Think.
Prevent.
Live.

The Oklahoma Child Death Review Board

2007 Annual Report

Containing information on cases reviewed and closed during the 2007 calendar year

A statutorily established Board contracted through the
Oklahoma Commission on Children and Youth
Published June 2008

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.

Acknowledgements

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

The Police Departments and County Sheriffs' Offices of Oklahoma

Department of Public Safety
Office of the Chief Medical Examiner
Oklahoma Commission on Children and Youth

Oklahoma Department of Human Services
Oklahoma State Bureau of Investigation
OSDH Vital Statistics

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The 2007 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, RN, MHR; Vice-Chair*
Chief Child Abuse Examiner	*Robert Block, MD*	*Debbie Lowen, MD*
OSDH, State Epidemiologist	*Kristy Bradley, DVM, MPH*	*Rebecca Coffman, MPH, RN*
Post Adjudication Review Board	*Jay Scott Brown, MA*	*Buddy Faye Foster*
Office of Juvenile Affairs	*Gene Christian, JD*	*Donna Glandon, JD*
OSDH, Maternal and Child Health Service	*Suzanna Dooley, MS*	*James Marks, MSW, LCSW; Margaret DeVault, MSW, LSW*
Oklahoma Academy of Pediatrics	*Pilar Escobar, MD*	
Oklahoma Health Care Authority	*Michael Fogarty, JD*	*Aimee Moore-Rizzo, RN*
Office of the Chief Medical Examiner	*Jeffery Gofton, MD*	*Eddie Johnson*
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*	*Lisa Smith, MA*
Oklahoma Coalition Against Domestic Violence and Sexual Assault	*Evelyn Hibbs*	*Marcia Smith; Tim Gray, JD*
Oklahoma Bar Association	*Jennifer King, JD*	
Oklahoma State Bureau of Investigation	*DeWade Langley*	*Jon Loffi, Dale Birchfield*
Oklahoma Court Appointed Special Advocate	*Nadine McIntosh*	
Oklahoma Osteopathic Association	*Julie Morrow, DO, FAAP*	
National Association of Social Workers	*Keri Pierce, MSW*	
Oklahoma Psychological Association	*Susan Schmidt, PhD*	
Law Enforcement Representative	*Richard Sexton*	*Tim Brown*
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*
State Department of Mental Health and Substance Abuse Services	*Terri White, PhD*	*Julie Young, MA*
Cherokee Tribe of Oklahoma	*Kara Whitworth*	

2007 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 2008

The following recommendations are based on the 378 death cases and 78 near death cases reviewed and closed in calendar year 2007. Recommendations this year are based on deaths due to **motor vehicles, drowning, unsafe sleep practices, fires, and child abuse/neglect**.

Traffic 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 89 cases (23.5% of all death cases reviewed) in 2007 involving motor vehicles.
Of these:

- Sixty-eight (76.4%) children were traveling in a car/van/pickup/SUV.
- Forty-six (51.7%) cases involved a driver not tested for driving under the influence.
- Forty-two (61.8%) of the 68 children riding in a car/van/pick-up were unrestrained.
- Thirty-one (34.8%) involved drivers age 17 years or younger.
- Fifteen (22.1%) operators of vehicles were cited for driving under the influence.
- Eleven (12.4%) were pedestrians.
- Three (3.4%) were riding All-Terrain Vehicles (ATVs), with the youngest nine years of age and the oldest 15. None were wearing a helmet. One occurred on private land, the remaining two occurred on public roadways.
- Two (2/2%) were riding a bicycle, with one wearing a helmet.

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.
- Legislation that bans the use of wireless hand-held telephone or electronic communication devise by motor vehicle operators.
- Strengthening of the booster seat legislation to include use up to age eight.
- 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.

Administrative recommendations

- Enforcement of child passenger safety restraint laws, which include fines for drivers transporting unrestrained children.
- Develop and disseminate a campaign that will promote the best practices related to booster seat usage.

Recommendations

- Provide, at no cost, driver education classes for all high school and career tech students.
- Increase accessibility and use of drug courts and drug treatment programs.

Unsafe Sleep Practices

Key Findings

There were a total of 105 (27.8%) deaths where unsafe sleeping practices contributed to the death.
Of these:

- Seventy-six (72.4%) were ruled Unknown manner of death, with the Medical Examiner stating unsafe sleep conditions might have contributed to the death.
- Twelve (3.2%) were ruled Accidental deaths with sleep conditions contributing to accidental suffocation/asphyxia.
- Twenty-seven (7.1%) deaths were classified as Sudden Infant Death Syndrome (SIDS). Of these 27 cases, four of the children were sharing the same sleep surface with an adult or sibling. Regarding sleep position, 11 children were sleeping on their stomach, six were on their backs, four were sleeping on their side, and it was unknown as to the sleep position of six of the children.

Recommendations

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

- The Office of the Chief Medical Examiner and law enforcement agencies should adopt the Centers for Disease Control's model policy for investigation and classification of Sudden Unexpected Infant Deaths (SUID) and Sudden Infant Death Syndrome (SIDS), including the use of scene re-creation and digital photography. The methods currently utilized do not adequately provide the opportunity to distinguish accidental overlay (smothering) from undetermined causes.
- Affordable childbirth classes should be available to all expectant mothers and address safe sleep issues prior to birth. Scholarships should also be available to those who cannot afford classes.
- Education on safe sleep environments should also be provided to families after delivery but prior to discharge.
- Education on safe sleep environments should be provided to families at the first well-child visit.
- Distribute cribs for low-income families.
- All hospitals in Oklahoma should adopt a policy regarding in-house safe sleep issues.

Recommendations

Drownings

Key Findings

In 2007 the Oklahoma Child Death Review Board reviewed 27 deaths due to drowning.
Of these:

- Nine (33.3%) occurred in a natural body of water. Of these, four were in lakes, four were in a river, and one was in a farm pond.
- Ten (37.0%) occurred in a residential swimming pool and all but one were residents or visitors of the home where the pool was located.
- Five (18.5%%) occurred in bathtubs.
- One (6.3%) occurred in an apartment pool
- One (6.3%) occurred in a ditch.
- One (6.3%) occurred in an abandoned well.
- Fourteen (51.9%) were four years of age and younger (nine of these were age two), nine (33.3%) were five through 12 years of age, and four (14.8%) 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:
Legislative 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 of any new pool/hot tub.

Administrative recommendations

- Increase access to swimming lessons for all children.
- Fund and distribute the "water watcher" badges that promote appropriate and responsible adult supervision of children around water.
- EMS/National Weather Service include a warning regarding the dangers of flash floods in weather alerts.

Fires

Key Findings

In 2007 the Oklahoma Child Death Review Board reviewed 18 deaths due to fires.
Of these:

- Nine fires were responsible for the 18 deaths.
- Only one (11.1%) of the nine fire incidents had a working smoke detector present in the residence.

Recommendations

- Two (22.2%) of the nine fire incidents investigators were 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:

- Smoke alarm giveaway programs should include carbon monoxide detectors.
- Increased penalties for homeowners who do not provide smoke alarms for rental houses.

Child Abuse/Neglect Deaths

Key Findings

In 2007 the Oklahoma Child Death Review Board reviewed and closed 34 cases that were concluded by the Board to have been a result of child abuse/neglect. Fifteen (44.1%) cases had previous child welfare referrals. 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:

- Increased funding of 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.

Agency Specific Recommendations

Oklahoma Safe Kids Coalition

- Promotion and establishment of funding for Safe Kids Oklahoma and its prevention programs. The programs include Child Passenger Safety, "Walk This Way" pedestrian safety, bicycle safety, burn prevention, and water safety.

Oklahoma Child Death Review Board

- Promotion and establishment of funding for the Oklahoma Child Death Review Board's Think. Prevent. Live. campaign that addresses (or will address) water, fires, wheeled activities, sleep, and child abuse/neglect prevention best practices.

Board Activities

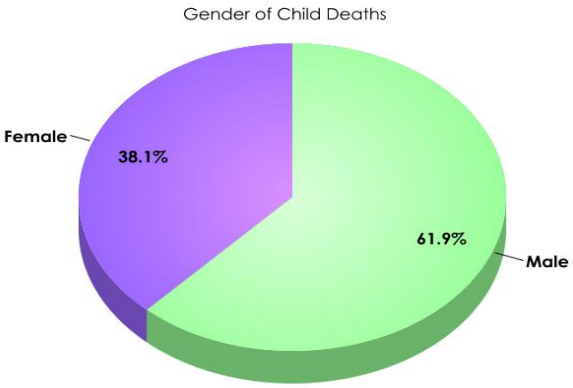
- Continued collaborations with the Domestic Violence Fatality Review Board.
- Continued collaborations with the Oklahoma Violent Death Reporting and Surveillance System, Injury Prevention Services, Oklahoma State Department of Health.
- Joined the Oklahoma County Fetal-Infant Mortality Review Community Action Team.
- Eleven letters to District Attorneys inquiring if charges had been filed.
- One letter to a District Attorney inquiring as to why a case was not referred to another county due to a conflict of interest.
- Seven letters to the Office of the Chief Medical Examiner regarding the manner/cause of death.
- Three letters to the Office of the Chief Medical Examiner requesting clarification of medical details.
- One letter to the Office of the Chief Medical Examiner regarding policies and procedures for responding to the scene of an infant death.
- Three letters to the Oklahoma Department of Human Services (OKDHS) regarding the licensing status of child care homes.
- Two letters to the OKDHS requesting an investigation be opened on a surviving sibling.
- Two letters to the OKDHS regarding locating families.
- Two letters to the OKDHS requesting a copy of a voluntary service agreement and safety plan.
- One letter to the OKDHS regarding surviving siblings.
- One letter to the OKDHS regarding the specific services a family received.
- One letter to the OKDHS regarding policies and procedures for medical appointments for children taken into custody.
- One letter to the OKDHS requesting OKDHS re-examine policies and procedures for investigating motor vehicle accidents when the driver was the person responsible for the child and also driving under the influence.
- One letter to the OKDHS regarding a foster child not being removed from a home when biological children were.
- One letter to the OKDHS regarding the status of a foster home.
- One letter to a law enforcement agency recommending improvement of scene investigation.
- One letter to a law enforcement agency inquiring as to its participation in an investigation when a conflict of interest was possible.
- One letter to a law enforcement agency requesting the results of an Internal Affairs investigation.
- One letter to a law enforcement agency requesting information from a gun trace.
- One letter to a law enforcement agency inquiring why perpetrator was not arrested at the scene.
- One letter to a law enforcement agency recommending the agency make a referral to child welfare when concerned for the safety of surviving siblings.
- One letter to a law enforcement agency referring a case for investigation.
- One letter to the Council on Law Enforcement Education and Training regarding training or policy on responding to a call concerning a dangerous animal.
- Two letters to physicians requesting expertise on a case.
- One letter to a hospital regarding sleep policies for mothers and babies in the neonatal unit.
- One letter to the Post-Adjudication Review Board communicating concerns and requesting the period of review be extended.
- One letter to the director of the Children First home-visitor program regarding policy for addressing home safety with clients.
- One letter to the director of the Oklahoma Coalition Against Domestic Violence and Sexual Assault regarding policy for addressing general home safety with clients.

