Think. Prevent. Live.

Keep Our Children Safe

The Oklahoma Child Death Review Board
2012 Annual Report

Includes the 2013 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 2013 annual recommendations of the Oklahoma Child Death Review Board as submitted to the Oklahoma Commission on Children and Youth.

FISCAL RECOMMENDATIONS

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)

Continue to provide the OKDHS with funding to hire additional child welfare staff with a salary competitive with positions in other states to be in compliance with the recommended national standard issued by the Child Welfare League of America and in accordance with the Pinnacle Plan.
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, including seat belt use.
- Sobriety testing results need to be documented in the Oklahoma Uniform Traffic Collision Report submitted to the Department of Public Safety.

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 from hospital and that the education include statistics on sleep related deaths.
- Adoption by law enforcement agencies and the OCME of the Center for Disease Control and Prevention's Sudden Unexpected Infant Death Investigation (SUIDI) protocols.

Reporting

- All hospitals and law enforcement agencies should have a policy in place to notify OKDHS/CW of unexpected child deaths.

Board Actions and Activities

Include but are not limited to:

- Continued collaborations with the Oklahoma Domestic Violence Fatality Review Board, including case review.
- Continued collaboration 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 Advisory Council.
- Continued partnership with Preparing for a Lifetime; It's Everyone's Responsibility, a statewide program aimed at reducing infant mortality.
- Followed up with a District Attorney requesting information as to why murder charges had been dropped on an alleged perpetrator.
- Three letters to hospitals: recommending notification to the Oklahoma Department of Human Services Child Welfare Division (OKDHS/CW) of unexpected child deaths, recommending increasing child maltreatment training for physicians and reminding of the child maltreatment reporting laws, and requesting the results of toxicological testing.
- Three letters to law enforcement agencies including but not limited to: letter of commendation for an exceptional scene investigation, recommending notification to OKDHS/CW of unexpected child deaths, and requesting an agency's policy for documentation requirements when responding to a domestic violence situation.
- Five letters to the Office of the Chief Medical Examiner (OCME) including but not limited to: requesting review of cases for possible amendments to manner and/or cause of death, requesting information on Policy and Procedures for determining what cases get which toxicological tests, requesting clarification of injuries documented in the Report of Autopsy and requesting explanation on how those injuries support the manner and cause of death, requesting explanation on why an infant who died unexpectedly did not get an autopsy.
- Referred one case to the Oklahoma Commission on Children and Youth, Office of Juvenile System Oversight for review of OKDHS/CW's handling of substance abuse referrals.
- Followed up with the OKDHS on three cases, including but not limited to: requesting the status of a licensed foster home, requesting the status of a licensed child care provider, requesting a copy of a foster home's plan for corrective action.
- One letter to the Office of Juvenile Affairs requesting information on what services were provided to a child.
- One letter to the legislature recommending fiscal support for the OCME.
- One letter to a private attorney requesting the status of adoption for a surviving sibling.

Cases Closed 2012

The Oklahoma Child Death Review Board is comprised of five review teams. The total number of deaths reviewed and closed in 2012 by all five teams is 223. The year of death for these cases ranged from 2002 to 2012.

2012 Deaths Reviewed		
Manner	**Number**	**Percent**
Accident	106	47.6%
Unknown	71	31.8%
Suicide	17	7.6%
Homicide	15	6.7%
Natural	14	5.8%

