

The Oklahoma



Child Death Review Board

2006 Annual Report

Containing information on cases reviewed and closed during the 2006 calendar year

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

Published June 2007



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

The loss of a child is difficult to comprehend. Whether a child dies from natural causes, an accident or intentional injuries, loved ones grieve. Often, 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 2006, the Board reviewed and closed 345 child deaths and 81 near death cases.

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 is an obvious tool in reducing the risk of death. Parent education regarding a variety of topics such as safe sleeping practices for infants and graduated driver licenses for teens is also needed. In addition to *safety items* and *knowledge*, parents must have access to resources such as health care, quality childcare, substance abuse treatment and mental health services for themselves and their children when necessary.

This annual report is dedicated to the children involved in the cases reviewed. The Child Death Review Board is privileged to learn about each precious 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 child 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 2006 Oklahoma State Child Death Review Board Members

Organization	Member	Designees
<i>Office of Child Abuse Prevention</i>	<i>Annette Jacobi, JD; Chair</i>	
<i>Oklahoma State Department of Health</i>	<i>Mike Crutcher, MD, MPH</i>	<i>Carolyn Parks, MHR, RN; Vice-Chair</i>
<i>Chief Child Abuse Examiner</i>	<i>Robert Block, MD</i>	<i>Debbie Lowen, MD</i>
<i>Post Adjudication Review Board</i>	<i>Jay Scott Brown, MA</i>	<i>Buddy Faye Foster</i>
<i>OSDH, State Epidemiologist</i>	<i>Brett Cauthen, MD, MPH</i>	<i>Rebecca Coffman, MPH, RN</i>
<i>Office of Juvenile Affairs</i>	<i>Richard "Gene" Christian, JD</i>	<i>Donna Glandon, JD</i>
<i>State Department of Mental Health and Substance Abuse Services</i>	<i>Terry Cline, PhD</i>	<i>Julie Young, MA</i>
<i>OSDH, Maternal and Child Health Service</i>	<i>Suzanna Dooley, MS</i>	<i>Jim Marks; Barbara Smith</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>Eddie Johnson</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>Lisa Smith, MA</i>
<i>Oklahoma Coalition Against Domestic Violence and Sexual Assault</i>	<i>Evelyn Hibbs</i>	<i>Marcia Smith; Tamatha Mosier</i>
<i>Oklahoma Bar Association</i>	<i>Jennifer King, JD</i>	
<i>Oklahoma State Bureau of Investigation</i>	<i>DeWade Langley</i>	<i>Rusty Featherstone; Jon Loffi; 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>National Association of Social Workers</i>	<i>Keri Pierce, MSW</i>	
<i>Oklahoma Psychological Association</i>	<i>Susan Schmidt, PhD</i>	
<i>Law Enforcement Representative</i>	<i>Richard Sexton</i>	<i>Tim Brown</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 Stephens-Stidham</i>	<i>Ruth Azeredo, DrPH</i>
<i>Oklahoma District Attorney's Council</i>	<i>Cathy Stocker, JD</i>	<i>Michael Fields, 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

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Recommendations

Oklahoma Child Death Review Board Recommendations Submitted to the Oklahoma Commission on Children and Youth May 2007

The following recommendations are based on the 345 death cases and 81 near death cases reviewed and closed in calendar year 2006. 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 108 cases (31.3% of 345) in 2006 involving motor vehicles.

Of these:

- Eighty-three (76.9%) children were traveling in a car/van/pickup/SUV.
- Fifty-six of the 83 (67.5%) children riding in a car/van/pick-up/SUV were unrestrained.
- Forty-one cases (38.7%) involved drivers age 17 years and younger.
- Nineteen cases (17.9%) the driver was cited for driving under the influence.
- Eleven (10.4%) were pedestrians.
- Nine (8.5%) were riding All-Terrain Vehicles (ATVs), with the youngest four years of age and the oldest 15.
- Of the nine riding ATVs, only one was wearing a helmet.
- One (0.9%) was riding a bicycle - helmet use unknown.

Recommendations

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

Legislative recommendations

- Mandatory 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 All-Terrain Vehicle (ATV) legislation that contains elements requiring helmet use, prohibiting passengers, prohibiting drivers age 12 and under, and requiring ATV safety training. Requirements should be statewide, including on private land.
- Enforcement of child passenger safety restraint laws, which fines drivers transporting unrestrained children.

Administrative recommendations

- Develop and disseminate a campaign that will promote the best practices related to booster seat usage.
- Provide, at no cost, driver education classes for all high school and career tech students.
- Increase accessibility and usage of drug courts and drug treatment programs.

Recommendations

- Promote and establish 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 which allows citizens the opportunity to send a card to Safe Kids with license plate information when a citizen has observed a child to be transported unrestrained. Safe Kids then contacts the family through a letter reminding them of the law and offering assistance for obtaining a car seat.
- Promote and establish of funding for the Safe Kids Oklahoma “Walk This Way” program which is aimed at reducing the number of child pedestrian injuries and fatalities.
- Promote and establish funding for the Safe Kids Oklahoma bicycle safety program, which includes conducting bicycle safety rodeos and provide free helmets to groups who conduct bike safety education events utilizing Safe Kids curriculum.

Unsafe Sleep Practices

Key Findings

There were a total of 72 (20.9%) deaths where unsafe sleeping practices may have contributed to the death.

Of these:

- Forty-seven were ruled Unknown manner of death, with the Medical Examiner stating unsafe sleep conditions might have contributed to the death.
- Twenty-eight deaths were classified as SIDS. Of those 28 cases, eight of the children were sharing the same sleep surface with an adult or sibling, and four of these included the possibility of overlay. Regarding sleep position, 11 children were sleeping on their stomach, six were sleeping on their backs, three were sleeping on their side, and the sleep position of eight of the children was unknown.
- Three were ruled Accidental deaths due to overlay.

Recommendations

In order to reduce the number of deaths of children due to unsafe sleeping conditions, the Oklahoma Child Death Review Board recommends:

- Affordable childbirth classes should be available to all expectant mothers. The Board further recommends that the classes include education of new parents on safe sleep issues.

Recommendations

Drowning

Key Findings

In 2006 the Oklahoma Child Death Review Board reviewed 16 deaths due to drowning. Of these:

- Seven (43.8%) occurred in a residential swimming pool and all but one were residents or visitors of the home where the pool was located
- Four (25.0%) occurred in a natural body of water (two lakes, one river, one creek)
- Four (25.0%) occurred in a bathtub
- One (6.3%) occurred in an apartment pool
- Eleven (68.8%) were 3 years of age and younger
- Three (18.8%) were 5 through 12 years of age
- Two (12.5%) were 13 years of age or older

Recommendations

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

- 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.
- Promote and establish 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 Engineer lakes.
- 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.
- Continue distribution of the State Department of Health's Injury Prevention Services Division informational brochures on pool/hot tub safety.

Fires

Key Findings

In 2006 the Oklahoma Child Death Review Board reviewed 20 deaths due to fires. Of these:

- Six (30.0%) of the cases did not have a working smoke detector present in the residence.
- Ten cases (50.0%) involved investigators unable to determine if a working smoke detector was present.

Recommendations

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

- Promote and establish funding for Safe Kids Oklahoma's burn prevention programs, which include the "Save-A-Life" smoke detector giveaway/installment programs, a fireworks safety

Recommendations

campaign, a childcare providers burn education curriculum, and a “Change Your Battery” campaign.

Child Abuse/Neglect Deaths

Key Findings

In 2006 the Oklahoma Child Death Review Board reviewed and closed 50 cases that were concluded by the Board to have been a result of child abuse/neglect. Additionally, 22 (40.7%) had previous child welfare referrals, with 11 of these being investigated and confirmed. Currently, Oklahoma’s child welfare workers and supervisors carry an active caseload that is two to three 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:

- Continue 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.
- 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.
- Make court records pertaining to custody and guardianship available for public inspection after a child death.
- Create a medical team to review the medical records in child abuse/neglect cases and submit an opinion.



Activities of the Board in 2006

- Began collaborations with the Oklahoma Domestic Violence Review Board.
- Conducted two press conferences in conjunction with the release of annual reports.
- Consulted with Fetal Infant Mortality Review coordinator from the Oklahoma State Health Department.
- Referred three cases to the Oklahoma Commission on Children and Youth.
- Referred four physicians to the appropriate licensing agency for review (The Oklahoma Board of Medical Licensure and Supervision and The Oklahoma Board of Osteopathic Examiners).
- Six letters to District Attorneys inquiring if charges had been filed.
- One letter to a District Attorney inquiring if an investigation was conducted.
- One letter to a District Attorney expressing the Board's concern for the welfare of children returned home.
- Four letters to hospitals regarding notification to OKDHS of any child death that is unattended by a physician.
- One letter to a hospital recommending changing policies and procedures for notifying families of test results after the discharge of the patient.
- One letter to a hospital regarding the policies and procedures for mothers who test positive for drugs at the time of delivery.
- One letter to a hospital recommending policies and procedures for reporting to OKDHS when a medically fragile child dies of an unrelated condition.
- Three letters to law enforcement agencies commending an outstanding scene investigation.
- Two letters to law enforcement agencies recommending maintaining a written report when they have responded to a death scene.
- Three letters to law enforcement agencies recommending increasing the thoroughness of scene investigations and/or notifying OKDHS of a child death.
- One letter to a law enforcement agency requesting they look into a case.
- Six letters to the Office of the Medical Examiner recommending a change in the manner and/or cause of death. (One case amended to Accident from Natural.)
- One letter to a physician recommending consultation with the Office of the Chief Medical Examiner.
- One letter to a public school regarding policies and procedures for medical emergencies on campus.
- One letter to OKDHS informing of a change of manner of death.
- Two letters to OKDHS commending an outstanding Child Welfare investigation.
- Four letters referring cases to OKDHS for Child Welfare investigation.
- Three letters to OKDHS regarding services recommended for families and/or recommending continued services for family.
- One letter to OKDHS regarding the status of a licensed child care facility.
- One letter to a Tribal EMS recommending cooperation with OKDHS and law enforcement in death investigations.

