# Think. Prevent. Live.

Keep Our Children Safe

# The Oklahoma Child Death Review Board
# 2008 Annual Report

Containing information on cases reviewed and closed during the 2008 calendar year

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

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 assistance 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
Oklahoma State Department of Health - Vital Statistics

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# 2008 Oklahoma Child Death Review Board Members

| Agency/Organization | Member | Designee(s) |
|---|---|---|
| *Office of Child Abuse Prevention-OSDH* | *Annette Wisk Jacobi, JD, Chair* | *Amber Shiek, Sherri Trice* |
| *Commissioner of Health-OSDH* | *James M. Crutcher, MD, MPH* | *Carolyn Parks, RN, MHR, Vice-Chair; Diana Pistole* |
| *Injury Prevention Services-OSDH* | *Pam Archer, MPH* | *Ruth Azeredo, DrPH* |
| *Chief Child Abuse Examiner* | *Robert Block, MD* | *Deborah Lowen, MD* |
| *State Epidemiologist-OSDH* | *Kristy Bradley, DVM, MPH* | |
| *Post Adjudication Review Board* | *Jay Scott Brown, MA* | *Buddy Faye Foster* |
| *Office of Juvenile Affairs* | *Gene Christian, JD* | *Donna Glandon, JD* |
| *Maternal and Child Health Services-OSDH* | *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* | *Amelia Moore-Rizzo, RN; Linda Grimes, RN* |
| *Office of the Chief Medical Examiner* | *Jeffery Gofton, MD*<br>*Eric Duval, DO* | *Eddie Johnson; Cherokee Ballard* |
| *Department of Human Services* | *Howard Hendrick, JD, MBA* | *Esther Rider-Salem, MSW* |
| *Oklahoma Commission on Children and Youth* | *Janice Hendryx, MSW*<br>*Lisa Smith, MA* | *Lisa Smith, MA; Joanne Verity, JD* |
| *Oklahoma Coalition Against Domestic Violence and Sexual Assault* | *Evelyn Hibbs* | *Tim Gray, JD; Marcia Smith* |
| *Oklahoma Bar Association* | *Jennifer King, JD* | |
| *Oklahoma State Bureau of Investigation* | *A. DeWade Langley* | *Dale Birchfield; Andi Grosvald-Hamilton; Lynda Stevens* |
| *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* |
| *Oklahoma District Attorney's Council* | *Cathy Stocker, JD* | *Michael Fields, JD; Michael Gahan, JD* |
| *Children's Hospital of Oklahoma* | *John Stuemky, MD* | *Amy Baum, MSW; Kathie Hatlelid, PA-C* |
| *Oklahoma Department of Mental Health and Substance Abuse Services* | *Terri White, PhD* | *Julie Young, MA* |
| *Indian Child Welfare* | *Kara Whitworth* | *Carmin Tecumseh* |

## 2008 Oklahoma Child Death Review Board Staff

*Lisa P. Rhoades, BA, Administrator*

*Ben Dunham, MA; Abdalla Khalid, BS, Case Managers*

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# Recommendations

The following are the 2009 annual recommendations of the Oklahoma Child Death Review Board as submitted to the Oklahoma Commission on Children and Youth in May 2009. The recommendations are based on the deaths reviewed and closed in 2008 that were due to motor vehicles, drowning, unsafe sleep practices, fires, and child abuse/neglect.

## Motor Vehicle Related Deaths

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. *(recommended seven previous times in the past 10 years)*
- Legislation that bans the use of wireless hand-held telephone or electronic communication device by motor vehicle operators. *(recommended one time in past 10 years)*
- Strengthening of the booster seat legislation to include use up to age 8. *(recommended four previous times in past 10 years)*
- Passage of All-Terrain Vehicle (ATV) legislation that contains elements requiring helmet use, prohibiting passengers, prohibiting drivers 12 years old and under, and requiring ATV safety training. Requirements should be statewide, including on private land. *(recommended three previous times in past 10 years)*

Administrative recommendations

- Enforcement of child passenger safety restraint laws, which include fines for drivers transporting unrestrained children. *(recommended nine previous times in past 10 years)*
- Develop and disseminate a campaign that will promote the best practices related to booster seat usage. *(recommended three previous times in past 10 years)*
- Provide, at no cost, driver education classes for all high school and career tech students. *(recommended eight previous times in past 10 years)*
- Increase accessibility and usage of drug courts and drug treatment programs. *(recommended nine previous times in past 10 years)*

## Sleep Related Deaths

In order to reduce the number of sleep related deaths, 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 clas-

sification of Sudden Unexpected Infant Deaths (SUID) and Sudden Infant Death Syndrome (SIDS), including the use of scene recreation and digital photography. The methods currently utilized do not adequately provide the opportunity to distinguish accidental overlay (smothering) from undetermined causes. *(recommended three previous times in past 10 years)*

- 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. *(recommended three previous times in past 10 years)*
- Education on safe sleep environments be provided to families after delivery but prior to discharge. *(recommended three previous times in past 10 years)*
- Education on safe sleep environments should be provided to families at the first well-child visit. *(already occurring for OHCA clients-recommended two previous times in past 10 years)*
- Distribute cribs for low-income families. *(recommended two previous times in past 10 years)*
- All hospitals in Oklahoma should adopt a policy regarding in-house safe sleep issues. *(recommended one previous time in past 10 years)*

**Drowning Deaths**

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. *(recommended four previous times in past 10 years)*

Administrative recommendations:

- Increase access to swimming lessons for all children. *(recommended one previous time in past 10 years)*
- Fund and distribute the "water watcher" badges that promote appropriate and responsible adult supervision of children around water. *(recommended one previous time in past 10 years)*
- Work with Oklahoma Parks and Recreation to provide water watcher badges at Oklahoma lakes. *(not previously recommended)*
- EMS/National Weather Service include a warning regarding the dangers of flash floods in weather alerts. *(recommended four previous times in past 10 years)*

# Recommendations

## Fire Deaths

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

- Smoke alarm give away programs should include carbon monoxide detectors. *(recommended one previous time in past 10 years)*
- Increased penalties for homeowners who do not provide smoke alarms for rental houses. *(recommended one previous time in past 10 years)*

## Child Abuse/Neglect Deaths

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

- Increased funding of primary and secondary prevention programs of the Oklahoma Department of Human Services, Oklahoma State Health Department, Department of Education, and the Oklahoma Department of Mental Health and Substance Abuse Services. *(recommended six previous times in past 10 years)*
- 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 and with a salary competitive with positions in other states. *(recommended nine previous times in past 10 years)*
- Make court records pertaining to custody and guardianship available for public inspection after a child death. *(recommended two previous times in past 10 years)*
- Create and support through funding, a medical team to review the medical records in child abuse/neglect cases and submit an opinion if requested by the court. *(recommended two previous times in past 10 years)*

## Agency Specific Recommendations

**Oklahoma Safe Kids Coalition** *(recommended five previous times in past 10 years)*

- Promotion and establishment of funding for the Safe Kids Oklahoma Child Passenger Safety Program. This program includes: providing car seats for low-income families; providing training and car seats for **every** child care center in the state starting July 2006; providing, through a loaner program, car seats for special needs children; piloting a program for providing car beds for babies born prematurely; and the "Please Be Seated" program 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.

# Recommendations

- Promotion and establishment of funding for the Safe Kids Oklahoma "Walk This Way" program which is aimed at reducing the number of child pedestrian injuries and fatalities.
- Promotion and establishment of funding for the Safe Kids Oklahoma bicycle safety program, which includes conducting bicycle safety rodeos and provided free helmets to groups who conduct bike safety education events utilizing Safe Kids curriculum.
- Promotion and establishment of funding for Safe Kids Oklahoma's burn prevention programs, which include the "Save-A-Life" smoke detector giveaway/ installment programs, and a fireworks safety campaign.
- Promotion and establishment of funding for Safe Kids Oklahoma's water safety programs, which include the Wee Water Wahoo and Wacky Water Wahoo water safety training events and the Brittany Project, which provides loaner life jackets at Oklahoma Corps of Engineer lakes.

**Oklahoma Child Death Review Board** *(recommended one previous time in past 10 years)*

Promotion and establishment of funding for the Oklahoma Child Death Review Board's Think. Prevent. Live. campaign that addresses deaths due to drowning, fires, wheeled activities, unsafe sleep practices, and child abuse/neglect.

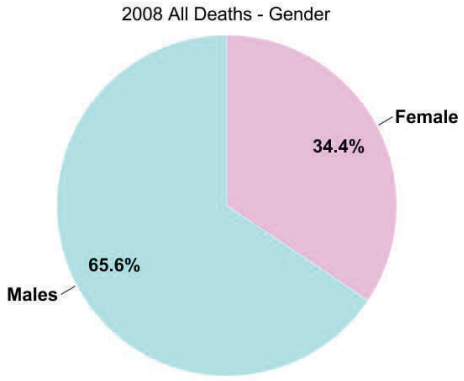
# Board Actions and Activities

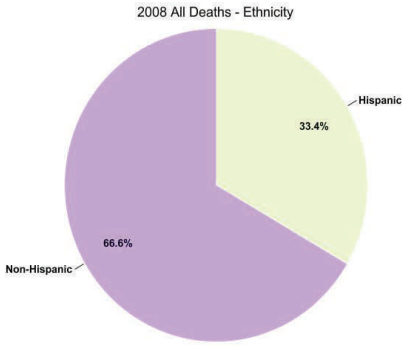
- Continued collaborating with the Oklahoma Domestic Violence Fatality Review Board, including statutory changes allowing the joint review of cases common to both Boards.
- Continued collaborations with the Oklahoma Violent Death Reporting and Surveillance System, Injury Prevention Services, Oklahoma State Department of Health.
- Continued participation with Central Oklahoma Fetal Infant Mortality Review Community Action Team.
- Eight letters to District Attorney's inquiring if charges had been filed.
- One letter to a District Attorney inquiring as to why a child was not yet adjudicated but had been in custody for 21 months.
- One letter requesting a District Attorney attend a meeting to discuss a case.
- Four letters to law enforcement agencies requesting an update on investigations.
- One letter to a law enforcement agency recommending improvement on child death investigations.
- One letter to a law enforcement agency requesting policies and procedures for allowing family access to a decedent at a medical facility.
- One letter of commendation to a law enforcement agency for an exceptional scene investigation.
- Five letters to the Oklahoma Department of Human Services (OKDHS) regarding the quality of investigations.
- Three letters to OKDHS regarding permanency plan for a near death victim and/or surviving siblings.
- Two letters to OKDHS requesting more information on the investigations.
- One letter to OKDHS making an official referral of suspected child abuse/neglect.
- One letter to OKDHS commending an exceptional investigation.
- Three letters to the Office of the Chief Medical Examiner requesting the manner and/or cause of death be amended.
- Three letters to the Office of the Chief Medical Examiner requesting more information on the pathological diagnoses.
- One letter to the Office of the Chief Medical Examiner requesting assistance in amending a death certificate.
- One letter to the Office of the Chief Medical Examiner regarding representation on the Tulsa Regional Team.
- One letter to the Medico-Legal Board requesting assistance in obtaining representation on the state Oklahoma Child Death Review Board.
- One letter to a medical facility recommending training on child abuse/neglect.
- One letter to a medical facility recommending notification to the Office of the Chief Medical Examiner of sudden, unexpected infant death.
- One letter to a medical facility requesting policies and procedures for allowing family access to a decedent.
- Two letters to funeral homes requesting death certificates be amended to reflect correct information.
- One letter to a county multi-disciplinary team referring a case for their review.
- One letter to a physician recommending child abuse medical examiner training.
- One letter to the Oklahoma Commission on Children and Youth requesting an Office of Juvenile Oversight report.