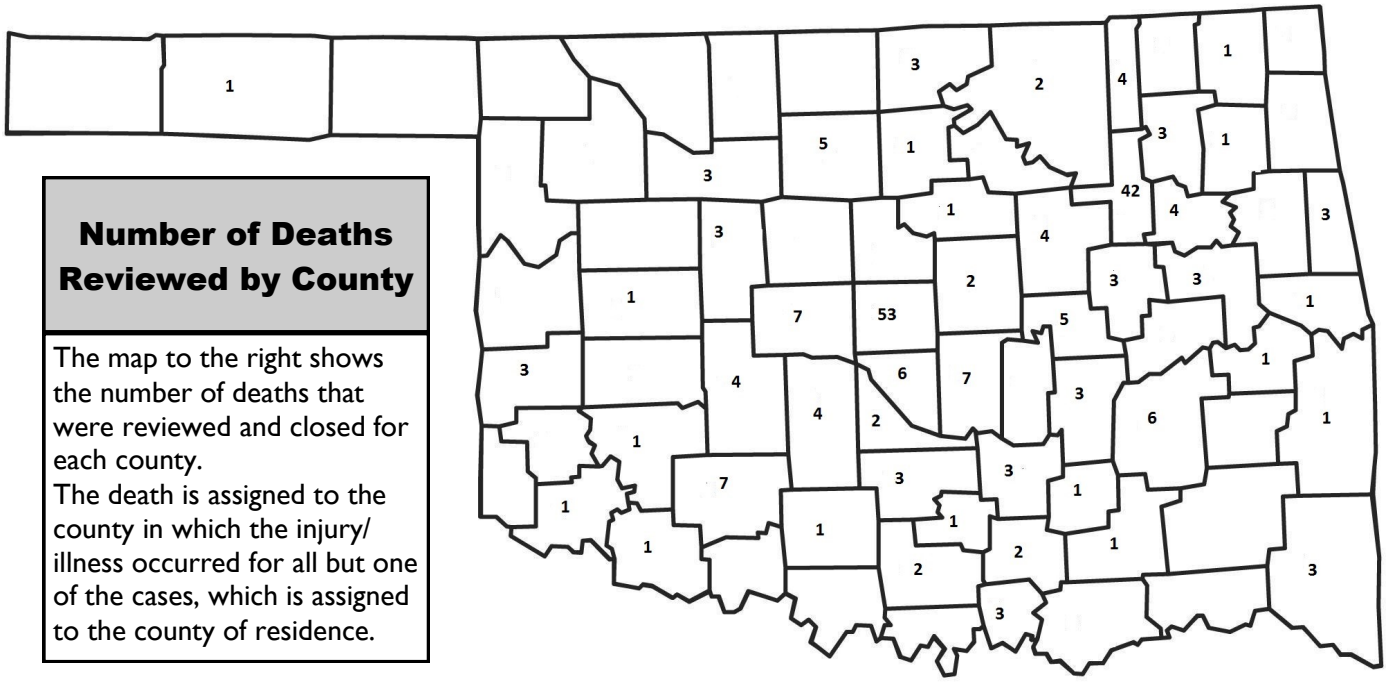
Race		
African American	24	10.8%
American Indian	40	17.9%
Asian	1	0.4%
Multi-race	14	6.3%
White	144	64.6%

Gender	Number	Percent
Males	131	58.7%
Females	92	41.3%

Ethnicity	Number	Percent
Hispanic (any race)	23	10.3%
Non-Hispanic	200	89.7%

Number of Deaths Reviewed by County

The map to the right shows the number of deaths that were reviewed and closed for each county.
The death is assigned to the county in which the injury/ illness occurred for all but one of the cases, which is assigned to the county of residence.



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 17 (7.6%) cases that had an open CPS case at the time of death.

Of the two foster care deaths, one manner of death was Suicide and other manner of death was Unknown.

Number of Cases with Previous Involvement in Selected State Programs

Agency	Number	Percent Of All Deaths
Oklahoma Health Care Authority	177	79.4%
OKDHS—TANF	152	68.2%
OKDHS - Child Support Enforcement	107	48.0%
OKDHS - Child Welfare	57	25.6%
OKDHS - Food Stamps	20	9.0%
Office of Juvenile Affairs	9	4.0%
OKDHS - Disability	7	3.1%
OKDHS - Foster Care	2	0.9%
OKDHS - Child Care Assistance	1	0.4%
OKDHS - Emergency Assistance	1	0.4%
OSDH - Children First	1*	0.4%
OSDH - Office of Child Abuse Prevention	0	-

Accidents

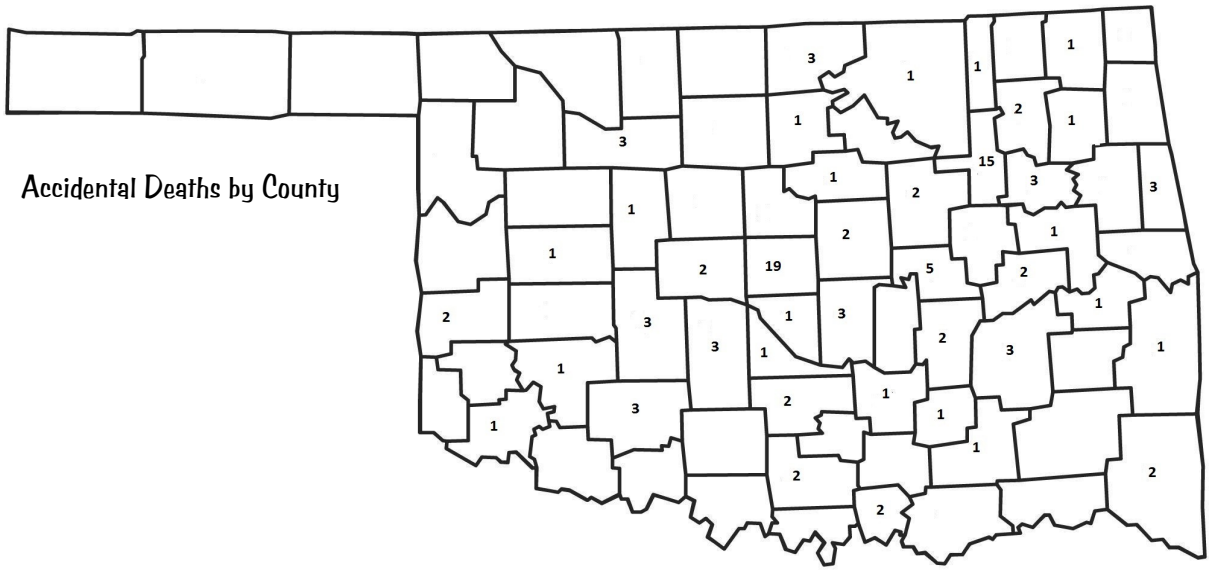
The Board reviewed and closed 106 deaths in 2012 whose manner of death was ruled Accident, also known as Unintentional Injuries. Vehicular deaths continue to be the top mechanism of death for this category.