Cases Closed in 2006

The Oklahoma Child Death Review Board reviewed and closed 345 cases in 2006. The state Board reviewed 123 of the cases and the local teams reviewed the remaining 222 cases. Males accounted for 214 (62.0%) of the deaths and females accounted for 131 (38.0%) deaths.

Please note that the year of review does not indicate the year of death. In other words, not all deaths reviewed in 2006 occurred in 2006. In fact, of deaths reviewed in 2006, 205 (59.4%), occurred in 2005. Only 76 (22.0%) of the deaths occurred in 2006.

Deaths Reviewed by the Board in 2006

Manner	Number	Percent
Accident	161	46.7%
Homicide	34	9.9%
Natural	60	17.4%
Suicide	16	4.6%
Unknown	74	21.4%

Accidents continue to be the most frequent manner of death seen by the Oklahoma Child Death Review Board.

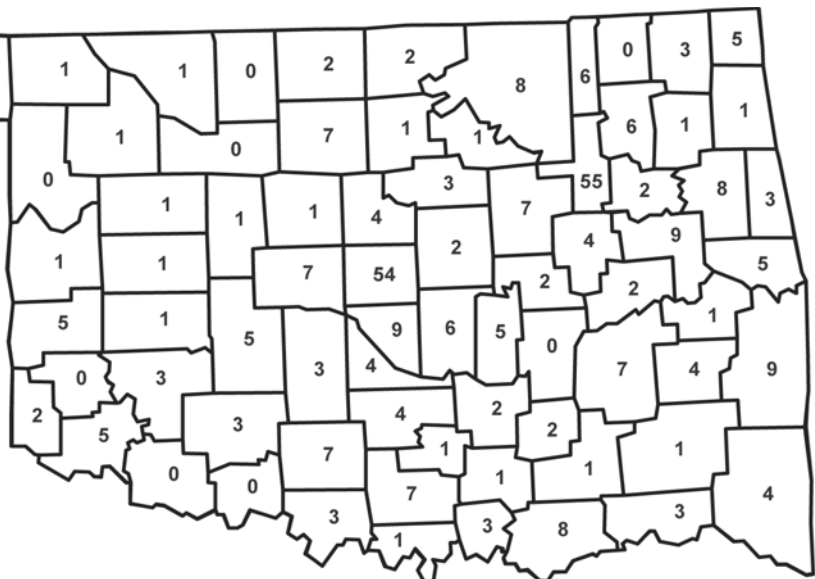


Race and Gender of All Cases Reviewed

African-American			
Male	31		
Female	9		
Total	40	11.6%	
American Indian			
Male	25		
Female	25		
Total	50	14.5%	
Pacific Islander			
Male	3		
Female	2		
Total	5	1.4%	
White			
Male	128		
Female	76		
Total	204	59.1%	
Hispanic			
Male	21		
Female	14		
Total	35	10.1%	
Other			
Male	5		
Female	7		
Total	12	3.5%	
Unknown			
Male	1		
Female	0		
Total	1	0.3%	

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 for which the Oklahoma Child Death Review Board collects information. **Please note that the information on this page concerns the families' involvement in state programs. The information on page eight concerns the deceased child's involvement in state programs.**

State aid had been applied for or was being provided to 284 (82.3%) of the families who lost a child reviewed by the Board in 2006. In nearly three-quarters (73.6%) of the cases closed by the Board in 2006, the family of the deceased had received TANF (Temporary Assistance for Needy Families) benefits from Oklahoma Department of Human Services at some point prior to the death event. In 154 of the cases (44.6%) the family had received TANF benefits within a year of the death.

The Oklahoma Department of Human Services - Child Welfare Services (OKDHS-CW) had prior contact with 134 (38.8%) of the families that lost a child whose death was reviewed in 2006. Forty-five (13.0%) of the families had contact within a year of the death.

Two (0.6%) of the deaths reviewed by the Board were of children in foster care at the time of death. One of the deaths was ruled by the medical examiner to be of natural causes. OKDHS did confirm an allegation of neglect against the foster care provider in that case. In the other death the medical examiner was unable to determine the manner or cause of death. OKDHS investigated the death but did not find any reason to suspect abuse or neglect contributed to the death.

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)	154	174	254
Child Welfare	45	92	134
Child Support	73	107	129
Medical	15	41	101
Food Stamps	5	33	78
Child Care	0	0	47
Emergency Assistance	0	0	21
Disability	9	11	17
Foster Care	2	2	2

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. One (0.3%) of the cases closed in 2006 had previous involvement with the Children First program.

The Office of Child Abuse Prevention (OCAP), also 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. One (0.3%) of the cases closed in 2006 had previous OCAP involvement.

The purpose of the 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. 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-four (27.2%) of the deaths reviewed in 2006 had a previous referral on the deceased child to OKDHS-CW for abuse and/or neglect. In 35 (37.2%) of those cases, the referral was confirmed.

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 (3.5%) cases closed in 2006 had previous ODMHSAS services; two (0.7%) had received services within 90 days 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 16 (4.6%) of the cases closed in 2006, including five that were actively involved with OJA at the time of their death.

Number of Decedents with Previous Involvement in Selected State Programs		
Agency	Number	Percent
Children First	1	0.3%
OKDHS - CW	94	27.2%
ODMHSAS	12	3.5%
Office of Child Abuse Prevention	1	0.3%
Office of Juvenile Affairs	16	4.6%

Accidents

Accidents remain the top manner of deaths reviewed by the Oklahoma Child Death Review Board at 161 (46.7%). Motor vehicle involved accidents (please see page 15) were the leading cause at 105 (65.2%). Drowning (page 16) was the second leading cause at 16 (9.9%) and fire-related deaths (page 19) rounded out the top three causes at 14 (8.7%).

Gender	Number	Percent
Male	98	60.9%
Female	63	39.1%

Race and Gender of Accident Victims

African-American			
Male	7		
Female	5		
Unknown	0		
Total	12	7.5%	
American Indian			
Male	12		
Female	9		
Unknown	0		
Total	21	13.0%	
Asian/Pacific Islander			
Male	1		
Female	0		
Unknown	0		
Total	1	0.6%	
White			
Male	63		
Female	38		
Unknown	0		
Total	101	62.7%	
Hispanic			
Male	11		
Female	7		
Unknown	0		
Total	18	11.3%	
Other			
Male	3		
Female	4		
Unknown	0		
Total	7	4.3%	
Unknown			
Male	1		
Female	0		
Unknown	0		
Total	1	0.6%	

Three (1.9%) of the asphyxia/suffocation deaths were under the age of one and involved bed-sharing circumstances.

All three (1.9%) hyperthermia deaths were children in a car, one accidentally left alone and two accidentally confined while playing. Safe Kids Tulsa initiated a reminder campaign to assist parents and caregivers with a mechanism for not forgetting a child in the car. For further information please call 918-494-7233.

The other category includes one of each: sports related, dog attack, fall, carbon monoxide poisoning, crushed by barbeque grill and kicked by a horse.

Type of Accidents Reviewed

Type	Number	Percent
Vehicular	105	65.2%
Drowning	16	9.9%
Fire Related	14	8.7%
Asphyxia/Suffocation	6	3.7%
Poisoning/Overdose	4	2.5%
Electrocution	4	2.5%
Confinement/Hyperthermia	3	1.9%
Injury during Delivery	2	1.2%
Firearm	1	0.6%
Other	6	3.7%

Suicides

In 2006 the Board reviewed and closed 16 suicide deaths. Thirteen of those deaths (81.3%) were male. White males alone accounted for 11 deaths (68.8%). Asphyxia was the most common means (10 cases or 62.5%) for committing suicide, firearms second at four deaths (25.0%), and poisoning/overdose and vehicular tied for third at one

Gender	Number	Percent
Male	13	81.3%
Female	3	18.8%

(6.3%) each. The vehicular death was ruled suicide due to the fact that the child had left a suicide note just prior to getting behind the wheel.