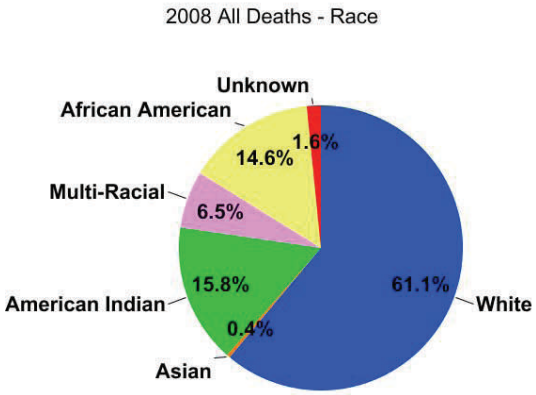
# Cases Closed 2008

The Oklahoma Child Death Review Board and the four Regional Review Teams reviewed and closed 247 deaths in 2008. Please note that the deaths reviewed in 2008 may not have occurred in 2008.

| 2008 Deaths | | |
|---|---|---|
| **Manner** | **Number** | **Percent** |
| Accident | 121 | 49.0% |
| Unknown | 72 | 29.1% |
| Natural | 28 | 11.3% |
| Homicide | 17 | 6.9% |
| Suicide | 9 | 3.7% |

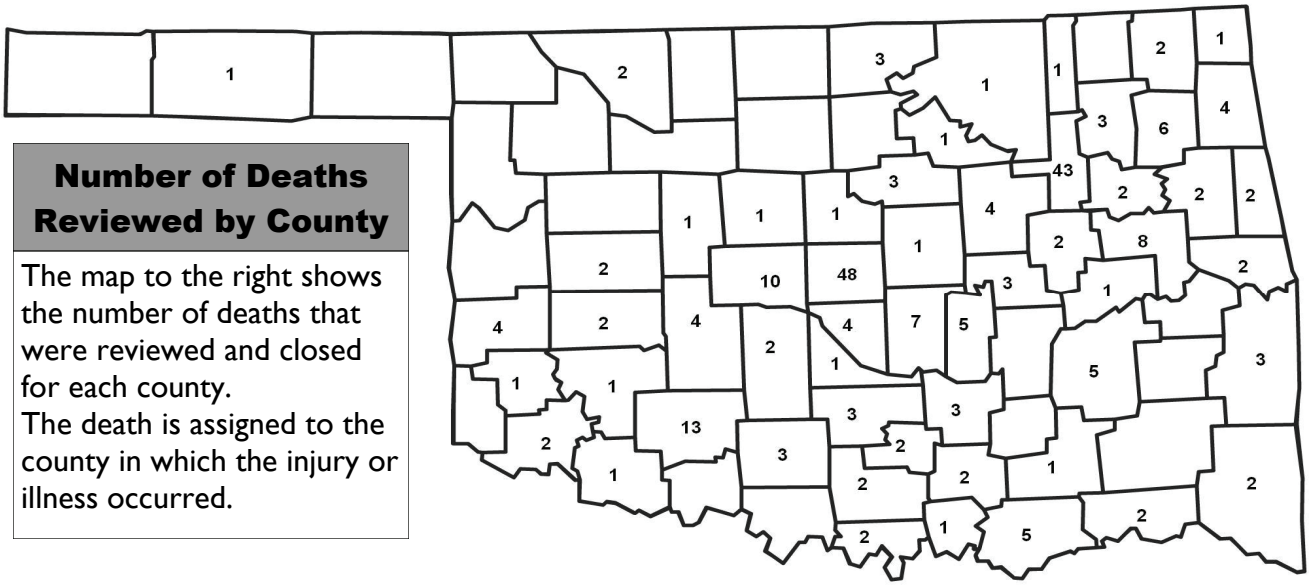



## Number of Deaths Reviewed by County

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



# Government Involvement

The chart below indicates a child's involvement in government sponsored programs, either at the time of death or previous to the time of death. The Child Welfare cases are those children who had an abuse and/or neglect investigation *prior* to the death incident. It does not reflect those child deaths that were investigated by OKDHS.
In addition to the information in the chart below, there were five foster care deaths reviewed and closed in 2008. Three were ruled Natural deaths by the Medical Examiner, one was ruled Undetermined, and one was ruled Homicide. Two (one of the natural deaths and the homicide) were ruled abuse/neglect by the Board. Three of the deaths occurred during trial reunification.

**Number of Decedents with Previous Involvement in Selected State Programs**

| Agency | Number | Percent Of All Deaths |
|---|---|---|
| OKDHS - TANF | 173 | 70.0% |
| Oklahoma Health Care Authority (Medicaid) | 123 | 49.8% |
| OKDHS - Child Support Enforcement | 103 | 41.7% |
| OKDHS - Child Welfare | 36 | 14.6% |
| OKDHS - Food Stamps | 34 | 13.8% |
| OKDHS Child Care Assistance | 22 | 8.9% |
| Office of Juvenile Affairs | 15 | 6.1% |
| OKDHS - Emergency Assistance | 9 | 3.6% |
| OKDHS - Disability | 9 | 3.6% |
| OSDH - Office of Child Abuse Prevention | 3 | 1.2% |
| OSDH - Children First | 2 | 0.8% |

# Accidents

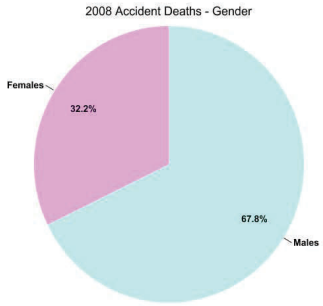
The Board reviewed and closed 121 deaths in 2008 whose manner of death was ruled Accident.

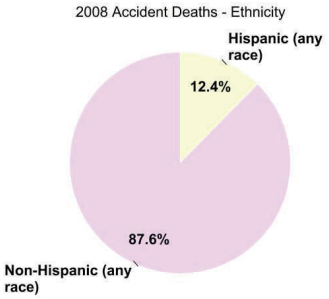
For the poisoning/overdose deaths, eight were accidental overdoses and two were acute intoxications. In four cases, there was a combination of drugs found in the decedent's system. Nine cases involved prescription drugs, none of which were prescribed for the child.

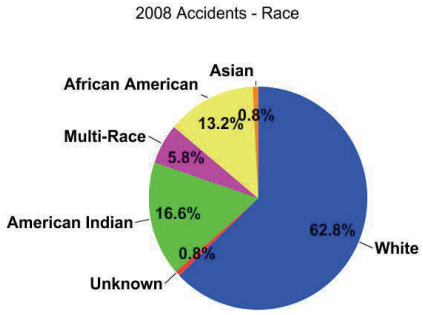
For the five crushing deaths, two cases involved televisions, two cases involved barnyard animals, and one case involved a dresser.

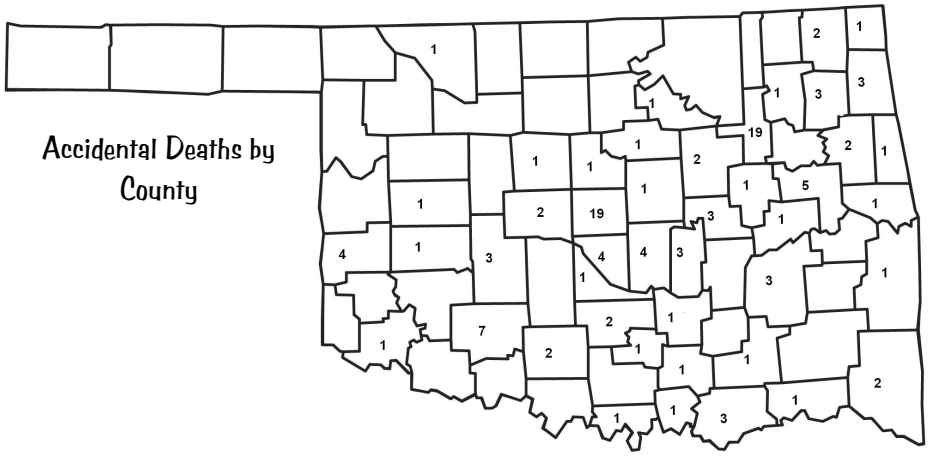
**Type of Accidents Reviewed**

| Type | Number | Percent |
|---|---|---|
| Vehicular | 73 | 60.3% |
| Drowning | 19 | 15.7% |
| Poisoning/O.D. | 10 | 8.3% |
| Asphyxia | 7 | 5.8% |
| Crush | 5 | 4.1% |
| Fire | 5 | 4.1% |
| Firearm | 1 | 0.8% |
| Sports Injury | 1 | 0.8% |



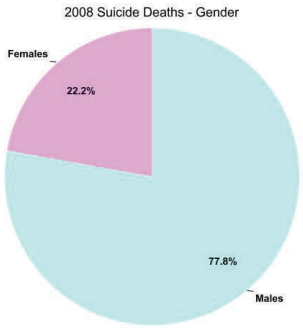



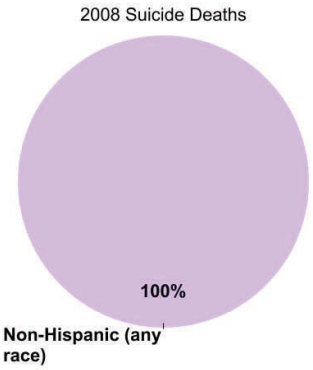



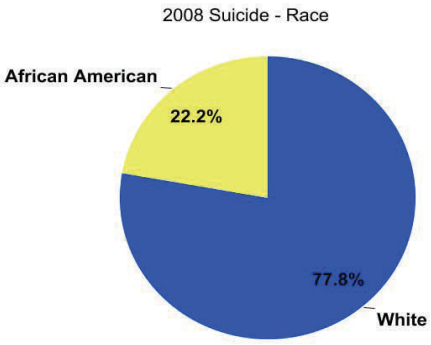
# Suicides

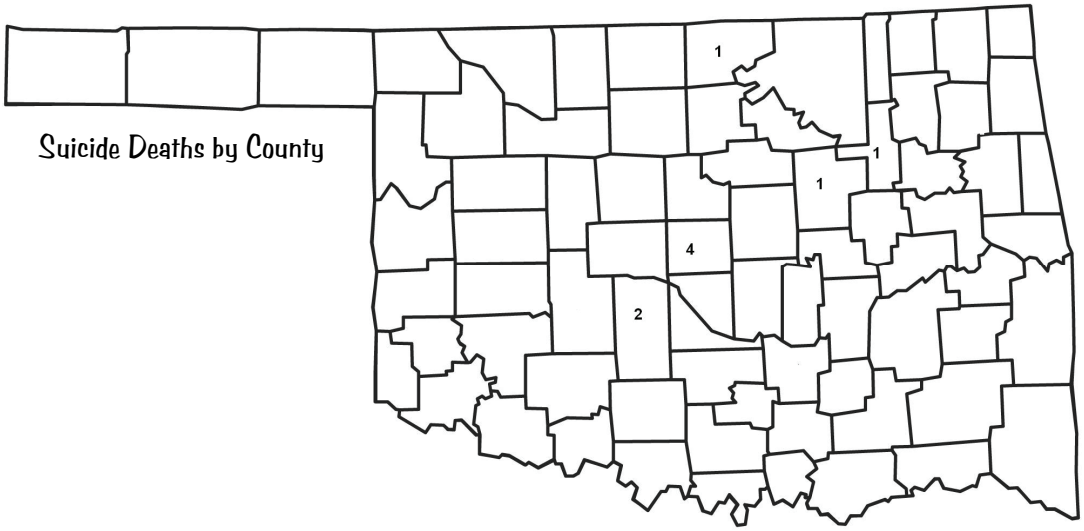
The Board reviewed and closed nine deaths in 2008 whose manner of death was ruled Suicide.
Two were documented as having school problems (academic and truancy).
One was documented as receiving prior mental health services.
One was documented as currently receiving mental health services.

| Method of Suicide | | |
|---|---|---|
| **Method** | **Number** | **Percent** |
| Firearm | 5 | 55.6% |
| Asphyxia | 4 | 44.4% |