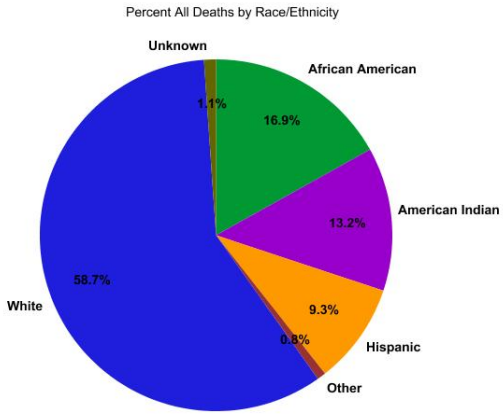
Cases Closed in 2007

The Board reviewed and closed 378 deaths in 2007. Please note that the deaths reviewed in 2007 may not have occurred in 2007.

Deaths Reviewed by the Board in 2007

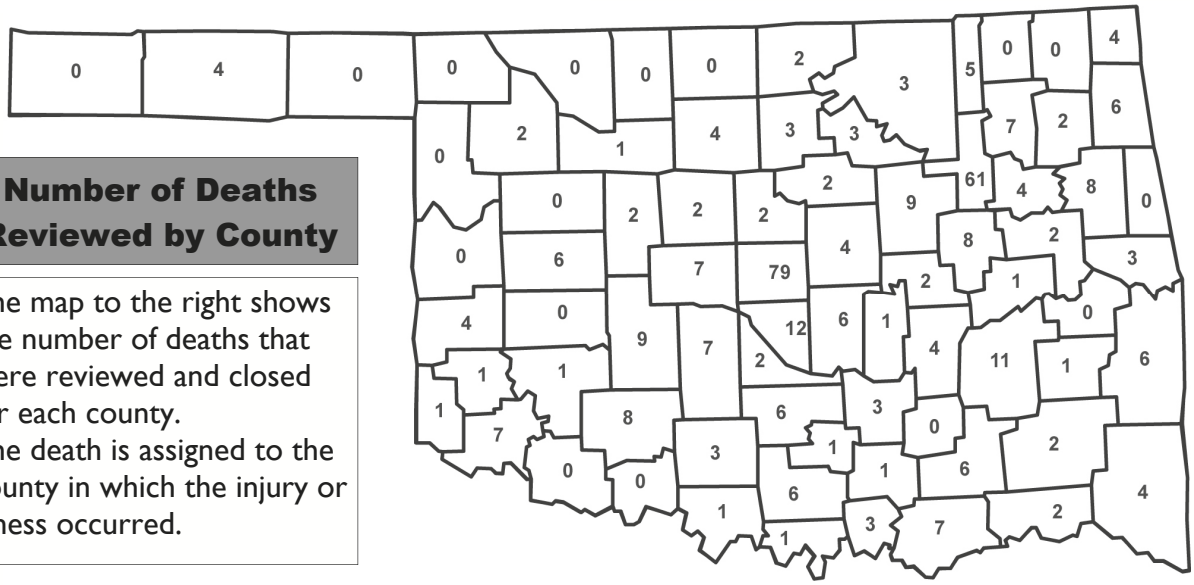
Manner	Number	Percent
Accident	170	45.0%
Homicide	47	12.4%
Natural	51	13.5%
Suicide	16	4.2%
Unknown	94	24.9%





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 Cases

There were eight foster care deaths reviewed and closed in 2007. Three (37.5%) were ruled Unknown by the Medical Examiner, three (37.5%) were Accidental, one was ruled Natural, and one Homicide. Two (one accident and the homicide) were ruled abuse/neglect by the Board. OKDHS confirmed abuse/neglect on one accident.

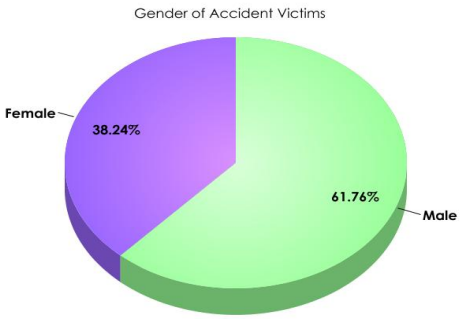
Number of Decedents with Previous Involvement in Selected State Programs

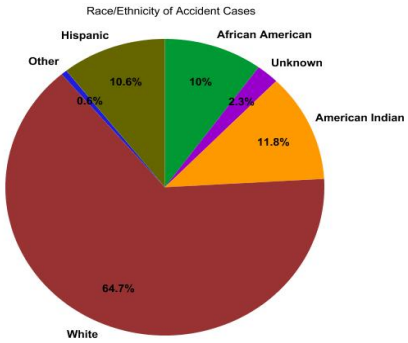
Agency	Number	Percent Of All Deaths
Children First	6	1.6%
OKDHS - CW	98	25.9%
ODMHSAS	6	1.6%
Office of Child Abuse Prevention	4	1.1%
Office of Juvenile Affairs	9	2.4%

Accidents

The Board reviewed and closed 170 deaths in 2007 ruled Accident.

Type of Accidents Reviewed		
Type	**Number**	**Percent**
Vehicular	89	52.4%
Drowning	25	14.7%
Fire Related	17	10.0%
Asphyxia/ Suffocation	17	10.0%
Poisoning/Overdose	9	5.3%
Confinement/ Hyperthermia	4	2.4%
Firearm	4	2.4%
Other	5	2.9%



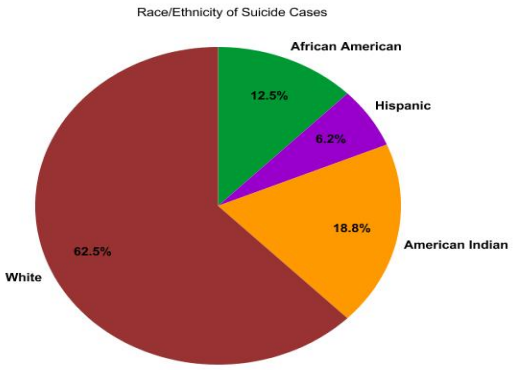


Suicides

The Board reviewed and closed 16 deaths in 2007 ruled Suicide.

Method of Suicide		
Method	**Number**	**Percent**
Firearm	8	50.0%
Asphyxia/ Suffocation	8	50.0%

Contributing Factors		
Factor	**Number**	**Percent**
Conflict with par-ents	5	31.3%
History of Mental Health Issues	3	18.8%
Conflict with boy-friend/girlfriend	1	6.3%
Substance Use/ Abuse	4	25%
School Problems	3	18.8%



Under the Care of a Counselor		
Seeing Counselor	**Number**	**Percent**
Yes	0	0.0%
No	7	43.7%
Unknown	9	56.3%

Homicides

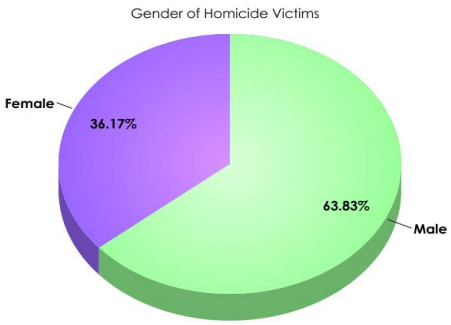
The Board reviewed and closed 47 deaths in 2007 ruled Homicide.
Two domestic violence incidents resulted in 6 deaths.

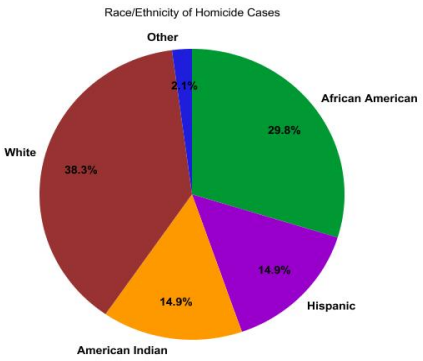
Cause of Death in Homicide Cases

Cause of Death	Number	Percent
Firearm Related	30	63.8%
Struck/Shaken	6	12.8%
Struck/Beaten	3	6.4%
Suffocation	3	6.4%
Drowned	1	2.1%
Fire Related	1	2.1%
Removed from the Womb	1	2.1%
Cut/Stabbed	1	2.1%
Head Trauma	1	2.1%

Person Arrested for Death

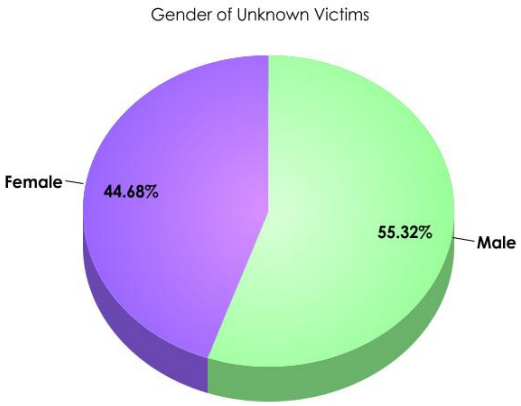
Perpetrator	Cases
Stranger	7
Biological Father	5
Other Juvenile	5
Mother's Boyfriend	3
Biological Mother & Biological Father	2
Biological Mother & Mother's Boyfriend	2
Biological Mother	1
Adoptive Father	1
Former Boyfriend	1
2 Juveniles	1
Adult Acquaintances	1
Neighbor	1
No Arrest Made	17

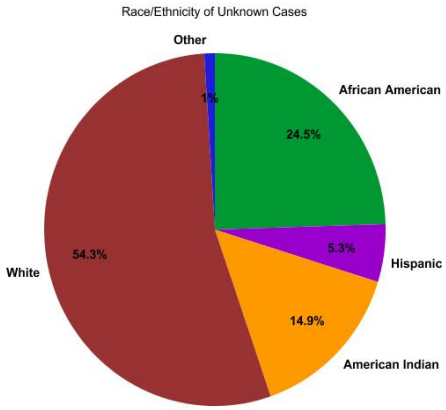




Unknown

The Board reviewed and closed 94 deaths in 2007 ruled Unknown.
Seventy-six (80.9%) of these were ruled Unknown manner of death with the Medical Examiner stating unsafe sleep conditions may have contributed to the death.
Four (4.3%) were suspicious for trauma or neglect.
One (1.06%) was a concealed pregnancy where the Medical Examiner was unable to determine the manner/cause of death.

