



Think. Prevent. Live.

Keep Our Children Safe

The Oklahoma Child Death Review Board 2010 Annual Report

Containing information on cases reviewed and closed during the 2010 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

Contact information:

Oklahoma Child Death Review Board
1111 N. Lee Ave.
Oklahoma City, OK 73103
<http://okkids.org>

Phone: (405) 606-4900
Fax: (405) 524-0417

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Recommendations

The following are the 2011 annual recommendations of the Oklahoma Child Death Review Board as submitted to the Oklahoma Commission on Children and Youth. The majority of the recommendations are based on the deaths reviewed and closed in 2010 that were due to motor vehicles, drowning, unsafe sleep practices, fires, and child abuse/neglect.

Motor Vehicle Related Recommendations

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.
Year first recommended: **2002**
Total number of deaths since first recommended: **831**
Number of additional deaths since last recommended: **81**
- Legislation that bans the use of wireless hand-held telephone or electronic communication device by motor vehicle operators.
Year first recommended: **2008**
Total number of deaths since first recommended: **226**
Number of additional deaths since last recommended: **81**
- Strengthening of the booster seat legislation to include use up to age 8.
Year first recommended: **2005**
Total number of deaths since first recommended: **45**
Number of additional deaths since last recommended: **3** (Specific to children between six and eight years of age.)
- Passage of All-Terrain Vehicle (ATV) legislation that contains elements prohibiting passengers, prohibiting drivers aged 12 and under, and requiring ATV safety training. Requirements should be statewide, including on private land.
Year first recommended: **2006**
Total number of deaths since first recommended: **23**
Number of additional deaths since last recommended: **5**

Administrative recommendations:

- Enforcement of child passenger safety restraint laws, which include fines for drivers transporting unrestrained children.
Year first recommended: **2000**
Total number of deaths since first recommended: **502**

Recommendations

Number of additional deaths since last recommended: **50** (Specific to unrestrained occupants.)

- Develop and disseminate a campaign that will promote the best practices related to booster seat usage.

Year first recommended: **2006**

Total number of deaths since first recommended: **34**

Number of additional deaths since last recommended: **3** (Specific to children between six and eight years of age.)

- Provide, at no cost, driver education classes for all high school and career tech students.

Year first recommended: **2001**

Total number of deaths since first recommended: **277**

Number of additional deaths since last recommended: **27** (Specific to decedent as driver.)

- Increase accessibility and usage of drug courts and drug treatment programs.

Year first recommended: **2000**

Total number of deaths since first recommended: **1039**

Number of additional deaths since last recommended: **81**

Sleep Related Recommendations

- 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 recreation and digital photography. The methods currently utilized do not adequately provide the opportunity to distinguish accidental overlay (smothering) from other causes.

Year first recommended: **2007**

Total number of deaths since first recommended: **334**

Number of additional deaths since last recommended: **79**

- 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.

Year first recommended: **2006**

Total number of deaths since first recommended: **411**

Recommendations

Number of additional deaths since last recommended: **79**

- Education on safe sleep environments should be provided to families after delivery but prior to discharge.

Year first recommended: **2006**

Total number of deaths since first recommended: **411**

Number of additional deaths since last recommended: **79**

- Education on safe sleep environments should be provided to families at the first well-child visit.

Year first recommended: **2007**

Total number of deaths since first recommended: **334**

Number of additional deaths since last recommended: **79**

- Distribute cribs to low-income families.

Year first recommended: **2007**

Total number of deaths since first recommended: **334**

Number of additional deaths since last recommended: **79**

- All hospitals in Oklahoma should adopt a policy regarding in-house safe sleep issues.

Year first recommended: **2008**

Total number of deaths since first recommended: **221**

Number of additional deaths since last recommended: **79**

*An unsafe sleep environment is defined as the child not in his/her own personal sleep area (i.e. crib, bassinette, play pen), with pillows or other items, including people, and/or placed face down to sleep.

Drowning Recommendations

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.

Year first recommended: **2005**

Total number of deaths since first recommended: **47**

Number of additional deaths since last recommended: **9** (Specific to private pools only.)

Recommendations

Administrative recommendations:

- Increase access to swimming lessons for all children.
Year first recommended: **2008**
Total number of deaths since first recommended: **55**
Number of additional deaths since last recommended: **25**
- Fund and distribute “Water Watcher” badges that promote appropriate and responsible adult supervision of children around water.
Year first recommended: **2008**
Total number of deaths since first recommended: **55**
Number of additional deaths since last recommended: **25**
- Work with Oklahoma Parks and Recreation to provide “Water Watcher” badges at Oklahoma lakes.
Year first recommended: **2009**
Total number of deaths since first recommended: **8**
Number of additional deaths since last recommended: **0** (There were no lake deaths reviewed and closed in 2010.)
- EMS/National Weather Service include a warning regarding the dangers of flash floods in weather alerts.
Year first recommended: **2010**
Total number of deaths since first recommended: **49**
Number of additional deaths since last recommended: **9** (Specific to open water and a drainage ditch.)

Fire Recommendations

- Smoke alarm give-away programs should include carbon monoxide detectors.
Year first recommended: **2008**
Total number of deaths since first recommended: **19**
Number of additional deaths since last recommended: **5**
- Increased penalties for homeowners who do not provide smoke alarms for rental houses.
Year first recommended: **2008**
Total number of deaths since first recommended: **10**
Number of additional deaths since last recommended: **2** (There were two cases where the smoke alarm information was unknown.)

Recommendations

Child Abuse/Neglect Recommendations

- 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.

Year first recommended: **2003**

Total number of deaths since first recommended: **337**

Number of additional deaths since last recommended: **54**

- 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.

Year first recommended: **2000**

Total number of deaths since first recommended: **439**

Number of additional deaths since last recommended: **54**

- Make court records pertaining to custody and guardianship available for public inspection after a child death.

Year first recommended: **2007**

Total number of deaths since first recommended: **168**

Number of additional deaths since last recommended: **54**

- 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.

Year first recommended: **2007**

Total number of deaths since first recommended: **168**

Number of additional deaths since last recommended: **54**

- Recommend the legislature ensure funding for the Period of Purple Crying distribution project of the Preparing for a Lifetime; It's Everyone's Responsibility infant mortality reduction initiative.

Year first recommended: **2011**

Total number of deaths since first recommended: **N/A**

Number of additional deaths since last recommended: **N/A**

- Recommend the legislature support the findings of the Shaken Baby Prevention Education Initiative created by H.B. 2920 of the 2010 Legislative Session.

Recommendations

Year first recommended: **2011**

Total number of deaths since first recommended: **N/A**

Number of additional deaths since last recommended: **N/A**

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 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.
- 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 providing free helmets to groups who conduct bike safety education events utilizing Safe Kids curriculum.
- Promotion and establishment of funding for Safe Kids Oklahoma 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 the Safe Kids Oklahoma 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.

Year first recommended: **2004**

Total number of deaths since first recommended: **1083**

Number of additional deaths since last recommended: **127**

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.

Recommendations

Year first recommended: **2008**

Total number of deaths since first recommended: **645**

Number of additional deaths since last recommended: **238**

New Recommendations:

- Creation of a drug death review board to look at the drug deaths (all ages) occurring in Oklahoma.
- Creation of substance abuse programs for pregnant women who have a positive drug screen prior to delivery.
- Legislation requiring first responders (law enforcement, EMS, medico-legal investigators) to undergo mandatory specialized training in child death scene investigation.
- Women's health providers to include domestic violence screenings at health appointments.
- Continued financial support for the Child Protection Committee of The Children's Hospital of Oklahoma.