Race and Gender of Suicide Victims			
African-American			
Male	0		
Female	0		
Unknown	0		
Total	0	0.0%	
American Indian			
Male	1		
Female	1		
Unknown	0		
Total	2	12.5%	
Asian/Pacific Islander			
Male	0		
Female	0		
Unknown	0		
Total	0	0.0%	
White			
Male	11		
Female	2		
Unknown	0		
Total	13	81.3%	
Hispanic			
Male	1		
Female	0		
Unknown	0		
Total	1	6.3%	
Other			
Male	0		
Female	0		
Unknown	0		
Total	0	0.0%	
Unknown			
Male	0		
Female	0		
Unknown	0		
Total	0	0.0%	

Contributing factors (as noted by Board members) included:

- Conflict with parents - 5 (31.3%)
- History of mental health issues - 4 (25%)
- Conflict with boyfriend/ girlfriend - 3 (18.8%)
- Substance use/abuse-3 (18.8%)
- School problems - 1 (6.2%)
- Unknown - 6 (37.5%)

The use of suicide screening tools in schools has been increasing across the United States. There is debate among professionals; however, as to whether there is sufficient evidence to prove screening reduces the number of suicides or if screening potentially creates negative consequences.

Method of Suicide		
Method	Number	Percent
Asphyxia	10	62.5%
Firearm	4	25.0%
Poisoning/Overdose	1	6.3%
Vehicular Death	1	6.3%



Homicides

The total number of homicides reviewed and closed by the Board was 34, comprising 9.9% of all cases reviewed and closed. Twenty-six (76.5%) cases had one or more persons arrested for the death.

Gender	Number	Percent
Male	21	61.8%
Female	13	38.2%

Lawmakers in 2006 passed legislation designed to protect children including the Kelsey Smith-Briggs Child Protection Reform Act (H.B. 2840) and the Caitlin Wooten Act (S.B. 1037). Please see <http://www.lsb.state.ok.us/> for further information.

Race and Gender of Homicide Victims			
African-American			
Male	7		
Female	0		
Unknown	0		
Total	7	20.6%	
American Indian			
Male	2		
Female	1		
Unknown	0		
Total	3	8.8%	
Asian/Pacific Islander			
Male	0		
Female	0		
Unknown	0		
Total	0	0.0%	
White			
Male	9		
Female	10		
Unknown	0		
Total	19	55.9%	
Hispanic			
Male	3		
Female	2		
Unknown	0		
Total	5	14.7%	
Other			
Male	0		
Female	0		
Unknown	0		
Total	0	0.0%	
Unknown			
Male	0		
Female	0		
Unknown	0		
Total	0	0.0%	

Person Arrested for Death	
Perpetrator	# of Cases
Biological Father	4
Stranger	4
Mother's Boyfriend	3
Other Juvenile	3
Biological Mother	3
Biological Mother & Mother's Boyfriend	2
Child Care Worker	2
Biological Mother & Biological Father	1
Grandfather	1
3 Strangers	1
2 Relation Unknown	1
2 Adult Acquaintances	1
No Arrest Made	8

Cause of Death in Homicide Cases		
Cause of Death	Number	Percent
Firearm Related	13	38.2%
Struck/Shaken	9	26.5%
Fire Related	4	11.8%
Head Injury	3	8.8%
Suffocation	2	5.9%
Vehicular Related	2	5.9%
Cut/Stabbed	1	2.9%

Prosecutorial Information
Of the 26 homicide cases where an arrest was made, seven are still pending, 13 pled guilty, three were convicted at trial, one was dismissed by the state, one was found not guilty by reason of insanity and one was acquitted.
The convictions and guilty pleas led to six cases receiving life without the possibility of parole, two cases of life with the possibility of parole and eight cases where the defendant received between two and 30 years.



Unknown

The Board reviewed and closed 74 deaths where the Medical Examiner ruled the manner of death Unknown. Forty-six (62.2%) of these were found in questionable sleeping environments, including bed-sharing, sleeping in a car seat, and/or in a prone sleeping position.

Gender	Number	Percent
Male	44	59.5%
Female	30	40.5%

Race and Gender of Undetermined Victims			
African-American			
Male	7		
Female	3		
Unknown	0		
Total	10	13.5%	
American Indian			
Male	7		
Female	8		
Unknown	0		
Total	15	20.3%	
Asian/Pacific Islander			
Male	1		
Female	2		
Unknown	0		
Total	3	4.1%	
White			
Male	25		
Female	13		
Unknown	0		
Total	38	51.4%	
Hispanic			
Male	3		
Female	3		
Unknown	0		
Total	6	8.1%	
Other			
Male	1		
Female	1		
Unknown	0		
Total	2	2.7%	
Unknown			
Male	0		
Female	0		
Unknown	0		
Total	0	0.0%	

Ten (13.5%) had toxicological issues, including testing positive for illicit drugs at birth or overdoses that could not be concluded to be either purposeful or accidental.

Five (6.8%) were suspicious for trauma, including two that had head injuries at the time of autopsy, one where the mother concealed the pregnancy and then hid the child after birth, and one child who had a near-death incident three years prior to the death.

Four (5.4%) had no findings at the autopsies and scene investigations and ranged in age from 15 months to 17 years of age.

Three (4.1%) were the result of a fire and the Medical Examiner was unable to determine if the fire was purposefully or accidentally set.

Two (2.7%) were the result of firearms.

One (1.4%) was ruled possible seizure disorder.

One (1.4%) was found at autopsy to have plastic embedded in the throat, but was still ruled Unknown.



Natural Deaths - Reviewed

The chart below reflects the 60 natural causes of death reviewed and closed by the Board in 2006. Not all natural deaths are subject to a full review by the Board. In these instances, the death certificate is reviewed by a physician (page 14). Twenty-eight of the natural deaths (46.7%) were due to Sudden Infant Death Syndrome (page 18).

Gender	Number	Percent
Male	38	63.3%
Female	22	36.7%

Race and Gender of Natural Victims

African-American			
Male	10		
Female	1		
Unknown	0		
Total	11	18.3%	
American Indian			
Male	3		
Female	6		
Unknown	0		
Total	9	15.0%	
Asian/Pacific Islander			
Male	1		
Female	0		
Unknown	0		
Total	1	1.7%	
White			
Male	20		
Female	13		
Unknown	0		
Total	33	55.0%	
Hispanic			
Male	3		
Female	2		
Unknown	0		
Total	5	8.3%	
Other			
Male	1		
Female	0		
Unknown	0		
Total	1	1.7%	
Unknown			
Male	0		
Female	0		
Unknown	0		
Total	0	0.0%	

Forty-six (75.4%) were under the age of one year and 54 (88.5%) were under the age of five.

The "Other Conditions" category includes but is not limited to: necrotizing enterocolitis, aspiration of gastric content, Rocky Mountain Spotted Fever, Fungal infection, hydrocephalus, respiratory distress syndrome, cystic encephalomalacia, dehydration, cardiac arrhythmia, influenza and viral pneumonia.



Illnesses and Diseases Encountered in Natural Death Cases

Illness/Disease	Number	Percent
SIDS	28	46.7%
Pneumonia	6	10.0%
Congenital Anomalies	4	6.7%
Septicemia	4	6.7%
Naegleria	2	3.4%
Other Conditions	12	20.0%
Unknown	4	6.7%

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 2006 are as follows:

Cause of Death or Medical Condition	Number of Death Certificates Received	Percent
Prematurity	55	36.2%
Congenital Disorder	23	15.1%
Infectious Disease	20	13.2%
Neoplasm	14	9.2%
Cardiac Disease	12	7.9%
Neurological Condition	10	6.6%
Respiratory Disorder	9	5.9%
Gastrointestinal Disorder	3	2.0%
Parasitic Infection	1	0.7%
Not Specified/Unclear	5	3.3%
TOTAL	152	100.0%

Vehicle Related Deaths

There were 108 vehicle-related deaths reviewed and closed by the Board in 2006. This represents 31.3% of all deaths reviewed. Two of the deaths were homicides, one of the deaths was a suicide; the remaining 105 represent 65.2% of the accidental deaths reviewed.

Gender	Number	Percent
Male	59	54.6%
Female	49	45.4%

In December of 2006, the Oklahoma Highway and Safety Office indicated there was a reduction in accidents that involved 16 and 17 year-old drivers and attributed it to the strengthened graduated driver's license law that was passed in 2005. In the cases that were reviewed by the Board in 2006, 39 (36.8%) involved 16 and 17 year-old drivers.

Vehicle of Decedent

Vehicle	Number	Percent
Car/Van/SUV	83	76.9%
ATV	9	8.3%
Motorcycle	2	1.9%
Electric Scooter	1	0.9%
Bicycle	1	0.9%
Aircraft	1	0.9%
Pedestrian	11	10.2%

S.B. 1830, also known as the All-Terrain Vehicle (ATV) bill, was introduced in the legislature in 2006; the bill died in committee. The bill sought to require helmet use for children under 18 years of age, limit passengers on ATVs, and require ATV safety training. Of the nine ATV deaths reviewed by the Board, one (11.1%) was wearing a helmet and four (44.4%) were passengers.