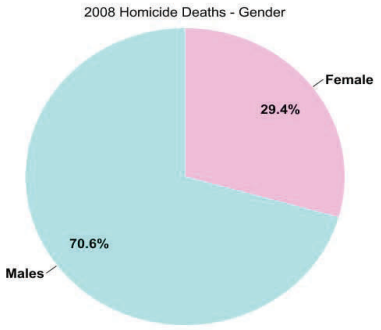



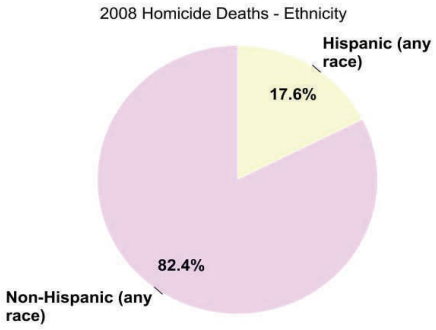



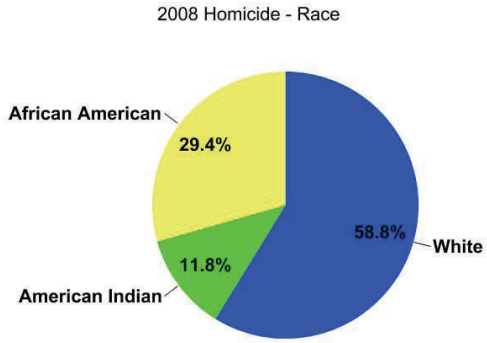
# Homicides

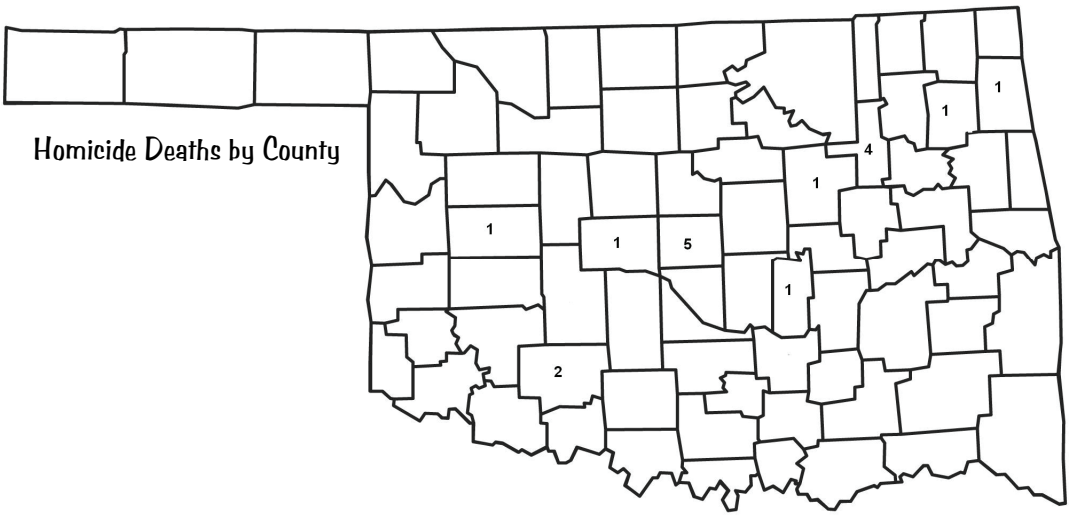
The Board reviewed and closed 17 deaths in 2008 whose manner of death was ruled Homicide.

| Cause of Death in Homicide Cases | | |
|---|---|---|
| **Cause of Death** | **Number** | **Percent** |
| Abusive Head Trauma | 8 | 47.0 |
| Firearm | 7 | 41.2 |
| Abusive Abdominal Trauma | 1 | 5.9 |
| Asphyxiation | 1 | 5.9 |



# Unknown

The Board reviewed and closed 72 deaths in 2008 ruled Undetermined or Unknown. Fifty-seven (79.2%) of these were infants that the Medical Examiner stated the sleep environments may have contributed to the death.

An additional five (6.9%) were infants found in unsafe sleep environments but also had medical issues.

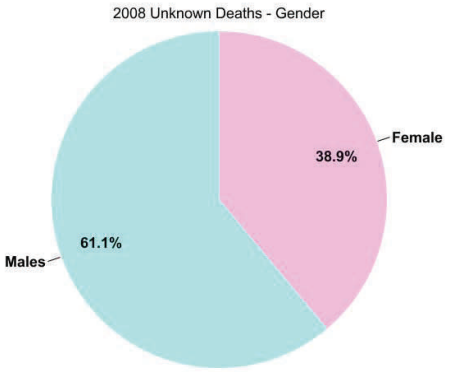
Two (2.8%) had prenatal drug exposure.

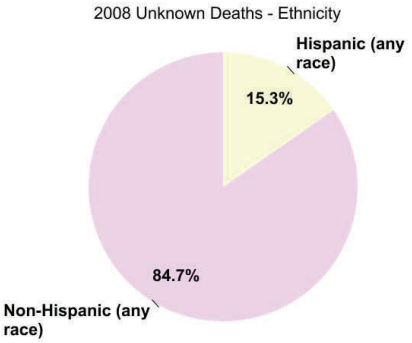
Two (2.8%) were toddlers (15 and 19 months) where no anatomical cause of death could be determined at the time of autopsy.

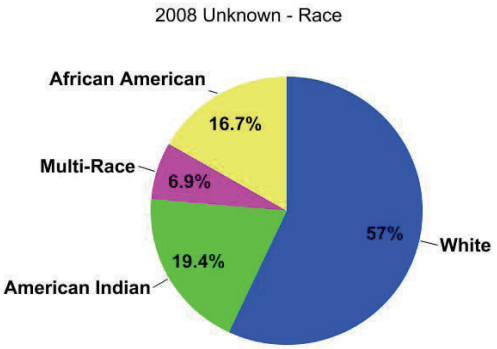
Two (2.8%) were older children (10 and 13 years) with histories of medical issues.

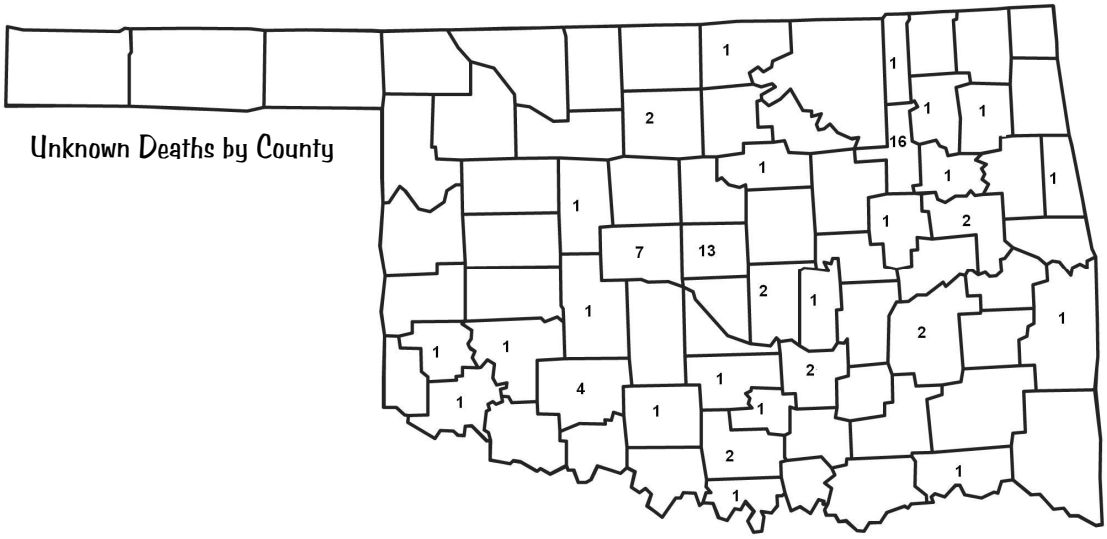
Two (2.8%) were older children (2 and 7 years) with possible medical issues.

One (1.4%) was suspicious for trauma.



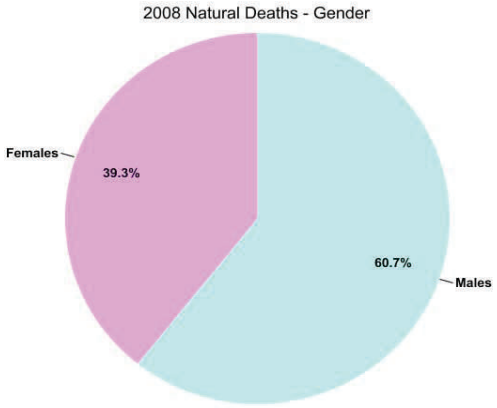



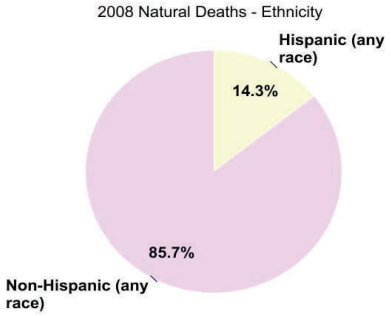



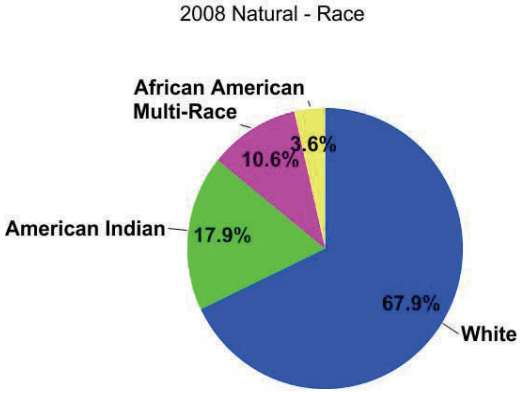
# Natural Deaths - Reviewed

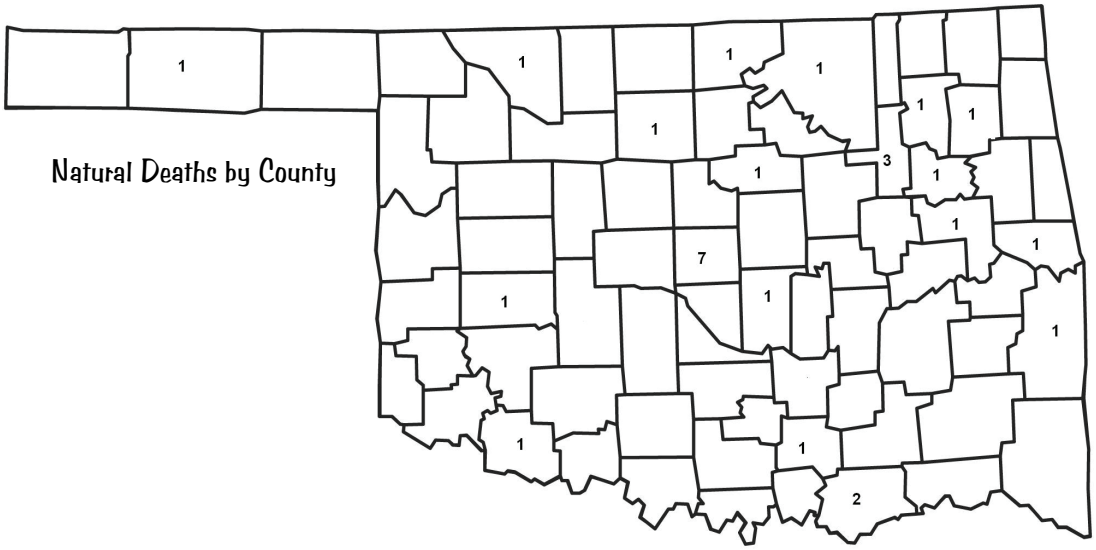
The Board reviewed and closed 28 deaths in 2008 ruled Natural.

| Causes of Death in Natural Death Cases | | |
|---|---|---|
| **Illness/Disease** | **Number** | **Percent** |
| SIDS | 15 | 53.6% |
| Infectious Diseases | 5 | 17.9% |
| Congenital Anomalies | 2 | 7.1% |
| Metabolic | 2 | 7.1% |
| Brain cyst | 1 | 3.6% |
| Cardiac | 1 | 3.6% |
| Complications of Cerebral Palsy | 1 | 3.6% |
| Diabetes | 1 | 3.6% |



