewed. Six of the accidents were traffic related. Two of the accidental deaths were due to drowning and one child was crushed during rodeo practice. These deaths ranged in age from eight months to 17 years old and included five girls and four boys.

The four undetermined deaths were all infants in unsafe sleeping conditions. Two were placed to sleep face down and two were possible overlay deaths. There were two boys and two girls.

Manner of Death for Southwestern Oklahoma Victims

Manner	Number	Percent
Accident	9	56.3%
Homicide	0	0.0%
Natural	2	12.5%
Suicide	1	6.3%
Undetermined	4	25.0%

The suicide was a 13 year-old boy who used a firearm.

Southwestern Oklahoma Child Death Review Team Members

Organization	Team Member	Designee
Law Enforcement Representative	Det. Chris Perkins; Chair	Det. Doug Mabry, Det. Mike Turner
Mental Health Representative	Eileen McGee; Vice-Chair	Melanie Smith
Medical Representative	Pilar Escobar, MD	
Medical Examiner's Office	Bryan Louch	
CASA Representative	Nadine McIntosh	
Oklahoma Department of Human Services	Belinda Maldonado	Stephanie Turner
Office of Juvenile Affairs	Johnny Moats	
Safe Kids Coalition	Barbara Newton	
Jackson County District Attorney's Office	John Wampler, JD	

Tulsa Regional Review Team

The Tulsa Regional Child Death Review Board reviewed and closed 83 cases in 2005. Although the other regional teams meet once per quarter, the Tulsa regional team meets every other month due to the higher number of deaths that occur in this region.

Gender of Tulsa Region Victims

Gender	Number	Percent
Male	48	57.8%
Female	35	42.2%

Of the 31 accidental deaths, 15 were traffic related. Five of the deaths were the result of overdoses, four were the result of drowning, two children died of suffocation/strangulation, one child died in a fire, one suffered a gunshot wound, one infant was left in a car, one child was crushed while moving a soccer goal and one infant died when the infant became stuck on a floor furnace. Seventeen of the accidental deaths were boys and 14 were girls. Twelve of the accidental deaths were under five years old; seven were between the ages of five and 15, and twelve were 16 years of age or older.

Manner of Death for Tulsa Region Victims

Manner	Number	Percent
Accident	31	37.3%
Homicide	8	9.6%
Natural	20	24.1%
Suicide	5	6.0%
Undetermined	19	22.9%

The undetermined deaths included ten boys and nine girls. Eight of the undetermined deaths were infants found dead in unsafe sleep conditions. Fourteen of the undetermined deaths were under a year of age.

Tulsa Regional Child Death Review Team Members

Organization	Team Member	Designee
Medical Representative	Deborah Lowen; Chair	
Tulsa County District Attorney's Office	Tim Harris, JD	Brandon Whitworth, JD; Vice-Chair
Law Enforcement Representative	Sgt. Whitney Allen	Det. Darren Carlock
Fire Department Representative	Steve Coldwell	
Washington County District Attorney's Office	Shelly Clements, JD	
Medical Examiner's Office	Ronald Distefano, DO	
Safe Kids Coalition	Mary Beth Ogle	
Oklahoma Department of Human Services	Nancy Robison	
Children's First Representative	Lori Sweeny	Sharon Konemann
Mental Health Representative	Jamie Vogt	

Tulsa Regional Review Team

There were 12 boys and eight girls who died of natural causes. Nineteen of the twenty deaths were under five years old. The remaining natural death was a 16 year-old girl. SIDS accounted for seven of the natural deaths.

All but one of the suicide deaths used suffocation/strangulation as the means to end their life. The remaining suicide victim used a handgun. This group included four boys ranging in age from 12 to 17 and one 16 year-old girl.

Of the eight homicide victims five were boys and three were girls. Three were under five years old; the other five were 13 years of age or older. Five of the homicide victims were killed by firearms. The other three were either shaken or beaten. A list of perpetrators is included in the chart below.

Homicide Perpetrators in Tulsa Cases

Perpetrator	Number
Other Juvenile	2
Biological Mother	1
Biological Mother and Mother's Boyfriend	1
Mother's Boyfriend	1
Adult Acquaintance	1
No Relationship	1
Unknown	1

Near Death Cases Reviewed in 2005

The Oklahoma Child Death Review Board reviewed and closed 51 near death cases in 2005. 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 determined by a physician.

The Board reviewed and closed 51 near death cases in 2005. Twenty seven of the cases (52.9%) had prior Child Welfare involvement. In 20 of the cases the child had a prior Child Welfare referral. Ten of those were confirmed by OKDHS for abuse and/or neglect. In 23 of the cases a sibling of the child had a previous Child Welfare referral. Twelve of those cases were confirmed.

Gender of Near Death Cases

Gender	Number	Percent
Male	34	66.7%
Female	17	33.3%

Race of Near Death Cases

Race	Number	Percent
African-American	8	15.7%
American Indian	6	11.8%
Hispanic	2	3.9%
Hispanic/ American Indian	1	2.0%
White	33	64.7%
Unknown	1	2.0%

Abuse/Neglect Allegations Confirmed by OKDHS Against:

Perpetrator	Number
Not Confirmed	17
Both Biological Parents	13
Biological Mother	7
Biological Father	4
Daycare Worker	2
Foster Parent	2
Biological Mother and Step-Father	1
Biological Mother and Mother's Boyfriend	1
Biological Mother's Boyfriend	1
Biological Mother and Grandparent	1
Biological Mother, Grandmother and Grand-mother's Boyfriend	1
Step-Mother	1

Injuries in Near Death Cases

Injury	Number	Percent
Struck/Shaken	10	19.6%
Near Drowning	9	17.6%
Poisoning/ Overdose	8	15.7%
Vehicular	8	15.7%
Natural Illness	3	5.9%
Suffocation/ Strangulation	2	3.9%
Fire Related	2	3.9%
In utero Drug Exposure	2	3.9%
Other	7	13.7%

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

In addition to these numbers, the Joint Oklahoma Information Network (www.join.ok.gov) provides a wealth of information on community resources available to the public.

National Resources

NATIONAL MCH CENTER FOR CHILD DEATH REVIEW

KEEPING KIDS ALIVE

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*.

ICAN 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
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