Use of Safety Restraints by Victims

Seatbelt/Car seat Use	Number	Percent
Properly Restrained	27	25.0%
Not Properly Restrained	53	49.1%
Unknown	3	2.8%
Not Applicable	25	23.1%

Age of Driver of Decedent's Vehicle

Age	Number	Percent
<13	4	3.7%
13-15	11	10.2%
16	13	12.0%
17	26	24.1%
18	8	7.4%
19-21	6	5.6%
>21	29	26.9%
N/A	11	10.2%

Activity of Decedent

Position	Number	Percent
Operator	36	33.3%
Front Passenger	27	25.0%
Rear Passenger	32	29.6%
Pedestrian/Bicycle	12	11.1%
Unknown	1	0.9%

Drowning Related Deaths

The Board reviewed and closed 16 drowning deaths in 2006. This accounts for 4.6% of the deaths reviewed by the Board in 2006. Eleven (68.8%) of the deaths were children under five years of age. Three (18.8%) were over ten years of age.

Seven (43.8%) children drowned in residential pools; four (25.0%) in a natural body of water; four (25.0%) in bathtubs, and one (6.3%) in an apartment pool. The natural bodies of water included: two lakes, one creek and one river.

Gender	Number	Percent
Male	11	68.8%
Female	5	31.3%

Safe Kids Oklahoma continued their Brittany Project during the summer of 2006 . This was the 10th consecutive year that the group provided free loaner lifejackets for children under 14 years of age at all 34 state lakes.

In 2006 the Oklahoma Child Death Review Board included in its annual recommendations that all pool/hot tub retailers in Oklahoma be mandated to distribute information on pool/hot tub safety to new pool/hot tub owners at the time of sale or installation. Brochures on pool/hot tub safety, which retailers can distribute to new owners, are available from the Oklahoma State Department of Health's Injury Prevention Services Division. The Board will again make this recommendation in 2007 (see page 3).

Location of Drowning		
Location	Number	Percent
Private, Residential Pool	7	43.8%
Natural Body of Water (i.e. creek, river, pond, lake)	4	25.0%
Bathtub	4	25.0%
Apartment Pool	1	6.3%

In June of 2006 Governor Henry signed the Kyle Williams Boating Safety Education Act into law. The new law requires kids between the ages of 12 and 16 to complete a boater safety course before operating a boat or personal watercraft. The free six hour class is administered by the Oklahoma Department of Public Safety.



Firearm Related Deaths

The Board reviewed and closed 20 cases that involved firearms with the majority used in homicides (13 or 65%),

Four (20.0%) of the deaths were suicides. Three (15.0%) of the deaths involved the deceased committing a crime when he was shot by either police or his intended victim. Three (15.0%) were shot due to gang activity. Three (15.0%) of the deaths were due to the deceased being unintentionally shot by his friend (all were ruled homicide). Two (10.0%) of the children killed by firearms were the victims of domestic violence. Both were shot by their mother's boyfriend. One (5.0%) was shot during a home invasion/robbery. One (5.0%) was the victim of a drive-by shooting at a dance. One (5.0%) was shot during a hunting accident. One (5.0%) child shot himself in the head but it is unknown if he intended to harm himself or was just playing with the gun when it went off. One (5.0%) occurred when a child was handling a gun which accidentally discharged.

The free gunlock giveaway program administered through Project ChildSafe continued in 2006, with sporting goods stores Bass Pro Shop and Academy Sports and Outdoors joining in on the campaign to increase gunlock use. Both stores conducted a giveaway in Oklahoma City in April 2006.

A study released in 2006 in the Archives of Pediatric and Adolescent Medicine found that 39 percent of the 201 children interviewed, indicated they knew the location of the parents' firearms. Twenty-two percent indicated they had handled the firearm, disputing parental claims that their children did not know the location of the firearms nor did they handle the firearms. The study compared parental responses with the children's responses and all were interviewed separately. The study involved families in rural Alabama who utilized a family practice clinic and the children were ages five to 14.

Gender	Number	Percent
Male	18	90.0%
Female	2	10.0%

Manner of Death for Firearm Victims

Manner	Number	Percent
Accident	1	5.0%
Homicide	13	65.0%
Suicide	4	20.0%
Undetermined	2	10.0%

Type of Firearm Used

Type of Firearm	Number	Percent
Handgun	13	65.0%
Shotgun	4	20.0%
Rifle	2	10.0%
Assault Rifle	1	5.0%

Sudden Infant Death Syndrome (SIDS)

The Board reviewed and closed 28 Sudden Infant Death Syndrome (SIDS) cases in 2006. For several years the Board, along with other safe sleep advocacy groups and the American Academy of Pediatrics, has stressed the message that infants need to be placed to sleep on their backs and on their own sleep surface. In six of the SIDS cases (21.4%) the infant was documented to be sleeping alone *and* on his or her back.

Two studies published in 2006 furthered the theory that the neurons in the brain responsible for rhythmic breathing may be disturbed, resulting in the gasping reflex being suppressed and therefore leading to sudden infant death.

Another study published in 2006 found that some SIDS deaths may be linked to a genetic mutation that affects the immune system and blood vessel growth.



Gender	Number	Percent
Male	18	64.3%
Female	10	35.7%

Age of Infant

Age (in months)	Number	Percent
Less than 2	6	21.4%
2—6	20	71.4%
More than 6	2	7.1%

Sleeping Position of Infant

Position	Number	Percent
On Stomach	11	39.3%
On Back	6	21.4%
On Side	3	10.7%
Unknown	8	28.6%

Sleeping Arrangement of Infant

Sleeping Arrangement	Number	Percent
Alone	20	71.4%
With Adult	7	25.0%
With Sibling	1	3.6%

For more information on SIDS contact:
Oklahoma State Department of Health
SIDS Program

(405) 271-4480

Fire Related Deaths

In 2006 the Oklahoma Child Death Review closed 20 fire related deaths. Eleven fires resulted in 20 deaths and of these eleven incidents, only two documented a working smoke detector. Smoke detector use was not applicable in one case.

Gender	Number	Percent
Male	9	45.0%
Female	11	55.0%

Oftentimes fire deaths result in smoke alarm giveaways immediately after the death; however, some Oklahoma communities have programs in place aimed at saving lives before the fire occurs. The Stillwater Early Childhood Fire Protection Program debuted in the fall of 2006. The program is aimed at children three to five years of age and involved 46 classrooms and more than 800 children. Every child received a smoke alarm and safety tips.

Age at Time of Death		
Age	Number	Percent
< 5	5	25.0%
5-10	7	35.0%
> 10	8	40.0%

The McAlester Army Ammunition Plant Fire Department visited schools during fire safety week in October 2006 in Pittsburg, Atoka, Coal and Latimer counties to lead an interactive fire safety program that included comedic skits and puppets.

Working Smoke Detector Present		
Detector	Number*	Percent
Yes	2	18.2%
No	3	27.3%
Unknown	5	45.5%
N/A	1	9.0%

*This number adds up to 11 due to there being 11 separate fire incidents. The N/A was a car fire.

Probable Cause of Fire and Total Number of Deaths

Cause	Number of Incidents	Total Number of Children Killed in Incidents
Space Heater/Electrical	3	4
Child Playing with Fire	2	3
Suspected Arson	1	3
Suspected Meth Lab	1	2
Could not Be Determined	4	8

Abuse/Neglect Deaths

The Oklahoma Child Death Review Board determined that 50 (14.5%) of the cases reviewed were due to abuse and/or neglect. The Oklahoma Department of Human Services investigated and confirmed abuse and/or neglect on 36 (72.0%) of these. Twenty-two of the fifty cases (44.0%) had a previous abuse/neglect referral on the deceased child. In 11 of these cases (22.0%) the referral was investigated and confirmed. Twenty-nine of the fifty cases (58.0%) had a previous abuse/neglect referral on a sibling. Eighteen (36.0%) of these were investigated and confirmed.

Gender	Number	Percent
Male	29	58.0%
Female	21	42.0%

An arrest was made in 25 of the cases (50.0%). In nineteen of the cases (38.0%) one or more of the biological parents were arrested for the death. Thirty-eight of the deaths (76.0%) occurred in either 2005 or 2006. The other 12 cases (24.0%) occurred in 2004 (seven deaths), 2003 (four deaths) and 2001 (one death).