# 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 2008 are as follows:

| Cause of Death or Medical Condition | Number of Death Certificates Received | Percent |
|---|---|---|
| Prematurity | 154 | 42.0% |
| Congenital Disorder | 98 | 26.8% |
| Infectious Disease | 38 | 10.4% |
| Cardiac Disease | 24 | 6.6% |
| Neoplasm | 22 | 6.0% |
| Intrauterine/Birth Complication | 14 | 3.8% |
| Renal Disorder | 4 | 1.1% |
| Blood Disorder | 4 | 1.1% |
| Neurological | 3 | 0.8% |
| Pulmonary Condition | 2 | 0.5% |
| Autoimmune Disease | 1 | 0.3% |
| Hepatic Disease | 1 | 0.3% |
| Unknown | 1 | 0.3% |
| TOTAL | 366 | 100.0% |

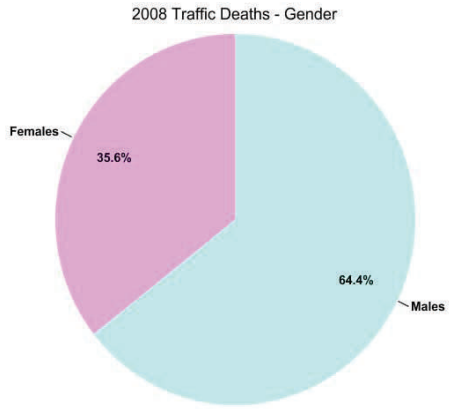
# Traffic Related Deaths

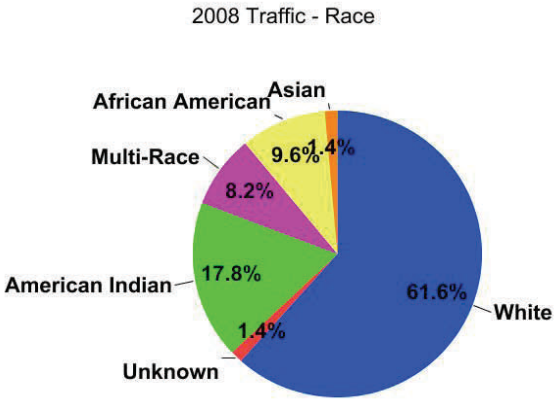
The Board reviewed and closed 73 deaths in 2008 related to traffic.
The two motorcycle deaths and one ATV death were utilizing a helmet.

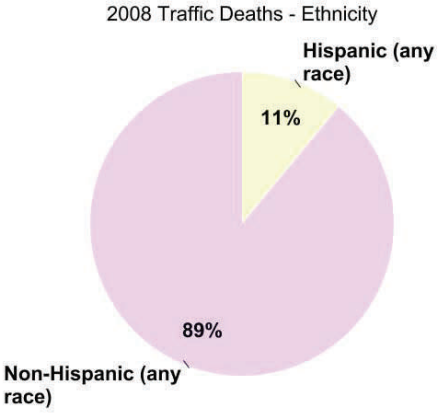
| Vehicle of Decedent | | |
|---|---|---|
| **Vehicle** | **Number** | **Percent** |
| Car | 30 | 41.1% |
| SUV | 14 | 19.2% |
| Pick-Up | 9 | 12.3% |
| Pedestrian | 5 | 6.8% |
| ATV | 4 | 5.5% |
| Van | 3 | 4.1% |
| Aircraft | 3 | 4.1% |
| Motorcycle | 2 | 2.7% |
| Bicycle | 2 | 2.7% |
| Moped | 1 | 1.4% |

| Use of Safety Restraints | | |
|---|---|---|
| **Seatbelt/Car seat Use** | **Number** | **Percent** |
| Properly Restrained | 31 | 42.5% |
| Not Properly Restrained | 25 | 34.2% |
| Not Applicable | 17 | 23.1% |

| Activity of Decedent | | |
|---|---|---|
| **Position** | **Number** | **Percent** |
| Operator | 27 | 37.0% |
| Rear Passenger | 20 | 27.4% |
| Front Passenger | 13 | 17.8% |
| Unknown Passenger Placement | 7 | 9.6% |
| Truck Bed | 1 | 1.4% |
| N/A | 5 | 6.8% |



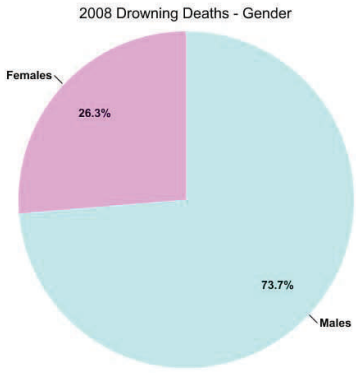



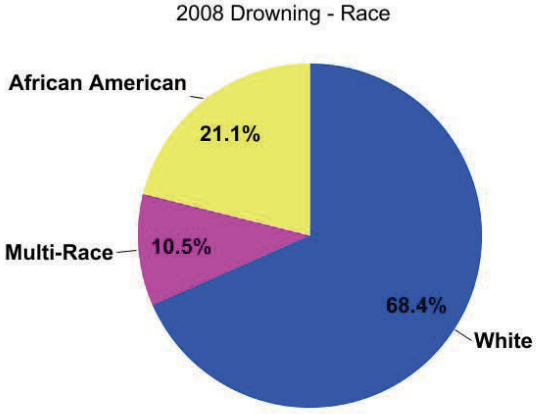
# Drowning Deaths

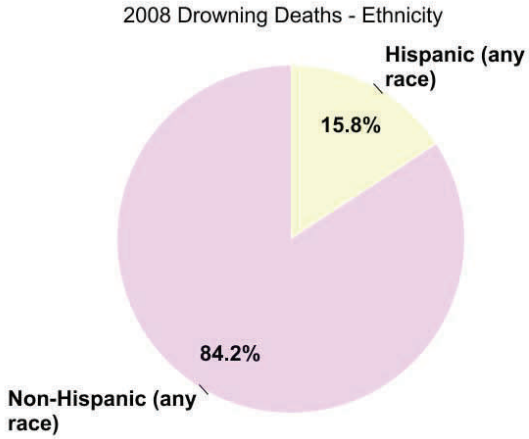
The Board reviewed and closed 19 deaths in 2008 due to drowning. All 19 were ruled Accidental manner of death.

| Location of Drowning | | |
|---|---|---|
| **Location** | **Number** | **Percent** |
| Private, Residential Pool | 7 | 36.8% |
| Natural Body of Water (i.e. creek, river, pond, lake) | 7 | 36.8% |
| Bathtub | 2 | 10.5% |
| Bucket | 2 | 10.5% |
| Koi Pond | 1 | 5.4% |

| Type of Residential Pool | | |
|---|---|---|
| **Type of Pool** | **Number** | **Percent** |
| Above Ground | 5 | 71.4% |
| In Ground | 2 | 28.6% |



# Sleep Related Deaths

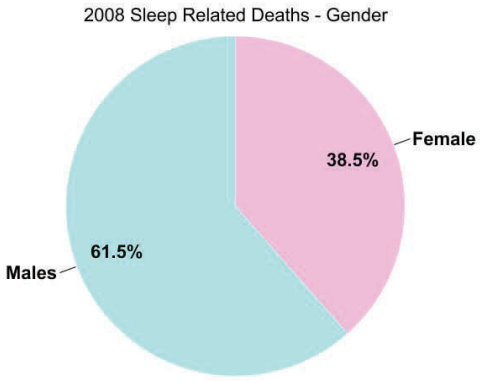
The Board reviewed and closed 78 deaths that were related to sleep environments. These include accidental asphyxiations, SIDS, and Undetermined manners of death where the pathologist noted the sleep environment was a possible contributor to the death.

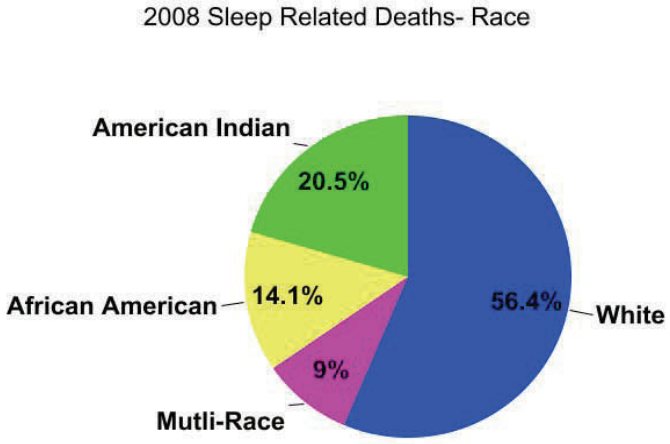
| Manner of Death for Sleep Related Deaths | | |
|---|---|---|
| **Manner** | **Number** | **Percent** |
| Accidental | 6 | 7.7% |
| Natural (SIDS) | 15 | 19.2% |
| Undetermined | 57 | 73.1% |

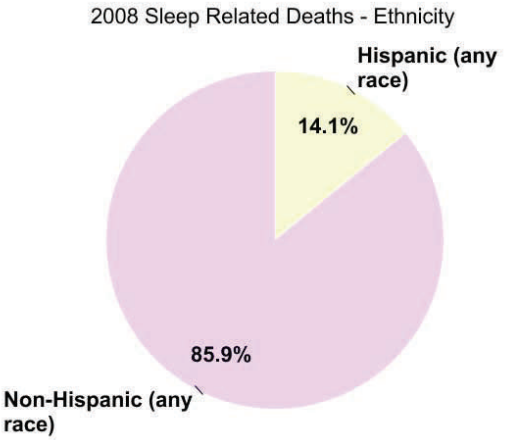
| Sleeping Position of Infant | | |
|---|---|---|
| **Position** | **Number** | **Percent** |
| On Stomach | 15 | 19.2% |
| On Back | 10 | 12.8% |
| On Side | 3 | 3.8% |
| Unknown | 39 | 50.0% |

| Sleeping Arrangement of Infant | | |
|---|---|---|
| **Sleeping Arrangement** | **Number** | **Percent** |
| Alone | 47 | 60.3% |
| With Adult and/or Sibling | 31 | 39.7% |

| Sleeping Location of Infant | | |
|---|---|---|
| **Location** | **Number** | **Percent** |
| Adult Bed | 39 | 50.0% |
| Crib | 13 | 16.7% |
| Couch | 11 | 14.1% |
| Bassinette/cradle | 4 | 5.1% |
| Chair | 3 | 3.8% |
| Playpen | 3 | 3.8% |
| Air Mattress | 2 | 2.6% |
| Car Seat | 1 | 1.3% |
| Unknown | 2 | 2.6% |



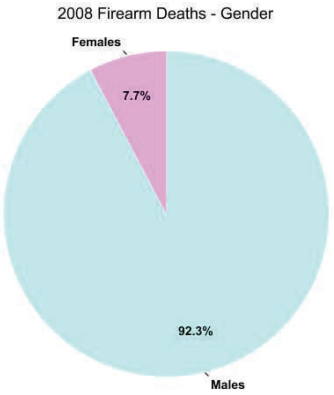



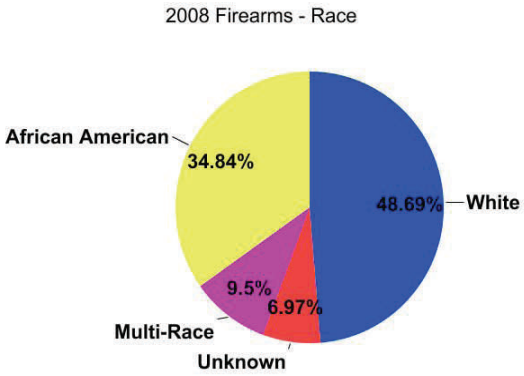
# Firearm Deaths

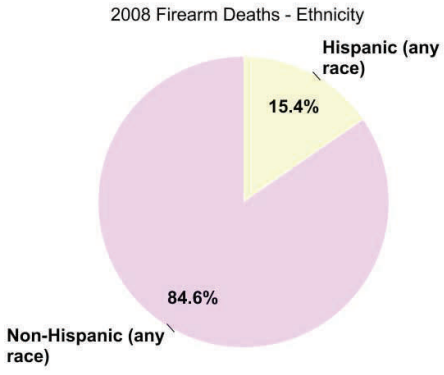
The Board reviewed and closed 13 deaths in 2008 due to firearms.