Board Actions and Activities

Include but are not limited to:

- Continued collaborations with the Oklahoma Domestic Violence Fatality Review Board, 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 statewide program aimed at reducing infant mortality.
- Followed up with the Oklahoma Department of Human Services (OKDHS) on 14 cases, including but not limited to: requesting that OKDHS request the Oklahoma State Bureau of Investigation investigate a case that had minimal law enforcement involvement; requesting clarification on the priority level a referral was assigned; expressing the CDRB's concern for the placement of a near death victim; requesting OKDHS conduct an internal review of a child death; making a formal referral; requesting the final disposition of a referral; and commending an exceptional investigation.
- Correspondence to an attending physician educating on when the diagnosis of Sudden Infant Death Syndrome can be utilized.
- Correspondence to an attending physician recommending the cause of death be amended to reflect the true cause of death and not the underlying condition.
- Referred a physician to the Oklahoma Board of Medical Licensure.
- Followed up with the Oklahoma Chief Medical Examiner's Office (OCME) on eight cases, including but not limited to: recommending the cause and/or manner of death be amended; referring cases to the OCME for review (cases that had not been referred to that office); requesting clarification of content in reports; and requesting clarification of policies and procedures.
- Followed up with the involved law enforcement agency, including but not limited to: recommending the agency adopt the Center for Disease Control's Sudden Unexpected Infant Death Investigation protocols; recommending the agency contact OKDHS when a child dies; requesting clarification on why a caregiver was not interviewed; recommending a case be reopened; recommending an agency follow statute and comply with CDRB requests for records; and requesting an agency request an out-of-state law enforcement agency make contact with a caregiver.
- Followed up with District Attorney's involved in four cases, including inquiring about charges and expressing concern for the sentence of a perpetrator.

Cases Closed 2010

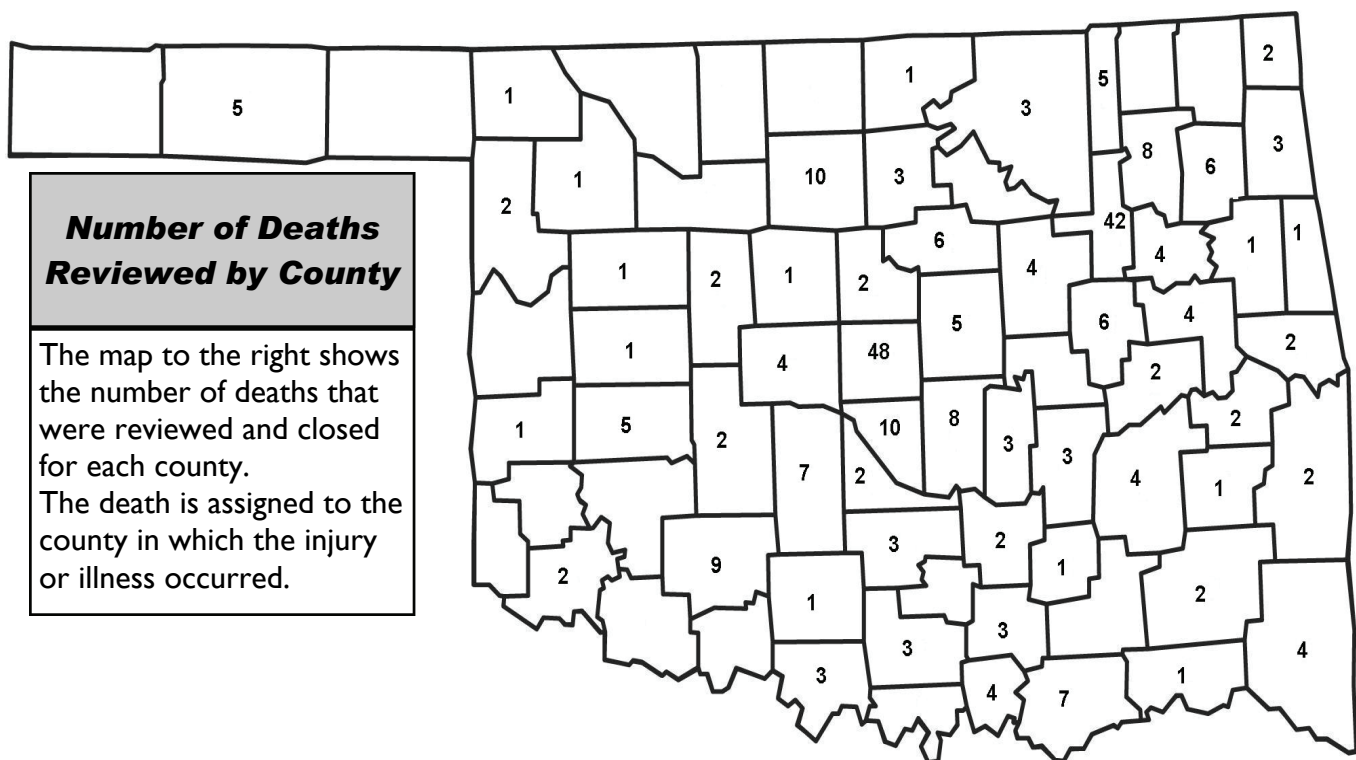
The Oklahoma Child Death Review Board is comprised of five review teams. The total number of deaths reviewed and closed in 2010 by all five teams is 282. The year of death for these cases ranged from 2005 to 2010.

2010 Deaths Reviewed		
Manner	Number	Percent
Accident	127	45.0%
Unknown	64	22.7%
Natural	43	15.3%
Homicide	26	9.2%
Suicide	22	7.8%

Race		
African American	40	14.2%
American Indian	37	13.1%
Asian	1	0.4%
Multi-race	16	5.7%
White	188	75.4%

Gender	Number	Percent
Males	186	66.0%
Females	96	34.0%

Ethnicity	Number	Percent
Hispanic (any race)	36	12.8%
Non-Hispanic	246	87.2%



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 referral **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 five foster care deaths reviewed and closed in 2010. Five were ruled accidental deaths, two were ruled natural deaths and one had an unknown manner of death. One was confirmed by the OKDHS/ CW as to the abuse/neglect allegations.

Number of Cases with Previous Involvement in Selected State Programs		
Agency	Number	Percent Of All Deaths
OKDHS - TANF	219	77.7%
Oklahoma Health Care Authority (Medicaid)	172	61.0%
OKDHS - Child Support Enforcement	136	48.2%
OKDHS - Child Welfare	52	18.4%
OKDHS - Food Stamps	51	18.1%
OKDHS - Disability	20	7.1%
Office of Juvenile Affairs	20	7.1%
OKDHS - Child Care Assistance	17	6.0%
OSDH - Children First	10	3.5%
OKDHS - Foster Care	5	1.8%
OSDH - Office of Child Abuse Prevention	3	1.1%
OKDHS - Emergency Assistance	3	1.1%

Accidents

The Board reviewed and closed 127 deaths in 2010 whose manner of death was ruled Accident.

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

Both of the accidental overdoses were due to a combination of prescription medications.