Manner of Death for Abuse/Neglect Victims

Manner	Number	Percent
Accident	22	44.0%
Homicide	15	30.0%
Undetermined	12	24.0%
Natural	1	2.0%

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

Individuals Arrested for Child's Death

Perpetrator	Number of Cases	Percent
Biological Mother	6	12.0%
Biological Father	6	12.0%
Biological Mother & Biological Father	4	8.0%
Mother's Boyfriend	3	6.0%
Biological Mother & Mother's Boyfriend	2	4.0%
Biological Mother & Step-Dad	1	2.0%
Grandfather	1	2.0%
Child Care Worker	1	2.0%
Two Unknown Perpetrators	1	2.0%

Age of Decedents by Race

Age of African-American Decedents

Age	Number	Percent
<1	17	42.5%
1	3	7.5%
2	2	5.0%
3	1	2.5%
4	0	0.0%
5	0	0.0%
6	0	0.0%
7	4	10.0%
8	2	5.0%
9	0	0.0%
10	0	0.0%
11	0	0.0%
12	1	2.5%
13	0	0.0%
14	0	0.0%
15	3	7.5%
16	6	15.0%
17	1	2.5%
Total	40	100.0%

Age of American Indian Decedents

Age	Number	Percent
<1	22	44.0%
1	3	6.0%
2	3	6.0%
3	2	4.0%
4	1	2.0%
5	2	4.0%
6	1	2.0%
7	1	2.0%
8	0	0.0%
9	2	4.0%
10	0	0.0%
11	0	0.0%
12	0	0.0%
13	0	0.0%
14	4	8.0%
15	2	4.0%
16	3	6.0%
17	4	8.0%
Total	50	100.0%

Age of White Decedents

Age	Number	Percent
<1	65	31.9%
1	13	6.4%
2	5	2.5%
3	8	3.9%
4	6	2.9%
5	5	2.5%
6	4	2.0%
7	2	1.0%
8	3	1.5%
9	2	1.0%
10	4	2.0%
11	5	2.5%
12	4	2.0%
13	8	3.9%
14	7	3.4%
15	17	8.3%
16	18	8.8%
17	28	13.7%
Total	204	100.0%

Age of Other Decedents

Age	Number
<1	4
4	1
5	1
8	1
12	2
15	1
Total	10

Age of Hispanic Decedents

Age	Number
<1	17
1	2
6	1
7	1
11	1
12	1
13	1
14	3
15	3
16	2
17	3
Total	35

Age of Asian Decedents

Age	Number
<1	1
7	1
12	1
13	1
14	1
Total	6

Age of Unknown Race Decedents

Age	Number
17	1

Age of Decedents by Manner

Age of All Decedents

Age	Number	Percent
<1	126	36.5%
1	21	6.1%
2	10	2.9%
3	11	3.2%
4	8	2.3%
5	8	2.3%
6	6	1.7%
7	10	2.9%
8	6	1.7%
9	4	1.2%
10	4	1.2%
11	6	1.7%
12	8	2.3%
13	10	2.9%
14	15	4.4%
15	26	7.5%
16	29	8.4%
17	37	10.7%
Total	345	100.0%

Age of Accident Decedents

Age	Number	Percent
<1	11	6.8%
1	9	5.6%
2	6	3.7%
3	11	6.8%
4	6	3.7%
5	8	5.0%
6	6	3.7%
7	8	5.0%
8	4	2.5%
9	4	2.5%
10	2	1.2%
11	4	2.5%
12	6	3.7%
13	6	3.7%
14	8	5.0%
15	16	9.9%
16	19	11.8%
17	27	16.8%
Total	161	100.0%

Age of Natural Decedents

Age	Number	Percent
<1	46	76.7%
1	4	6.7%
2	2	3.3%
3	0	0.0%
4	1	1.7%
5	0	0.0%
6	0	0.0%
7	1	1.7%
8	1	1.7%
9	0	0.0%
10	0	0.0%
11	1	1.7%
12	0	0.0%
13	0	0.0%
14	1	1.7%
15	1	1.7%
16	1	1.7%
17	1	1.7%
Total	60	100.0%



Age of Decedents by Manner (cont.)

Age of Homicide Decedents

Age	Number	Percent
<1	11	32.4%
1	3	8.8%
2	1	2.9%
3	0	0.0%
4	0	0.0%
5	0	0.0%
6	0	0.0%
7	0	0.0%
8	1	2.9%
9	0	0.0%
10	2	5.9%
11	1	2.9%
12	0	0.0%
13	0	0.0%
14	1	2.9%
15	5	14.7%
16	4	2.9%
17	5	14.7%
Total	34	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	6.3%
13	3	18.6%
14	4	25.0%
15	2	12.5%
16	3	18.8%
17	3	18.8%
Total	16	100.0%

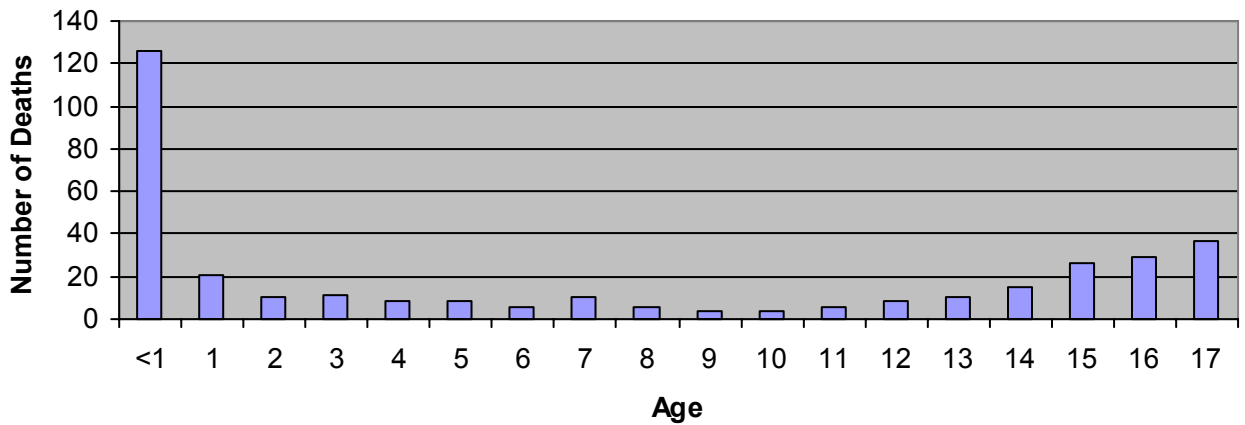
Age of Undetermined Decedents

Age	Number	Percent
<1	58	88.1%
1	5	6.8%
2	1	1.4%
3	0	0.0%
4	1	1.4%
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	2	2.7%
13	1	1.4%
14	1	1.4%
15	2	2.7%
16	2	2.7%
17	1	1.4%
Total	67	100.0%

