Think. Prevent. Live.

Keep Our Children Safe

The Oklahoma Child Death Review Board
2011 Annual Report

Includes the 2012 CDRB Recommendations

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 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 2012 annual recommendations of the Oklahoma Child Death Review Board as submitted to the Oklahoma Commission on Children and Youth.

FISCAL RECOMMENDATIONS

Motor Vehicle Related Fatalities

- Mandatory sobriety testing of drivers in motor vehicle accidents resulting in a child fatality and/or a critical or serious injury to a child.
- Children transitioning out of custody have access to driver's education and substance abuse education.

Office of the Chief Medical Examiner (OCME)

Continue support of the OCME goals to improve and maintain infrastructure. Changes in policy are not enough, there needs to be a financial commitment by the state of Oklahoma to affect positive change.

Oklahoma Department of Human Services (OKDHS)

Provide the OKDHS 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.

Changes in policy are not enough, there needs to be a financial commitment by the state of Oklahoma to affect positive change.

POLICY RECOMMENDATIONS

Motor Vehicle Related Fatalities

- Legislation banning the use of hand-held devices.
- Enforcement of child passenger safety laws.
- Mandatory sobriety testing of drivers in motor vehicle collisions resulting in a child fatality and/or a critical or serious injury to a child.
- Children transitioning out of custody have access to driver's education and substance abuse education.

Sleep Related Fatalities

- All delivery hospitals should adopt a policy regarding in-house safe sleep, including education on safe sleep after delivery but prior to discharge

Recommendations

from hospital and that the education include statistics on sleep related deaths.

- Adoption by law enforcement agencies and the OCME of the CDC's Sudden Unexpected Infant Death Investigation (SUIDI) protocols.

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.
- Continued partnership with Preparing for a Lifetime; It's Everyone's Responsibility, a statewide program aimed at reducing infant mortality.
- Followed up with District Attorneys (DA) on eleven cases, including but not limited to: recommending charges be filed, notifying that a child had died due to inflicted injuries, requesting prosecutorial status of case, requesting mental health history of alleged perpetrator be reviewed, requesting information on declined charges, requesting DA request Oklahoma State Bureau of Investigation to investigate a death, and requesting explanation of plan for reunification of a surviving sibling.
- Three letters to hospitals: requesting policies and procedures for reporting child abuse and/or neglect, recommending notification to the Oklahoma Department of Human Services (OKDHS) of unexpected child deaths, recommending following state law for mandatory reporting of child abuse and/or neglect, and recommending cooperation in child abuse/neglect investigations.
- Eight letters to law enforcement agencies including but not limited to: letters of commendation for exceptional scene investigations, recommending use of the Sudden Unexplained Infant Death Scene Investigation protocols, recommending notification to OKDHS of unexpected child deaths, requesting death investigation be reopened, requesting mental health history of alleged perpetrator be reviewed, and inquiring if notified OKDHS of unexpected child death.
- Five letters to the Office of the Chief Medical Examiner including but not limited to: requesting review of case for possible amendment to manner of death, requesting review of case for possible amendment to cause of death, and inquiring if notified OKDHS of unexpected child death.
- Referred one case to the Oklahoma Commission on Children and Youth, Office of Juvenile System Oversight.
- Followed up with the OKDHS on twelve cases, including but not limited to: requesting follow up information on surviving siblings, requesting clarification of information contained in written reports, formal referrals to OKDHS on surviving sibling(s), reminding to follow policy, expressing concern for how case was handled, requesting response to previously written letter, requesting physician contact in medical neglect investigations, requesting the status of a licensed foster home.
- One letter to tribe/tribal Indian Child Welfare recommending review of foster placement practices and safety of current foster placement(s).

Cases Closed 2011

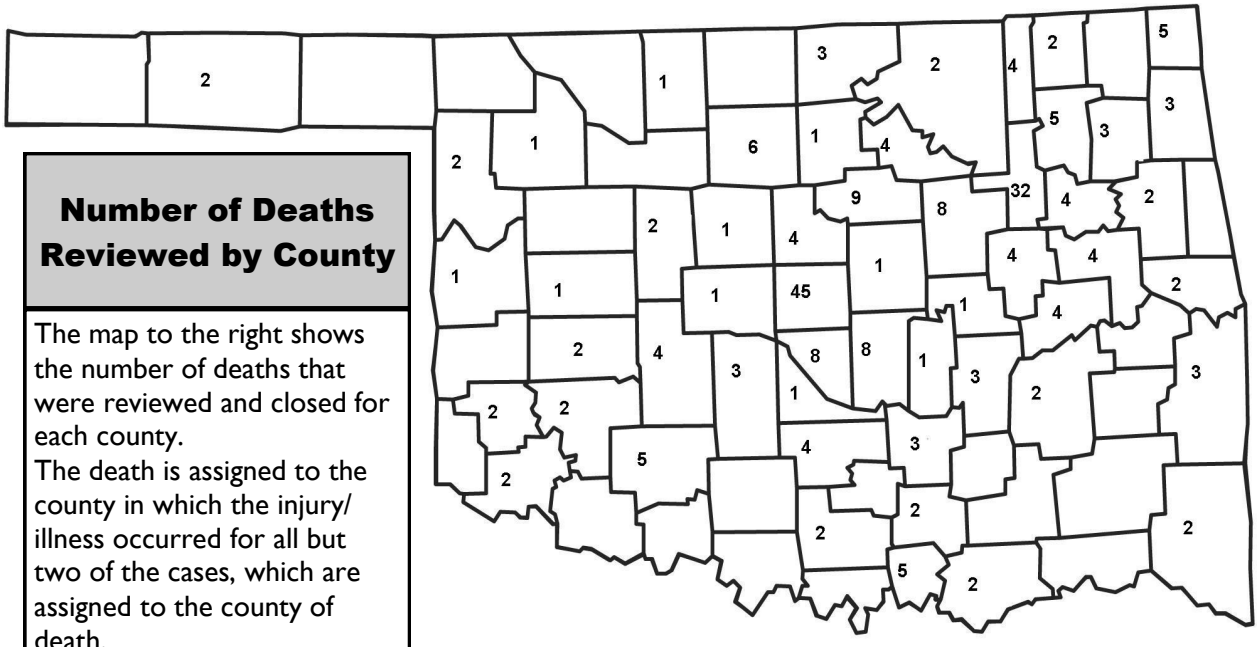
The Oklahoma Child Death Review Board is comprised of five review teams. The total number of deaths reviewed and closed in 2011 by all five teams is 236. The year of death for these cases ranged from 2004 to 2011.

2011 Deaths Reviewed		
Manner	**Number**	**Percent**
Accident	100	42.4%
Unknown	65	27.5%
Natural	30	12.7%
Homicide	28	11.9%
Suicide	13	5.5%

Race		
African American	36	15.3%
American Indian	37	15.7%
Asian	1	0.4%
Multi-race	8	3.4%
Pacific Islander	1	0.4%
White	153	64.8%

Gender	Number	Percent
Males	145	61.4%
Females	91	38.6%

Ethnicity	Number	Percent
Hispanic (any race)	24	10.2%
Non-Hispanic	212	89.8%



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/ illness occurred for all but two of the cases, which are assigned to the county of death.