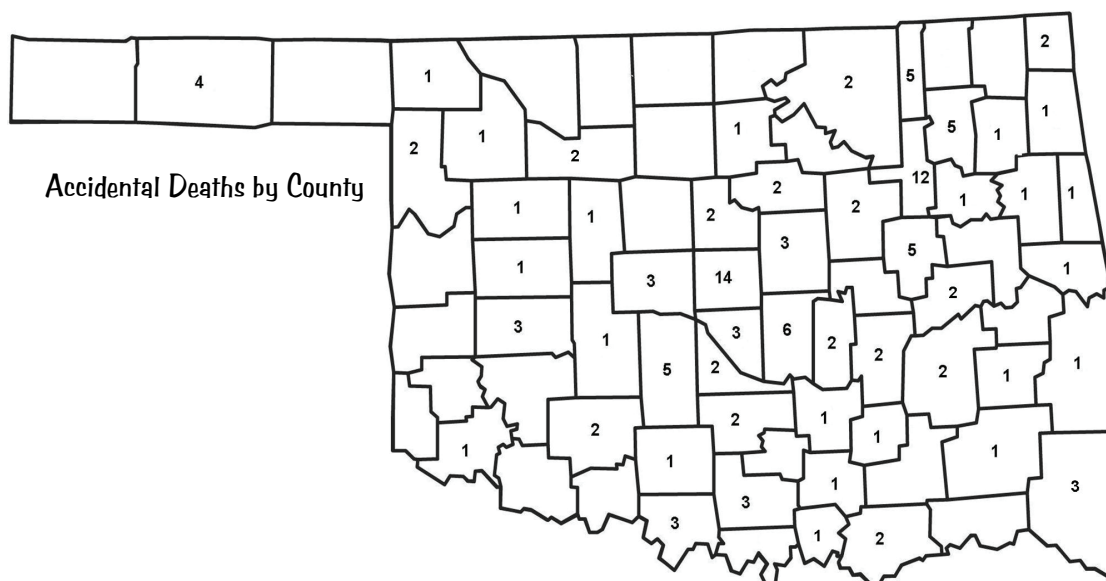
The crushing death was due to a forklift.

Mechanism of Death		
Type	Number	Percent
Vehicular	81	62.2%
Drowning	25	19.7%
Asphyxia/ Suffocation	11	8.7%
Fire	5	4.7%
Poisoning/ Overdose	2	1.6%
Firearm	1	0.8%
Crush	1	0.8%
Medical Misadventure	1	0.8%

Race		
African American	9	7.0%
American Indian	19	15.0%
Multi-race	5	4.0%
White	94	74.0%

Ethnicity	Number	Percent
Hispanic (any race)	19	15.0%
Non-Hispanic	108	85.0%

Gender	Number	Percent
Males	80	63.0%
Females	47	37.0%



Homicides

The Board reviewed and closed 26 deaths in 2010 whose manner of death was ruled Homicide.

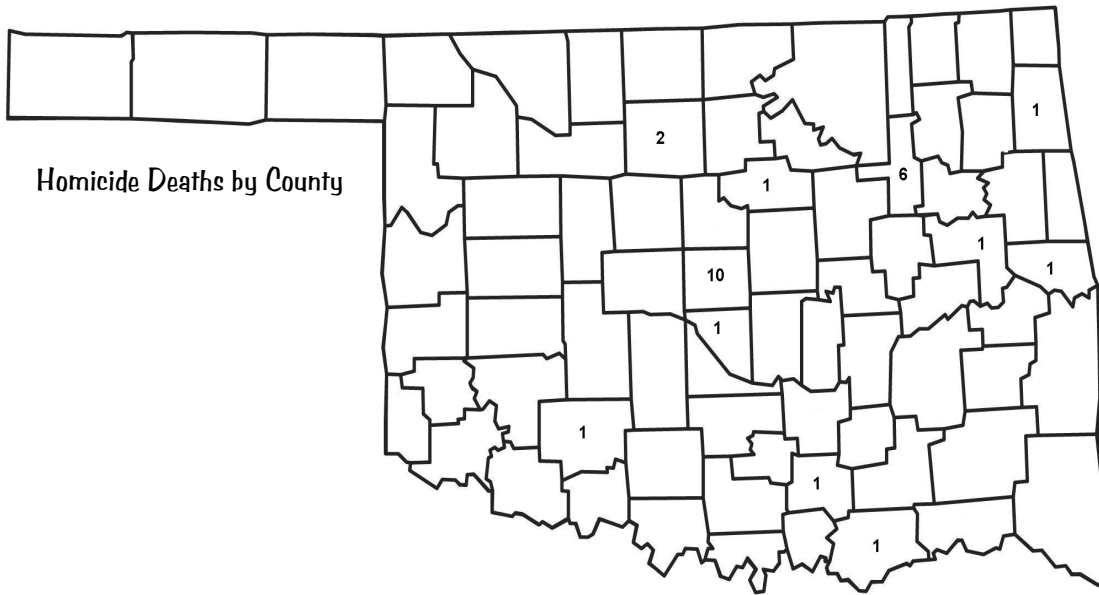
Thirteen (50%) of these were due to physical abuse, with nine (34.6%) specific to abusive head trauma.

Mechanism of Death		
Method	Number	Percent
Firearm	11	42.4%
Struck/ Shaken/Beat	11	42.4%
Drowning	1	3.8%
Overdose	1	3.8%
Stabbed	1	3.8%
Suffocation	1	3.8%

Gender	Number	Percent
Males	16	61.5%
Females	10	38.5%

Race		
African American	12	46.2%
American Indian	1	3.8%
Multi-race	3	11.5%
White	10	38.5%

Ethnicity	Number	Percent
Hispanic (any race)	2	7.7%
Non-Hispanic	24	92.3%



Naturals

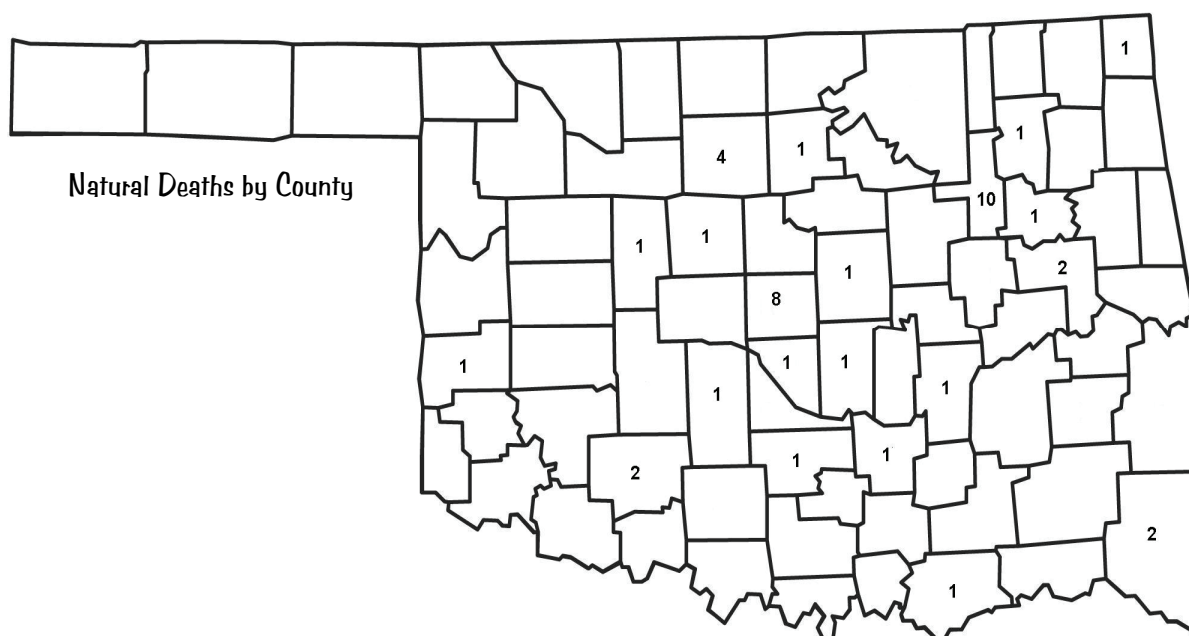
The Board reviewed and closed 43 deaths in 2010 whose manner of death was ruled Natural.