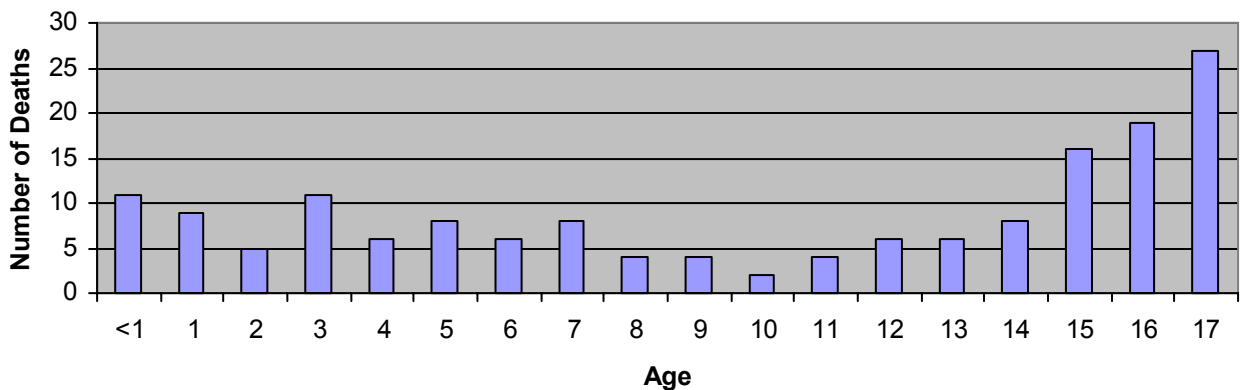


Age of Decedents by Manner

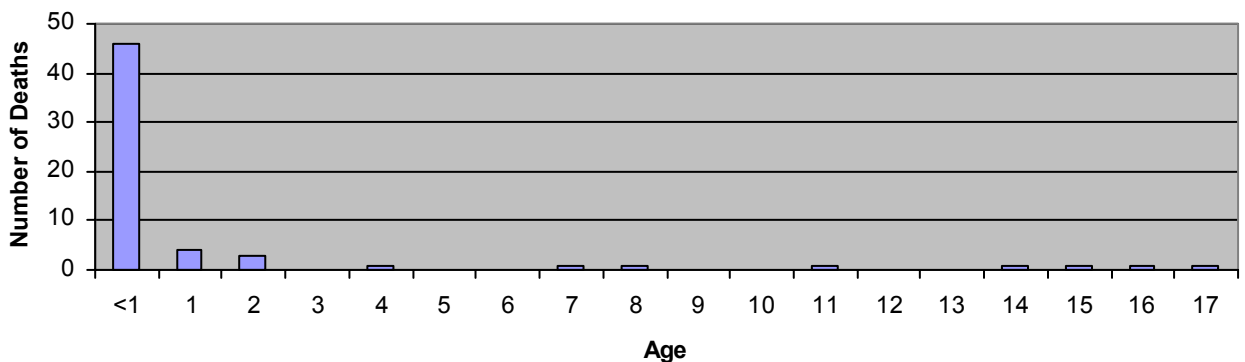
Total Number of Deaths by Age



Accidental Deaths by Age

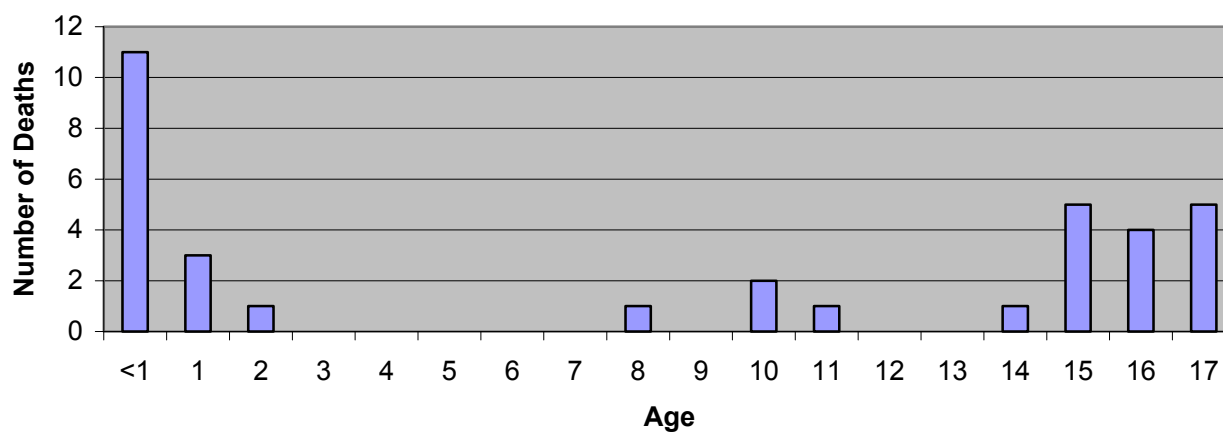


Natural Deaths by Age

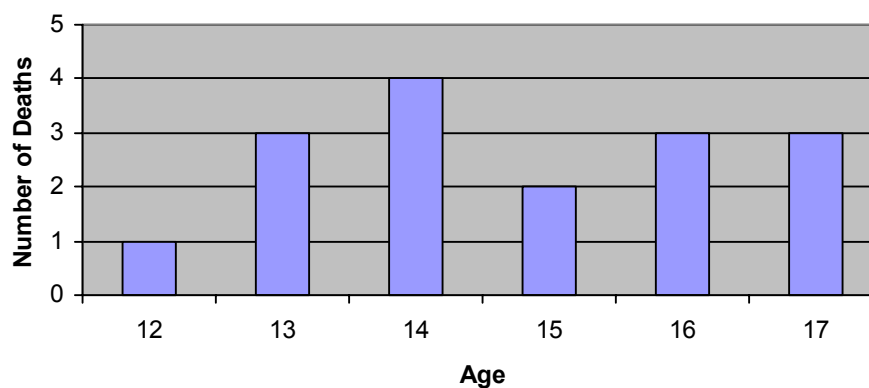


Age of Decedents by Manner

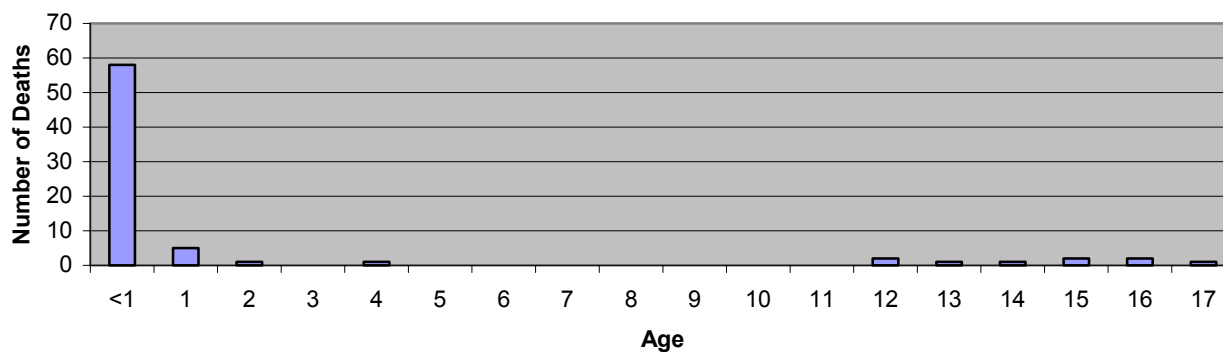
Homicide Deaths by Age



Suicide Deaths by Age

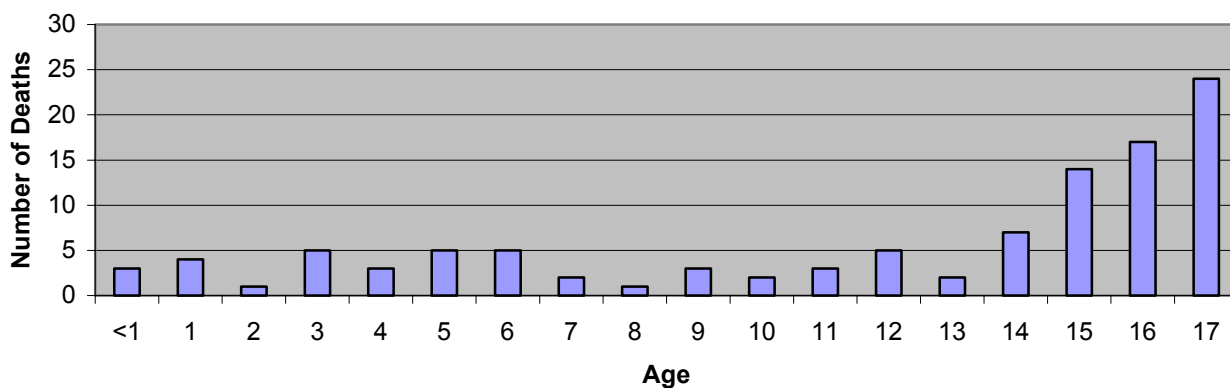


Undetermined Deaths by Age

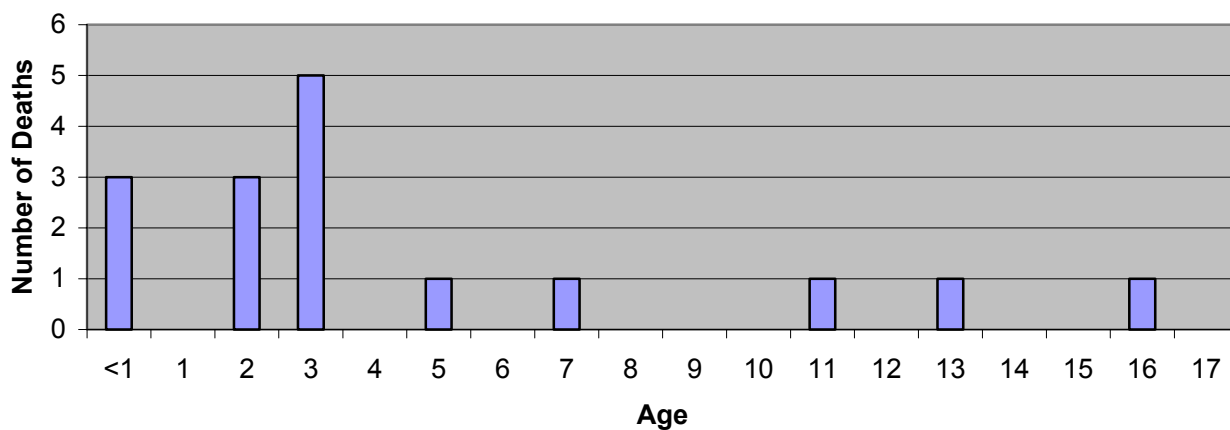


Age of Decedents by Selected Causes

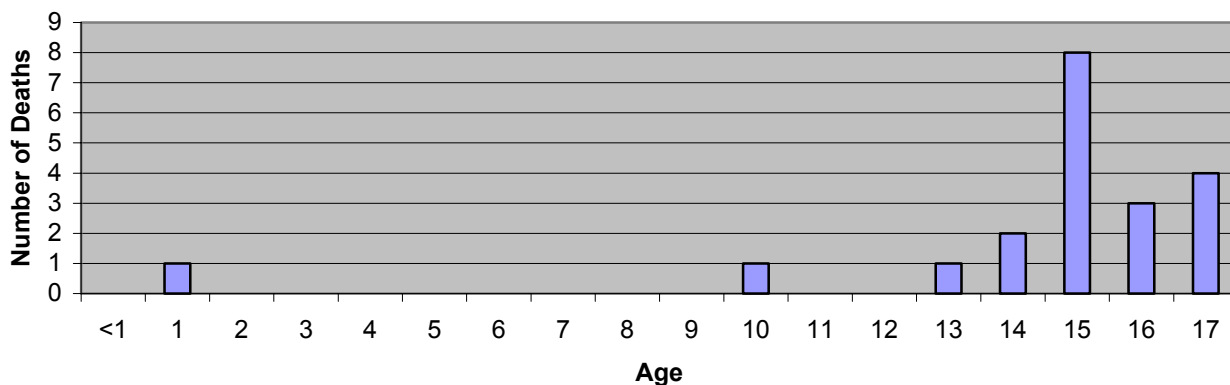
Vehicle Deaths by Age



Drowning Deaths by Age

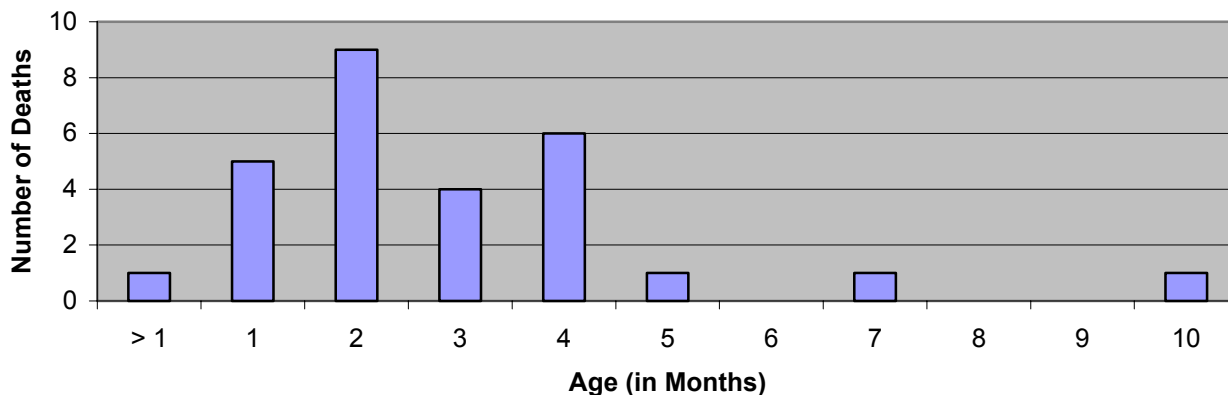


Firearm Deaths by Age

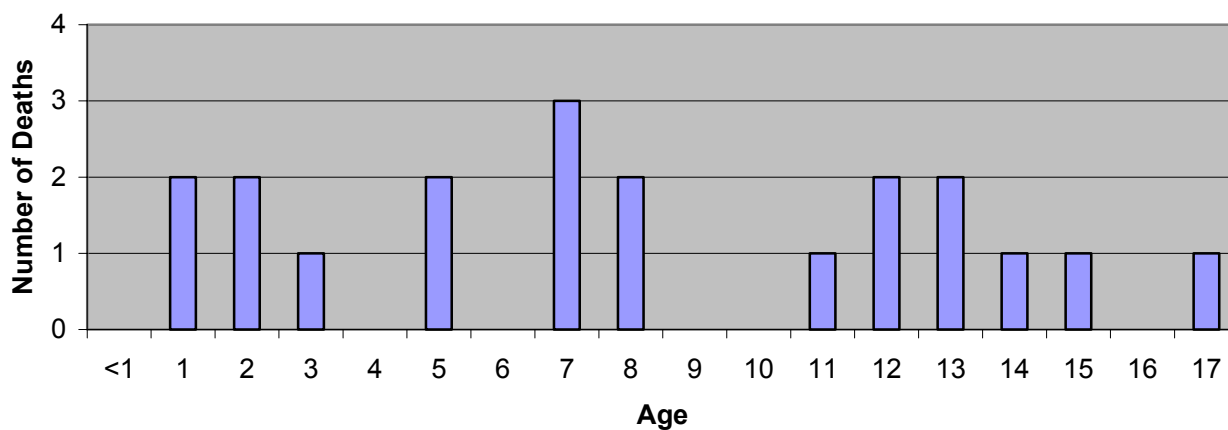


Age of Decedents by Selected Causes

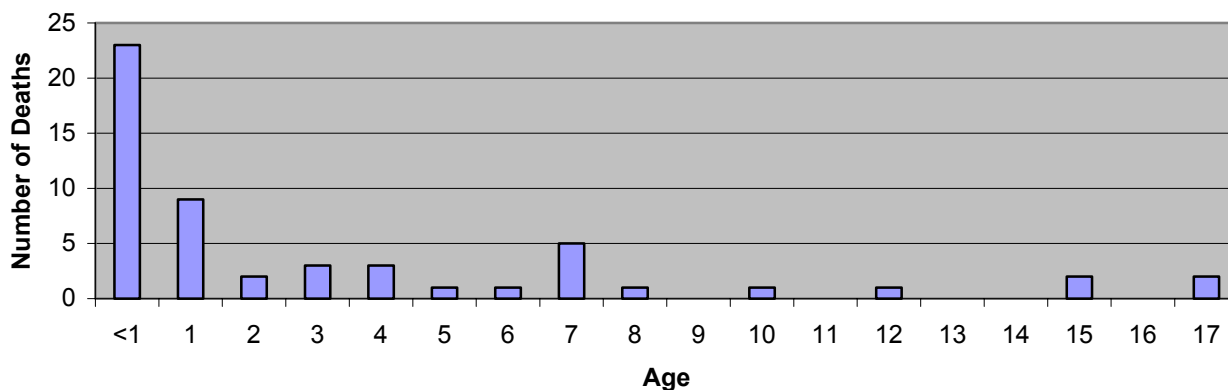
SIDS Deaths by Age



Fire Deaths by Age



Abuse/Neglect Deaths by Age



Regional Review Teams

In addition to the State Child Death Review Board, there are four Regional Review Teams. Combined, the teams reviewed 222 (64.3%) of the 345 cases reviewed and closed in 2006. This is an increase from the 177 cases the Regional Review Teams closed in 2005. In addition the Regional Review Teams closed 27 (33.3%) of the near death cases (page 34) reviewed in 2006.