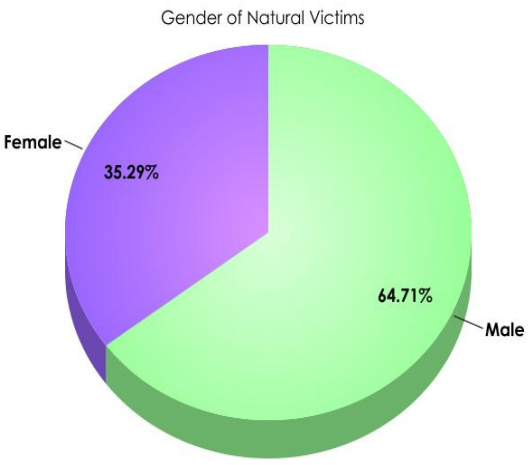


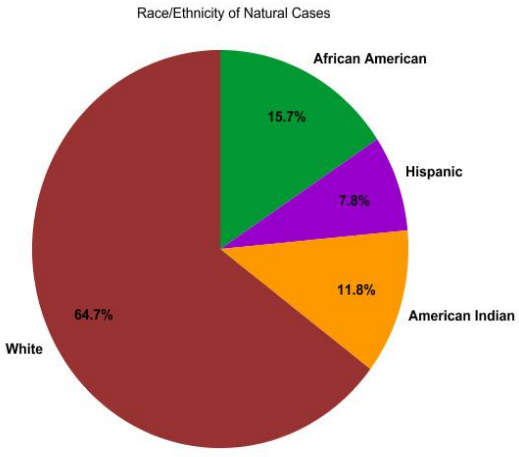


Natural Deaths - Reviewed

The Board reviewed and closed 51 deaths in 2007 ruled Natural.

Illnesses and Diseases Encountered in Natural Death Cases		
Illness/Disease	**Number**	**Percent**
SIDS	27	52.9%
Asthma	4	7.8%
Congenital Anomalies	3	5.9%
Septicemia	2	3.9%
Other Conditions	13	25.5%
Unknown	11	21.6%





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 coincide 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.

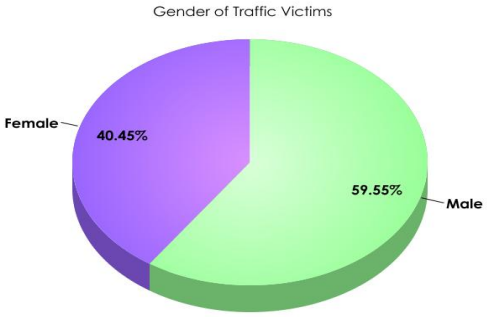
The death certificate review process findings in 2007 are as follows:

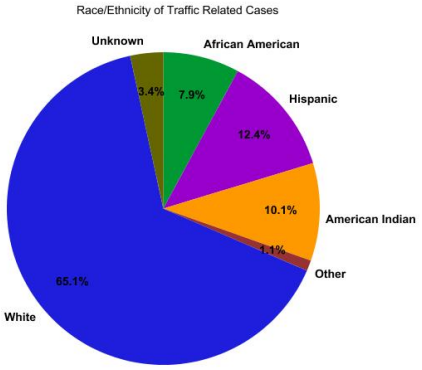
Cause of Death or Medical Condition	Number of Death Certificates Received	Percent
Prematurity	208	42.4%
Congenital Disorder	78	15.9%
Infectious Disease	50	10.2%
Neoplasm	40	8.1%
Neurological Condition	36	7.3%
Cardiac Disease	35	7.2%
Intrauterine/Birth Complication	16	3.3%
Renal Disorder	9	1.8%
Pulmonary Condition	9	1.8%
Metabolic Disorder	5	1.0%
Gastrointestinal Disorder	4	0.8%
Endocrine Condition	1	0.2%
TOTAL	491	100.0%

Traffic Deaths

The Board reviewed and closed 89 deaths in 2007 related to motor vehicles. There were forty-six (51.7%) cases where the driver was not tested for driving under the influence. Fifteen (22.1%) operators of vehicles were cited for driving under the influence. Of the All Terrain Vehicles (ATV), one occurred on private land and two were on public roadways; none were wearing a helmet. Of the two bicycle fatalities one was wearing a helmet.

Vehicle of Decedent		
Vehicle	**Number**	**Percent**
Car/Van/SUV	68	76.4%
ATV	3	3.4%
Bicycle	2	2.2%
Aircraft	2	2.2%
Motorcycle	1	1.1%
Charter Bus	1	1.1%
Commercial Truck	1	1.1%
Pedestrian	11	12.4%





Use of Safety Restraints by Victims		
Seatbelt/Car seat Use	Number	Percent
Properly Restrained	20	22.5%
Not Properly Restrained	42	47.2%
Unknown	6	6.7%
Not Applicable	21	23.6%

Activity of Decedent		
Position	**Number**	**Percent**
Operator	20	22.5%
Front Passenger	15	16.9%
Rear Passenger	35	39.3%
Pedestrian/ Bicycle	13	14.6%
Unknown	6	6.7%

Age of Driver of Decedent's Vehicle		
Age	**Number**	**Percent**
<13	3	3.4%
13-15	4	4.5%
16	14	15.7%
17	10	11.2%
18	2	2.2%
19-21	5	5.6%
>21	40	44.9%
N/A	11	12.4%

Drowning Deaths

The Board reviewed and closed 27 deaths in 2007 due to drowning. Of these, 25 were accidental manner of death, one was a homicide, and one unknown. The "other" locations were an apartment pool, a ditch, and an abandoned well. Fourteen (51.9%) were four years of age and younger (nine of these were age two), nine (33.3%) were five through 12 years of age, and four (14.8%) were 13 years of age or older.

Location of Drowning

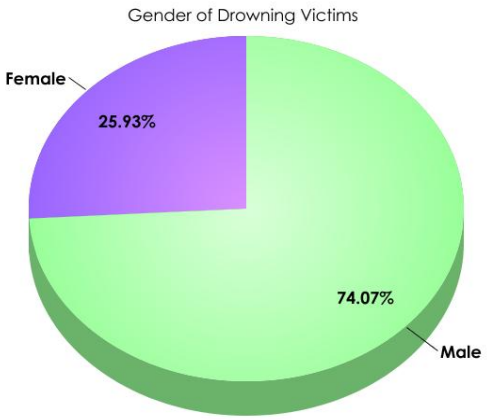
Location	Number	Percent
Private, Residential Pool	10	37.0%
Natural Body of Water (i.e. creek, river, pond, lake)	9	33.3%
Bathtub	5	18.5%
Other	3	11.1%

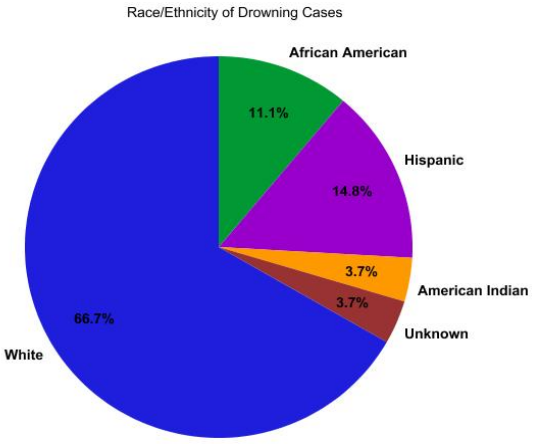
Owner of Residential Pool

Pool Owner	Number	Percent
Parents of Deceased Child	7	70.0%
Grandparents of Deceased Child	1	10.0%
Neighbor	1	10.0%
Party Host	1	10.0%

Type of Residential Pool

Type of Pool	Number	Percent
Above Ground	8	80.0%
In Ground	2	20.0%

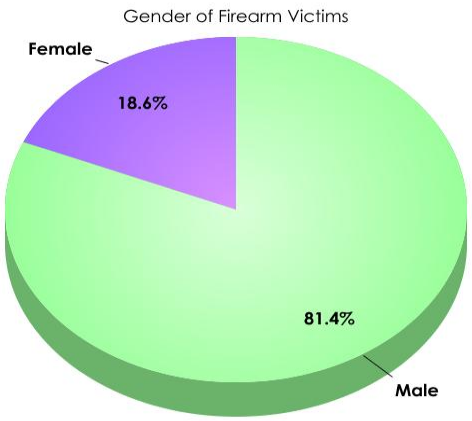




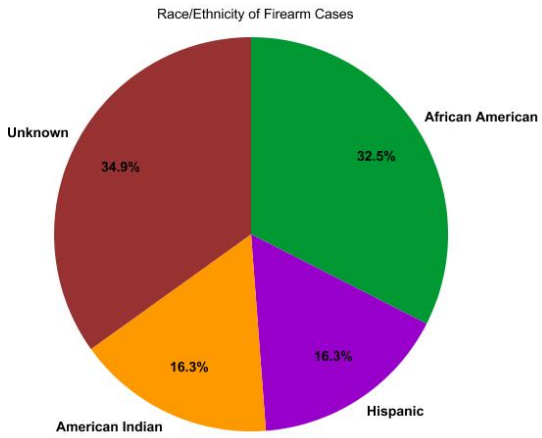
Firearm Deaths

The Board reviewed and closed 43 deaths in 2007 that involved firearms. The age of the youngest shooter was four years old, the oldest 48; average age of shooter was 21.46 years of age.