Mechanism of Death		
Illness/Disease	Number	Percent
SIDS	18	41.9%
Infectious Disease	11	25.6%
Seizure Disorder	3	7.0%
Cardiovascular	2	4.7%
Other Conditions	4	9.3%
Congenital Anomaly	1	2.3%
Malnutrition	1	2.3%
Prematurity	1	2.3%
Undetermined	1	2.3%
Unknown	1	2.3%

Race		
African American	8	18.6%
American Indian	4	9.3%
Multi-race	1	2.3%
White	30	69.8%

Ethnicity	Number	Percent
Hispanic (any race)	8	18.6%
Non-Hispanic	35	81.4%

Gender	Number	Percent
Males	30	69.8%
Females	13	30.2%



Suicides

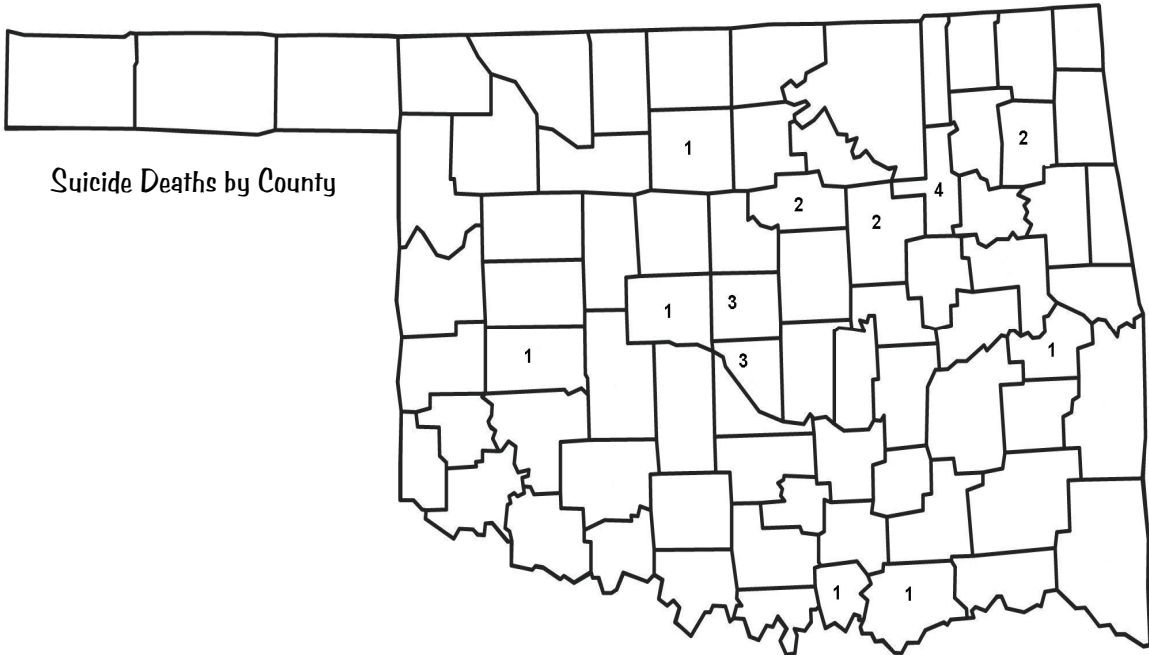
The Board reviewed and closed 22 deaths in 2010 whose manner of death was ruled Suicide.

Mechanism of Death		
Method	Number	Percent
Firearm	14	63.7%
Asphyxia	7	31.8%
Motor Vehicle	1	4.5%

Race		
African American	1	4.5%
American Indian	2	9.1%
White	19	86.4%

Gender	Number	Percent
Males	19	86.4%
Females	3	13.6%

Ethnicity	Number	Percent
Hispanic (any race)	0	0%
Non-Hispanic	22	100%



Unknown

The Board reviewed and closed 64 deaths in 2010 ruled Unknown. Fifty-nine (92.2%) were 2 years or younger.

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Fifty-four (84.4%) were less than 1 year of age.

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Fifty-one (79.7%) involved questionable safe sleeping environments.

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Seven (10.9%) were suspicious for trauma.

Two (3.1%) were premature infants with maternal drug exposure in utero.

Two (3.1%) were premature infants with maternal drug exposure in utero.
Two (3.1%) had questionable safe sleep environments as well as upper respiratory ill-

Two (3.1%) had questionable safe sleep environments as well as upper respiratory illnesses. One (1.6%) died of hyperthermia and the pathologist was unable to determine an exact manner of death.

One (1.6%) died of hyperthermia and the pathologist was unable to determine an exact manner of death.

Race		
African American	10	15.6%
American Indian	11	17.2%
Asian	1	1.6%
Multi-Race	7	10.9%
White	35	54.7%

Ethnicity	Number	Percent
Hispanic (any race)	6	9.4%
Non-Hispanic	58	90.6%

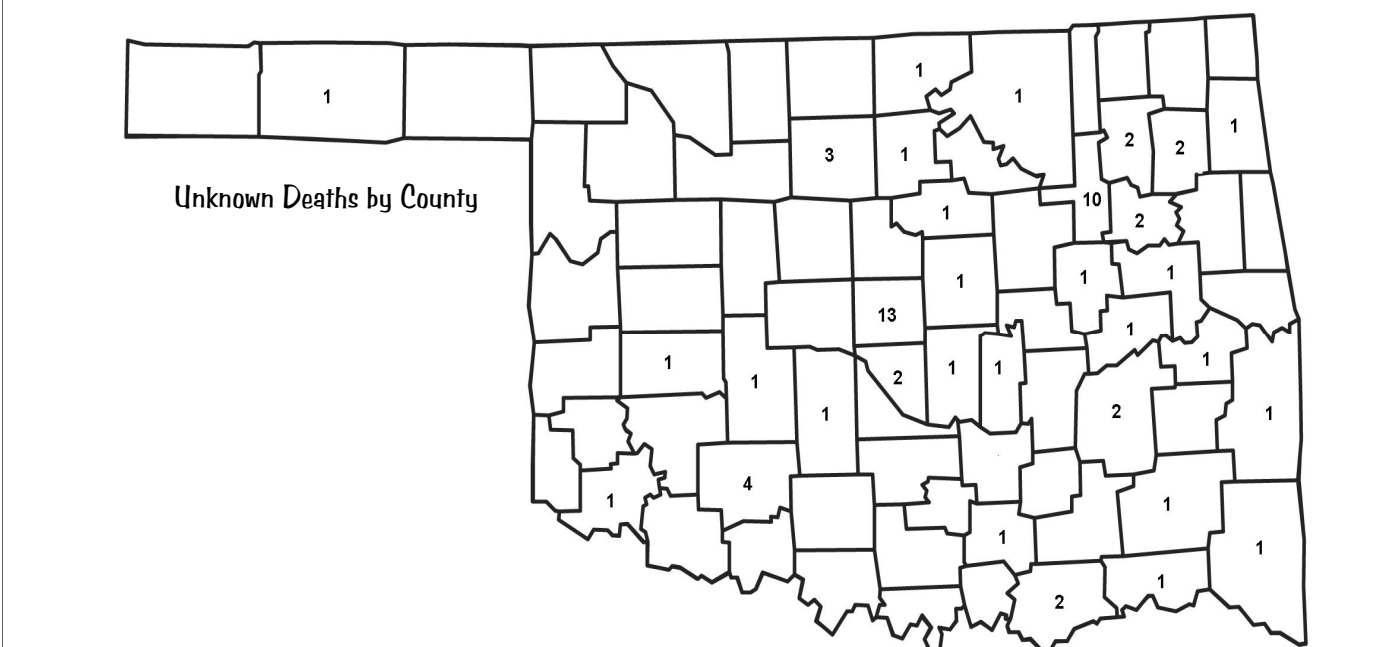
Gender	Number	Percent
Males	41	64.1%
Females	23	35.9%