| Manner of Death for Firearm Victims | | |
|---|---|---|
| **Manner** | **Number** | **Percentage** |
| Homicide | 7 | 53.8% |
| Suicide | 5 | 38.5% |
| Accident | 1 | 7.7% |




| Type of Firearm Used | | |
|---|---|---|
| **Type of Firearm** | **Number** | **Percent** |
| Handgun | 10 | 76.9% |
| Shot gun | 2 | 15.4% |
| Rifle | 1 | 7.7% |



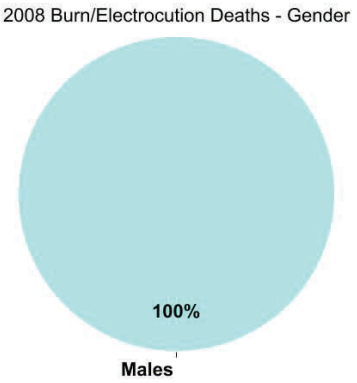



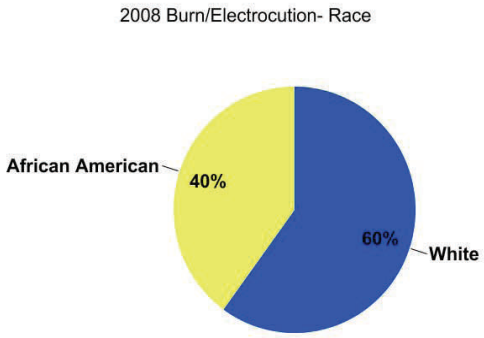
# Burn/Electrocution Deaths

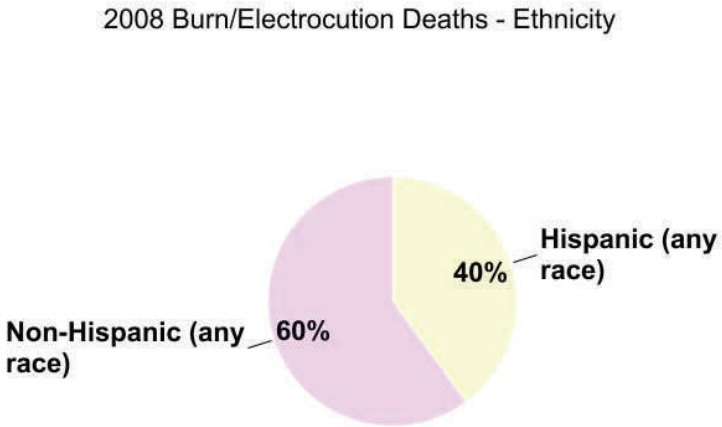
The Board reviewed and closed five deaths in 2008 due to burns or electrocution.
Three fires resulted in four deaths. All four died of smoke inhalation.
The electrocution death was due to an electrical cord being cut.

| Working Smoke Detector Present | | |
|---|---|---|
| **Detector** | **Number** | **Percent** |
| Yes | 2 | 40.0% |
| No | 2 | 40.0% |
| N/A | 1 | 20.0% |

| Fire Ignition Source | | |
|---|---|---|
| **Source** | **Number** | **Percent** |
| Candles | 2 | 40.0% |
| Electrical Wiring | 1 | 20.0% |
| Unknown | 1 | 20.0% |
| N/A | 1 | 20.0% |



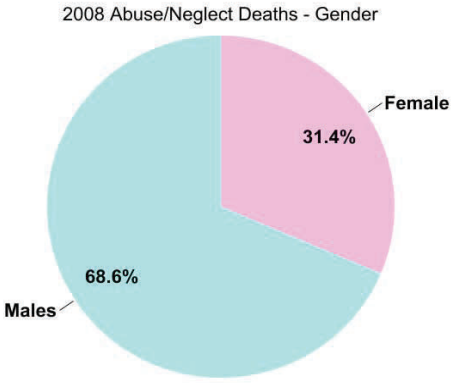



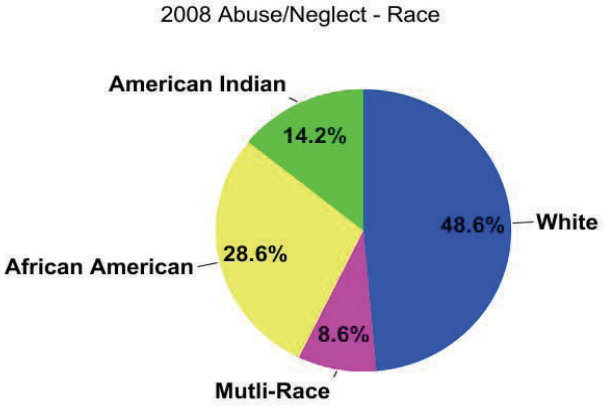
# Abuse/Neglect Deaths

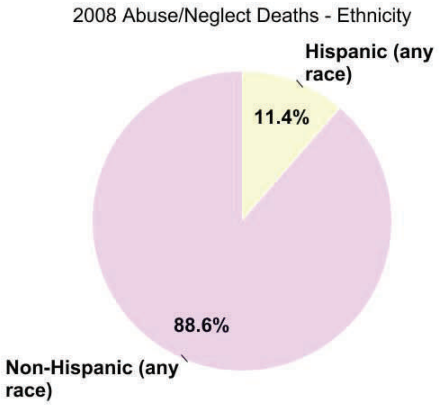
The Board reviewed and closed 35 cases where it was determined that abuse or neglect contributed to the death. Ten (28.6) cases were ruled abuse and 25 (71.4) cases were ruled neglect.

| Manner of Death for Abuse/Neglect Cases | | |
|---|---|---|
| **Manner** | **Number** | **Percent** |
| Accident | 21 | 60.0% |
| Homicide | 11 | 31.4% |
| Undetermined | 3 | 8.6% |




| Injuries in Abuse/Neglect Cases | | |
|---|---|---|
| **Injury** | **Number** | **Percent** |
| Physical Abuse | 10 | 28.5% |
| Drowning | 9 | 25.7% |
| Traffic Related | 5 | 14.3% |
| Asphyxia | 4 | 11.4% |
| Fire/Burn | 2 | 5.7% |
| Poisoning/OD | 2 | 5.7% |
| Fall/Crush | 1 | 2.9% |
| Maternal Drug Exposure | 1 | 2.9% |
| Bed Sharing While Intoxicated | 1 | 2.9% |

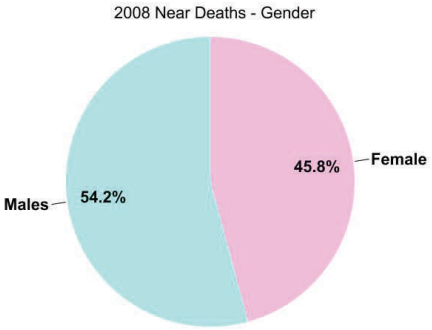


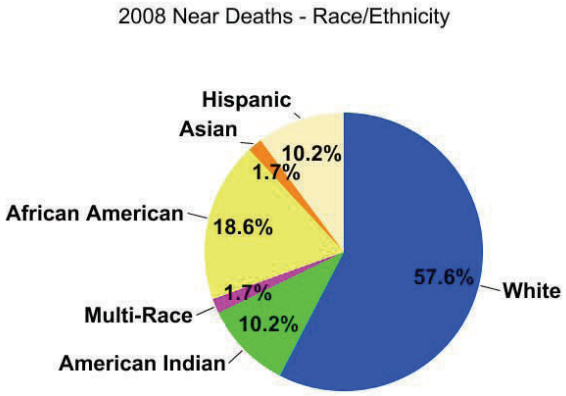




**To report suspected child abuse or neglect in Oklahoma *PLEASE* call: 1-800-522-3511**

# Near Deaths

The Board reviewed and closed 59 near death cases in 2008. 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. Forty-five (76.3%) were reported as having an acute injury as a result of the near death event; 14 (23.7%) were reported as having a chronic condition as a result of the near death event. Forty-four (74.6%) were confirmed by OKDHS as to having been abuse and/or neglect. Ten (16.9%) had a previous referral that was confirmed by OKDHS.




| Injuries in Near Death Cases | | |
|---|---|---|
| **Injury** | **Number** | **Percent** |
| Struck/Shaken | 26 | 44.1% |
| Poison/Overdose | 9 | 15.3% |
| Near Drowning | 9 | 15.3% |
| Fall | 3 | 5.0% |
| Fire/Burn | 3 | 5.0% |
| Vehicular | 1 | 1.7% |
| Suffocation/ Strangulation | 1 | 1.7% |
| Multiple Injuries | 1 | 1.7% |
| Other | 6 | 10.2% |

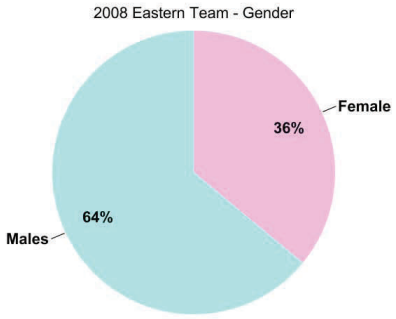
| Person(s) Responsible for Care of Child At Time of Near Death Event* | |
|---|---|
| **PRFC** | **Number** |
| Biological Mother | 35 |
| Biological Father | 21 |
| Parent's Paramour | 10 |
| Other relative | 4 |
| Babysitter | 3 |
| Foster Parent | 2 |
| Licensed Child Care Provider | 1 |
| Other | 6 |

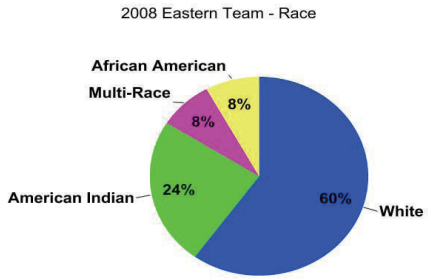
*Does not add up to 59 as more than one person can be named a PRFC in the allegations.

# Eastern Regional Review Team

The Eastern Team reviewed and closed 25 cases in 2008. The team meets quarterly in Muskogee, OK. Counties include Adair, Cherokee, Craig, Delaware, Haskell, Latimer, LeFlore, McIntosh, Mayes, Muskogee, Nowata, Okmulgee, Ottawa, Rogers, Sequoyah, and Wagoner. There were no Hispanic deaths in this review area.

| Manner of Death for Eastern Oklahoma Cases | | |
|---|---|---|
| **Manner** | **Number** | **Percent** |
| Accident | 14 | 56.0% |
| Homicide | 2 | 8.0% |
| Natural | 3 | 12.0% |
| Suicide | 0 | 0.0% |
| Undetermined | 6 | 24.0% |



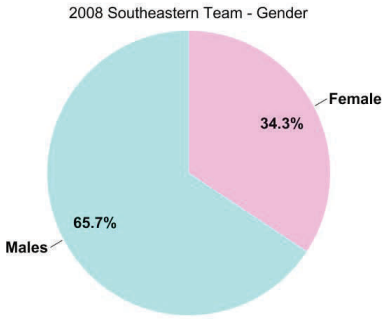

## 2008 Team Members

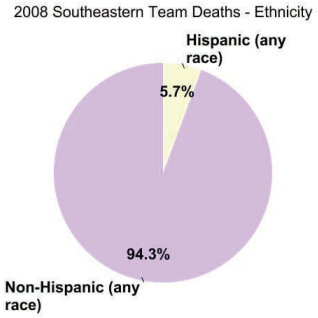
| Organization | Team Member | Designee |
|---|---|---|
| Medical Representative | Michael Stratton, DO; Chair | Timothy Holder, MD |
| Muskogee Public Schools | Debbie Winburn; Vice-Chair | |
| Cherokee Nation Mental Health | Misty Boyd, PhD | |
| Muskogee County Sheriff's Office | Coletta Peyton | |
| Oklahoma Department of Human Services | Janetta Garrett | Renee McMahan |
| CASA of Muskogee County | Katharine Eaton | |
| Oklahoma Coalition on Domestic Violence | Evelyn Hibbs | Gwyn LaCrone |
| Muskogee County Children First Program | Linda Hitcheye | |
| District Attorney's Office | Vacant | |
| Muskogee County Health Department | Tonya James | |
| Kids Space, Children's Advocacy Center | Ann Mathews | Lindsey Groom, Walter Davis |
| Muskogee County EMS | Rebecca Smith | Carlene Morrison |
| Muskogee County Council on Youth Services | Cindy Perkins | Tom Luker/Michael Adair |
| Muskogee Police Department | Vacant | |
| Muskogee County Regional Hospital (ER) | Sheila Villines, RN | |
| Special Education Specialist | Lillian Young, PhD | |