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 below, there were 25 (10.6%) cases that had an open CPS case at the time of death. Of the four foster care deaths, one was a homicides and three were undetermined deaths, one of which was ruled Homicide by a third party pathologist. Two were substantiated by 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	167	70.8%
Oklahoma Health Care Authority (Medicaid)	167	70.8%
OKDHS - Child Support Enforcement	98	41.5%
OKDHS - Child Welfare	69	25.4%
OKDHS - Food Stamps	35	14.8%
OKDHS - Disability	18	7.6%
OKDHS - Child Care Assistance	8	3.4%
OKDHS - Foster Care	4	1.7%
OKDHS - Emergency Assistance	1	0.4%
OSDH - Office of Child Abuse Prevention	0	—
OSDH - Children First	0	—

Accidents

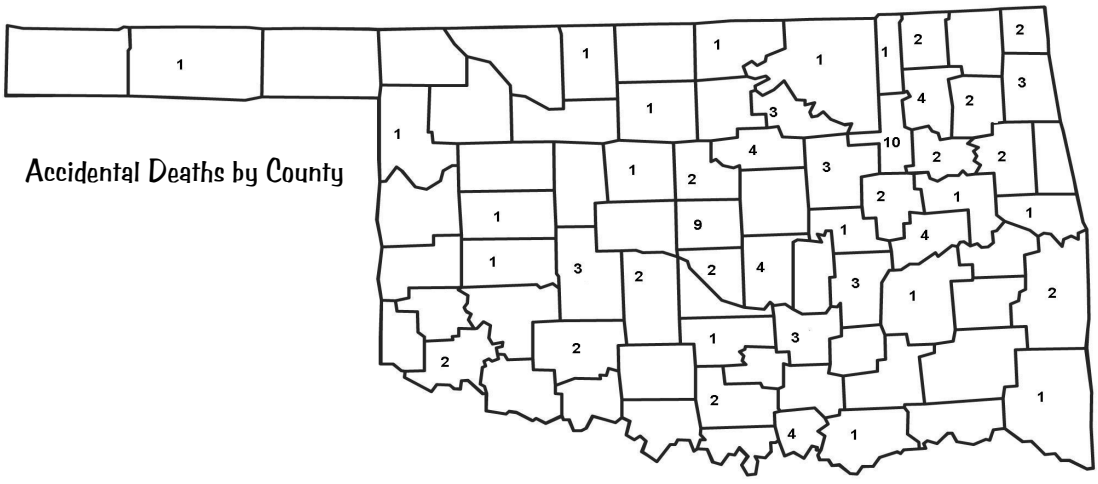
The Board reviewed and closed 100 deaths in 2011 whose manner of death was ruled Accident, also known as unintentional injuries. Vehicular deaths continue to be the top mechanism of death for this category.

Mechanism of Death		
Type	**Number**	**Percent**
Vehicular	64	64%
Drowning	18	18%
Poisoning/ Overdose	8	8%
Fire	3	3%
Exposure	3	3%
Asphyxia/ Suffocation	2	2%
Crush	1	1%
Electrocution	1	1%

Race		
African American	5	5%
American Indian	17	17%
Multi-race	6	6%
Pacific Islander	1	1%
White	71	71%

Ethnicity	Number	Percent
Hispanic (any race)	16	16%
Non-Hispanic	84	84%

Gender	Number	Percent
Males	59	59%
Females	41	41%



Homicides

The Board reviewed and closed 28 deaths in 2011 whose manner of death was ruled Homicide.

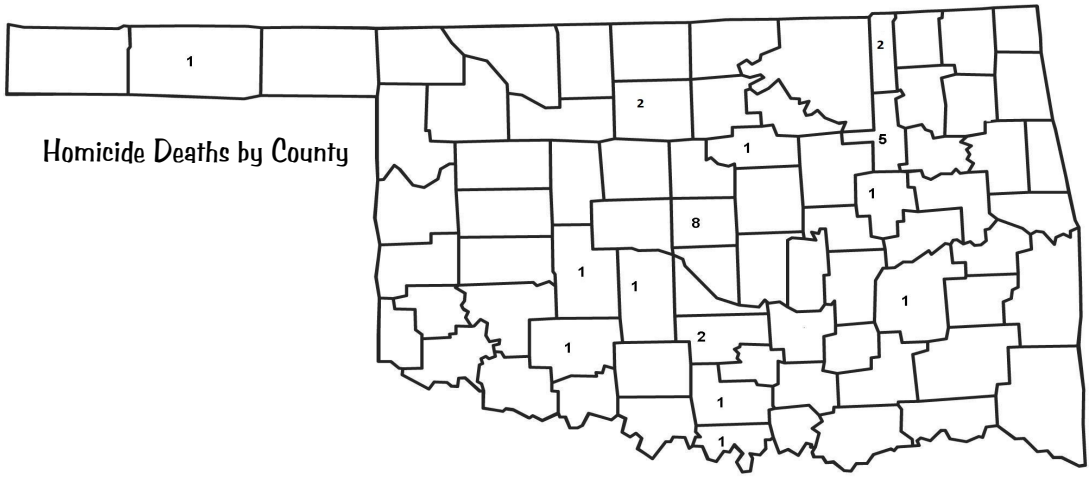
Sixteen (57.1%) of these were due to physical abuse, with 12 specific to abusive head trauma; an additional two had head and abdominal trauma.

Mechanism of Death		
Method	**Number**	**Percent**
Struck/ Shaken/Beat	16	57.1%
Firearm	9	32.1%
Drowning	1	3.6%
Asphyxia	1	3.6%
Unknown	1	3.6%

Race		
African American	9	32.1%
American Indian	5	17.9%
White	14	50.0%

Gender	Number	Percent
Males	18	64.3%
Females	10	35.7%

Ethnicity	Number	Percent
Hispanic (any race)	4	14.3%
Non-Hispanic	24	85.7%



Naturals

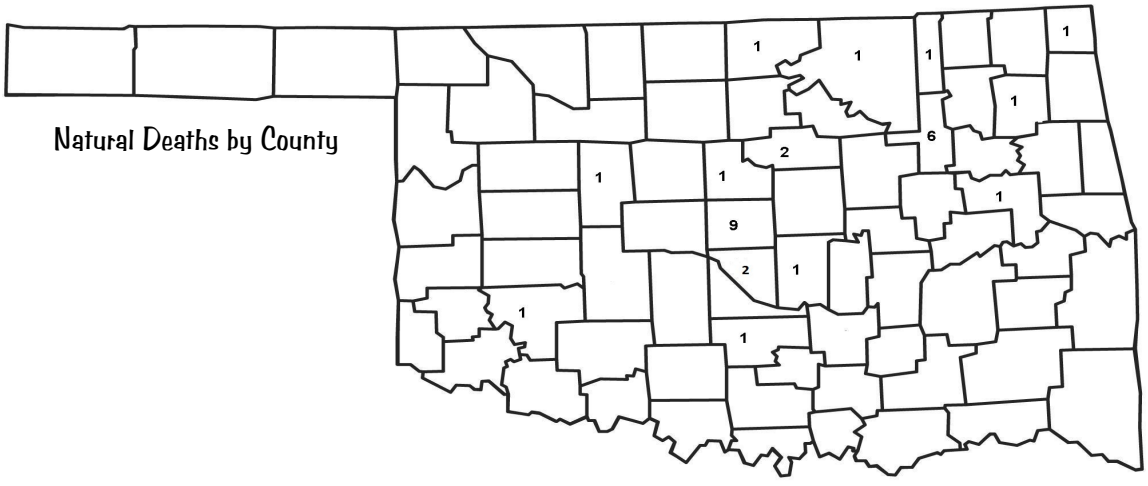
The Board reviewed and closed 30 deaths in 2011 whose manner of death was ruled Natural.