Race		
African American	10	15.6%

Ethnicity	Number	Percent
Hispanic (any race)	6	9.4%
Non-Hispanic	58	90.6%

Indian		
Asian	1	1.6%
Multi-Race	7	10.9%
White	35	51.7%

Gender	Number	Percent
Males	41	64.1%
Females	23	35.9%



Traffic Related Deaths

The Board reviewed and closed 81 accidental deaths in 2010 related to traffic. For the ATV deaths, all were operators and only two were wearing a helmet. The child in the motorcycle death was wearing a helmet; the children on the bicycles/tricycle were not wearing helmets.

Vehicle of Decedent

Vehicle	Number	Percent
Car	24	29.6%
Pick-Up	18	22.2%
SUV	18	22.2%
Pedestrian	8	9.9%
ATV	5	6.3%
Bicycle	3	3.7%
Van	2	2.5%
Motorcycle	1	1.2%
Tricycle	1	1.2%
Tractor	1	1.2%

Race

Race	Number	Percent
African American	2	2.5%
American Indian	16	19.8%
Multi-race	3	3.7%
White	60	74.1%

Ethnicity

Ethnicity	Number	Percent
Hispanic (any race)	11	13.6%
Non-Hispanic	70	86.4%

Use of Safety Restraints

Seatbelt/Car seat Use	Number	Percent
Properly Restrained	18	22.2%
Not Properly Restrained	50	61.7%
Not Applicable	13	16.1%

Gender

Gender	Number	Percent
Males	52	64.2%
Females	29	35.8%

Activity of Decedent

Position	Number	Percent
Operator	27	33.3%
Rear Passenger	25	31.0%
Front Passenger	15	18.5%
Unknown Passenger Placement	1	1.2%
Truck Bed	1	1.2%
Other*	4	4.9%
N/A	8	9.9%

*Other includes the fender of a tractor, a child in utero, a child riding the sideboards, and a child exiting a vehicle with the car stopped in traffic (game)

Drowning Deaths

The Board reviewed and closed 25 accidental deaths in 2010 due to drowning.

Location of Drowning

Location	Number	Percent
Private, Residential Pool	9	36.0%
Open Body of Water (i.e. creek, river, pond, lake)	8	32.0%
Bathtub	6	24.0%
Drainage Ditch	1	4.0%
Bucket	1	4.0%

Type of Residential Pool

Type of Pool	Number	Percent
Above Ground	5	55.6%
In Ground	4	44.4%

Type of Open Body of Water

Open Body	Number	Percent
Pond	6	75.0%
River	2	25.0%

Race

African American	2	8.0%
American Indian	1	4.0%
Multi-Race	1	4.0%
White	21	84.0%

Ethnicity

Ethnicity	Number	Percent
Hispanic (any race)	4	16.0%
Non-Hispanic	21	84.0%

Gender

Gender	Number	Percent
Males	15	60.0%
Females	10	40.0%

Sleep Related Deaths

The Board reviewed and closed 79 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	10	12.6%
Natural (SIDS)	18	22.8%
Undetermined	51	64.6%

Position of Infant When Placed to Sleep		
Position	Number	Percent
On Back	22	27.8%
On Side	9	11.4%
On Stomach	11	13.9%
Unknown*	37	46.9%

Position of Infant When Found		
Position	Number	Percent
On Back	13	16.5%
On Side	10	12.7%
On Stomach	26	32.9%
Unknown*	30	37.9%

Sleeping Arrangement of Infant		
Sleeping Arrangement	Number	Percent
Alone	45	57.0%
With Adult and/or Other Child	34	43.0%

Race		
African American	14	17.7%
American Indian	14	17.7%
Asian	1	1.3%
Multi-race	8	10.1%
White	42	53.2%

Ethnicity	Number	Percent
Hispanic (any race)	10	12.7%
Non-Hispanic	69	87.3%

Gender	Number	Percent
Males	51	63.1%
Females	28	36.9%

Sleeping Location of Infant		
Location	Number	Percent
Adult Bed	40	50.6%
Couch	11	13.9%
Crib	9	11.4%
Playpen	4	5.1%
Bassinet	2	2.5%
Chair	1	1.3%
Floor	1	1.3%
Other	9	11.4%
Unknown*	2	2.5%

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

Firearm Deaths

The Board reviewed and closed 26 deaths in 2010 due to firearms.

Manner of Death for Firearm Victims		
Manner	Number	Percentage
Accident	1	3.9%
Homicide	11	42.3%
Suicide	14	53.8%

Race		
African American	10	38.4%
American Indian	1	3.9%
White	15	57.7%

Type of Firearm Used		
Type of Firearm	Number	Percent
Handgun	14	53.9%
Hunting Rifle	5	19.2%
Shot gun	2	7.7%
Assault Rifle	2	7.7%
Unknown	3	11.5%

Ethnicity	Number	Percent
Hispanic (any race)	1	3.9%
Non-Hispanic	25	96.1%

Gender	Number	Percent
Males	21	80.8%
Females	5	19.2%

Fire Deaths

The Board reviewed and closed five deaths in 2010 due to fires. Four fires resulted in five deaths. Four died of smoke inhalation, one died of thermal injuries.

Fire Ignition Source		
Source	Number	Percent
Appliance	2	40.0%
Matches	1	20.0%
Space Heater	1	20.0%
Wall Heater	1	20.0%

Working Smoke Detector Present		
Detector	Number	Percent
Yes	1	20.0%
No	2	40.0%
Unknown	2	40.0%

Race		
African American	2	40.0%
White	3	60.0%

Ethnicity	Number	Percent
Hispanic (any race)	0	0
Non-Hispanic	5	100%

Gender	Number	Percent
Males	3	60.0%
Females	2	40.0%

Abuse/Neglect Deaths

The Board reviewed and closed 42 cases where it was determined that abuse or neglect caused or contributed to the death.

Thirteen (31.0%) cases were ruled abuse, 28 (66.7%) cases were ruled neglect, and one (2.3%) was ruled both.

Manner of Death for Abuse/Neglect Cases		
Manner	Number	Percent
Accident	21	50.0%
Homicide	14	33.3%
Natural	2	4.8%
Suicide	3	7.1%
Undetermined	2	4.8%

Race		
Asian	1	2.4%
African American	7	16.6%
American Indian	2	4.8%
Multi-race	4	9.5%
White	28	66.7%

Gender	Number	Percent
Males	24	57.1%
Females	18	42.9%

Ethnicity	Number	Percent
Hispanic (any race)	6	14.3%
Non-Hispanic	36	85.7%

Near Deaths

The Board reviewed and closed 49 near death cases in 2010. A case is deemed near death if the child was admitted to the hospital diagnosed in serious or critical condition by the treating physician as a result of suspected abuse or neglect.

Forty-one (83.7%) were substantiated by OKDHS as to having been abuse and/or neglect. Thirteen (26.5%) had a previous referral that was investigated by OKDHS.