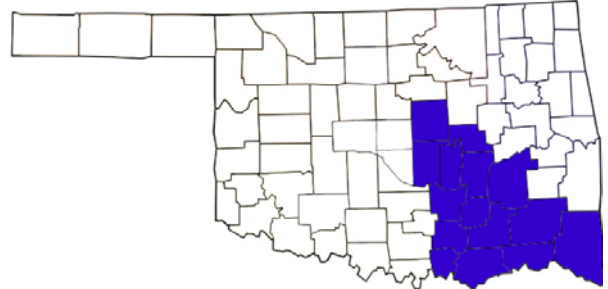
The Regional Review Teams meet quarterly, except for the Tulsa Regional Review Team, which meets every other month.



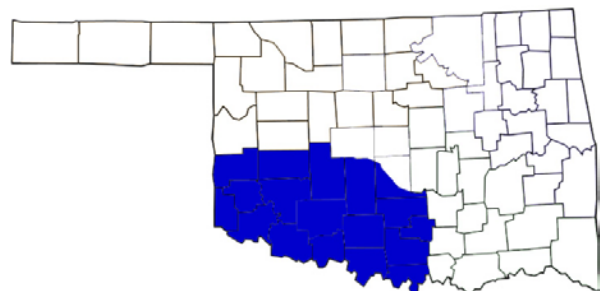
**Counties of the Eastern Oklahoma
Regional Child Death Review Team**



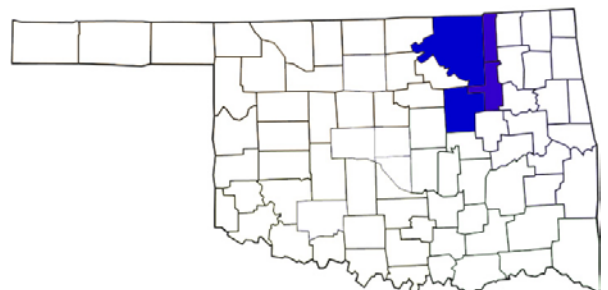
**Counties of the Southeastern Oklahoma
Regional Child Death Review Team**



**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 Child Death Review Team reviewed and closed 54 deaths in 2006. The 32 accidental deaths included: 20 traffic related deaths, six

Gender	Number	Percent
Male	34	63.0%
Female	20	37.0%

Manner of Death for Eastern Oklahoma Victims

Manner	Number	Percent
Accident	32	59.3%
Homicide	2	3.7%
Natural	7	13.0%
Suicide	2	3.7%
Undetermined	11	20.4%

fire related deaths, two drowning deaths, one struck by lightening, one overdose, one hanging, and one due to a child shooting himself with a gun he believed to be unloaded.

The seven natural deaths included four infants who died of SIDS , one child who died of hydrocephalous, one child who died of pneumonia, and one child who died of unknown natural causes.