Mechanism of Death		
Illness/Disease	**Number**	**Percent**
SIDS	18	60.0%
Neurological Disorder	2	6.7%
Asthma	2	6.7%
Pneumonia	2	6.7%
Other Infection	2	6.7%
Other Medical Condition	2	6.7%
Congenital Anomaly	1	3.3%
Prematurity	1	3.3%

Race		
African American	9	30.0%
American Indian	1	3.3%
White	20	66.7%

Ethnicity	Number	Percent
Hispanic (any race)	1	3.3%
Non-Hispanic	29	96.7%

Gender	Number	Percent
Males	20	66.7%
Females	10	33.3%



Suicides

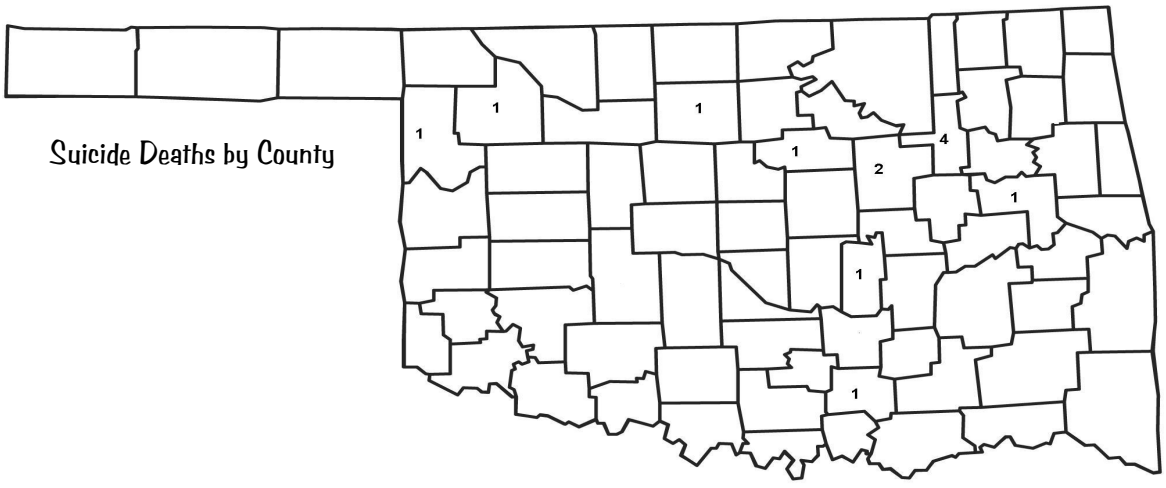
The Board reviewed and closed 13 deaths in 2011 whose manner of death was ruled Suicide.
Two (15.4%)were noted to have problems in school.
Three (23.1%) were noted to have had previous mental health treatment while one (7.7%) was receiving mental health services at the time of death.
Two (15.4%) were noted to be on medication for mental health at the time of death.
Four (30.8%) were noted to have a history of substance abuse.
Four (30.8%) were noted to have a history of child maltreatment.

Mechanism of Death		
Method	**Number**	**Percent**
Firearm	10	76.9%
Asphyxia	2	15.4%
Overdose	1	7.7%

Race		
American Indian	1	7.7%
Multi-Racial	1	7.7%
White	11	84.6%

Gender	Number	Percent
Males	9	69.2%
Females	4	30.8%

Ethnicity	Number	Percent
Hispanic (any race)	1	7.7%
Non-Hispanic	12	92.3%



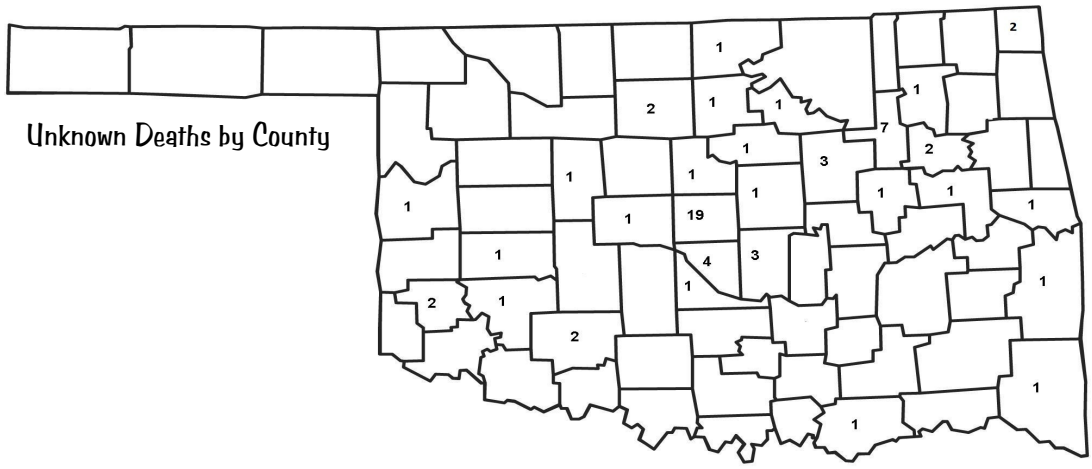
Unknown

The Board reviewed and closed 65 deaths in 2011 ruled Unknown. A death is ruled Unknown when there are no anatomical findings discovered during the autopsy to explain the death.
Sixty-one (93.8%) were 2 years or younger.
Fifty-seven (87.7%) were less than 1 year of age.
Forty-eight (73.8%) involved questionable safe sleeping environments; another five were found in a questionable safe sleep environment but also had concurrent conditions.
Five (7.7%) were suspicious for trauma; one (1.5%) was suspicious for neglect.
Other Unknown deaths included a premature baby with pre-natal drug exposure, an overdose, a toddler found wrapped in plastic, a three year old with medical conditions sleeping in high heat conditions, and a teenager who became unresponsive at school.

Race		
African American	13	20.0%
American Indian	13	20.0%
Asian	1	1.5%
Multi-Race	1	1.5%
White	37	57.0%

Ethnicity	Number	Percent
Hispanic (any race)	2	3.1%
Non-Hispanic	63	96.9%

Gender	Number	Percent
Males	39	60%
Females	26	40%



Traffic Related Deaths

The Board reviewed and closed 64 accidental deaths in 2011 related to traffic.
For the ATV deaths, two were operators and none were wearing a helmet.
The bicycle death was not wearing a helmet.