Injuries in Near Death Cases		
Injury	Number	Percent
Physical Abuse	24	49.0%
Poison/Overdose	13	26.6%
Fire	2	4.1%
Firearm	2	4.1%
Medical Condition	2	4.1%
Non-Organic Failure to Thrive	2	4.1%
Asphyxia	1	2.0%
Fall	1	2.0%
Drowning	1	2.0%
Stabbing	1	2.0%

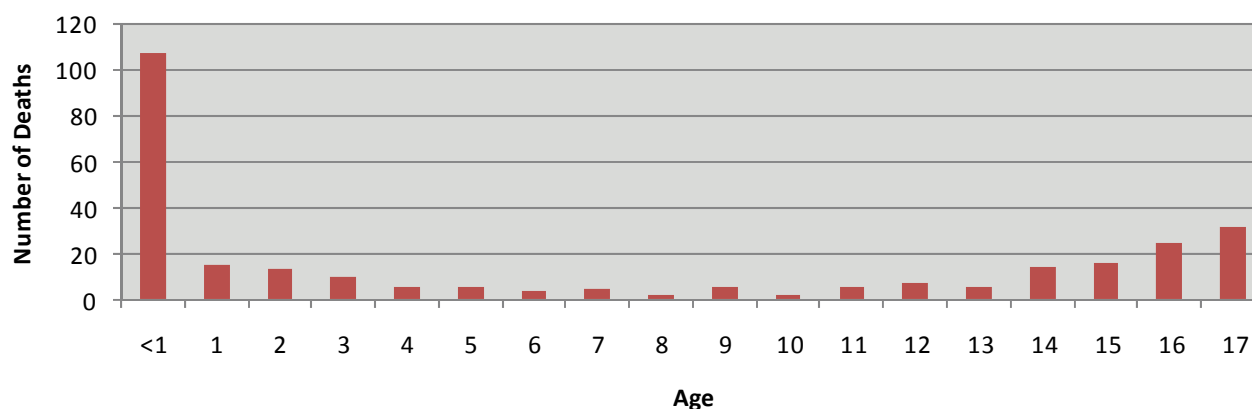
Race		
Asian	1	2.0%
African American	11	22.4%
American Indian	9	18.4%
Multi-race	2	4.1%
White	26	53.1%

Ethnicity	Number	Percent
Hispanic (any race)	4	8.2%
Non-Hispanic	45	91.8%

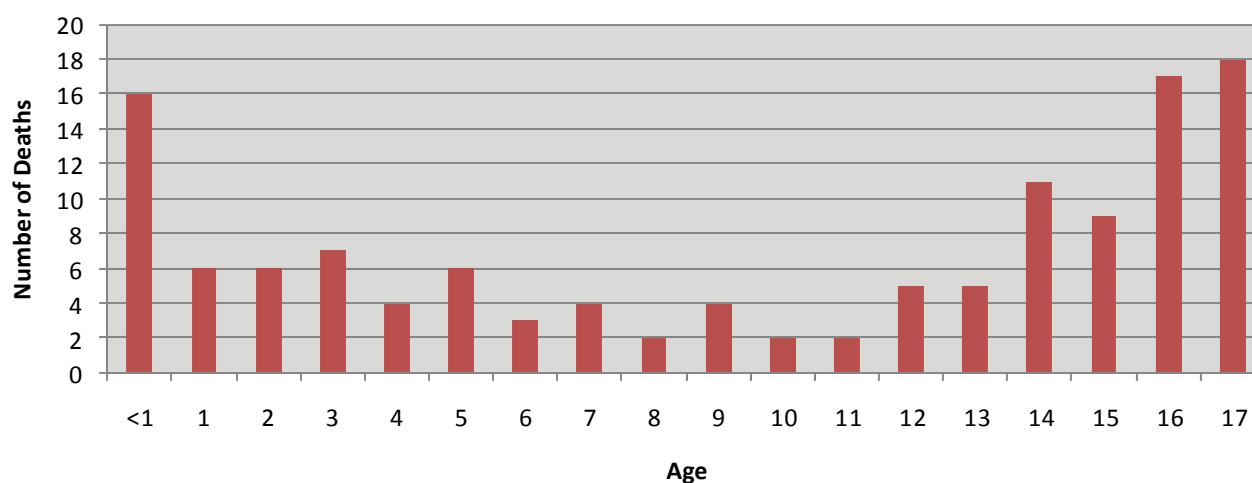
Gender	Number	Percent
Males	33	67.3%
Females	16	32.7%