Manner of Death for Firearm Victims		
Manner	**Number**	**Percent**
Accident	4	9.3%
Homicide	30	69.8%
Suicide	8	18.6%
Undetermined	1	2.3%



Type of Firearm Used		
Type of Firearm	**Number**	**Percent**
Handgun	36	83.7%
Shotgun	2	4.7%
Rifle	2	4.7%
Assault Rifle	1	2.3%
Unknown	2	4.7%



Sudden Infant Death Syndrome (SIDS)

The Board reviewed and closed 27 deaths in 2007 that were ruled Sudden Infant Death Syndrome.

Age of Infant

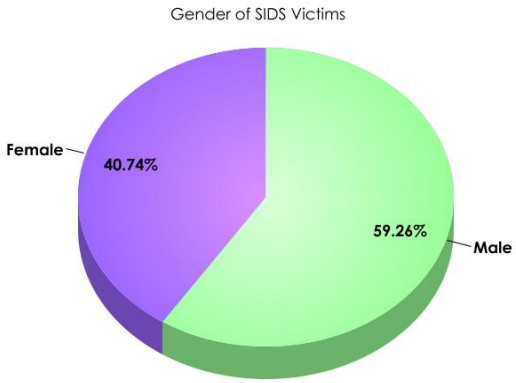
Age (in months)	Number	Percent
Less than 2	7	25.9%
2—6	19	70.4%
More than 6	1	3.7%

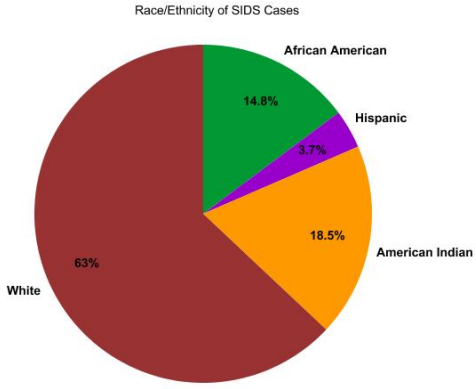
Sleeping Position of Infant

Position	Number	Percent
On Stomach	11	40.7%
On Back	6	22.2%
On Side	4	14.8%
Other	0	0.0%
Unknown	6	22.2%

Sleeping Arrangement of Infant

Sleeping Arrangement	Number	Percent
Alone	23	85.2%
With Adult	2	7.4%
With Sibling	2	7.4%





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

(405) 271-4480

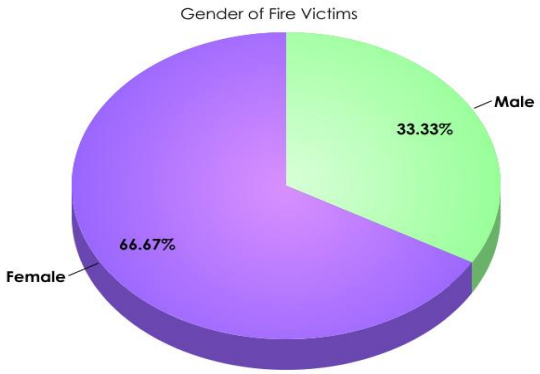
Fire Deaths

The Board reviewed and closed 18 deaths in 2007 due to fires. Seventeen were ruled accident and one was ruled homicide.

Working Smoke Detector Present

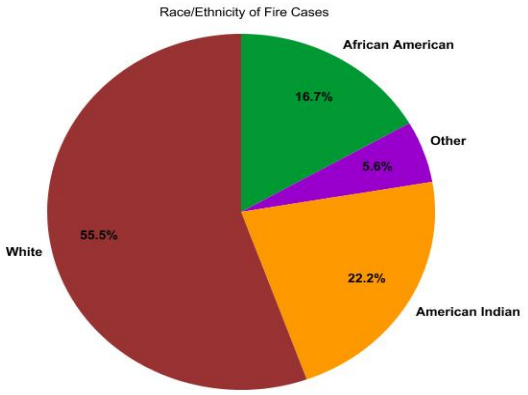
Detector	Number*	Percent
Yes	1	11.1%
No	6	66.7%
Unknown	2	22.2%

*This number adds up to 9 due to there being 9 separate fire incidents.



Age at Time of Death

Age	Number	Percent
< 5	6	33.3%
5-10	9	50.0%
> 10	3	16.7%

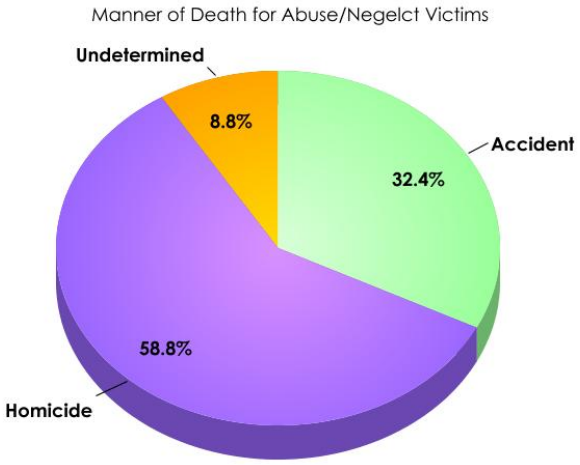


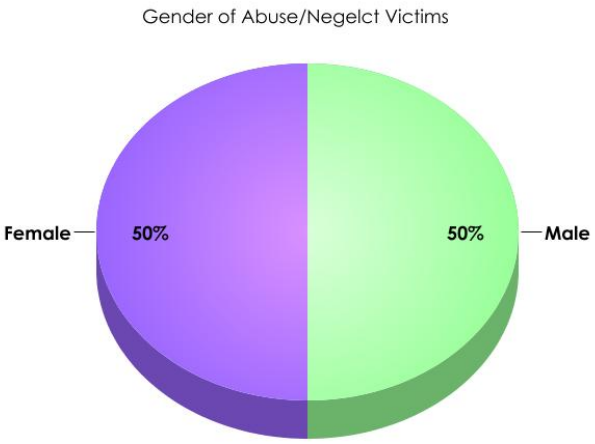
Probable Cause of Fire and Total Number of Deaths

Cause	Number of Incidents	Total Number of Children Killed in Incidents
Refrigerator Motor Shorted Out	1	5
Christmas Tree Caught Fire	1	3
Lighting	1	3
Candle Ignited Sofa	1	2
Furnace Shorted Out	1	1
Arson	1	1
Could not Be Determined	3	3

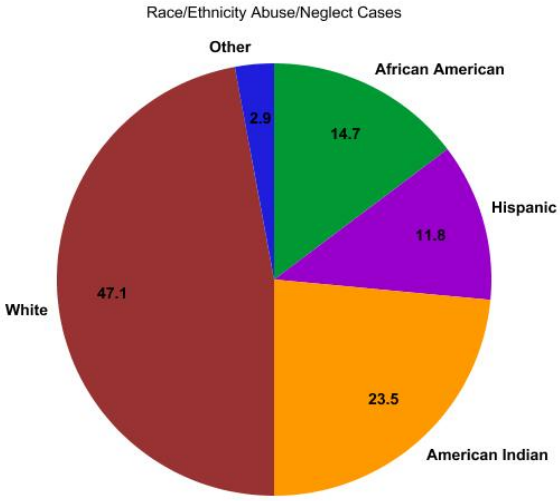
Abuse/Neglect Deaths

The Board reviewed and closed 34 deaths that the Board ruled abuse and/or neglect contributed to the death. Of these, 25 were investigated and ruled abuse and/or neglect by OKDHS.





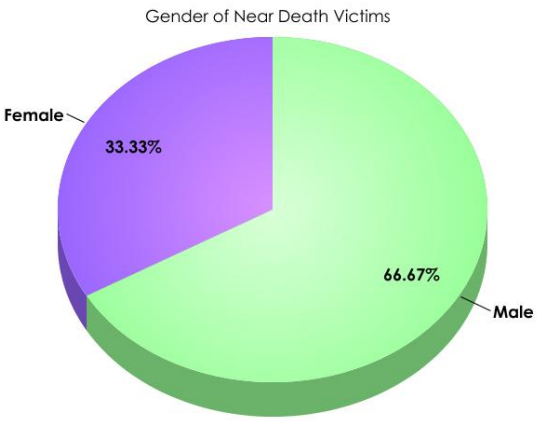
Individuals Arrested for Child's Death		
Perpetrator	**Number**	**Percent**
Biological Father	8	21.1%
Biological Mother & Biological Father	3	7.8%
Mother's Boyfriend	3	7.8%
Biological Mother	2	5.3%
Biological Mother & Mother's Boyfriend	2	5.3%
Child Care Worker	1	2.6%
3 Juveniles	1	2.6%
No Arrest Made	14	47.4%

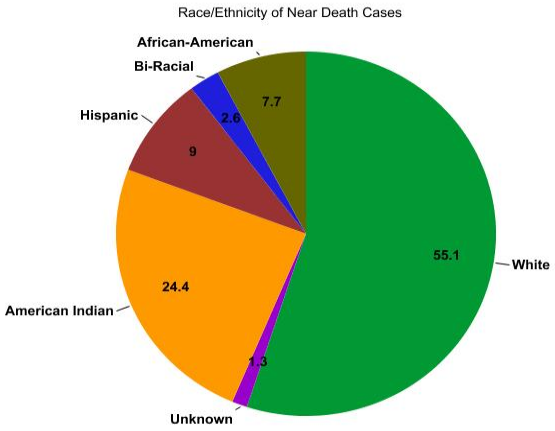


To report child abuse or neglect in Oklahoma *PLEASE* call:
1-800-522-3511

Near Deaths

The Board reviewed and closed 78 near death cases in 2007. A case is deemed near death if the child was admitted to the hospital in serious or critical condition as a result of abuse or neglect.