Vehicle of Decedent		
Vehicle	**Number**	**Percent**
Car	29	45.3%
Pick-Up	11	17.2%
Pedestrian	6	9.4%
SUV	5	7.8%
ATV	4	6.3%
Bicycle	2	3.1%
RV	2	3.1%
Airplane	1	1.6%
Motorized Hydraulic Lift	1	1.6%
Semi	1	1.6%
Skateboard	1	1.6%
Tow Truck	1	1.6%

Use of Safety Restraints		
Seatbelt/Car Seat Use	**Number**	**Percent**
Properly Restrained	14	21.9%
Not Properly Restrained	40	62.5%
Not Applicable	10	15.6%

Race		
African American	4	6.2%
American Indian	14	21.9%
Multi-race	1	1.6%
Pacific Islander	1	1.6%
White	44	68.7%

Activity of Decedent		
Position	**Number**	**Percent**
Front Passenger	19	29.7%
Rear Passenger	17	26.5%
Operator	14	21.9%
Unknown Passenger Placement	3	4.7%
Back of ATV	1	1.6%
Back of Trailer	1	1.6%
N/A	9	14.0%

Ethnicity	Number	Percent
Hispanic (any race)	10	15.6%
Non-Hispanic	54	84.4%

Gender	Number	Percent
Males	33	51.6%
Females	31	48.4%

Drowning Deaths

The Board reviewed and closed 18 accidental deaths in 2011 due to drowning. None of the drowning victims had a personal floatation device available to them.
Four were one year of age or younger; eight were two years of age or younger.

Location of Drowning		
Location	**Number**	**Percent**
Private, Residential Pool	7	38.9%
Open Body of Water (i.e. creek, river, pond, lake)	7	38.9%
Bathtub	3	16.7%
Unknown (incident occurred 7 years prior to death. No further information was available.)	1	5.6%

Race		
American Indian	2	11.1%
Multi-Race	4	22.2%
White	12	66.7%

Ethnicity	Number	Percent
Hispanic (any race)	2	11.1%
Non-Hispanic	16	88.9%

Type of Residential Pool		
Type of Pool	**Number**	**Percent**
Above Ground	4	57.1%
In Ground	3	42.9%

Gender	Number	Percent
Males	14	77.8%
Females	4	22.2%

Type of Open Body of Water		
Open Body	**Number**	**Percent**
Lake	3	42.8%
Creek	2	28.6%
Pond	1	14.3%
River	1	14.3%

Sleep Related Deaths

The Board reviewed and closed 68 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.

Three (4.4%) deaths occurred while mother was breastfeeding.

One death occurred eight years after an accidental overlay incident. The information on this death reflects the original injury situation. Other locations include: car seat, toddler bed, bouncy seat, air mattress (x3), and a double papason chair.

Manner of Death for Sleep Related Deaths

Manner	Number	Percent
Accidental	2	2.9%
Natural (SIDS)	18	26.5%
Undetermined	48	70.6%

Position of Infant When Placed to Sleep

Position	Number	Percent
On Back	20	29.4%
On Side	15	22.1%
On Stomach	12	17.6%
Unknown*	21	30.9%

Position of Infant When Found

Position	Number	Percent
On Back	9	13.2%
On Side	16	23.5%
On Stomach	18	26.5%
Unknown*	25	36.8%

Sleeping Arrangement of Infant

Sleeping Arrangement	Number	Percent
Alone	43	63.25
With Adult and/or Other Child	25	36.8%

Race

African American	17	25.0%
American Indian	10	14.7%
Asian	1	1.5%
Multi-race	1	1.5%
White	39	57.3%

Ethnicity	Number	Percent
Hispanic (any race)	2	2.9%
Non-Hispanic	66	97.1%

Gender	Number	Percent
Males	42	61.8%
Females	26	38.2%

Sleeping Location of Infant

Location	Number	Percent
Adult Bed	27	39.7%
Crib	11	16.2%
Bassinette	8	11.8%
Couch	7	10.3%
Floor	3	4.4%
Playpen	3	4.4%
Unknown*	2	2.9%
Other	7	10.3%

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

Firearm Deaths

The Board reviewed and closed 19 deaths in 2011 due to firearms.

Manner of Death for Firearm Victims		
Manner	**Number**	**Percentage**
Suicide	10	52.6%
Homicide	9	47.4%

Race		
African American	4	21.0%
American Indian	1	5.3%
Multi-Race	1	5.3%
White	13	68.4%

Type of Firearm Used		
Type of Firearm	**Number**	**Percent**
Handgun	10	52.7%
Hunting Rifle	4	21.0%
Shot gun	4	21.0%
Unknown	1	5.3%

Ethnicity	Number	Percent
Hispanic (any race)	2	10.5%
Non-Hispanic	17	89.5%

Gender	Number	Percent
Males	15	78.9%
Females	4	21.1%

Fire Deaths

The Board reviewed and closed three deaths in 2011 due to fires. All three died of smoke inhalation.

Fire Ignition Source		
Source	**Number**	**Percent**
Cigarette Lighter	1	33.3%
Electrical Wiring	1	33.3%
Space Heater	1	33.3%

Race		
Multi-Race	1	33.3%
White	2	66.6%

Ethnicity	Number	Percent
Hispanic (any race)	1	33.3%
Non-Hispanic	2	66.6%

Working Smoke Detector Present		
Detector	**Number**	**Percent**
Yes	0	0
No	2	66.6%
Unknown	1	33.3%

Gender	Number	Percent
Males	2	66.6%
Females	1	33.3%

Abuse/Neglect Deaths

The Board reviewed and closed 41 cases where it was determined that abuse or neglect caused or contributed to the death.
Nineteen (46.3%) cases were ruled abuse, 21 (51.2%) cases were ruled neglect, and one (2.4%) was ruled both.
One case the child died due to trauma inflicted 10 years prior-the age of this child is reflected as to the age when the injuries were received and not the age when the child died.

Manner of Death for Abuse/Neglect Cases		
Manner	**Number**	**Percent**
Accident	17	41.5%
Homicide	17	41.5%
Suicide	1	2.4%
Undetermined	6	14.6%

Race		
African American	5	12.2%
American Indian	9	22.0%
Multi-race	2	4.8%
White	25	61.0%

Gender	Number	Percent
Males	23	56.1%
Females	18	43.9%

Ethnicity	Number	Percent
Hispanic (any race)	6	14.6%
Non-Hispanic	35	85.4%

Near Deaths

The Board reviewed and closed 53 near death cases in 2011. 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.
Thirty-five (66.0%) were substantiated by OKDHS as to having been abuse and/or neglect. Sixteen (30.2%) had a previous referral that was investigated by OKDHS; an additional 7 (13.2%) had a sibling with a previous investigation.