Age of Decedents by Manner

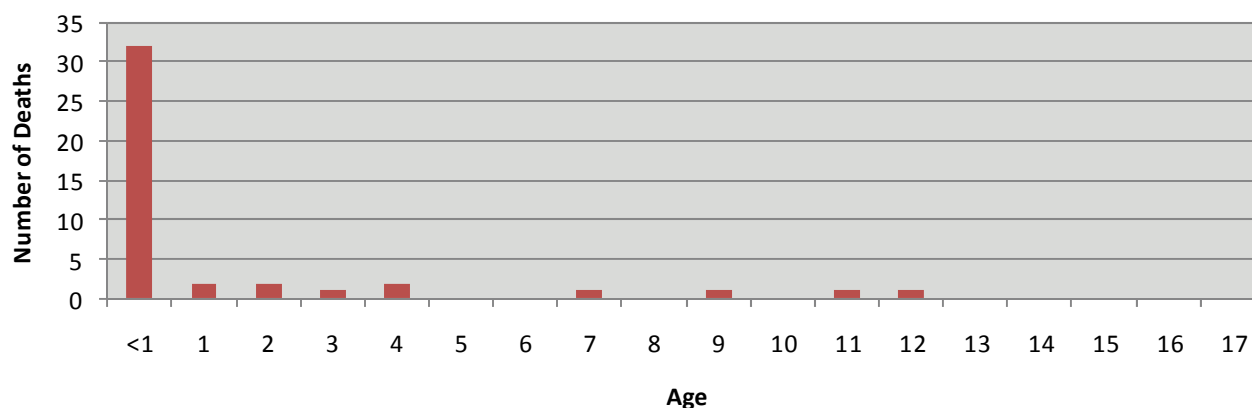
All Deaths by Age



Accidental Deaths by Age

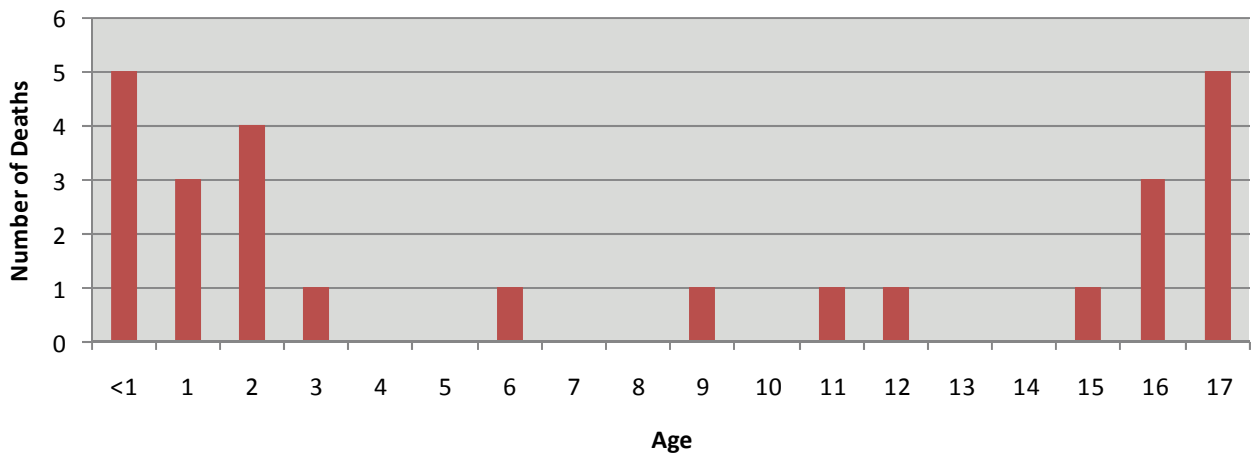


Natural Deaths by Age

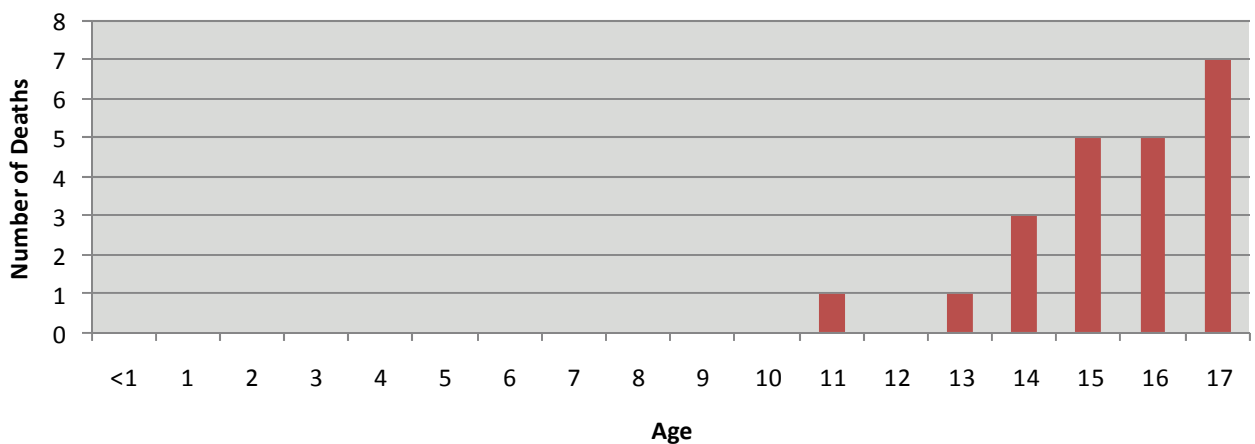


Age of Decedents by Manner

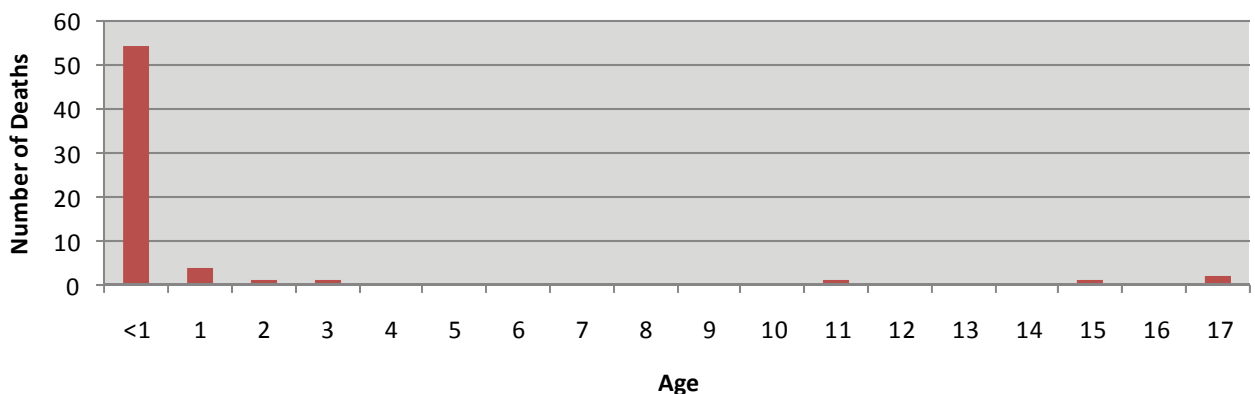
Homicide Deaths by Age



Suicide Deaths by Age

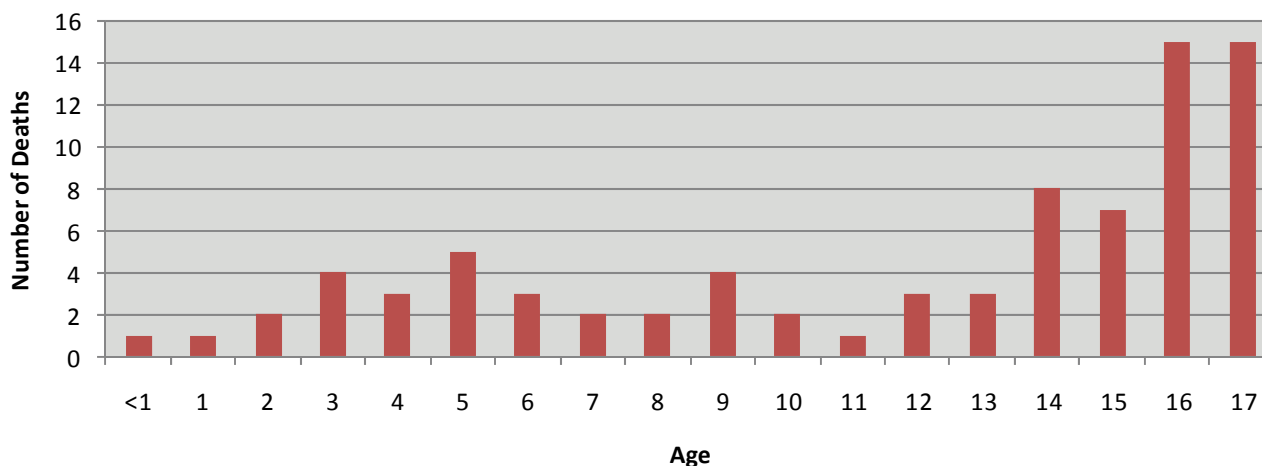


Unknown Deaths by Age

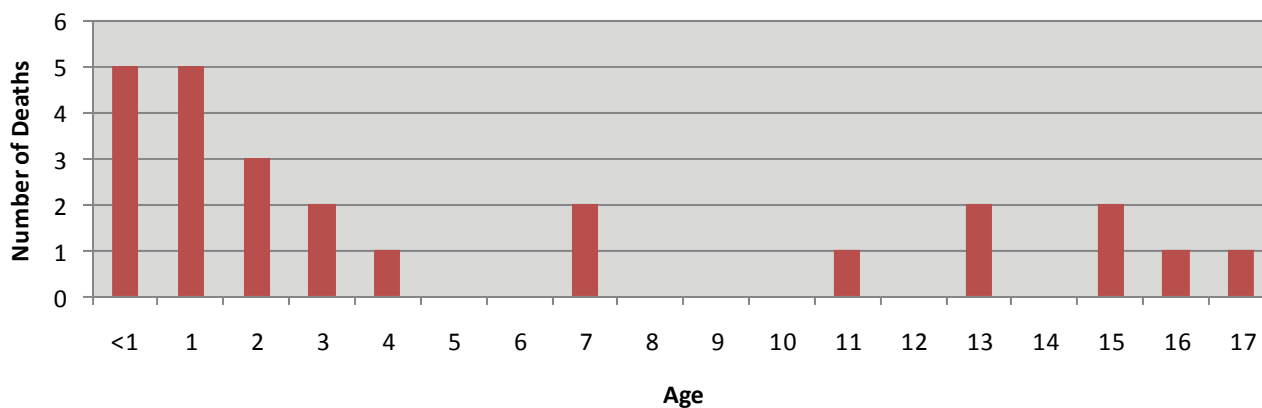


Age of Decedents by Select Causes