Injuries in Near Death Cases

Injury	Number	Percent
Struck/Shaken	17	21.8%
Vehicular	11	14.1%
Poison/Overdose	7	9.0%
Near Drowning	6	6.7%
Fall	5	6.4%
Struck/Hit	4	5.1%
Fire Related	3	3.8%
Suffocation/ Strangulation	3	3.8%
Natural Illness	3	3.8%
Other	19	24.4%

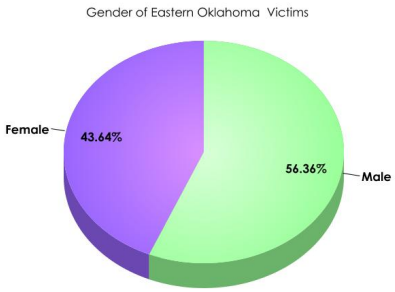
Abuse/Neglect Allegations Confirmed by OKDHS Against:

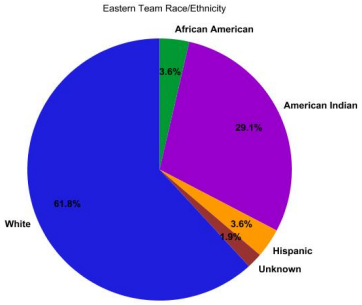
Perpetrator	Number
Not Confirmed	27
Biological Mother	15
Biological Father	13
Biological Mother and Biological Father	8
Biological Mother and Mother's Boyfriend	6
Foster Parent	3
Mother's Boyfriend	1
Childcare Worker	1
Other	4

Eastern Regional Review Team

The Eastern Team reviewed and closed 55 cases in 2007. The team meets quarterly in Muskogee, OK. Counties include Adair, Cherokee, Craig, Delaware, Haskell, Latimer, Le-Flore, McIntosh, Mayes, Muskogee, Nowata, Okmulgee, Ottawa, Rogers, Sequoyah, and Wagoner.

Manner of Death for Eastern Oklahoma Cases		
Manner	**Number**	**Percent**
Accident	27	49.1%
Homicide	2	3.6%
Natural	11	20.0%
Suicide	3	5.5%
Undetermined	12	21.8%





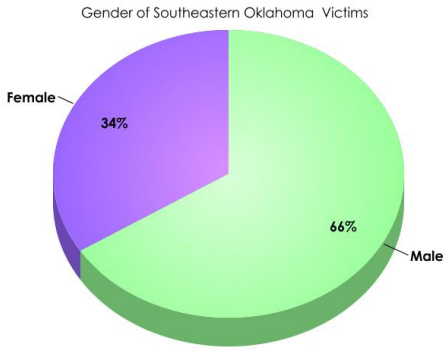
2007 Team Members

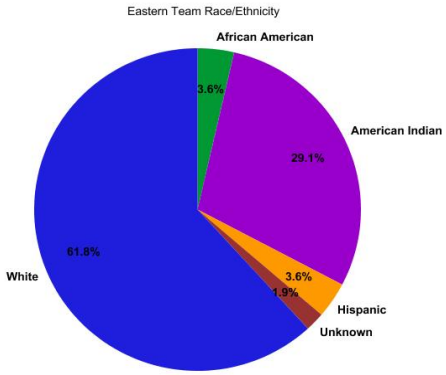
Organization	Team Member	Designee
Medical Representative	Michael Stratton, DO; Chair	Timothy Holder, MD
Muskogee Public Schools	Debbie Winburn; Vice-Chair	
Cherokee Nation Mental Health	Misty Boyd, PhD	
Muskogee County Sheriff's Office	Tim Brown	Jan Ray
Muskogee County OKDHS	Theresa Buckmaster	Cathy 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
Muskogee County Health Department	Tonya James	
Kids Space	Ann Mathews	Walter Davis, Julie Vinson
Muskogee County EMS	Rebecca Smith	Carlene Morrison
Muskogee County Council on Youth Services	Cindy Perkins	Darren Smith
Muskogee Police Department	AJ Rudd	
Muskogee County Regional Hospital (ER)	Sheila Villines, RN	
Community Representative	Lillian Young, PhD	

Southeastern Regional Review Team

The Southeastern Team reviewed and closed 50 cases in 2007. The team meets quarterly in Shawnee, OK. Counties include Atoka, Bryan, Choctaw, Coal, Hughes, Johnston, Lincoln, McCurtain, Marshall, Okfuskee, Pittsburg, Pontotoc, Pottawatomie, Pushmataha, and Seminole.

Manner of Death for Southeastern Oklahoma Victims		
Manner	**Number**	**Percent**
Accident	27	54.0%
Homicide	2	4.0%
Natural	6	12.0%
Suicide	3	6.0%
Undetermined	12	24.0%





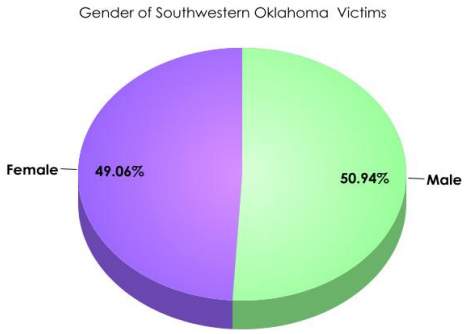
2007 Team Members

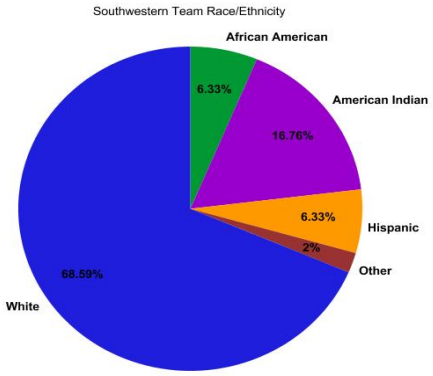
Organization	Team Member	Designee
Child Advocacy Center (Unzner Center)	Laura Allison; Chair	Sharon Trammell
Judicial Representative	Judge Glenn Dale Carter (Ret.); Vice-Chair	
CASA Representative	Gwen Gjovig	
Law Enforcement Representative	Kelly Howard	
Oklahoma Department of Human Services	Carmen Hutchins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

Southwestern Regional Review Team

The Southwestern Team reviewed and closed 53 cases in 2007. The team meets quarterly in Duncan, OK. The counties include Beckham, Caddo, Carter, Comanche, Cotton, Garvin, Grady, Greer, Harmon, Jackson, Jefferson, Kiowa, Love, McClain, Murray, Stephens, Tillman, and Washita.

Manner of Death for Southwestern Oklahoma Victims		
Manner	**Number**	**Percent**
Accident	29	54.7%
Homicide	12	22.6%
Natural	3	5.7%
Suicide	1	1.9%
Undetermined	8	15.1%





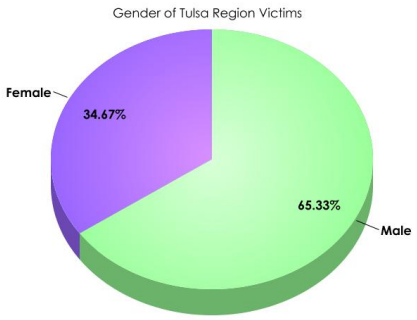
2007 Team Members

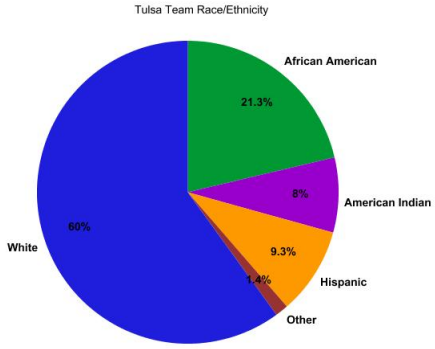
Organization	Team Member	Designee
Law Enforcement Representative	Det. Chris Perkins; Chair	Dets. Keith Stewart, John Randolph
Mental Health Representative	Melanie Smith; Vice-Chair	
Office of Juvenile Affairs	Abby Kimbro	
Medical Representative	Pilar Escobar, MD	
Medical Examiner's Office	Bryan Louch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

Tulsa Regional Review Team

The Tulsa Team reviewed and closed 75 cases in 2007. The team meets every other month in Tulsa, OK and covers Creek, Osage, Tulsa and Washington counties.

Manner of Death for Tulsa Region Victims		
Manner	**Number**	**Percent**
Accident	29	38.7%
Homicide	10	13.3%
Natural	9	12.0%
Suicide	7	9.3%
Undetermined	20	26.7%