Eastern Oklahoma Child Death Review Team Members

Organization	Team Member	Designee
Medical Representative	Michael Stratton, DO; Chair	
Muskogee Public Schools	Debbie Winburn; Vice-Chair	
Cherokee Nation Mental Health	Misty Boyd, PhD	
Muskogee County Sheriff's Office	Tim Brown	Darrin Smith, Jan Ray
Muskogee County OKDHS	Theresa Buckmaster	Cathy Young
CASA of Muskogee County	Katharine Eaton	
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	Walter Davis, Julie Vinson
Muskogee County EMS	Rebecca Smith	Carlene Morrison
Muskogee County Council on Youth Services	Cindy Perkins	Darren Smith
Muskogee Police Department	John Toles	Reed Felts
Muskogee County Regional Hospital (ER)	Sheila Villines	
Muskogee County Health Department	Carol Weigel	
Community Representative	Lillian Young, PhD	

Southeastern Review Team

The Southeastern Oklahoma Regional Child Death Review Team reviewed and closed 45 cases in 2006. The 27 accidental deaths included 18 traffic related deaths, three drowning deaths, two fire deaths, one child kicked by a horse, one electrocuted, one due to hyperthermia and one due to carbon monoxide poisoning.

Gender	Number	Percent
Male	25	55.5%
Female	20	44.4%

The four homicide cases consisted of two infants who died of non-accidental head trauma, one struck on the head by an assailant and one shot by mother's ex-boyfriend.

**Manner of Death for
Southeastern Oklahoma Victims**

Manner	Number	Percent
Accident	27	60.0%
Homicide	4	8.9%
Natural	5	11.1%
Suicide	3	6.7%
Undetermined	6	13.3%

The natural deaths consisted of four medical illnesses and one SIDS death, while the three suicides consisted of two hangings and one firearm related death.

Bed-sharing was present in four of the six undetermined deaths. In one of the undetermined deaths the level of diphenhydramine in the infant's liver suggested a possible overdose. The other undetermined death was an infant found wedged between a mattress and a wall.

Southeastern Oklahoma Child Death Review Team Members

Organization	Team Member	Designee
Unzner Centre	Laura Allison, MSW; Chair	Sharon Trammell
Judicial Representative	Judge Glenn Dale Carter (Ret.); Vice-Chair	
CASA Representative	Gwen Gjovig	
Law Enforcement Representative	Kelly Howard	
Oklahoma Department of Human Services	Carmen Hutchins	Deborah Winn, Rita Hart
Youth and Family Resources Center	Susan Morris	Aubree Holsapple
Medical Representative	Kelly Neher	Joye Byrum
County Health Department Representative	Carolyn Parks	
District Attorney's Office	Richard Smotherman, JD	Melissa Estes, JD
Community Representative	Vacant	

Southwestern Review Team

The Southwestern Oklahoma Regional Child Death Review Team closed 48 cases in 2006. The 24 accidental deaths included: 19 traffic related deaths, one child accidentally hanged himself, one electrocuted, one died of positional asphyxia in a car seat, one crushed by a barbeque grill that fell on top of him and one overlaid by his sibling while they slept in the same bed.

Gender	Number	Percent
Male	29	60.4%
Female	19	39.6%

The four homicides consisted of two juveniles who were shot, one child was shaken and one child was struck in the head. Two of the natural deaths were due to SIDS. The

Manner of Death for Southwestern Oklahoma Victims

Manner	Number	Percent
Accident	24	50.0%
Homicide	4	8.3%
Natural	6	12.5%
Suicide	1	2.1%
Undetermined	13	27.1%

other four were due to medical illnesses. Nine of the thirteen undetermined deaths were infants sharing a sleep surface with a parent or sibling. One of the undetermined deaths occurred when a mother concealed her pregnancy, gave birth and placed the infant in a plastic bag. The Medical Examiner determined the baby was born alive. Another undetermined death occurred when a pregnant mother was injured in a domestic violence incident. The infant was born 3 weeks early and died shortly after birth. The remaining undetermined death was listed as a possible seizure disorder.

Southwestern Oklahoma Child Death Review Team Members

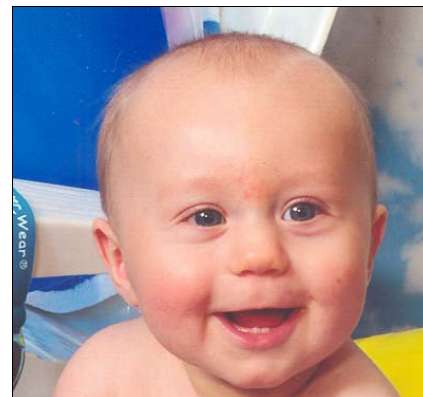
Organization	Team Member	Designee
Law Enforcement Representative	Det. Chris Perkins; Chair	Dets. Keith Stewart, John Randolph
Mental Health Representative	Eileen McGee; Vice-Chair	Melanie Smith
Office of Juvenile Affairs	Abby Kimbro	
Medical Representative	Pilar Escobar, MD	
Medical Examiner's Office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

Tulsa Regional Review Team

The Tulsa Regional Child Death Review Team closed 75 cases in 2006. Twenty-one of the 34 accidental death cases were due to traffic related fatalities. The remaining 13 included: seven drowning deaths, three accidental overdoses, one dog attack, one struck by lightning and one suffocation due to overlay.

Gender	Number	Percent
Male	47	62.7%
Female	28	37.3%

Seven of the 12 homicides were firearm deaths. The remaining homicides include: one strangled, one stabbed, one struck, one scalded and one case where the child died of pneumonia after a history of physical abuse. In five of



Manner of Death for Tulsa Region Victims

Manner	Number	Percent
Accident	34	45.3%
Homicide	12	16.0%
Natural	10	13.3%
Suicide	3	4.0%
Undetermined	16	21.3%

the homicide cases the child's caretaker was arrested for the death (see page 33).

Seven of the ten natural deaths were due to SIDS. In the other three natural deaths, two died of naegleria and one died of influenza.

Tulsa Regional Child Death Review Team Members

Organization	Team Member	Designee
Medical Representative	Deborah Lowen, MD; 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	
Medical Examiner's Office	Ronald Distefano, DO	
Washington County District Attorney's Office	Rick Esser, JD	Robert Fries, JD
Safe Kids Coalition	Mary Beth Ogle	
Mental Health Representative	Rose Perry	
Children's First Representative	Lori Sweeney	Sharon Konemann
Oklahoma Department of Human Services	Steffanie Ward	

Tulsa Regional Review Team

Eight of the 16 undetermined deaths involved infants sharing the same sleep surface with a parent and/or sibling. Two involved infants with extremely elevated drug levels in their system that could not be explained. Two involved infants sleeping alone but either on their stomach or side. Two involved infants who died under suspicious circumstances. One teenager died of a gunshot wound, and one teenager died of an overdose. In these two cases the Medical Examiner was unable to determine if the deaths were suicides or accidental.

Three suicide deaths included two males and one female. They ranged in age from 13 to 17 years old. They included one hanging, one overdose and one gunshot.



Individuals Arrested in Tulsa Homicide Cases

Perpetrator	Number of Cases
Other Juvenile	2
Biological Father	2
Stranger	2
Biological Mother	1
Biological Mother and Mother's Boyfriend	1
Mother's Boyfriend	1
3 Acquaintances	1
No Arrest Made	2

Near Death Cases Reviewed in 2006

The Board closed 81 near death cases in 2006. For a case to be considered a near death, the child's injury must result in the child being admitted to a hospital in serious or critical condition and the injury must be due to suspected abuse and or neglect. Sixty-four (79%) of the cases resulted in a confirmed finding by OKDHS (see table below).

Gender	Number	Percent
Male	43	53.1%
Female	38	46.9%

In 33 (40.7%) of these cases the injured child had a previous abuse/neglect referral to the Oklahoma Department of Human Services. Twenty-two of those cases were investigated and confirmed. Thirty-four (42.0%) of the cases had a sibling with a prior abuse/neglect referral to OKDHS. Twenty-five of those cases were investigated and confirmed.

Near Death Allegations Confirmed by OKDHS Against:

Perpetrator	Number of Cases
Both Biological Parents	13
Biological Mother	22
Biological Father	10
Biological Mother and Mother's Boyfriend	5
Biological Mother and Step-Father	2
Child Care Worker	2
Biological Father and Father's Girlfriend	1
Biological Father and Step-Mother	1
Foster Parents	1
Adoptive Parents	1
Other	6

Race of Near Death Cases

Race	Number	Percent
African-American	11	13.6%
American Indian	15	18.5%
Hispanic	3	3.7%
White	50	61.7%
African-American/ American Indian	1	1.2%
Unknown	1	1.2%

Injuries in Near Death Cases

Injury	Number	Percent
Struck/Shaken	22	27.2%
Poisoning/ Overdose	11	13.6%
Near Drowning	10	12.3%
Vehicular	7	8.6%
Fire Related	5	6.2%
Fall	4	4.9%
Suffocation/ Strangulation	3	3.7%
Pre-natal Drug Exposure	3	3.7%
Other	16	18.5%

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	(405) 606-4900 or 1-866-335-9288
Oklahoma Health Care Authority	(405) 522-7300
Oklahoma Mental Health and Substance Abuse Services	(405) 522-3908
Oklahoma Office of Juvenile Affairs	(405) 530-2800
Oklahoma SAFE KIDS Coalition	(405) 271-5695
Oklahoma State Department of Education	(405) 521-3301
Oklahoma State Department of Health	(405) 271-5600
Acute Disease 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.



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

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The Police Departments and County Sheriffs' Offices of Oklahoma

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