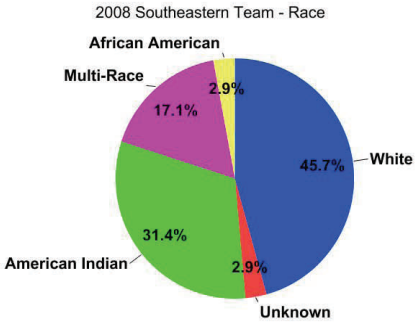
# Southeastern Regional Review Team

The Southeastern Team reviewed and closed 35 cases in 2008. 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 Cases | | |
|---|---|---|
| **Manner** | **Number** | **Percent** |
| Accident | 23 | 65.7% |
| Homicide | 1 | 2.9% |
| Natural | 4 | 11.4% |
| Suicide | 0 | 0.0% |
| Undetermined | 7 | 20..0% |



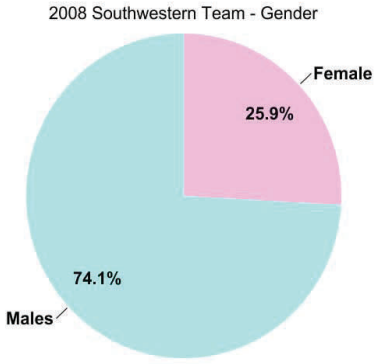

## 2008 Team Members

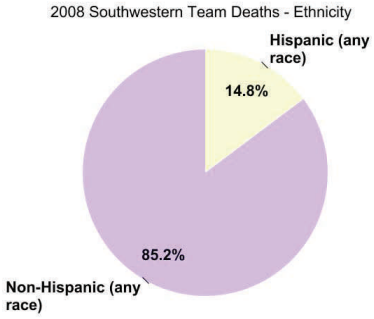
| Organization | Team Member | Designee |
|---|---|---|
| Child Advocacy Center (Unzner Center) | Cara Wilkinson | |
| Judicial Representative | Judge Glenn Dale Carter (Ret.); Chair | |
| CASA Representative | Gwen Gjovig | |
| Law Enforcement Representative | Russell Frantz | Julie Huskins/Anthony Grasso |
| Oklahoma Department of Human Services | Carmen Hutchins | Dane Smart |
| Community Representative | Shawna Jackson | |
| Youth and Family Resources Center | Susan Morris | Michelle Mayberry |
| Medical Representative | Joye Byrum | |
| State Board Member | Carolyn Parks | Jay Scott Brown |
| District Attorney | Vacant | |
| Medical Examiner Investigator | Vacant | |

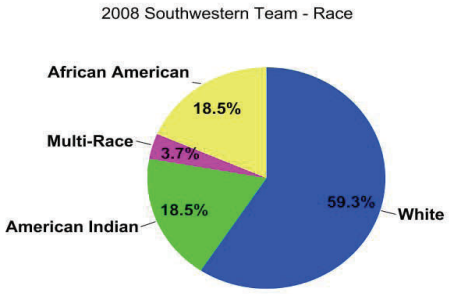
# Southwestern Regional Review Team

The Southwestern Team reviewed and closed 27 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 | 13 | 48.2% |
| Homicide | 2 | 7.4% |
| Natural | 1 | 3.7% |
| Suicide | 2 | 7.4% |
| Undetermined | 9 | 33.3% |




## 2008 Team Members

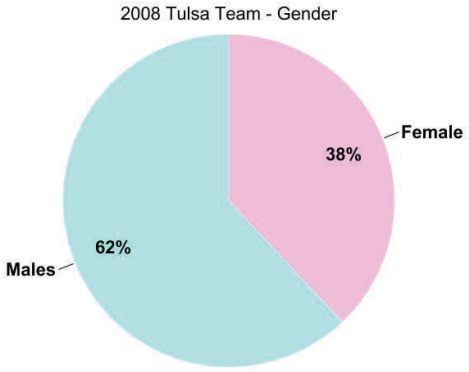
| Organization | Team Member | Designee |
|---|---|---|
| Law Enforcement Representative | Vacant | |
| Mental Health Representative | Barbara Davis | |
| Office of Juvenile Affairs | Abby Kimbro | |
| Medical Representative | Pilar Escobar, MD | |
| Medical Examiner Investigator | Bryan Louch | Jim Delbridge |
| CASA Representative | Nadine McIntosh | |
| Oklahoma Department of Human Services | Ann Middleton, Chair | |
| Jackson County District Attorney's Office | John Wampler, JD | |
| Safe Kids Coalition | Vacant | |

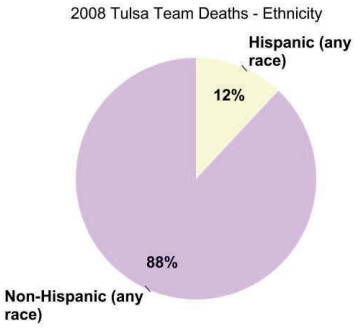
# Tulsa Regional Review Team

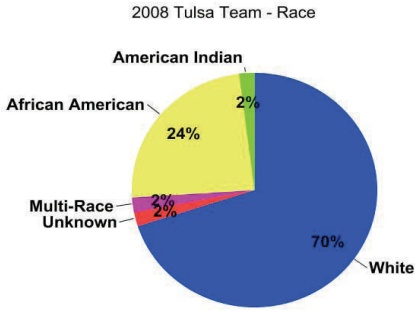
The Tulsa Team reviewed and closed 50 cases in 2007. The team meets every other month in Tulsa, OK and covers Creek, Osage, Tulsa and Washington counties.

**Manner of Death for Tulsa Region Victims**

| Manner | Number | Percent |
|---|---|---|
| Accident | 22 | 44.0% |
| Homicide | 4 | 8.0% |
| Natural | 5 | 10.0% |
| Suicide | 2 | 4.0% |
| Undetermined | 17 | 34.0% |



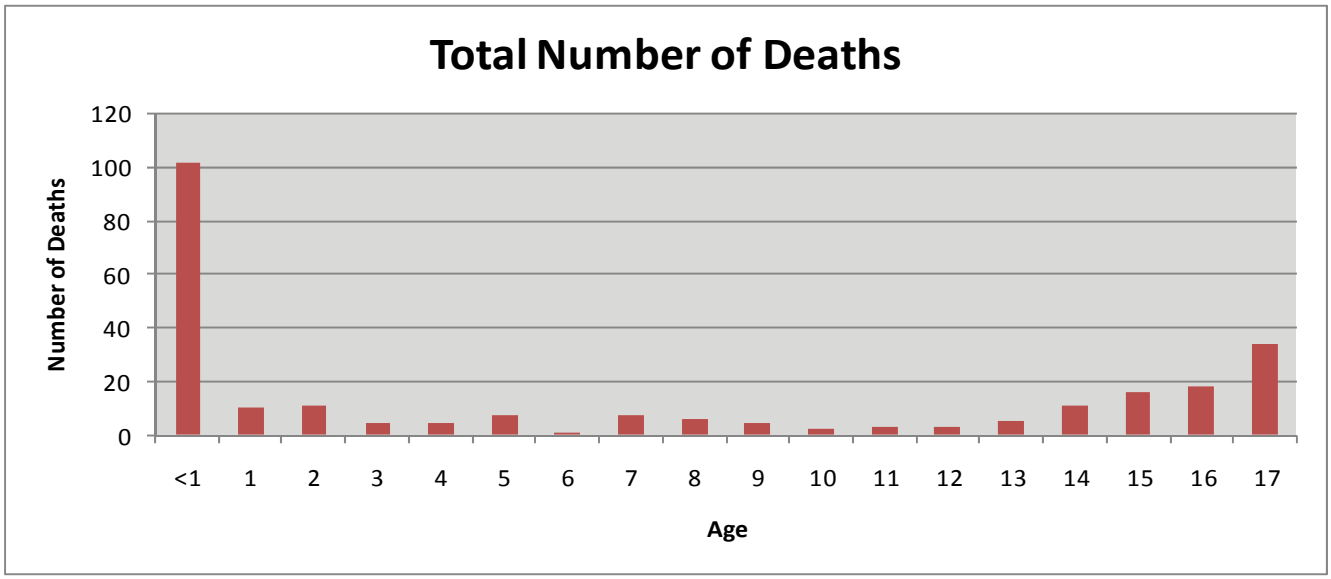



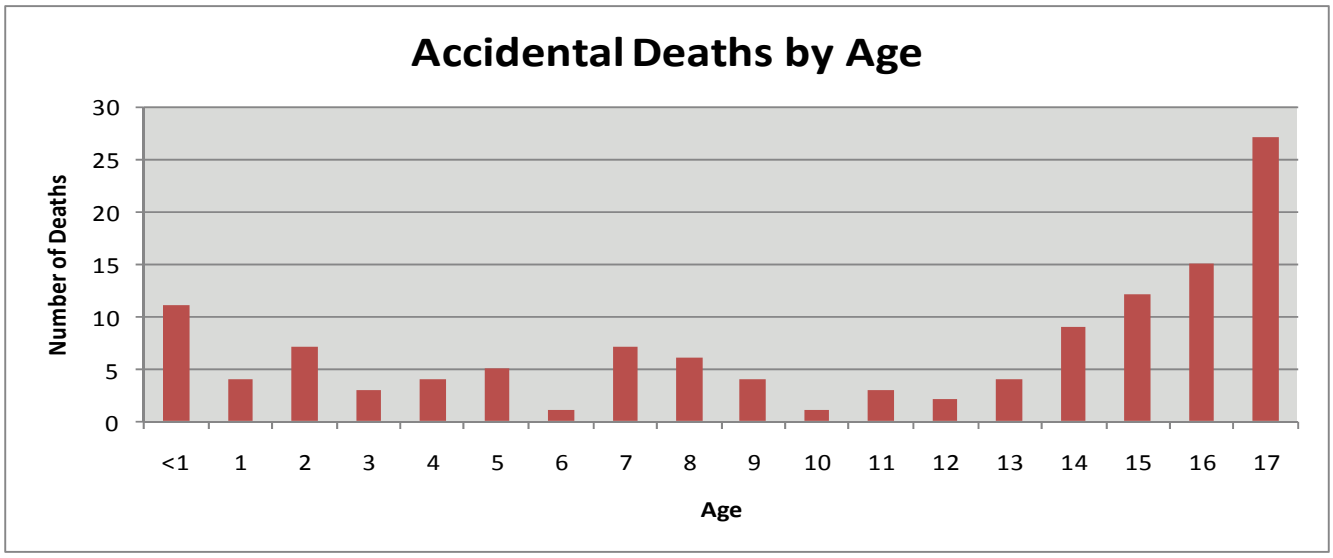



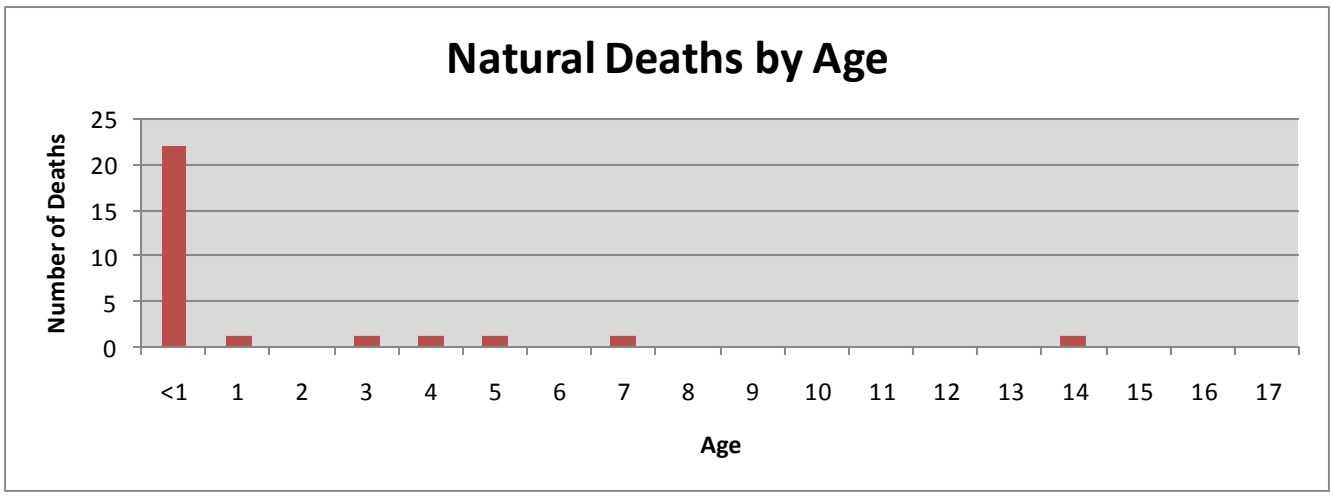

## 2008 Team Members

| Organization | Team Member | Designee |
|---|---|---|
| Medical Representative | Deborah Lowen; Chair | |
| Tulsa County District Attorney's Office | Tim Harris, JD | Jake Cain, JD; Vice-Chair |
| Law Enforcement Representative | Sgt. Whitney Allen | Det. Darren Carlock |
| Fire Department Representative | Steve Coldwell | Phil Reid |
| Medical Examiner | Vacant | |
| Safe Kids Coalition | Mary Beth Ogle | |
| Mental Health Representative | Rose Perry | |
| Children First Representative | Lori Sweeny | Sharon Konemann |
| Oklahoma Department of Human Services | Stefanie Ward | Jackie Hewitt |