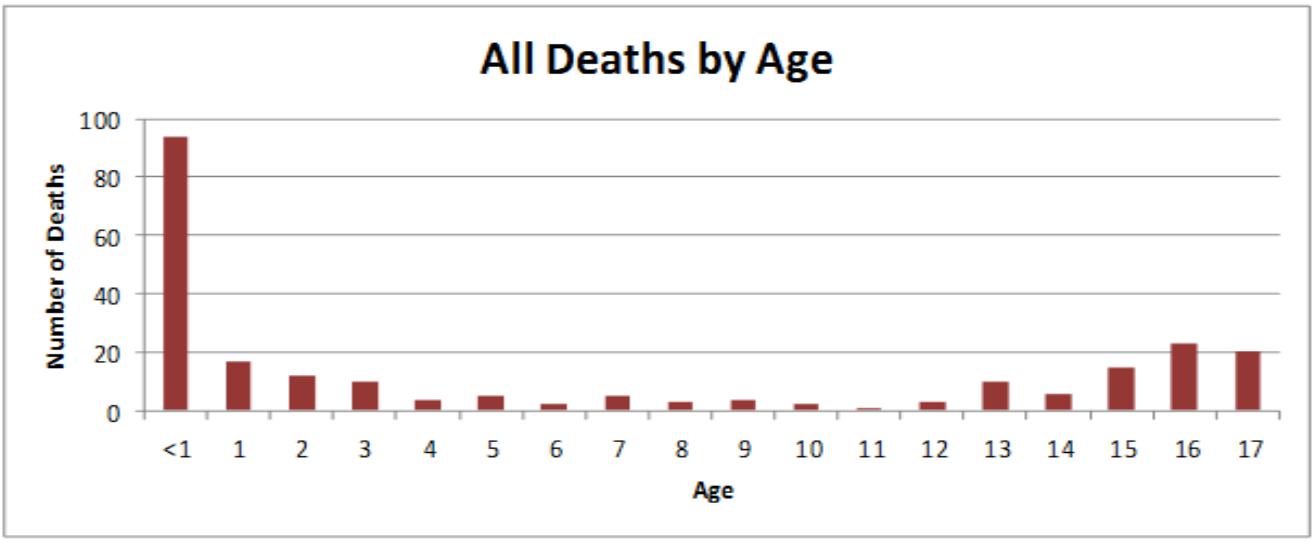
Injuries in Near Death Cases		
Injury	**Number**	**Percent**
Physical Abuse	27	50.9%
Drowning	6	11.3%
Poison/Overdose	5	9.4%
Vehicular	4	7.5%
Fall	3	5.7%
Fire	2	3.8%
Hyperthermia	2	3.8%
Medical Condition	2	3.8%
Asphyxia	1	1.9%
Firearm	1	1.9%

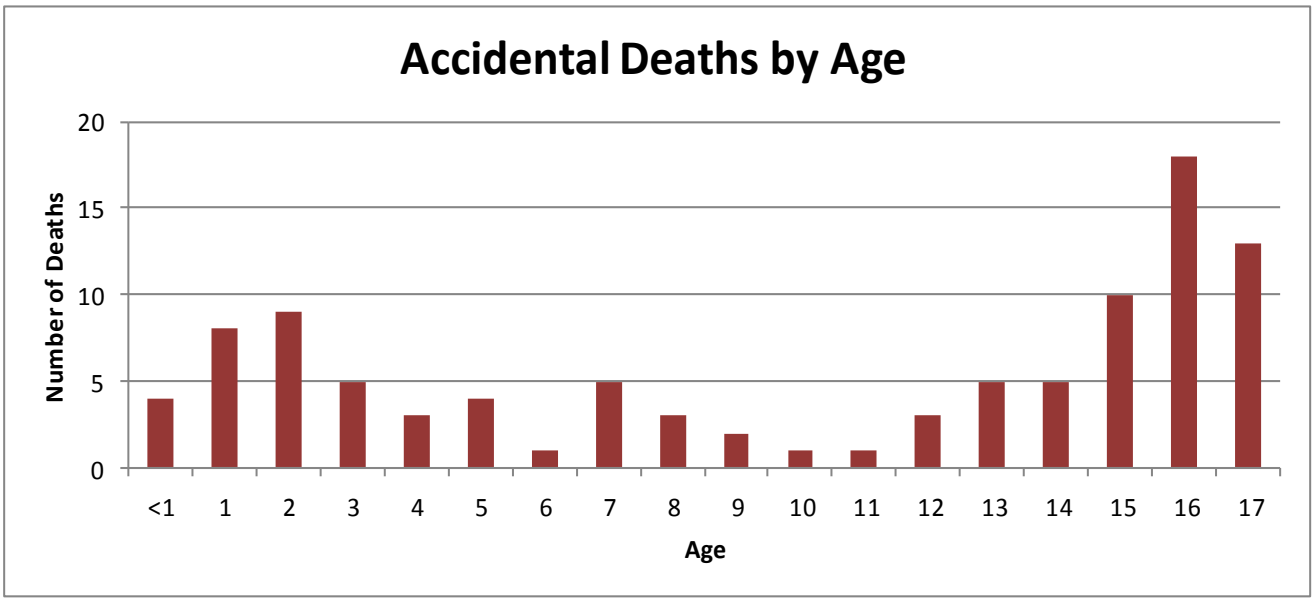
Race		
African American	7	13.2%
American Indian	14	26.4%
Multi-race	3	5.7%
Unknown	1	1.9%
White	28	52.8%

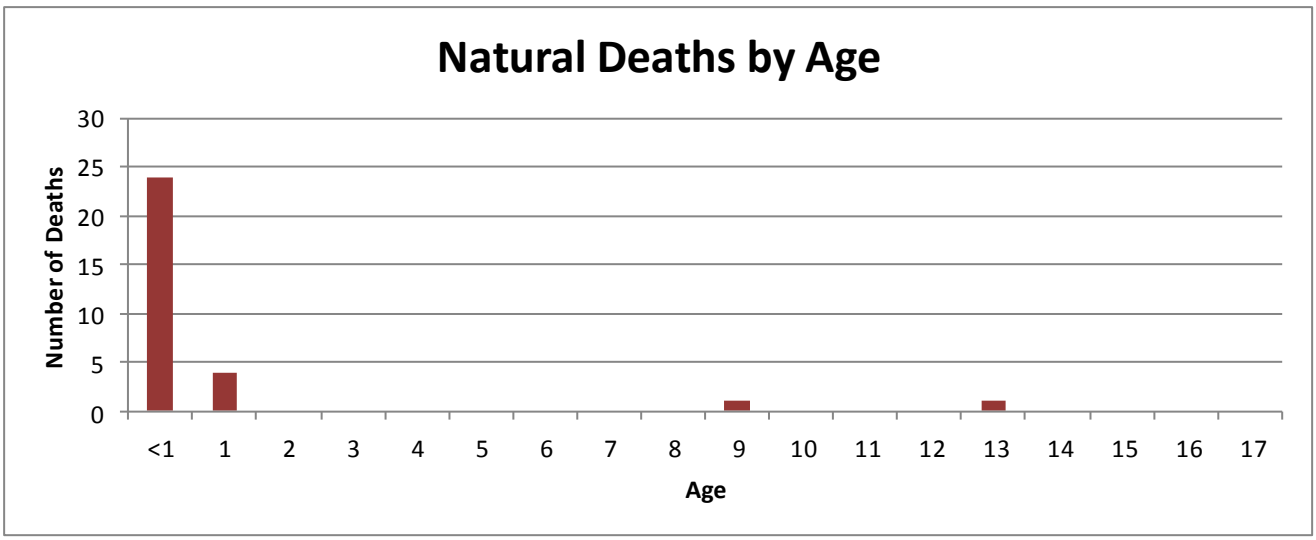
Ethnicity	Number	Percent
Hispanic (any race)	8	15.1%
Non-Hispanic	45	84.9%

Gender	Number	Percent
Males	35	66.0%
Females	18	34.0%

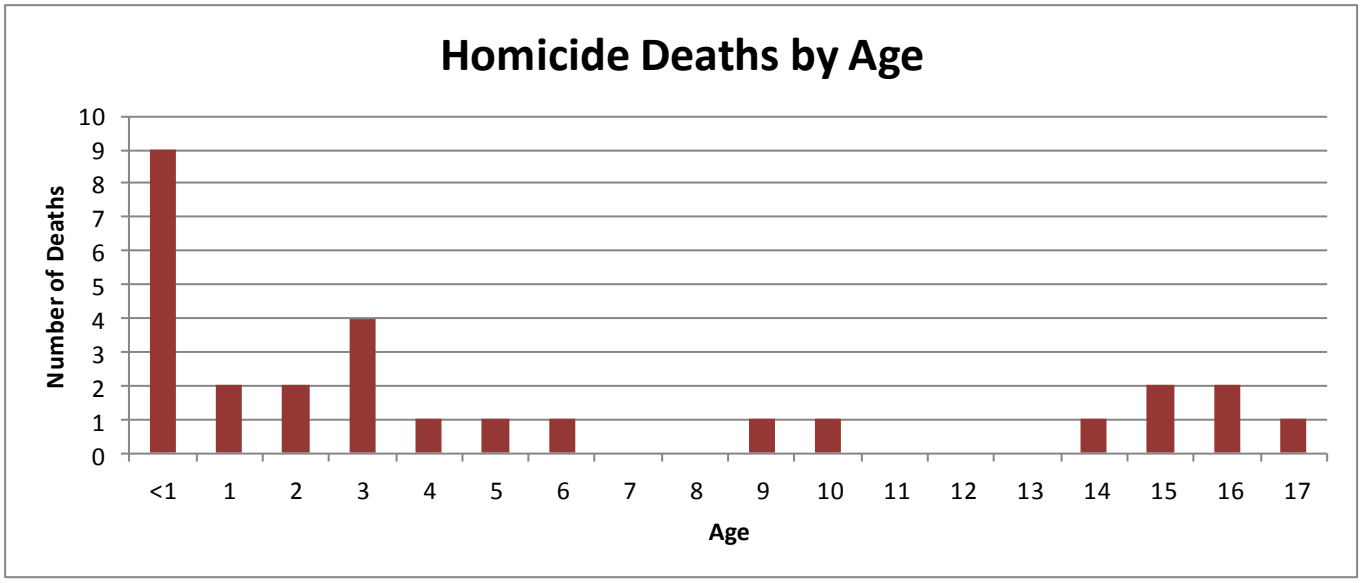
Age of Decedents by Manner

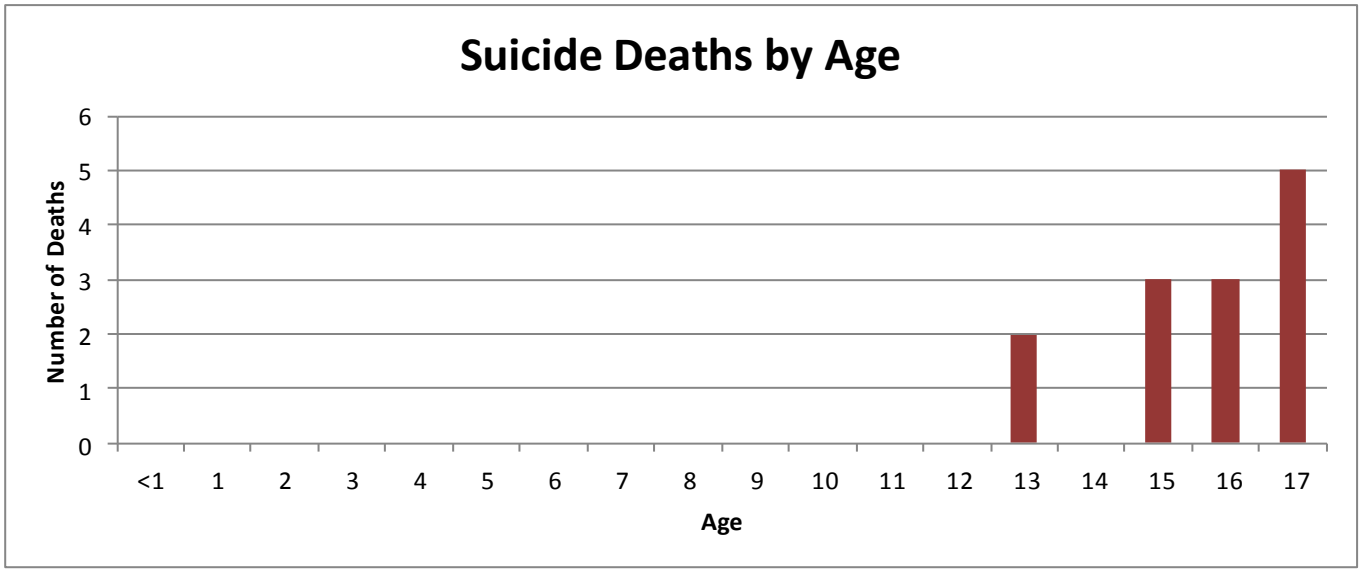


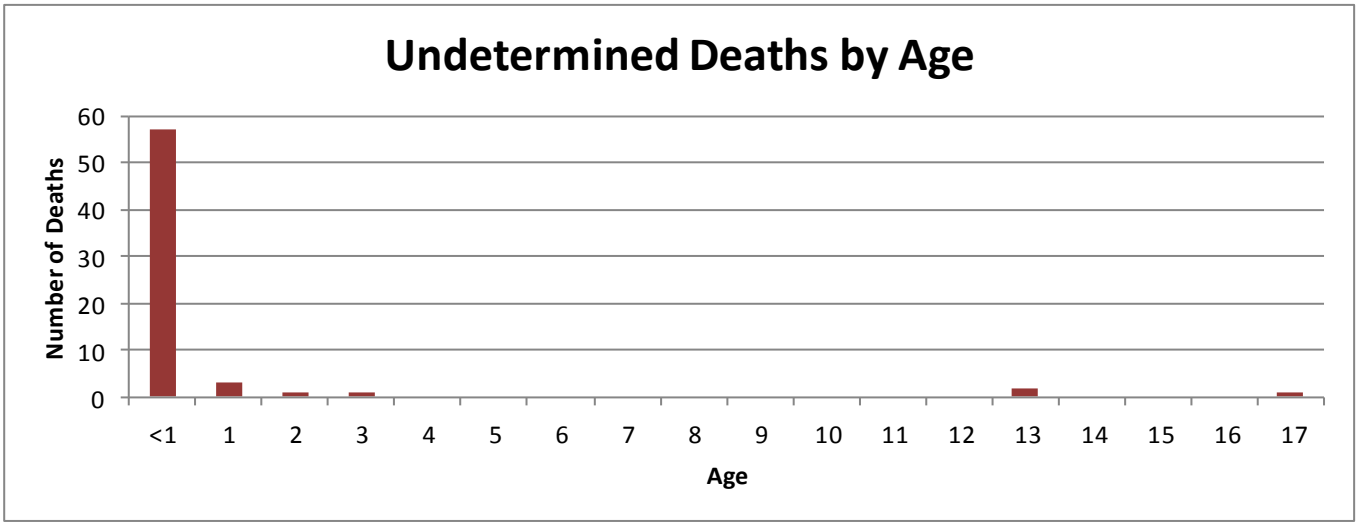




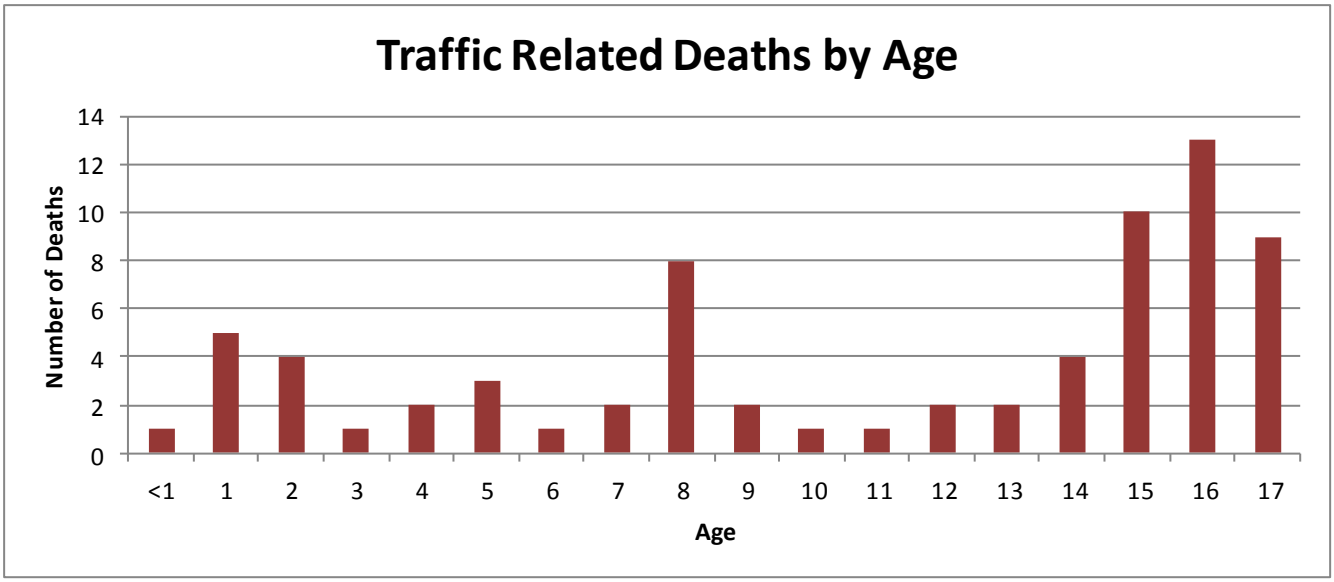
Age of Decedents by Manner

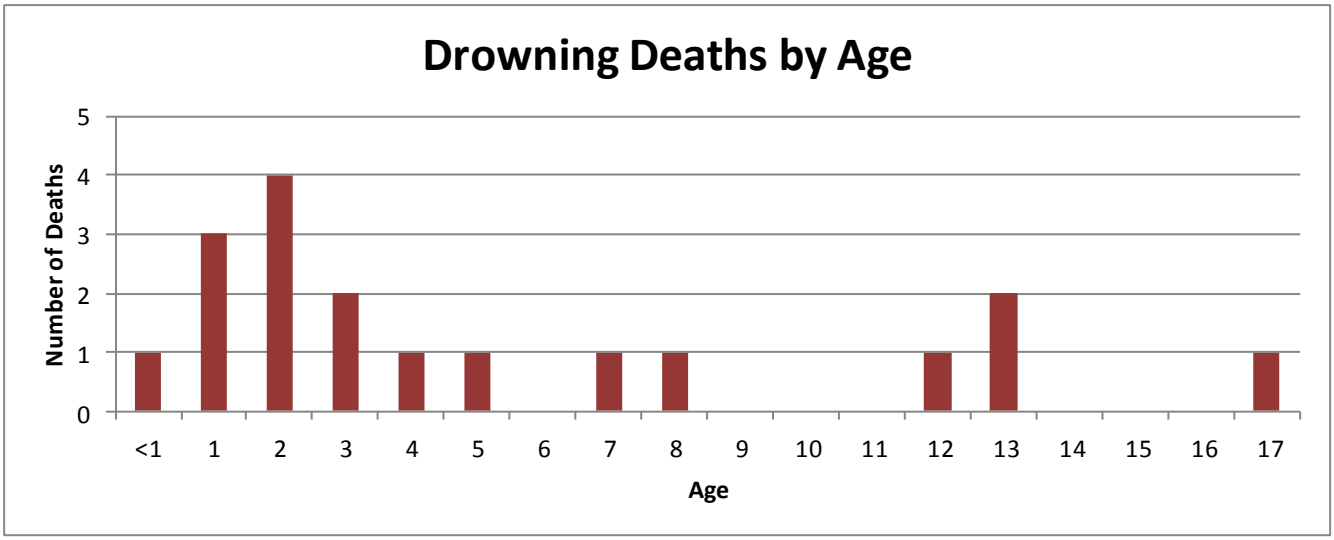


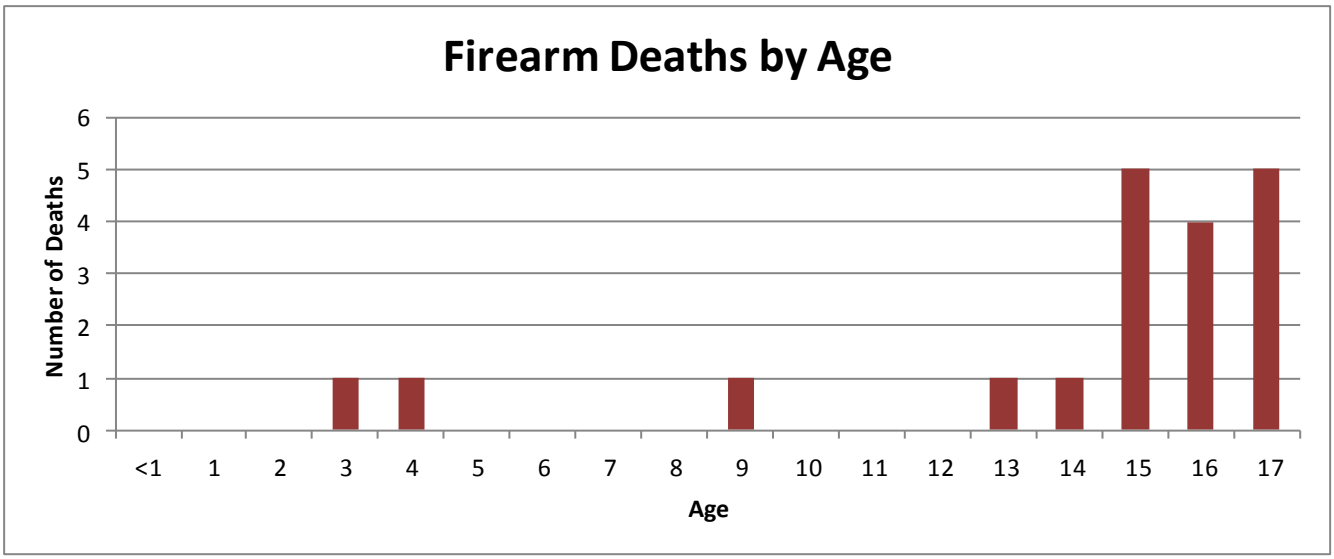




Age of Decedents by Select Causes







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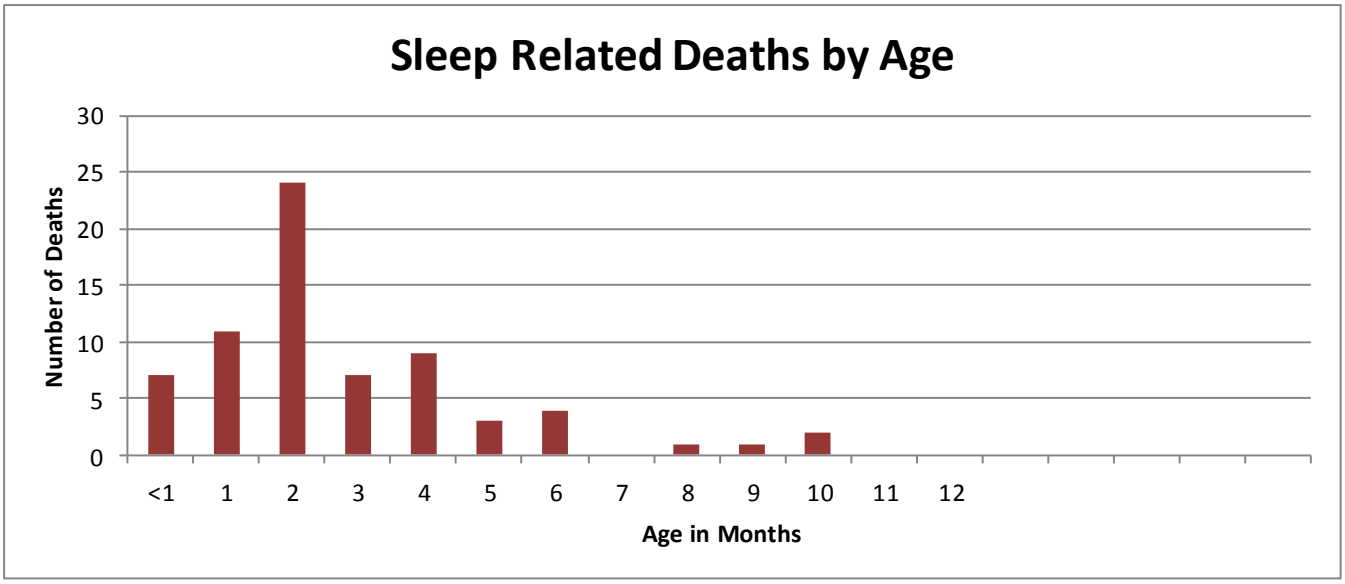

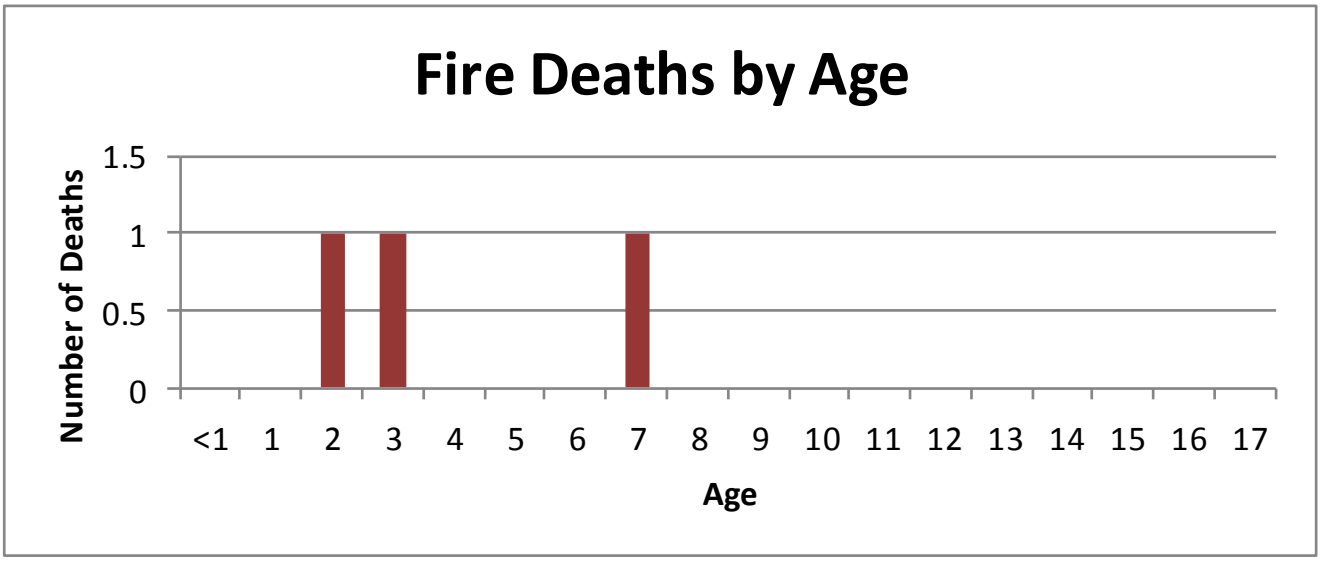

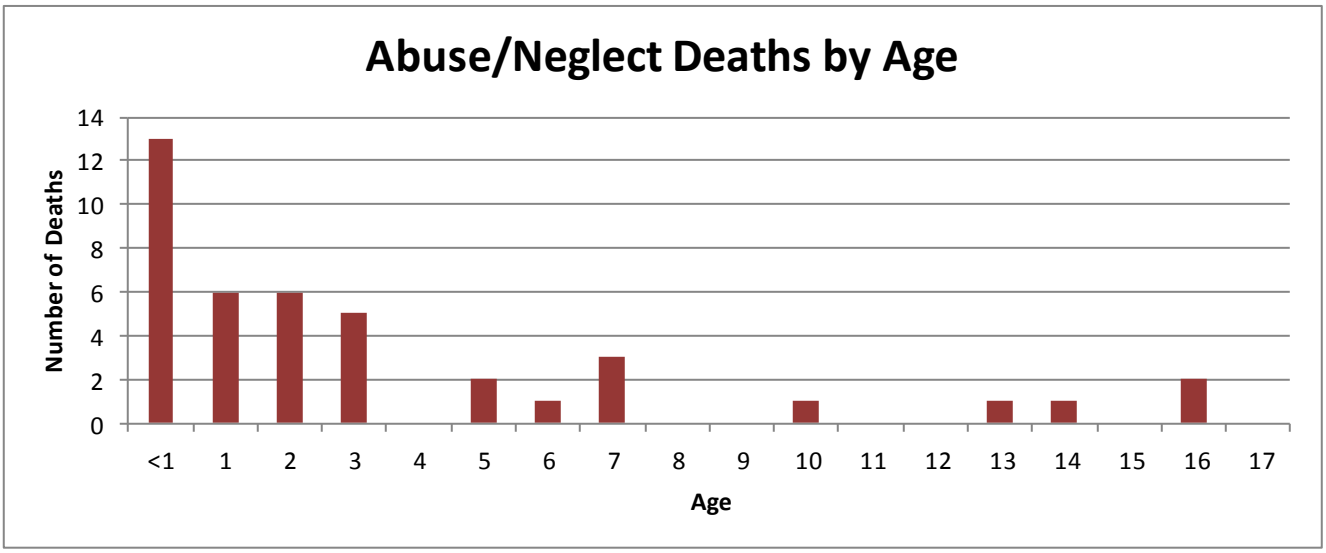

Resources

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
Suicide Prevention Resource Center	www.sprc.org

Proud partner of Preparing for a Lifetime to ensure a safe and healthy start for Oklahoma babies.

For more information please visit: http://www.iio.health.ok.gov

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