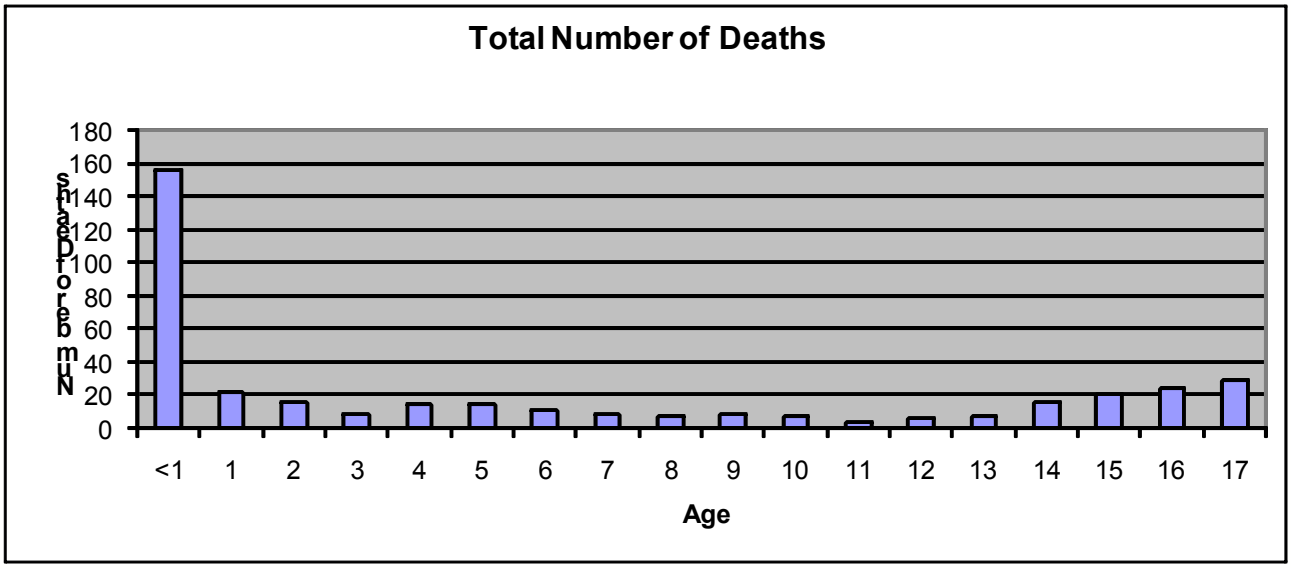


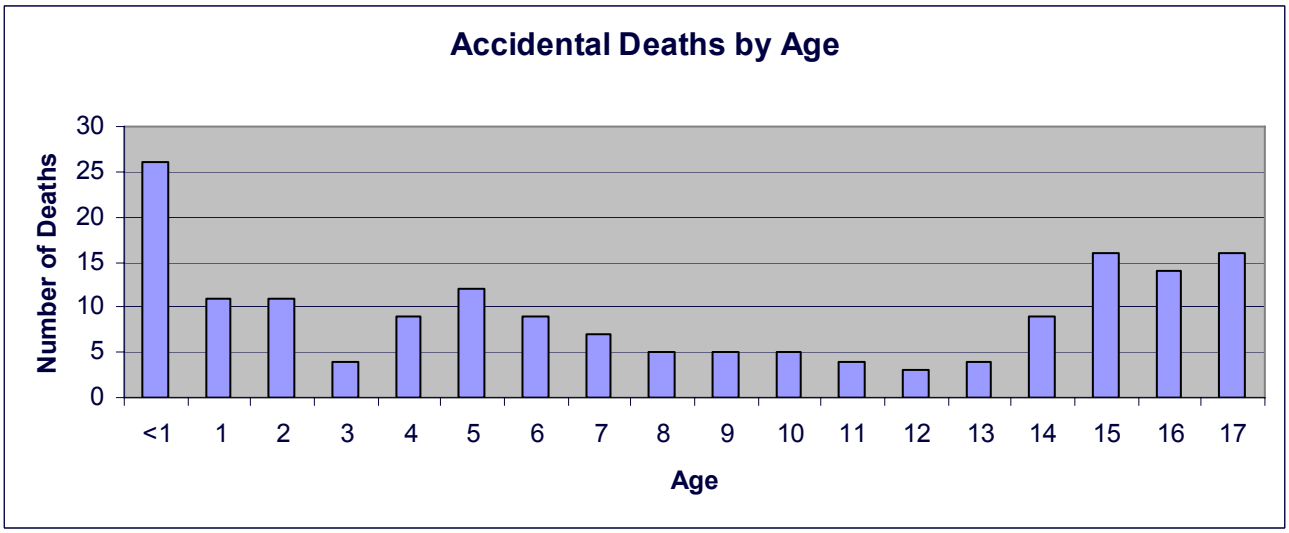


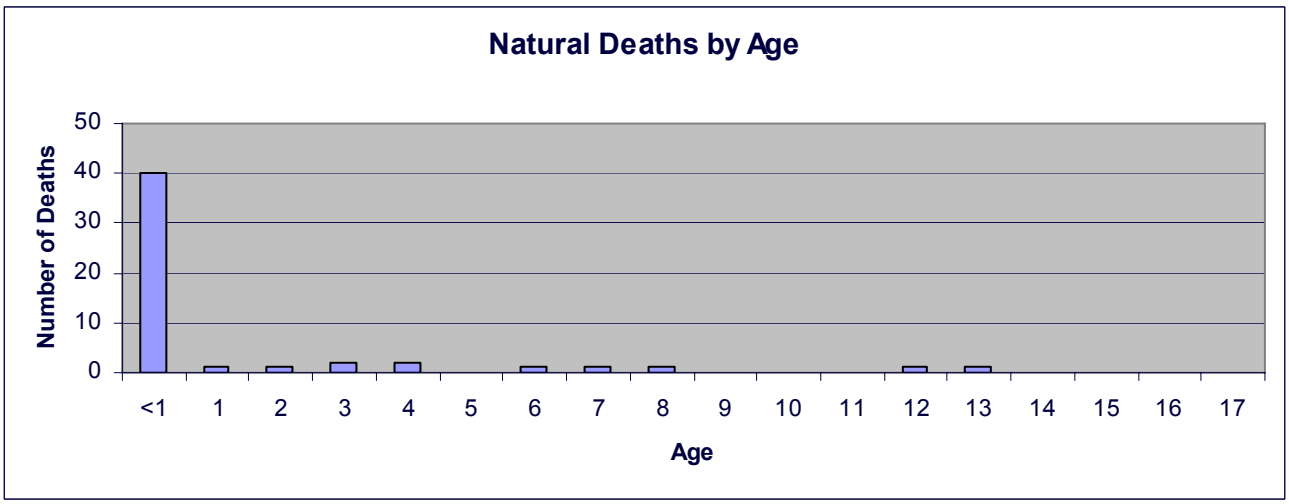
2007 Team Members

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	
Medical Examiner's Office	Ronald Distefano, DO	
Safe Kids Coalition	Mary Beth Ogle	
Mental Health Representative	Rose Perry	
Children's First Representative	Lori Sweeny	Sharon Konemann
Oklahoma Department of Human Services	Steffanie Ward	