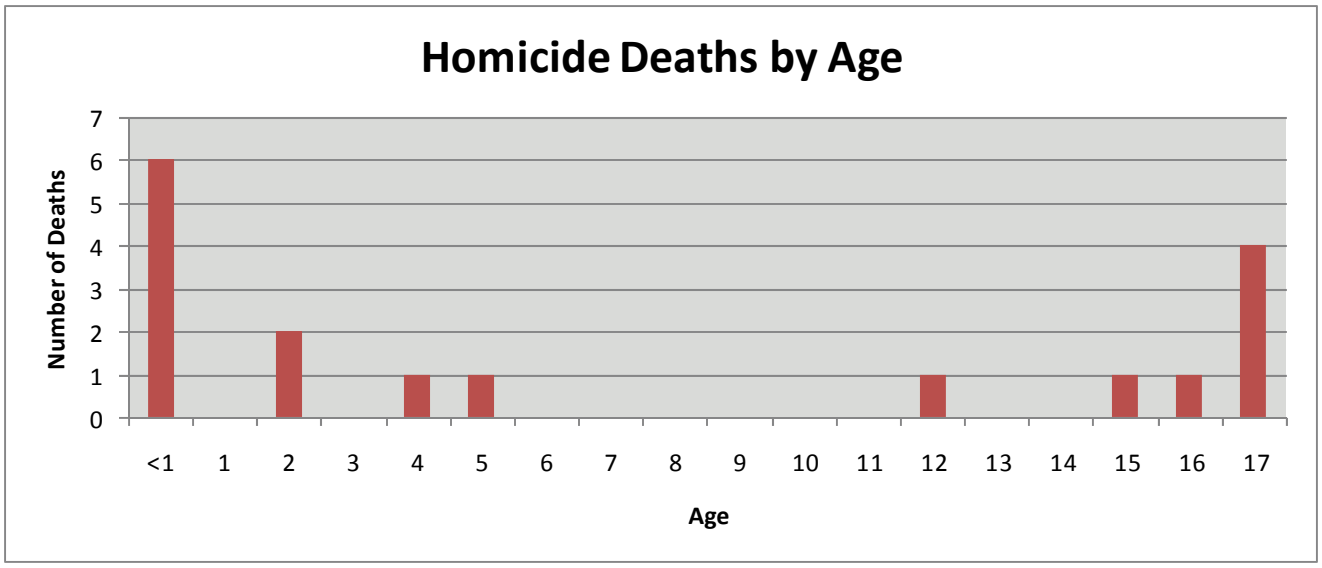
# Age of Decedents by Manner

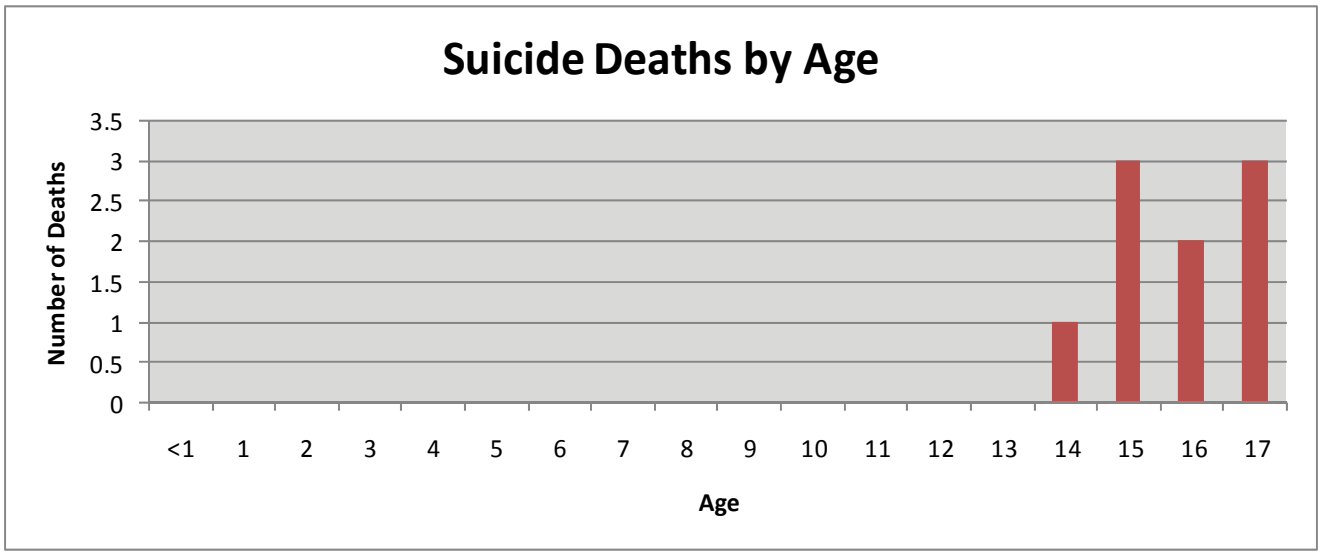


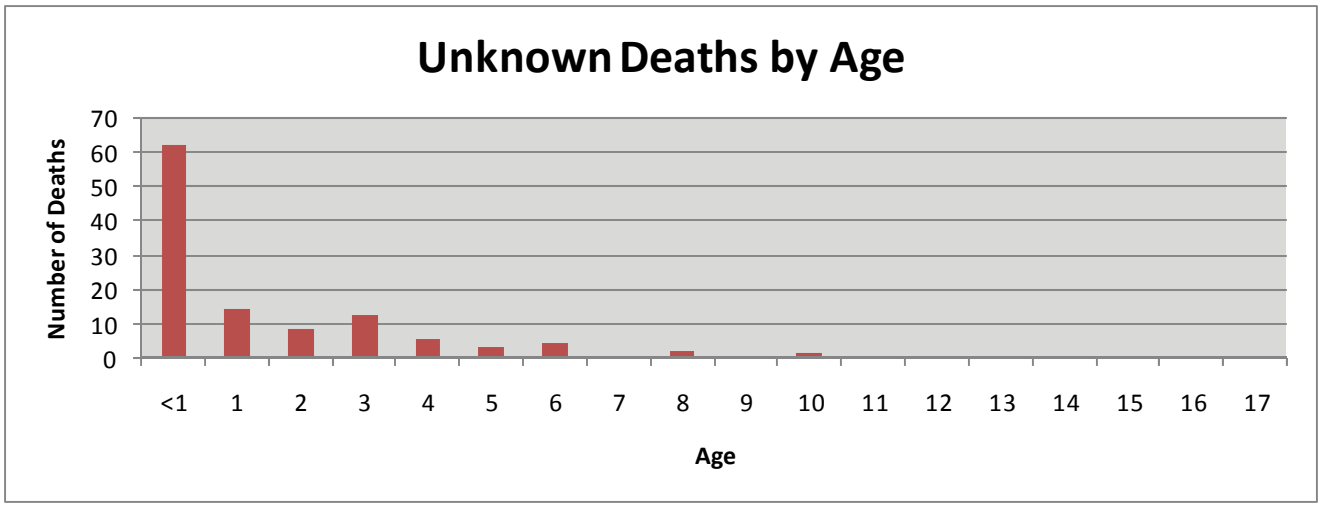



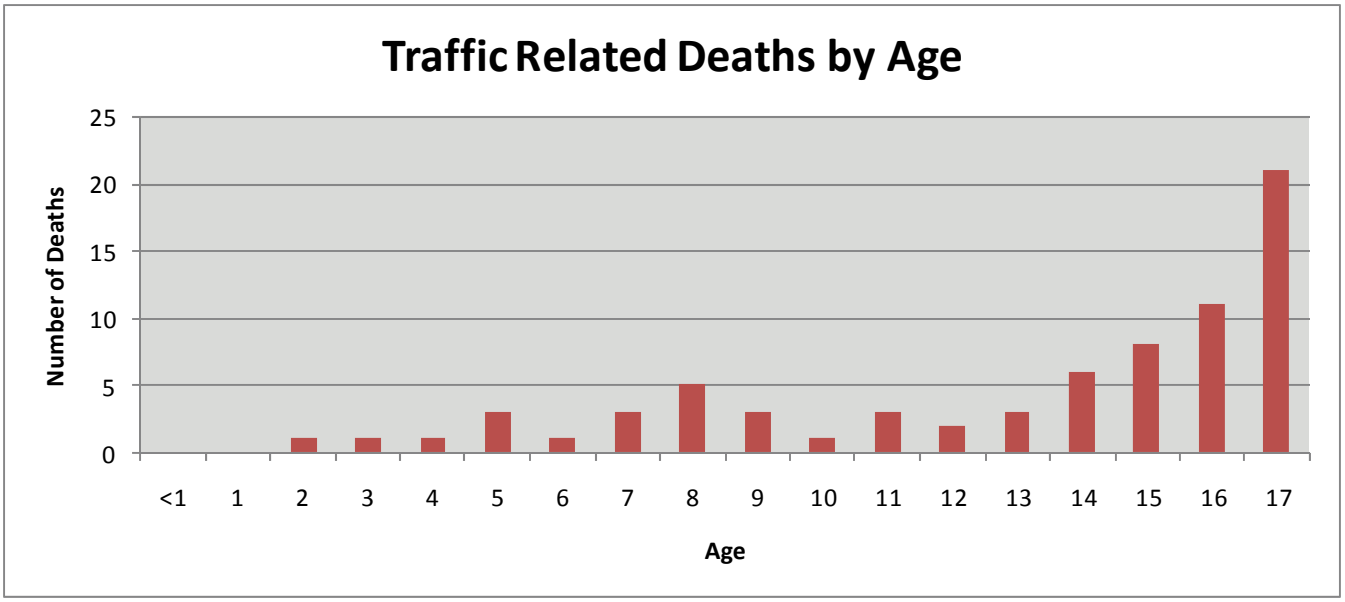
# Age of Decedents by Manner

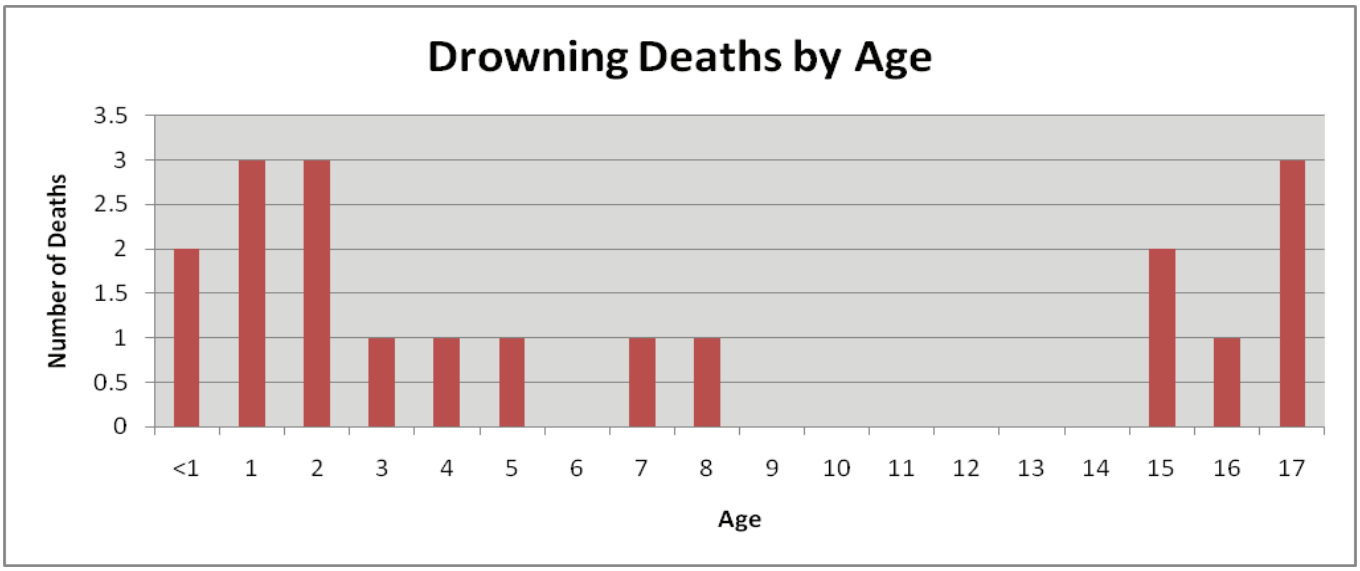


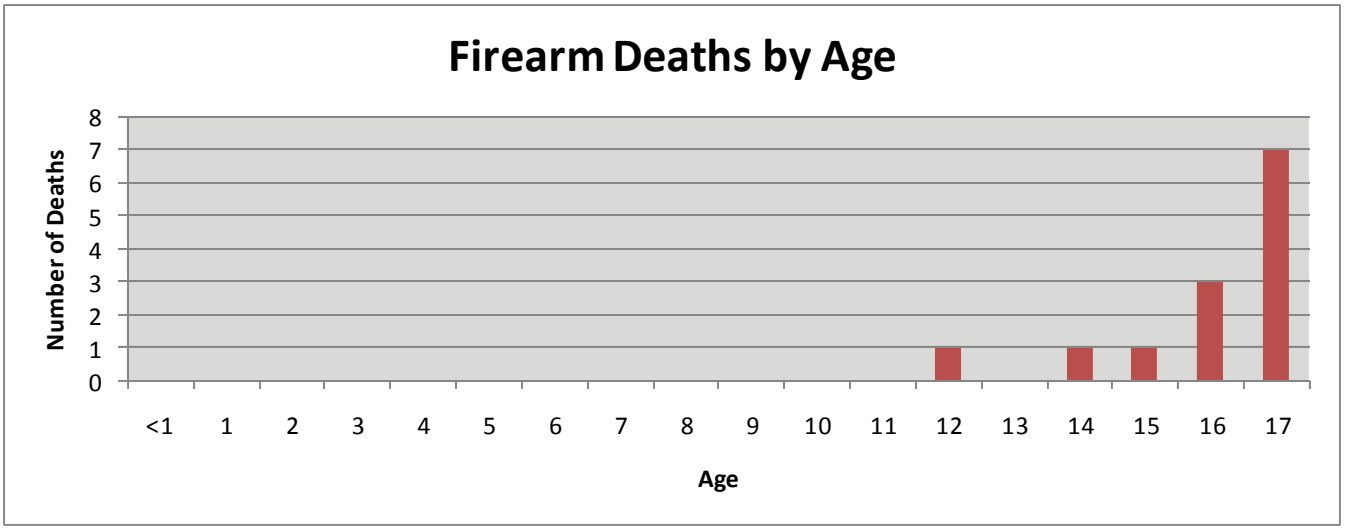



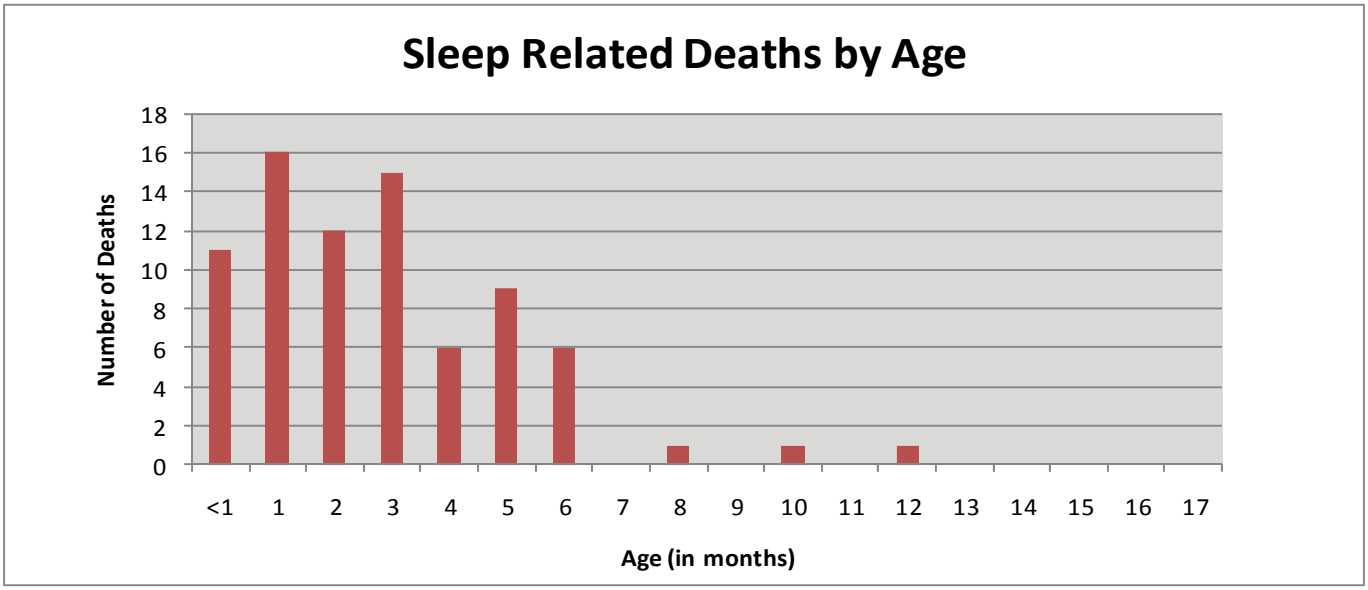
# Age of Decedents by Select Causes

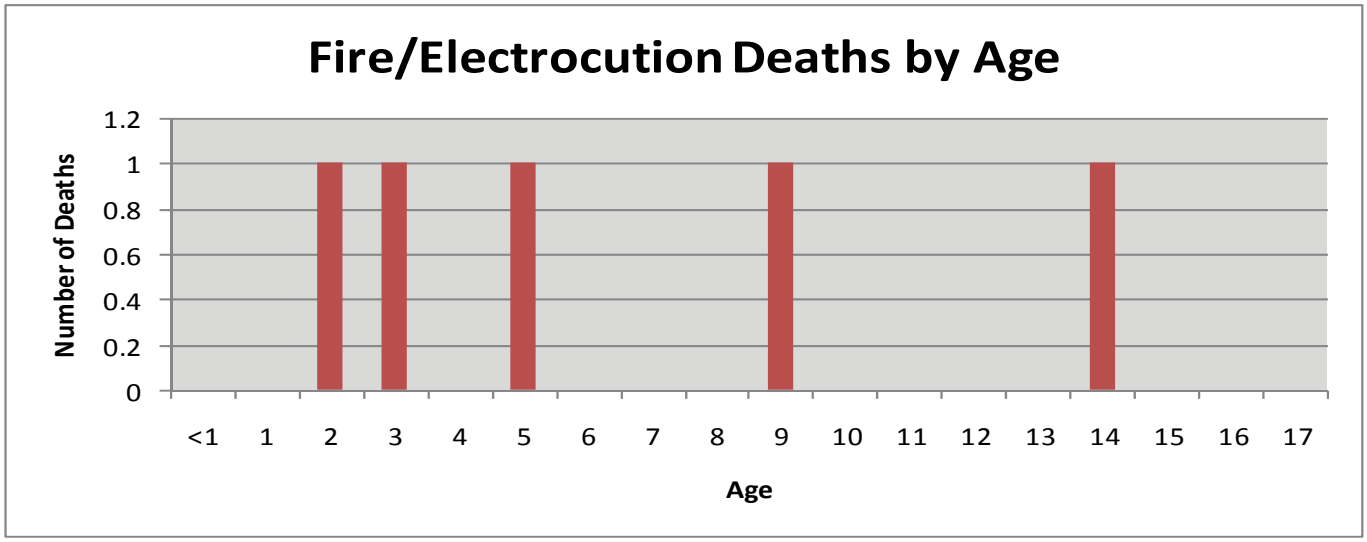


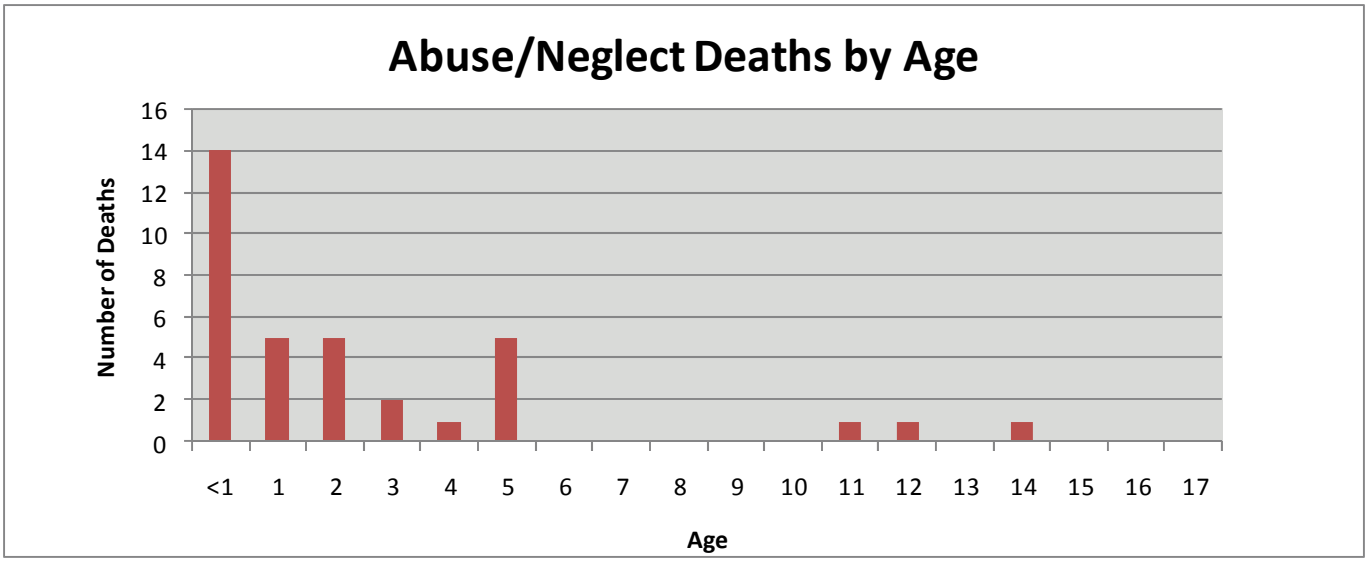



# Age of Decedents by Select Causes



# Resources

| | |
|---|---|
| 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<br>(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 |
| Oklahoma 211 Collaborative | www.211Oklahoma.com |
| Joint Oklahoma Information Network | www.join.ok.gov |
| Suicide Prevention Resource Center | www.sprc.org |

This publication, printed in June 2009 by the University of Oklahoma Health Sciences Center printing office, is issued by the Oklahoma Child Death Review Board. 350 copies were produced at a cost of $3255.00. Copies have been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries.