



Think. Prevent. Live.

Keep Our Children Safe

The Oklahoma Child Death Review Board 2009 Annual Report

Containing information on cases reviewed and closed during the 2009 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

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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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Recommendations

The following are the 2010 annual recommendations of the Oklahoma Child Death Review Board as submitted to the Oklahoma Commission on Children and Youth. The recommendations are based on the deaths reviewed and closed in 2009 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 eight times in the past 11 years. A total of 750 vehicular related deaths have been reviewed and closed since the first time this recommendation was made.)
- Legislation that bans the use of wireless hand-held telephone or electronic communication device by motor vehicle operators. (Recommended two times in the past 11 years. A total of 145 vehicular related deaths have been reviewed and closed since the first time this recommendation was made.)
- Strengthening of the booster seat legislation to include use up to age eight. (Recommended five times in the past 11 years. A total of 42 vehicular related deaths for children between the ages of six and eight have been reviewed and closed since the first time this recommendation was made.)
- Passage of All-Terrain Vehicle (ATV) legislation that contains elements prohibiting passengers, prohibiting driver ages 12 and under, and requiring ATV safety training. Requirements should be statewide, including on private land. (Recommended four times in the past 11 years. A total of 18 ATV related deaths have been reviewed and closed since the first time this recommendation was made.)

Administrative Recommendations

- Enforcement of child passenger safety restraints laws, which include fines for drivers transporting unrestrained children. (Recommended ten times in the past 11 years. A total of 452 vehicular related deaths have been reviewed and closed where the child was not utilizing a safety restraint since the first time this recommendation was made.)
- Develop and disseminate a campaign that will promote the best practices related to booster seat usage. (Recommended four times in the past 11 years. A total of 31 vehicular related deaths for children between the ages of six and eight

Recommendations

have been reviewed and closed since the first time this recommendation was made.)

- Provide, at no cost, driver education classes for all high school and career tech students. (Recommended nine times in the past 11 years. A total of 250 vehicle related deaths where the driver was the decedent have been reviewed and closed since the first time this recommendation was made.)
- Increase accessibility and usage of drug courts and drug treatment programs. (Recommended ten times in the past 11 years. A total of 958 vehicle related deaths have been reviewed and closed since the first time this recommendation was made.)

Sleep Related Deaths

In order to reduce the number of deaths of children due to unsafe sleep environments, 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), including the use of scene re-creation and digital photography. The methods currently utilized do not adequately provide the opportunity to distinguish accidental suffocation from other causes. (Recommended three times in the past 11 years. A total of 255 sleep related deaths have been reviewed and closed since the first time this recommendation was made.)
- Affordable childbirth classes should be available to all expectant mothers and address safe sleep issues prior to birth. Scholarships should be available to those who cannot afford classes. (Recommended four times in the past 11 years. A total of 332 sleep related deaths have been reviewed and closed since the first time this recommendation was made.)
- Education on safe sleep environments should be provided to families after delivery but prior to discharge. (Recommended four times in the past 11 years. A total of 332 sleep related deaths have been reviewed and closed since the first time this recommendation was made.)
- Education on safe sleep environments should be provided to families at the first well-child visit. (This is already occurring for Oklahoma Health Care Authority clients-Recommended three times in the past 11 years. A total of 255 sleep related deaths have been reviewed and closed since the first time this recommendation was made.)

Recommendations

- Distribute cribs for low-income families. (Recommended three times in the past 11 years. A total of 255 sleep related deaths have been reviewed and closed since the first time this recommendation was made.)
- All hospitals in Oklahoma should adopt a policy regarding in-house safe sleep issues. (Recommended two times in the past 11 years. A total of 142 sleep related deaths have been reviewed and closed since the first time this recommendation was made.)

Drowning Deaths

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

Legislative Recommendation:

- 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 five times in the past 11 years. A total of 38 private pool/hot tub related deaths have been reviewed and closed since the first time this recommendation was made.)

Administrative Recommendations:

- Increase access to swimming lessons for all children. (Recommended two times in the past 11 years. A total of 30 drowning related deaths have been reviewed and closed since the first time this recommendation was made.)
- Fund and distribute the “water watcher” badges that promote appropriate and responsible adult supervision of children around water. (Recommended two times in the past 11 years. A total of 30 drowning related deaths have been reviewed and closed since the first time this recommendation was made.)
- Work with Oklahoma Parks and Recreation to provide water watcher badges at Oklahoma lakes. (Recommended one time in the past 11 years. A total of 8 lake related drowning deaths have been reviewed and closed since the first time this recommendation was made.)
- EMS/National Weather Service include a warning regarding the dangers of flash floods in weather alerts. (Recommended five times in the past 11 years. A total of 40 deaths that occurred in open bodies of water have been reviewed and closed since the first time this recommendation was made.)

Fire Deaths

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

- Smoke alarm give away programs should include carbon monoxide detectors. (Recommended two previous times in past 11 years. A total of 14 fire related

Recommendations

deaths have been reviewed and closed since the first time this recommendation was made.)

- Increased penalties for homeowners who do not provide smoke alarms for rental houses. (Recommended two previous times in the past 11 years. A total of eight fire related deaths where there was no smoke alarm have been reviewed and closed since the first time this recommendation was made.)

Child Maltreatment Deaths

In order to reduce the number of death due to child maltreatment (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 seven times in the past 11 years. A total of 283 abuse and/or neglect related deaths have been reviewed and closed since the first time this recommendation was made.)
- 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 ten times in the past 11 years. A total of 385 abuse and/or neglect related deaths have been reviewed and closed since the first time this recommendation was made.)
- Make court records pertaining to custody and guardianship available for public inspection after a child death. (Recommended three times in the past 11 years. A total of 114 abuse and/or neglect related deaths have been reviewed and closed since the first time this recommendation was made.)
- 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 three times in the past 11 years. A total of 114 abuse and/or neglect related deaths have been reviewed and closed since the first time this recommendation was made.)

Agency Specific Recommendations

Oklahoma Safe Kids Coalition

- 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

Recommendations

the state since 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 .

- 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 funding for the Safe Kids Oklahoma bicycle safety program, which includes conducting bicycle safety rodeos and provides free helmets to groups who conduct bike safety education events utilizing Safe Kids curriculum.
- Promotion and establishment of funding for Safe Kid’s 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.

(All recommended six times in the past 11 years. A total of 956 unintentional injury deaths have been reviewed and closed since the first time this recommendation was made.)

Oklahoma Child Death Review Board

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

(Recommended two times in the past 11 years. A total of 407 deaths related to wheeled activities, sleep environment, drowning, fires, and child maltreatment have been reviewed and closed since the first time this recommendation was made.)

Board Actions and Activities

Include but are not limited to:

- Continued collaborations with the Oklahoma Domestic Violence Fatality Review, including case review.
- 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.
- Began partnership with Preparing for a Lifetime, a program of the Oklahoma State Department of Health aimed at reducing infant mortality.
- Nine letters to District Attorneys inquiring if criminal charges had been filed.
- Recommended a District Attorney in one case proceed with an investigation without a definitive “homicide” determination from the Office of the Chief Medical Examiner.
- One letter to a District Attorney expressing the Board’s concern regarding placement of a child.
- Seven letters to law enforcement agencies regarding the scene investigation.
- Recommended the Department of Public Safety create an informational brochure explaining the specifics of Oklahoma’s Graduated Licensing Law for distribution to families.
- Recommended a hospital improve its policies and procedures to include notification to the Office of the Chief Medical Examiner (OCME) when a child dies unexpectedly, to ensure an autopsy is conducted on the child.
- Requested the OCME amend the manner and/or cause on two cases. (Both requests denied.)
- Recommended the OCME consult with other involved medical professionals on one case.
- Requested information from the Oklahoma Department of Human Services (OKDHS) regarding the delay in finalizing investigative reports on six cases.
- Requested the OKDHS open up a subsequent investigation in three cases.
- Requested an update as to the status of OKDHS’s use of foster homes in two unrelated cases.
- Requested an update as to the status of OKDHS’s use of a child care providers in two unrelated cases.
- Requested OKDHS reopen an investigation ruled “unable to locate” after the family was located in another county.
- Inquired to OKDHS as to the use of medical evaluations between foster home placements.
- Recommended OKDHS investigate all unexpected child deaths.

Cases Closed 2009

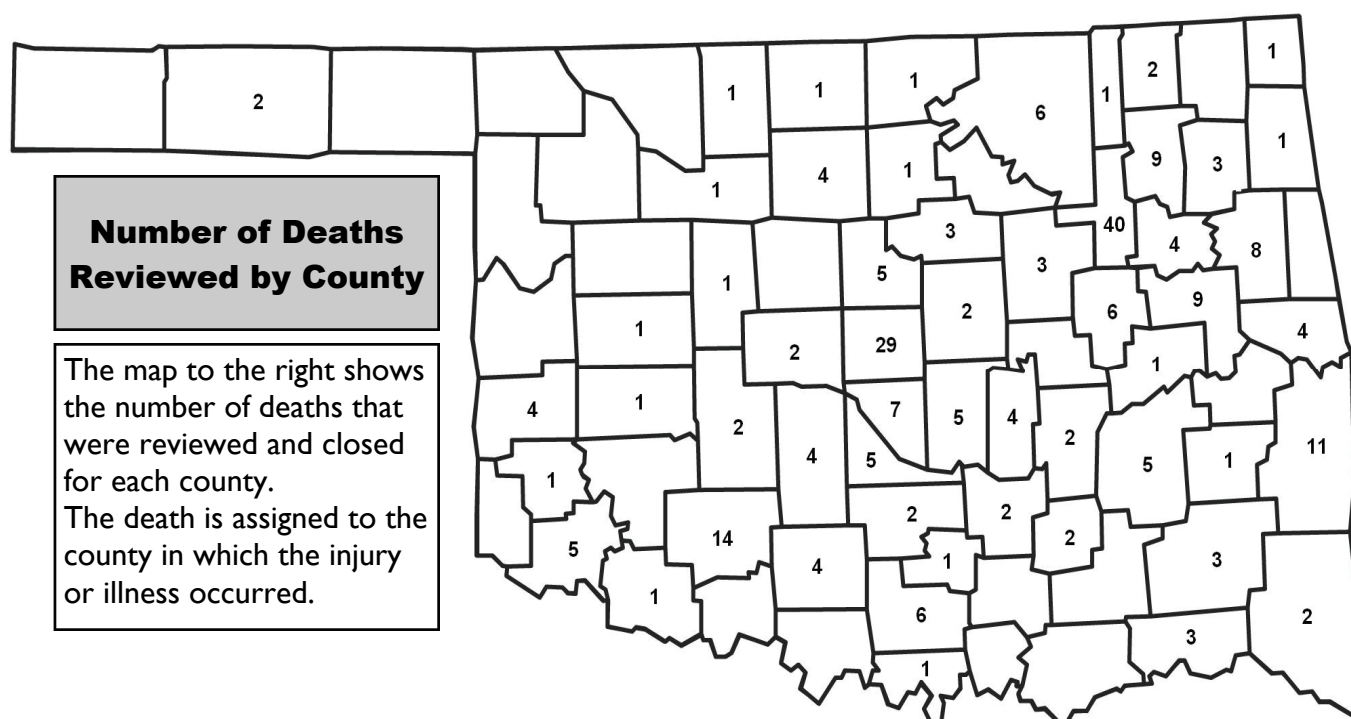
The Oklahoma Child Death Review Board is comprised of five review teams. The total number of deaths reviewed and closed in 2009 by all five teams is 250. The year of death for these cases ranged from 2006 to 2009.

2009 Deaths Reviewed		
Manner	Number	Percent
Accident	116	46.4%
Unknown	61	24.4%
Homicide	32	12.8%
Suicide	21	8.4%
Natural	20	8.0%

Race		
African American	36	14.4%
American Indian	32	12.8%
Asian	2	0.8%
Multi-race	14	5.6%
Pacific Islander	1	0.4%
White	165	66.0%

Gender	Number	Percent
Males	163	65.2%
Females	87	34.8%

Ethnicity	Number	Percent
Hispanic (any race)	27	10.9%
Non-Hispanic	223	89.1%



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 the Oklahoma Department of Human Services.

In addition to the information in the chart below, there were eight foster care deaths reviewed and closed in 2009. Five were ruled accidental deaths, two were ruled natural deaths and one had an unknown manner of death. Four were confirmed by the OKDHS/CW as to the abuse/neglect allegations. Three of the cases resulted in OKDHS/CW ceasing the use of the family as a foster placement.

Number of Cases with Previous Involvement in Selected State Programs		
Agency	Number	Percent Of All Deaths
OKDHS - TANF	191	76.4%
Oklahoma Health Care Authority (Medicaid)	179	71.6%
OKDHS - Child Support Enforcement	109	43.6%
OKDHS - Food Stamps	39	15.6%
OKDHS - Child Welfare	37	14.8%
OKDHS - Child Care Assistance	22	8.8%
Office of Juvenile Affairs	14	5.6%
OKDHS - Disability	12	4.8%
OKDHS - Emergency Assistance	11	4.4%
OSDH - Office of Child Abuse Prevention	1	0.4%
OSDH - Children First	1	0.4%

Accidents

Nine (81.8%) of the 11 asphyxia deaths were infants.

Four (66.6%) of the six accidental overdoses were due to multiple substances.

The crushing deaths were due to a television, a dresser, and a horse.

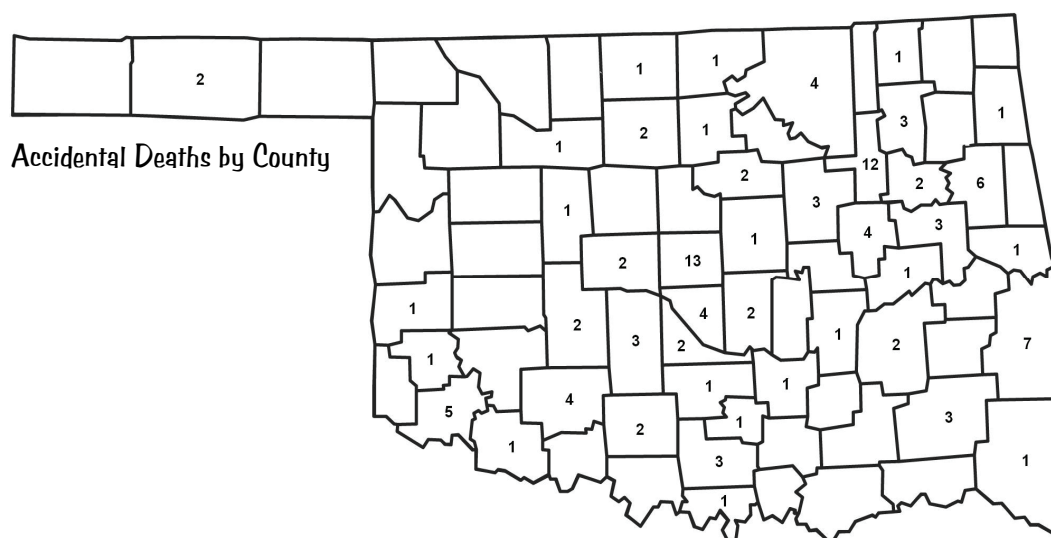
Type of Accidents Reviewed	Race
1	1
2	2
3	3
4	4
5	5
6	6
7	7
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9	9
10	10
11	11
12	12
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97	97
98	98
99	99
100	100

Type of Accidents Reviewed		
Type	Number	Percent
Vehicular	71	61.5%
Drowning	11	9.4%
Fire	10	8.6%
Asphyxia	11	9.4%
Poisoning/OD	6	5.1%
Crush	3	2.6%
Firearm	1	0.9%
Electrocution	1	0.9%
Other	2	1.7%

Race		
African American	10	8.6%
American Indian	16	13.8%
Asian	1	0.8%
Multi-race	3	2.6%
Pacific Islander	1	0.8%
White	85	73.3%

Gender	Number	Percent
Males	61	52.6%
Females	55	47.4%

Ethnicity	Number	Percent
Hispanic (any race)	14	12.6%
Non-Hispanic	102	87.4%



Suicides

Five (23.8%) were documented as having had school problems.
Three (14.3%) were documented as having received prior mental health services.
Two (9.5%) were documented as currently receiving mental health services.
Two (9.5%) overdoses were on the child's own prescription medication.

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Method of Suicide		
Method	Number	Percent
Firearm	10	47.6%
Asphyxia	6	28.6%
Overdose	4	19.4%
Motor Vehicle	1	0.4%

Race		
African American	1	4.8%
American Indian	1	4.8%
Multi-race	1	4.8%
White	18	85.6%

Gender	Number	Percent
Males	17	81.0%
Females	4	19.0%

Ethnicity	Number	Percent
Hispanic (any race)	2	9.5%
Non-Hispanic	19	90.5%



Homicides

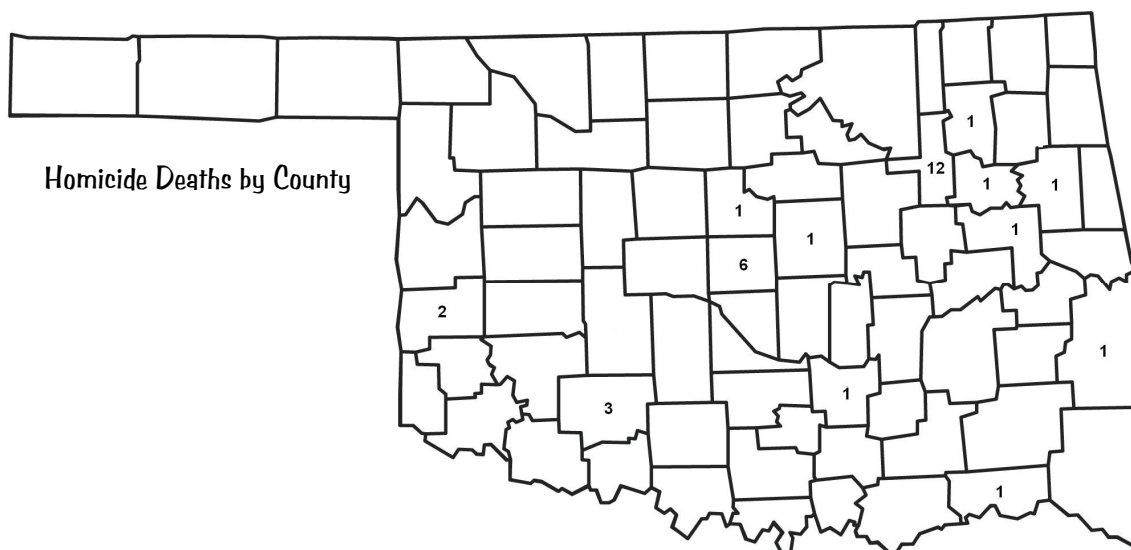
The Board reviewed and closed 32 deaths in 2009 whose manner of death was ruled Homicide.

Causes of Death in Homicide Cases		
Cause of Death	Number	Percent
Firearm	15	46.9%
Abusive Head Trauma	9	28.1%
Abusive Abdominal Trauma	3	9.4%
Stabbing	2	6.3%
Asphyxiation	1	3.1%
Vehicular	1	3.1%
Head Trauma (assault/non-child abuse)	1	3.1%

Race		
African American	15	46.9%
American Indian	1	3.1%
Multi-race	2	6.2%
White	14	43.8%

Ethnicity	Number	Percent
Hispanic (any race)	14	43.8%
Non-Hispanic	18	56.2%

Gender	Number	Percent
Males	25	78.1%
Females	7	21.9%



Unknown

The Board reviewed and closed 61 deaths in 2009 ruled Undetermined or Unknown. Fifty-one (83.6%) of these were infants that the Medical Examiner stated the sleep environments may have contributed to the death.

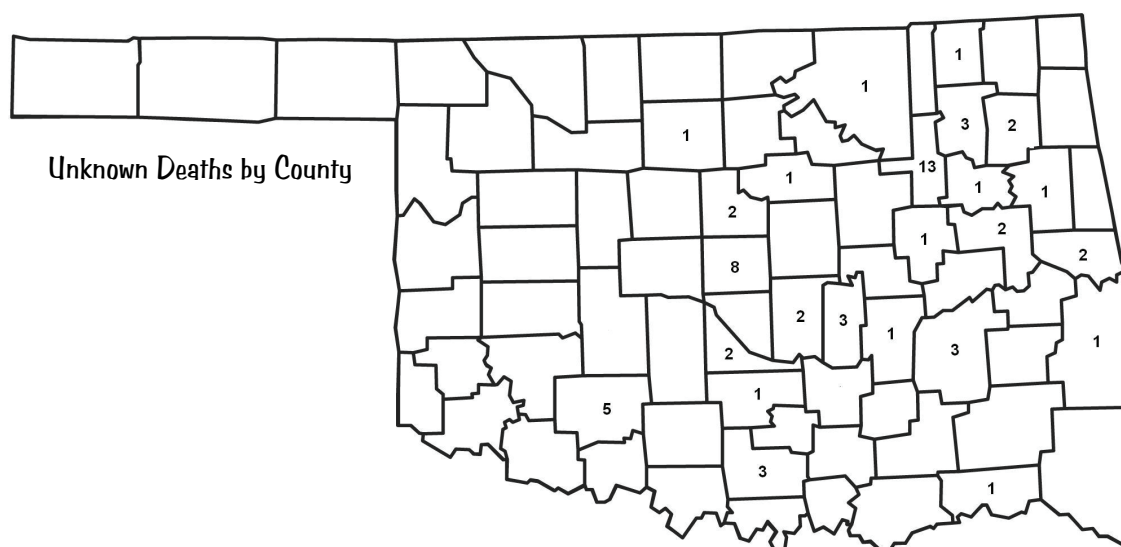
One (1.6%) was possibly a homicide but skeletal remains could not assist with determining the exact injury so the manner and cause of death were ruled Unknown by the pathologist.

One (1.6%) had a suspicious injury (subdural hematoma) found at autopsy but was also ruled an Unknown manner and cause of death by the pathologist.

Race		
African American	7	11.5%
American Indian	11	18.0%
Asian	1	1.6%
Multi-race	8	13.1%
White	34	55.7%

Ethnicity	Number	Percent
Hispanic (any race)	8	13.1%
Non-Hispanic	53	86.9%

Gender	Number	Percent
Males	39	63.9%
Females	22	36.1%



Natural Deaths - Reviewed

The Board reviewed and closed 20 deaths in 2009 ruled Natural.

Causes of Death in Natural Death Cases

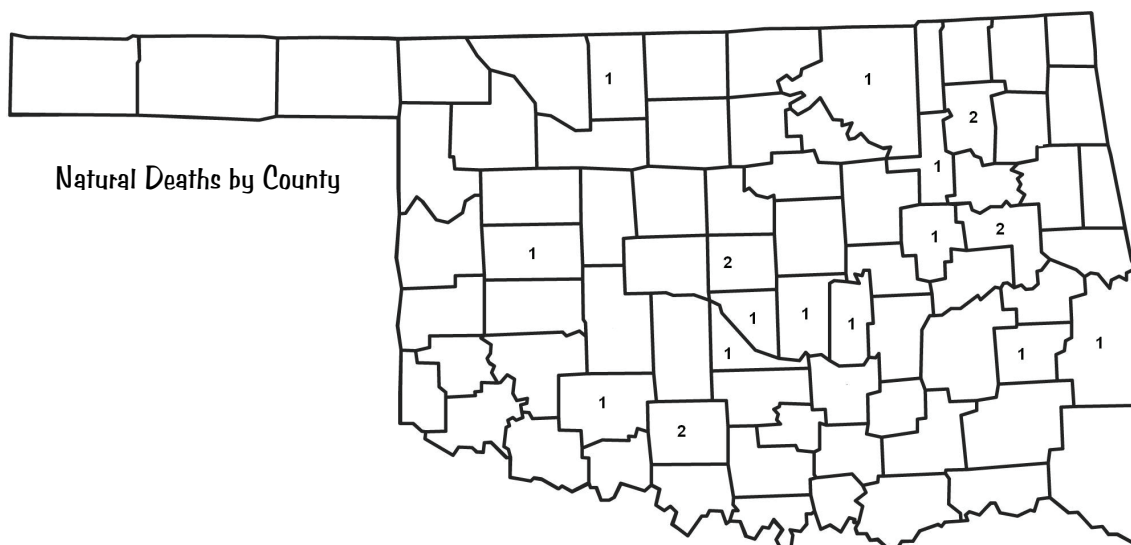
Illness/Disease	Number	Percent
Infectious Diseases	8	40.0%
SIDS	7	35.0%
Cardiovascular	2	10.0%
Other Medical Conditions	2	10.0%
Seizure Disorder	1	5.0%

Race

African American	3	15.0%
American Indian	2	10.0%
Multi-race	1	5.0%
White	14	70.0%

Gender	Number	Percent
Males	13	65.0%
Females	7	35.0%

Ethnicity	Number	Percent
Hispanic (any race)	1	5.0%
Non-Hispanic	19	95.0%



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. If the death certificate fails to adequately describe a death, the physician may request medical records to obtain more information. These deaths are classified by the underlying condition that eventually led to the death of the child.

The death certificate review process findings in 2009 are as follows:

Cause of Death or Medical Condition	Number of Death Certificates Received	Percent
Prematurity	137	37.4%
Congenital Disorder	112	30.6%
Infectious Disease	36	9.8%
Neoplastic Disease	26	7.1%
Intrauterine/ Birth Complication	19	5.2%
Neurological	11	3.0%
Cardiac Disease	5	1.4%
Renal Disease	5	1.4%
Pulmonary Disease	3	0.8%
Auto-Immune Disease	3	0.8%
Blood Disorder	2	0.5%
Hepatic Disease	2	0.5%
Vascular Disease	1	0.3%
Toxicity	1	0.3%
Unknown	3	0.8%
TOTAL	366	100%

Traffic Related Deaths

The Board reviewed and closed 71 accidental deaths in 2009 related to traffic. For the ATV deaths, both were passengers and both were not wearing a helmet. The motorcycle and bicycle deaths also were not wearing a helmet.

Vehicle of Decedent		
Vehicle	Number	Percent
Car	33	46.5%
Pick-Up	12	16.9%
Pedestrian	8	11.3%
SUV	7	9.9%
Van	4	5.6%
ATV	2	2.8%
Aircraft	2	2.8%
Motorcycle	1	1.4%
Bicycle	1	1.4%
Hay Trailer	1	1.4%

Use of Safety Restraints		
Seatbelt/Car seat Use	Number	Percent
Properly Restrained	19	26.8%
Not Properly Restrained	39	54.9%
Not Applicable	13	18.3%

Activity of Decedent		
Position	Number	Percent
Rear Passenger	24	33.8%
Operator	19	26.8%
Front Passenger	13	18.3%
Unknown Passenger Placement	5	7.0%
Truck Bed	1	1.4%
Trailer Bed	1	1.4%
N/A	8	11.3%

Race		
African American	3	4.2%
American Indian	10	14.1%
Asian	1	1.4%
Multi-race	2	2.8%
Pacific Islander	1	1.4%
White	54	76.1%

Ethnicity	Number	Percent
Hispanic (any race)	7	9.9%
Non-Hispanic	64	90.1%

Gender	Number	Percent
Males	40	56.3%
Females	31	43.7%

Drowning Deaths

The Board reviewed and closed 11 deaths in 2009 due to drowning.

Location of Drowning		
Location	Number	Percent
Private, Residential Pool	6	54.5%
Open Body of Water (i.e. creek, river, pond, lake)	5	45.5%

Type of Residential Pool		
Type of Pool	Number	Percent
Above Ground	3	50.0%
In Ground	3	50.0%

Type of Open Body of Water		
Open Body	Number	Percent
Lake	3	60.0%
Pond	1	20.0%
Creek	1	20.0%

Race		
African American	3	27.3%
American Indian	1	9.1%
White	7	63.6%

Ethnicity	Number	Percent
Hispanic (any race)	2	18.2%
Non-Hispanic	9	81.8%

Gender	Number	Percent
Males	8	72.7%
Females	3	27.3%

Sleep Related Deaths

The Board reviewed and closed 65 deaths that were related to sleep environments. These included 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	7	10.9%
Natural (SIDS)	7	10.9%
Undetermined	51	78.2%

Position of Infant When Placed to Sleep		
Position	Number	Percent
On Stomach	17	26.2%
On Back	14	21.5%
On Side	2	3.1%
Unknown*	32	49.2%

Position of Infant When Found		
Position	Number	Percent
On Stomach	20	30.8%
On Back	13	20.0%
On Side	4	6.1%
Unknown*	28	43.1%

Sleeping Arrangement of Infant		
Sleeping Arrangement	Number	Percent
Alone	29	44.6%
With Adult and/or Other Child	36	55.4%

Race		
African American	6	9.2%
American Indian	12	18.5%
Asian	1	1.5%
Multi-race	9	13.9%
White	37	56.9%

Ethnicity	Number	Percent
Hispanic (any race)	5	7.7%
Non-Hispanic	60	92.3%

Gender	Number	Percent
Males	41	63.1%
Females	24	36.9%

Sleeping Location of Infant		
Location	Number	Percent
Adult Bed	28	43.1%
Crib	14	21.6%
Couch	7	10.8%
Bassinette/cradle	5	7.7%
Floor	5	7.7%
Playpen	3	4.6%
Chair	1	1.5%
Car Seat	1	1.5%
Plastic Tub	1	1.5%

*This information is unknown due to the lack of information collected by scene investigators

Firearm Deaths

The Board reviewed and closed 27 deaths in 2009 due to firearms.

Manner of Death for Firearm Victims		
Manner	Number	Percentage
Homicide	15	55.6%
Suicide	10	37.0%
Accident	1	3.7%
Undetermined	1	3.7%

Type of Firearm Used		
Type of Firearm	Number	Percent
Handgun	18	66.7%
Hunting Rifle	4	14.8%
Shot gun	3	11.1%
Assault Rifle	1	3.7%
Unknown	1	3.7%

Race		
African American	11	40.7%
Multi-race	2	7.4%
White	14	51.9%

Ethnicity	Number	Percent
Hispanic (any race)	2	7.4%
Non-Hispanic	25	92.6%

Gender	Number	Percent
Males	25	92.6%
Females	2	7.4%

Fire Deaths

The Board reviewed and closed 10 deaths in 2009 due to fires. Five fires resulted in ten deaths. All ten died of smoke inhalation.

Fire Ignition Source		
Source	Number	Percent
Unknown	3	30.0%
Electrical Wiring	2	20.0%
Wood Stove	2	20.0%
Space Heater	2	20.0%
Electrical Outlet	1	10.0%

Race		
African American	2	20.0%
White	8	80.0%

Ethnicity	Number	Percent
Hispanic (any race)	2	20.0%
Non-Hispanic	8	80.0%

Working Smoke Detector Present		
Detector	Number	Percent
Yes	4	40.0%
No	3	30.0%
Unknown	3	30.0%

Gender	Number	Percent
Males	6	50.0%
Females	5	50.0%

Abuse/Neglect Deaths

The Board reviewed and closed 42 cases where it was determined that abuse or neglect caused or contributed to the death. Twelve (28.6) cases were ruled abuse and 30 (71.4) cases were ruled neglect.

Manner of Death for Abuse/Neglect Cases		
Manner	Number	Percent
Accident	23	54.8%
Homicide	14	33.3%
Undetermined	5	11.9%

Race		
African American	8	19.0%
American Indian	10	23.8%
Multi-race	2	4.8%
White	22	52.4%

Injuries in Abuse/Neglect Cases		
Injury	Number	Percent
Traffic Related	14	33.3%
Physical Abuse	12	28.6%
Drowning	4	9.5%
Unsafe/Unsanitary Sleep Environment	4	9.5%
Bed Sharing While Under the Influence	3	7.1%
Firearm Related	2	4.8%
Fire/Burn	1	2.4%
Overdose	1	2.4%
Maternal Drug Exposure	1	2.4%

Ethnicity	Number	Percent
Hispanic (any race)	3	7.1%
Non-Hispanic	39	92.9%

Gender	Number	Percent
Males	20	47.6%
Females	22	52.4%

Near Deaths

The Board reviewed and closed 53 near death cases in 2009. A case is deemed near death if the child was admitted to the hospital in serious or critical condition as a result of suspected abuse or neglect. Thirty-two (60.3%) were substantiated by OKDHS as to having been abuse and/or neglect. Thirteen (24.5%) had a previous referral that was investigated by OKDHS.

Injuries in Near Death Cases		
Injury	Number	Percent
Physical Abuse	24	45.3%
Poison/Overdose	8	15.1%
Near Drowning	4	7.5%
Asphyxia	4	7.5%
Fall	4	7.5%
Vehicular	3	5.7%
Animal Attack	2	3.8%
Medical Condition	2	3.8%
Exposure	1	1.9%
Fire	1	1.9%

Race		
African American	10	18.9%
American Indian	5	9.4%
Multi-race	2	3.8%
White	36	67.9%

Ethnicity	Number	Percent
Hispanic (any race)	2	3.8%
Non-Hispanic	51	96.2%

Number of Near Deaths Reviewed per Team		
Team	Number	Percent
Eastern	4	7.5%
Southeastern	6	11.3%
Southwestern	9	17.0%
State	25	47.2%
Tulsa	9	17.0%

Gender	Number	Percent
Males	31	41.5%
Females	22	58.5%

State Review Team

The State Team reviewed and closed 70 cases in 2009. The team meets monthly in Oklahoma City, OK. Counties include Alfalfa, Beaver, Blaine, Canadian, Cimarron, Cleveland, Custer, Dewey, Ellis, Garfield, Grant, Harper, Kay, Kingfisher, Logan, Major, Noble, Oklahoma, Pawnee, Payne, Roger Mills, Texas, Woods, and Woodward.

Manner of Death for State Team Cases		
Manner	Number	Percent
Accident	35	50.0%
Homicide	7	10.0%
Natural	8	11.4%
Suicide	6	8.6%
Undetermined	14	14.2%

Race		
African American	12	17.1%
American Indian	4	5.7%
Multi-race	4	5.7%
White	50	71.5%

Gender	Number	Percent
Males	47	67.1
Females	23	32.9

Ethnicity	Number	Percent
Hispanic (any race)	10	14.3%
Non-Hispanic	60	85.7%

Eastern Regional Review Team

The Eastern Team reviewed and closed 56 cases in 2009. 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.

Manner of Death for Eastern Team Cases

Manner	Number	Percent
Accident	27	48.2%
Homicide	5	8.9%
Natural	6	10.8%
Suicide	5	8.9%
Undetermined	13	23.2%

Race

Race	Number	Percent
African American	5	8.9%
American Indian	13	23.2%
Multi-Race	4	7.1%
White	34	60.8%

Gender	Number	Percent
Males	37	66.1%
Females	19	33.9%

Ethnicity	Number	Percent
Hispanic (any race)	2	3.6%
Non-Hispanic	54	96.4%

2009 Team Members

Organization	Team Member	Designee
Medical Representative	Michael Stratton, DO; Chair	Timothy Holder, MD
Muskogee Public Schools	Debbie Winburn; Vice-Chair	Heather Jones
Cherokee Nation Mental Health	Misty Boyd, PhD	
Oklahoma Department of Human Services	Janetta Garrett	Renee McMahan
Muskogee Regional Medical Center-ER	Ted Galbraith	
CASA of Muskogee County	Kathryn Eaton	
Oklahoma Coalition on Domestic Violence	Evelyn Hibbs	Gwyn LaCrone
Muskogee County Children First Program	Linda Hitcheye	
Muskogee County Health Department	Tonya James	
Kids Space, Children's Advocacy Center	Ann Mathews	Lindsey Groom/Walter Davis
Muskogee County Council on Youth Services	Cindy Perkins	Michael Adair
Muskogee County Sheriff's Office	Coletta Peyton	
Muskogee County EMS	Rebecca Smith	Carlene Morrison
Community Representative	Lillian Young, PhD	

Southeastern Regional Review Team

The Southeastern Team reviewed and closed 21 cases in 2009. 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 Team Cases

Manner	Number	Percent
Accident	8	38.1%
Homicide	3	14.3%
Natural	0	0.0%
Suicide	3	14.3%
Undetermined	7	33.3%

Race

African American	2	9.5%
American Indian	3	14.3%
Multi-Race	5	23.8%
White	11	52.4%

Gender	Number	Percent
Males	14	66.7%
Females	7	33.3%

Ethnicity

Ethnicity	Number	Percent
Hispanic (any race)	1	4.8%
Non-Hispanic	20	95.2%

2009 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	Linda Roark
Law Enforcement Representative	Russell Frantz	Anthony Grasso/Rod Taylor
Oklahoma Department of Human Services	Carmen Hutchins	Dane Smart
Community Representative	Shawna Jackson	
Youth and Family Resources Center	Susan Morris	Michelle Mayberry
Medical Representative	Starla Griffith	Joye Byrum
Health Department	Carolyn Parks	Jay Scott Brown
District Attorney	Richard Smotherman	Kathryn Savage

Southwestern Regional Review Team

The Southwestern Team reviewed and closed 50 cases in 2009. 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 Team Cases

Manner	Number	Percent
Accident	26	52.0%
Homicide	5	10.0%
Natural	4	8.0%
Suicide	4	8.0%
Undetermined	11	22.0%

Race

African American	5	10.0%
American Indian	3	6.0%
Asian	1	2.0%
Multi-race	1	2.0%
Pacific Islander	1	2.0%
White	39	78.0%

Gender	Number	Percent
Males	34	68.0%
Females	16	12.0%

Ethnicity	Number	Percent
Hispanic (any race)	6	12.0%
Non-Hispanic	44	88.0%

2009 Team Members

Organization	Team Member	Designee
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	

Tulsa Regional Review Team

The Tulsa Team reviewed and closed 53 cases in 2009. The team meets every other month in Tulsa, OK. The counties include Creek, Osage, Tulsa, and Washington.

Manner of Death for Tulsa Team Cases		
Manner	Number	Percent
Accident	20	37.8%
Homicide	12	22.6%
Natural	2	3.6%
Suicide	3	5.8%
Undetermined	16	30.2%

Race		
African American	12	22.6%
American Indian	8	15.1%
Asian	1	1.9%
Multi-race	1	1.9%
White	31	58.5%

Gender	Number	Percent
Males	31	58.5%
Females	22	41.5%

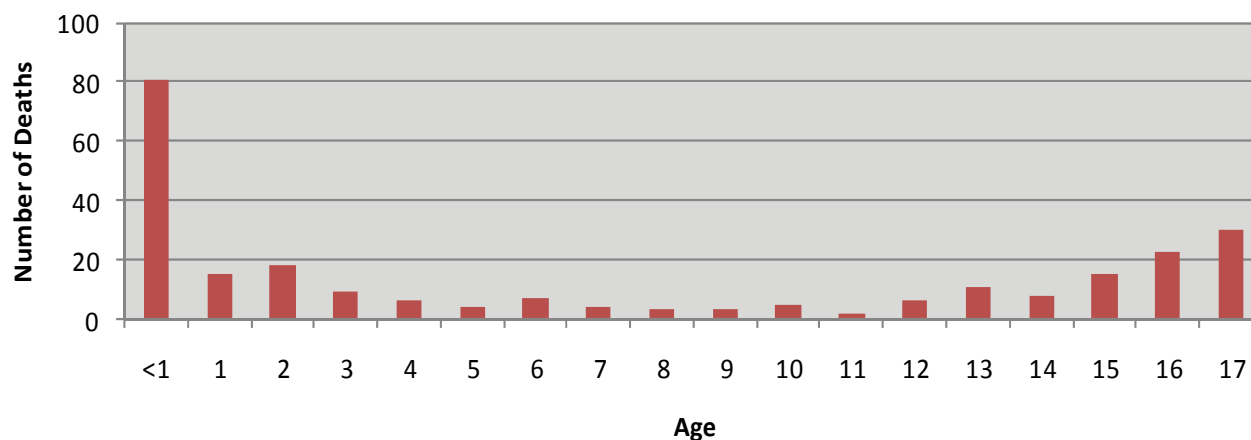
Ethnicity	Number	Percent
Hispanic (any race)	8	15.1%
Non-Hispanic	45	84.9%

2009 Team Members

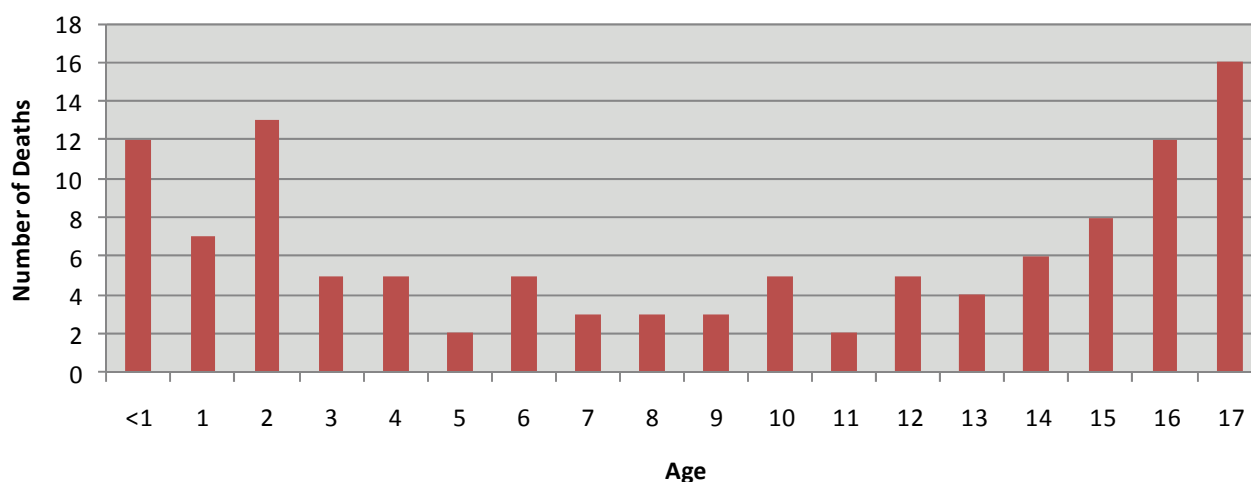
Organization	Team Member	Designee
Medical Representative	Deborah Lowen; Chair	
Tulsa County District Attorney's Office	Tim Harris, JD	Jake Cain, JD; Vice-Chair
Law Enforcement Representative	Sgt. Whitney Allen	Darren Carlock/Brandon Wykoff/Dianna Baumann/Scott Murphy
Fire Department Representative	Steve Coldwell	Phil Reid
Medical Examiner	Josh Lanter, MD	
Safe Kids Coalition	Mary Beth Ogle	Susan West, Jeanne Draughon
Mental Health Representative	Rose Perry	Amy Howard
Children First Representative	Lori Sweeny	Sharon Konemann

Age of Decedents by Manner

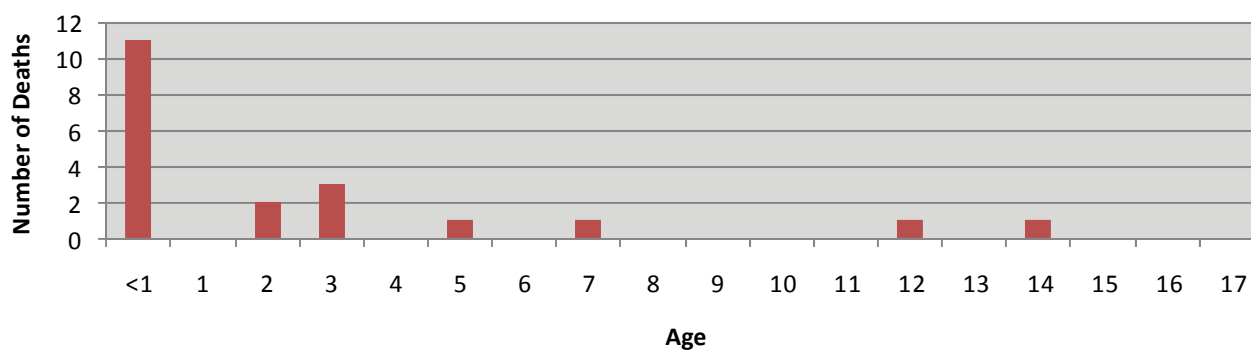
Total Number of Deaths



Accidental Deaths by Age

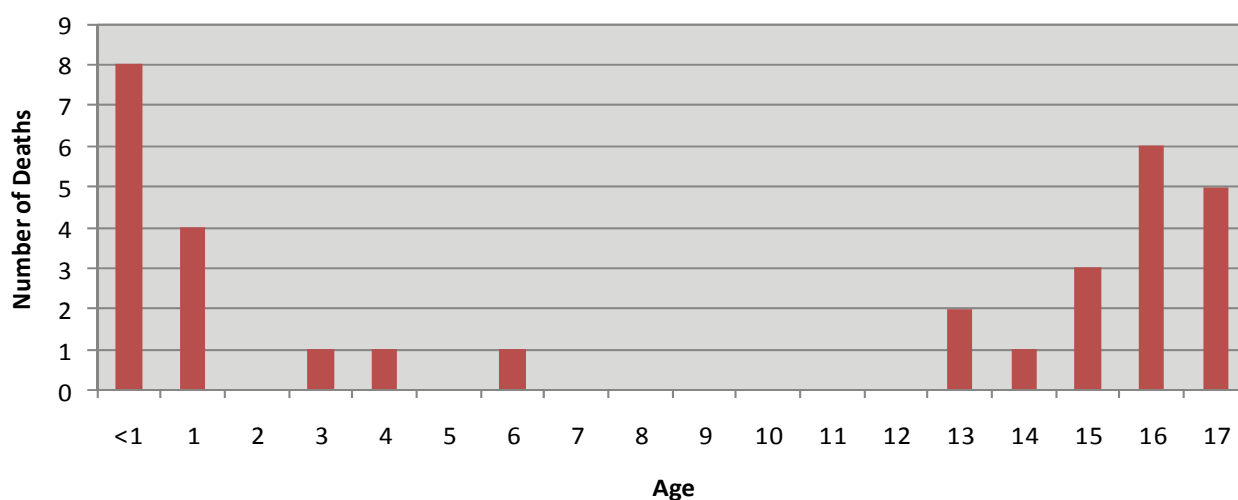


Natural Deaths by Age

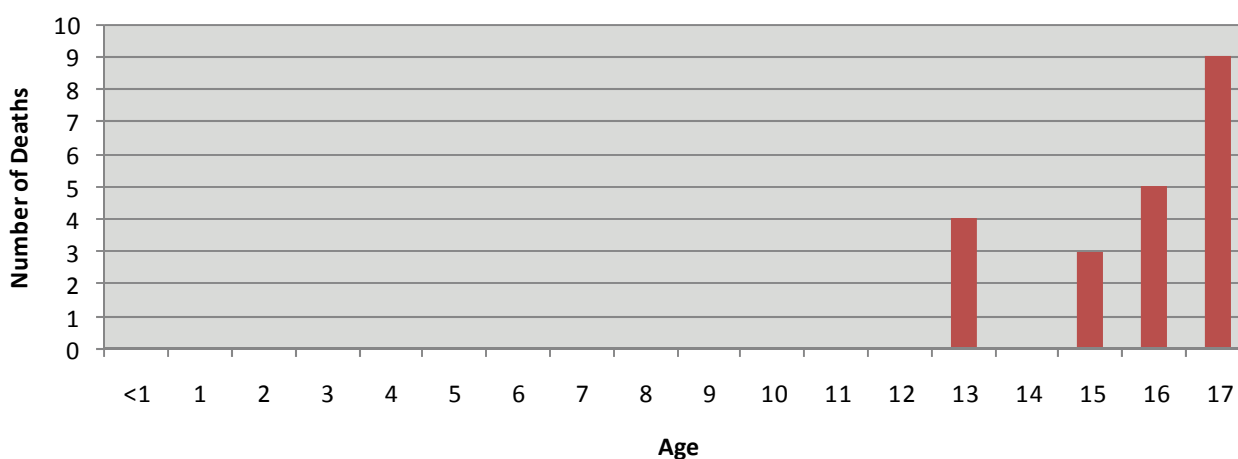


Age of Decedents by Manner

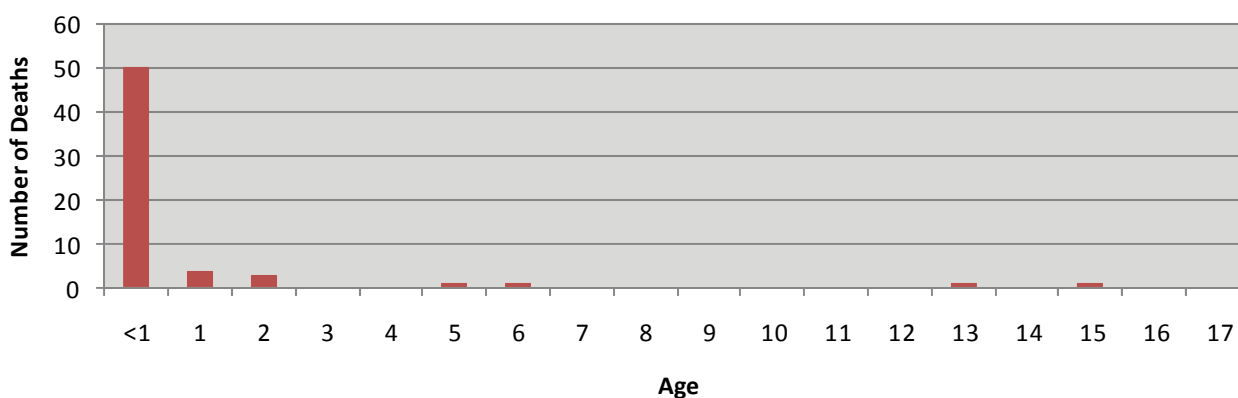
Homicide Deaths by Age



Suicide Deaths by Age

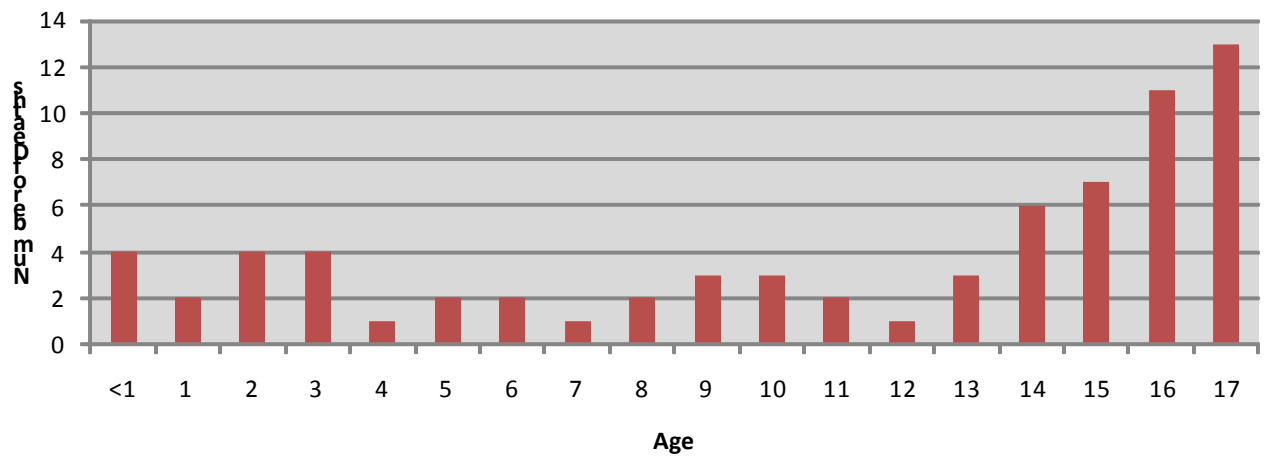


Unknown Deaths by Age

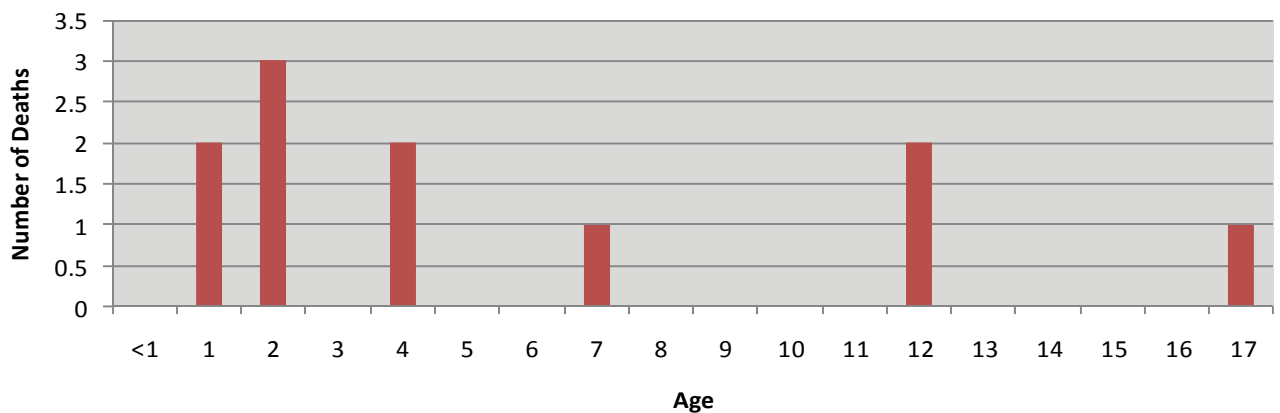


Age of Decedents by Select Causes

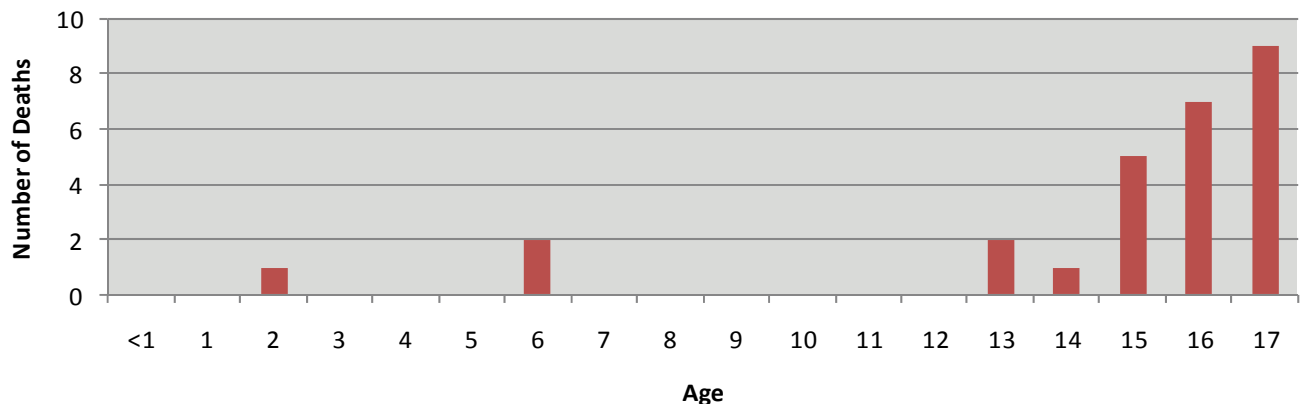
Traffic Related Deaths by Age



Drowning Deaths by Age

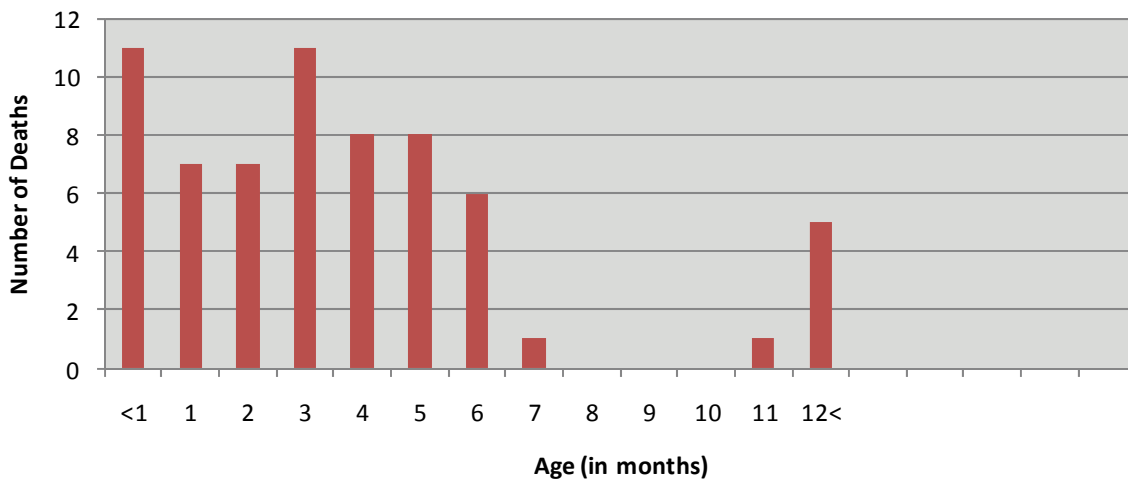


Firearm Deaths by Age

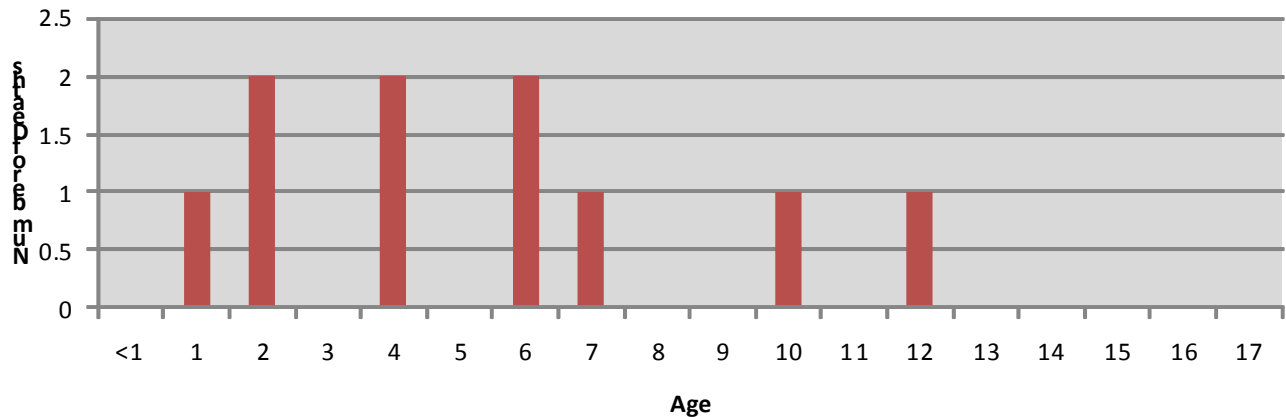


Age of Decedents by Select Causes

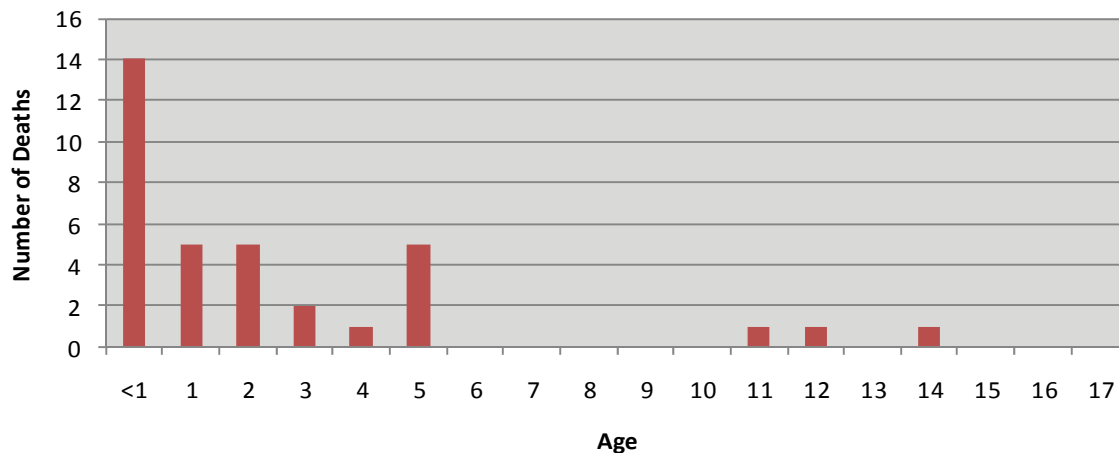
Sleep Related Deaths by Age



Fire Deaths by Age



Abuse/Neglect Deaths by Age



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 (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



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For more information please visit:

http://www.ok.gov/health/Child_and_Family_Health/Improving_Infant_Outcomes/index.html

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