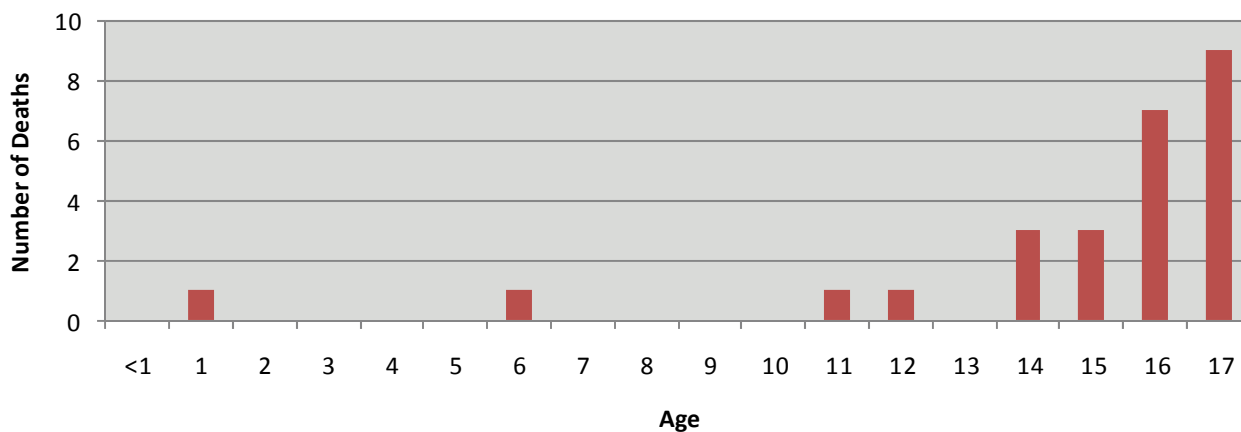
Traffic Related Deaths by Age



Drowning Deaths by Age

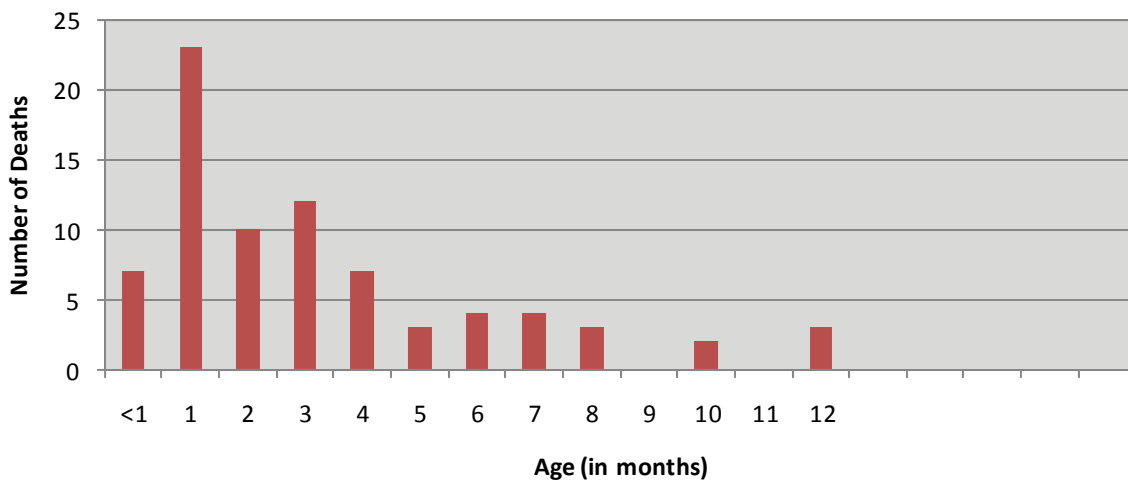


Firearm Deaths by Age

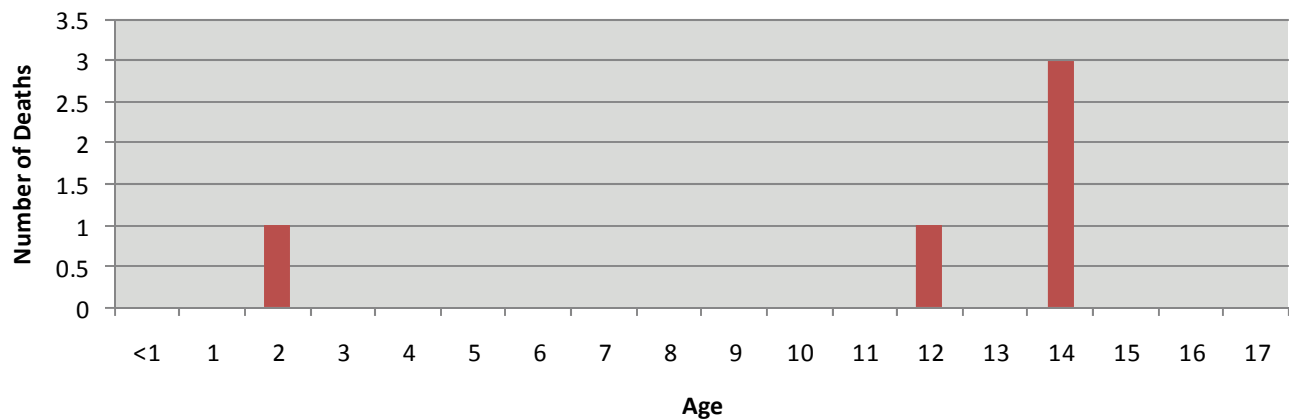


Age of Decedents by Select Causes

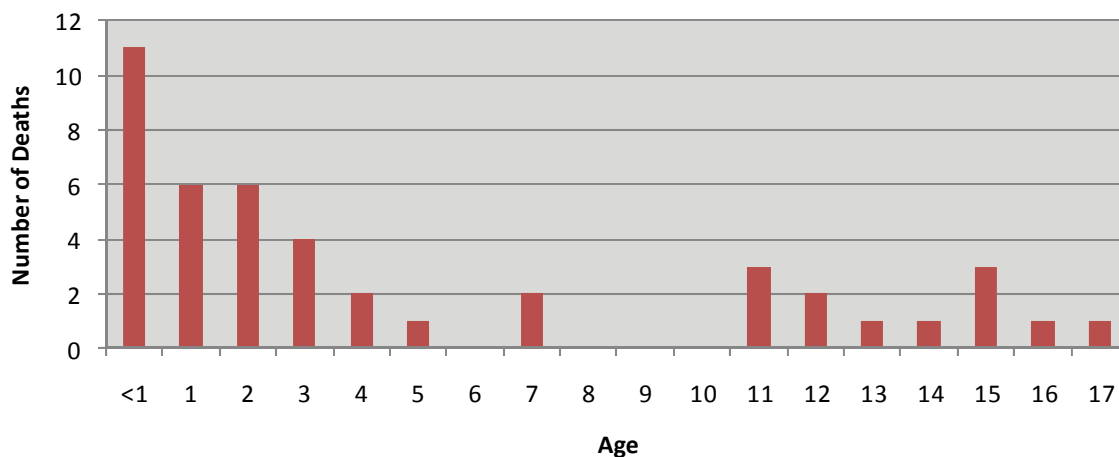
Sleep Related Deaths by Age



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
SAFE KIDS Oklahoma	(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.iio.health.ok.gov>

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