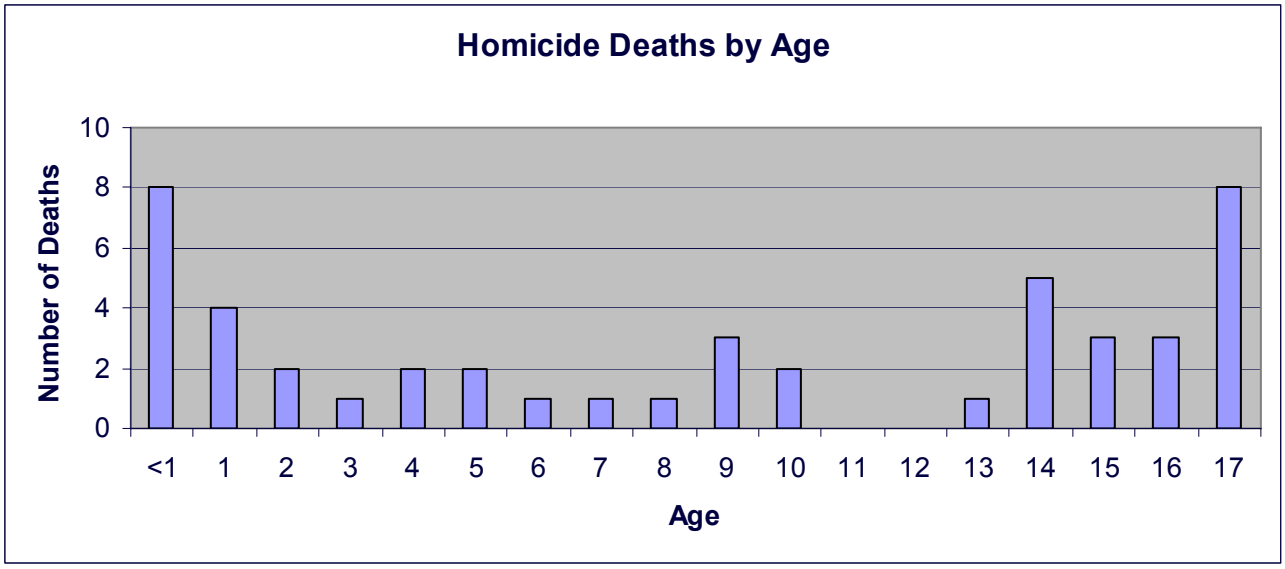
Age of Decedents by Manner

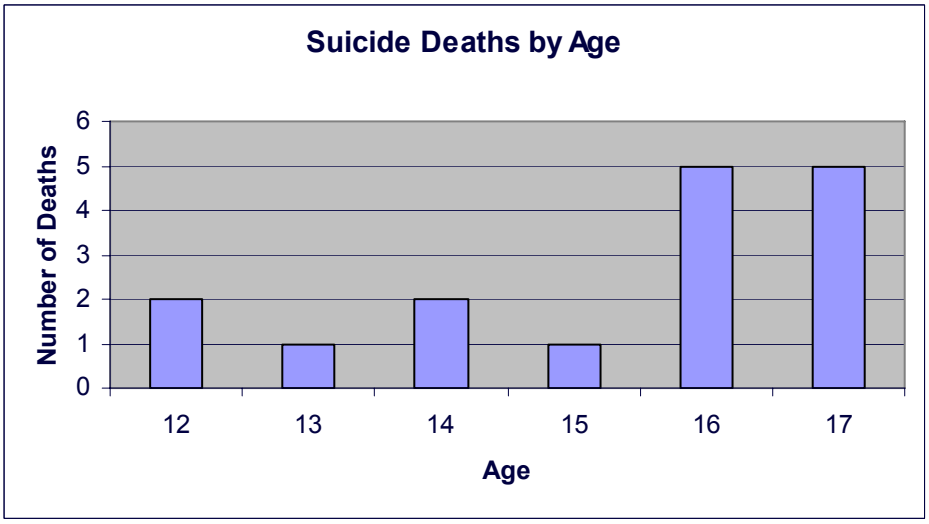


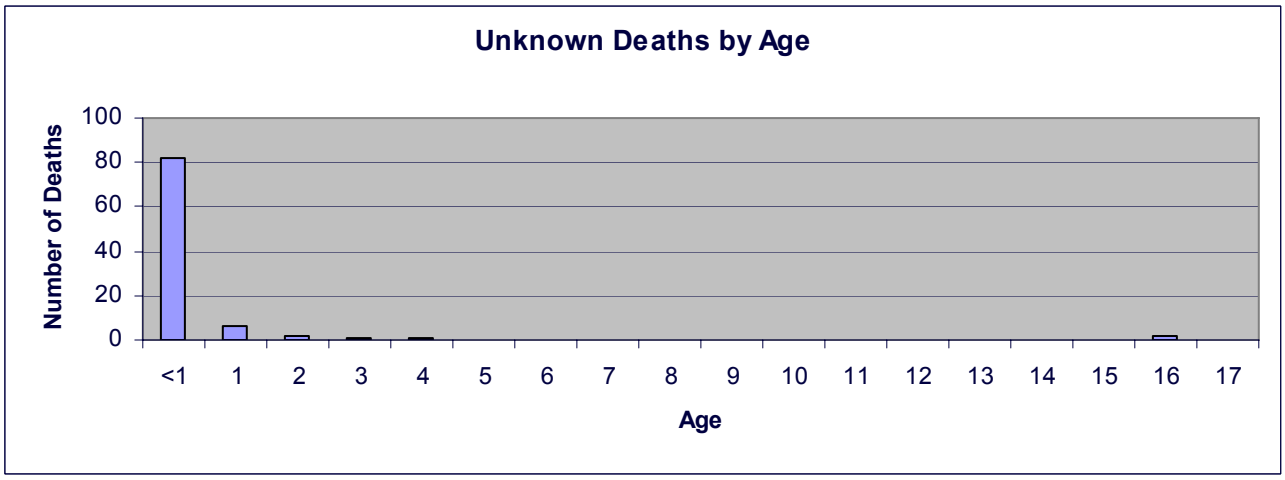




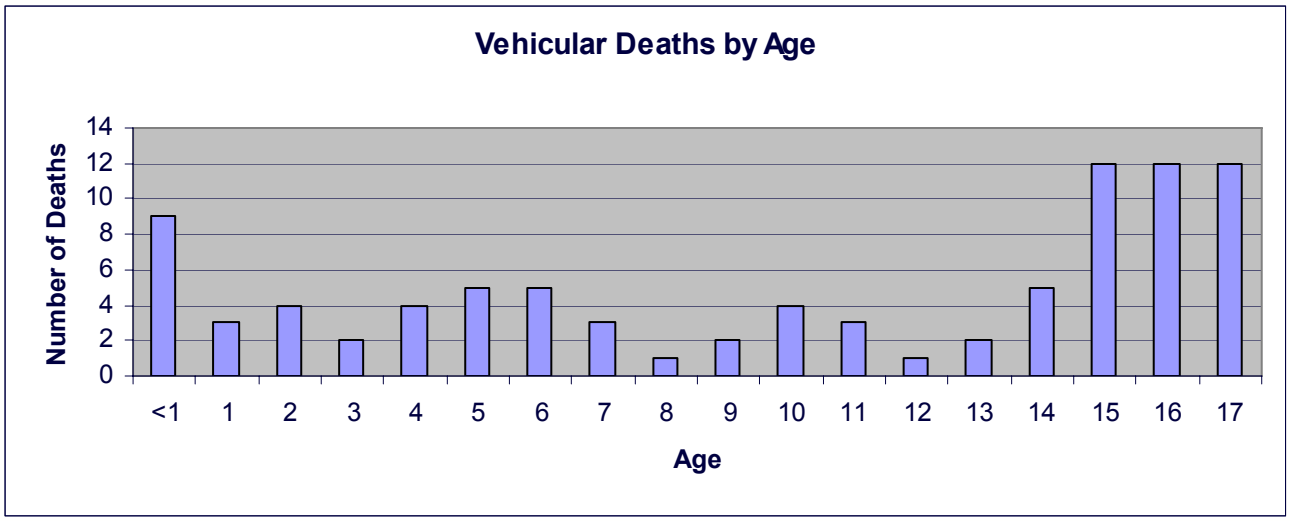
Age of Decedents by Manner

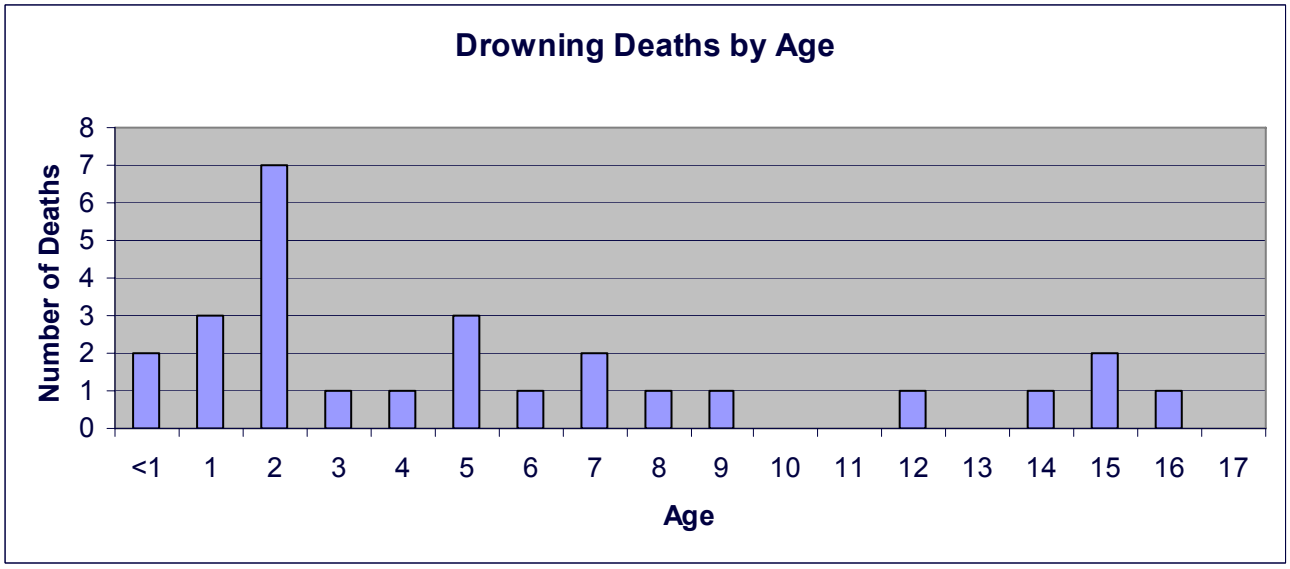


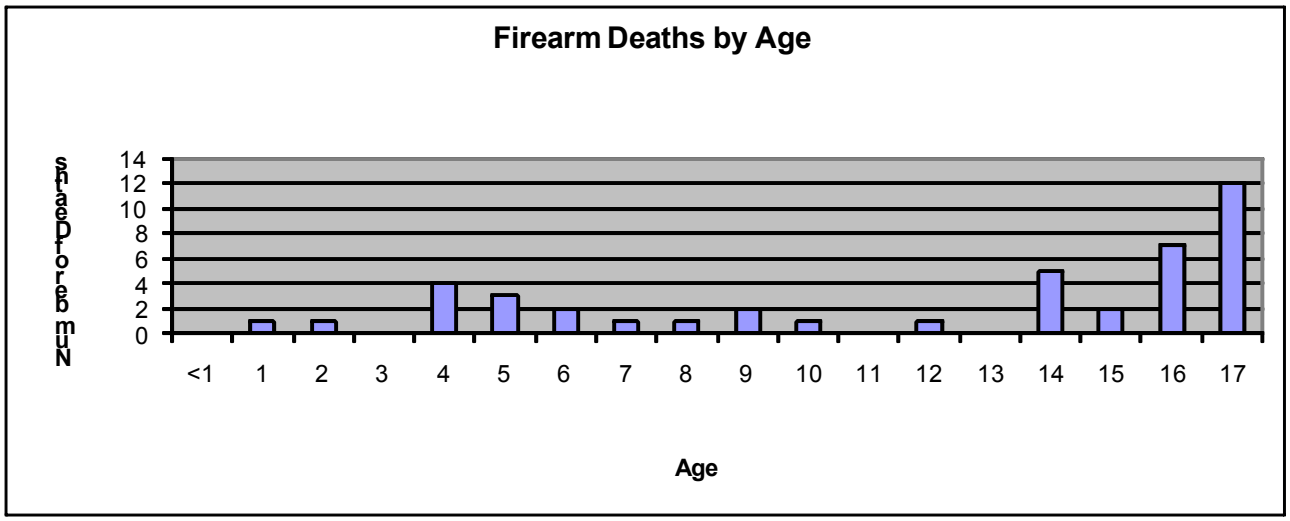




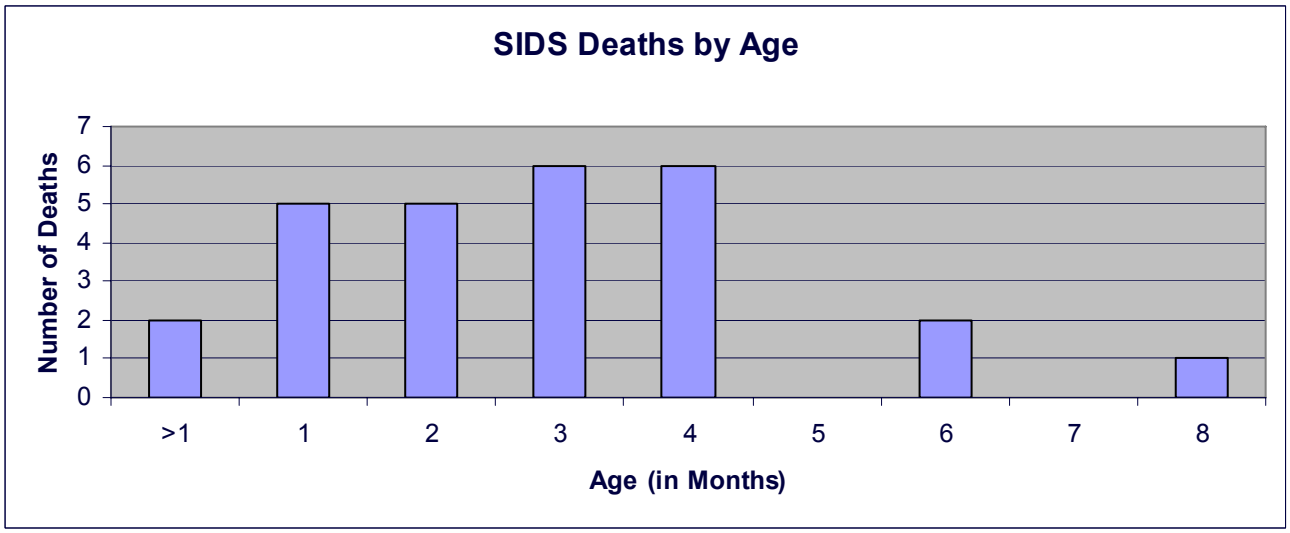
Age of Decedents by Selected Causes

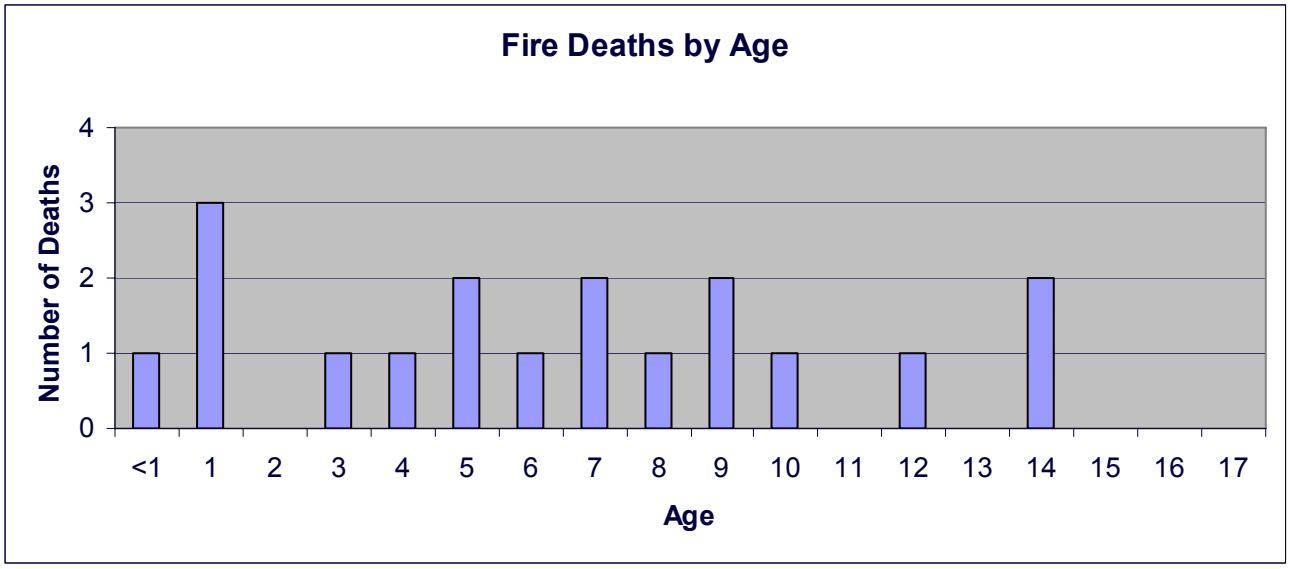


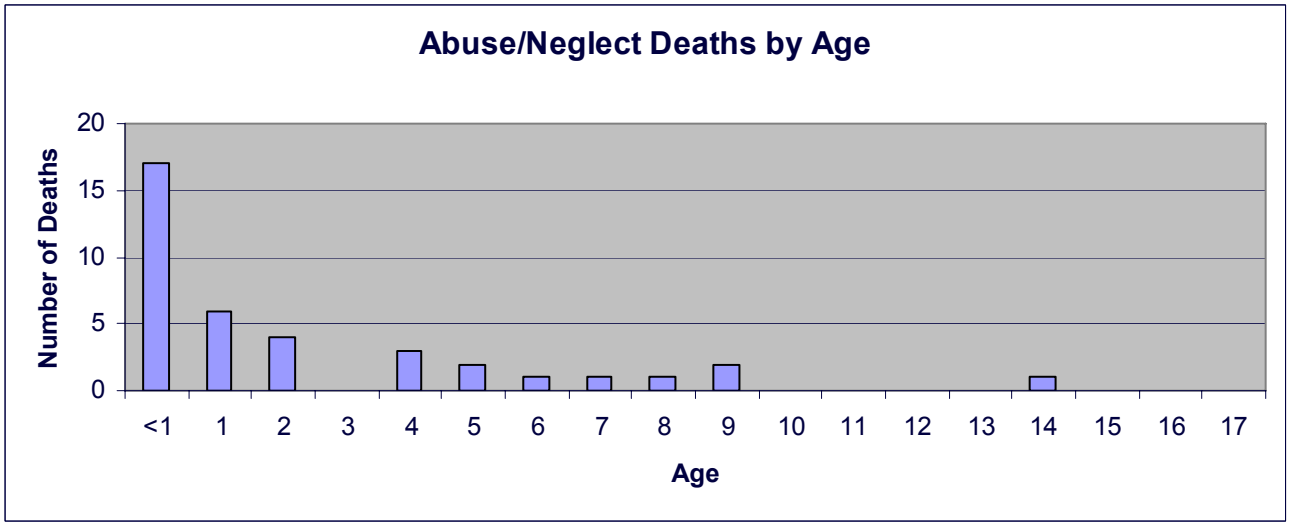




Age of Decedents by Selected Causes

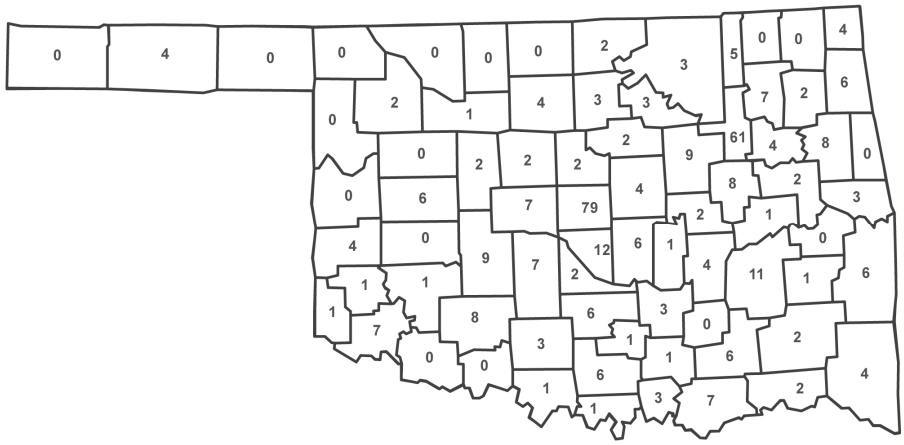




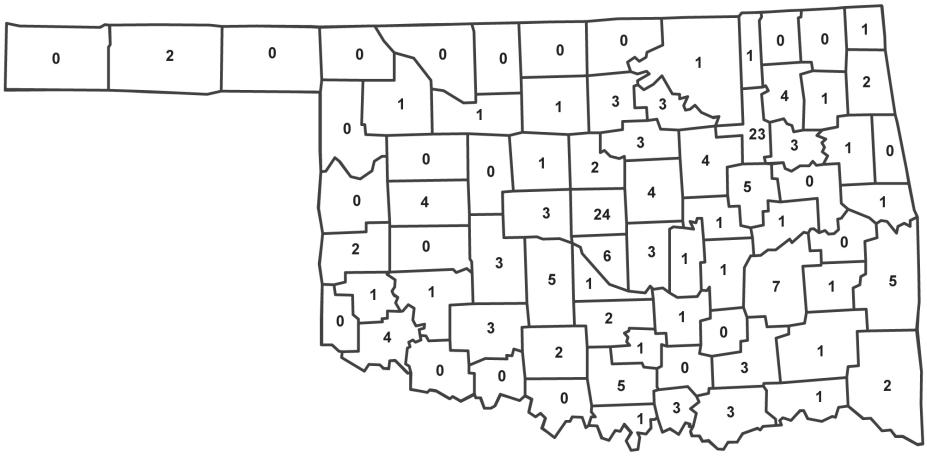


Deaths by County

All Deaths by County



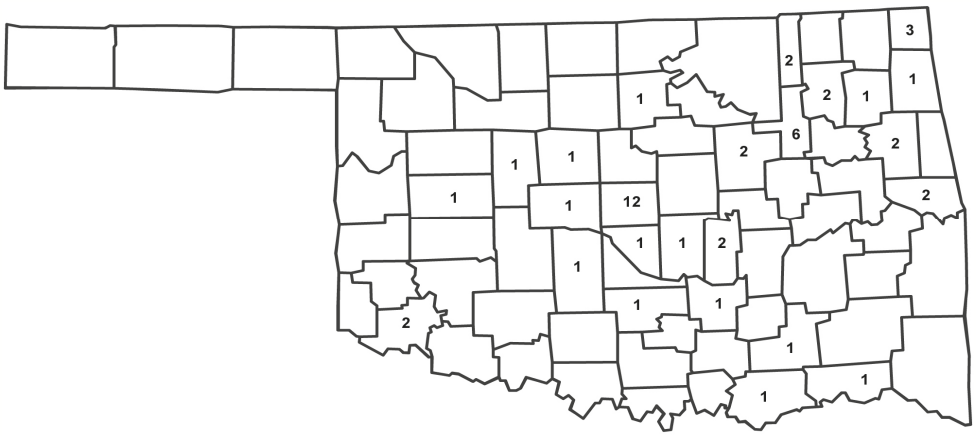
Accidents by County



Homicides by County

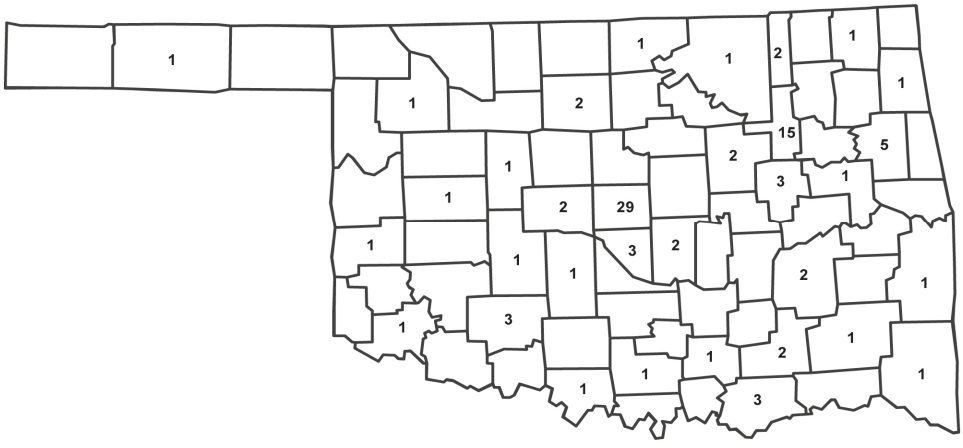
Deaths by County cont.

Natural Deaths by County



Suicide Deaths by County

Unknown Deaths by County



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 (405) 606-4900
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.

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