Mechanism of Death		
Type	**Number**	**Percent**
Vehicular	55	52.0%
Drowning	19	18.0%
Asphyxia/ Suffocation	11	10.4%
Fire	11	10.4%
Poisoning/OD	4	3.8%
Crush	1	0.9%
Electrocution	1	0.9%
Explosion	1	0.9%
Exposure	1	0.9%
Firearm	1	0.9%
Tornado	1	0.9%

Race		
African American	12	11.3%
American Indian	23	21.7%
Multi-race	3	2.8%
White	68	64.2%

Ethnicity	Number	Percent
Hispanic (any race)	10	9.4%
Non-Hispanic	96	90.6%

Gender	Number	Percent
Males	59	55.7%
Females	47	44.3%



Homicides

The Board reviewed and closed 15 deaths in 2012 whose manner of death was ruled Homicide.

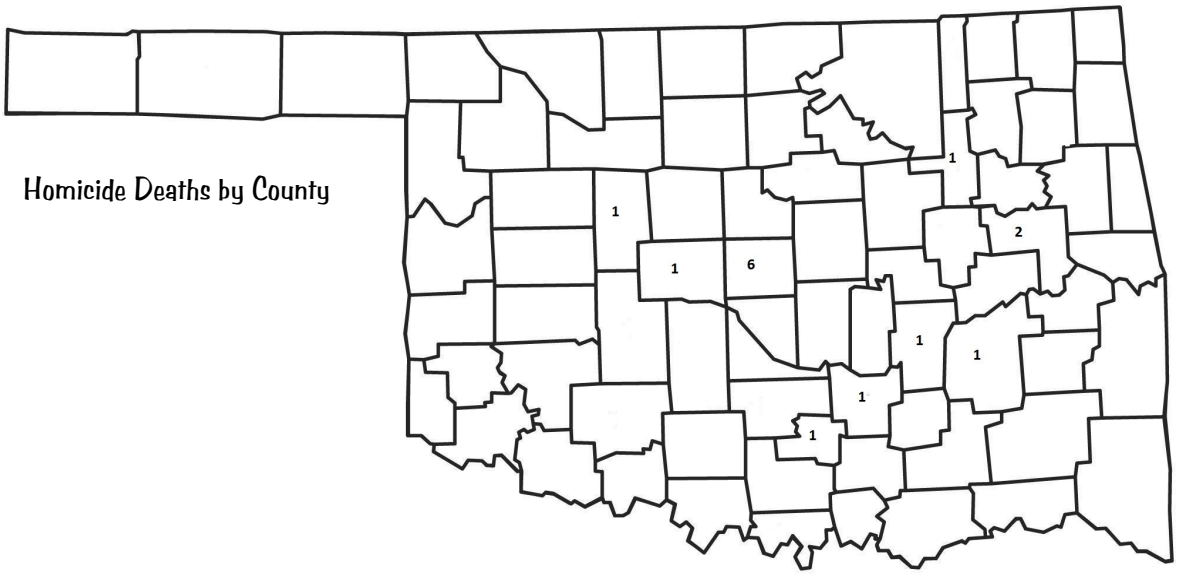
Seven (46.7%) of these were due to physical abuse, with six (40.0%) specific to abusive head trauma.

Mechanism of Death		
Method	**Number**	**Percent**
Struck/ Shaken/Beat	7	46.7%
Firearm	5	33.3%
Stabbing	2	13.3%
Drowning	1	6.7%

Race		
African American	4	26.6%
American Indian	3	20.0%
Multi-Race	1	6.7%
White	7	46.7%

Gender	Number	Percent
Males	5	33.3%
Females	10	66.7%

Ethnicity	Number	Percent
Hispanic (any race)	1	6.7%
Non-Hispanic	14	93.3%



Naturals

The Board reviewed and closed 14 deaths in 2012 whose manner of death was ruled Natural.

Mechanism of Death		
Illness/Disease	**Number**	**Percent**
SIDS	8	57.2%
Congenital Anomaly	2	14.3%
Blood Disorder	1	7.1%
Cardiovascular	1	7.1%
MRSA Pneumonia	1	7.1%
Neurological Disorder	1	7.1%

Race		
African American	2	14.3%
American Indian	1	7.1%
Asian	1	7.1%
Multi-Race	2	14.3%
White	8	57.2%

Ethnicity	Number	Percent
Hispanic (any race)	2	14.3%
Non-Hispanic	12	85.7%

Gender	Number	Percent
Males	9	64.3%
Females	5	35.7%

Suicides

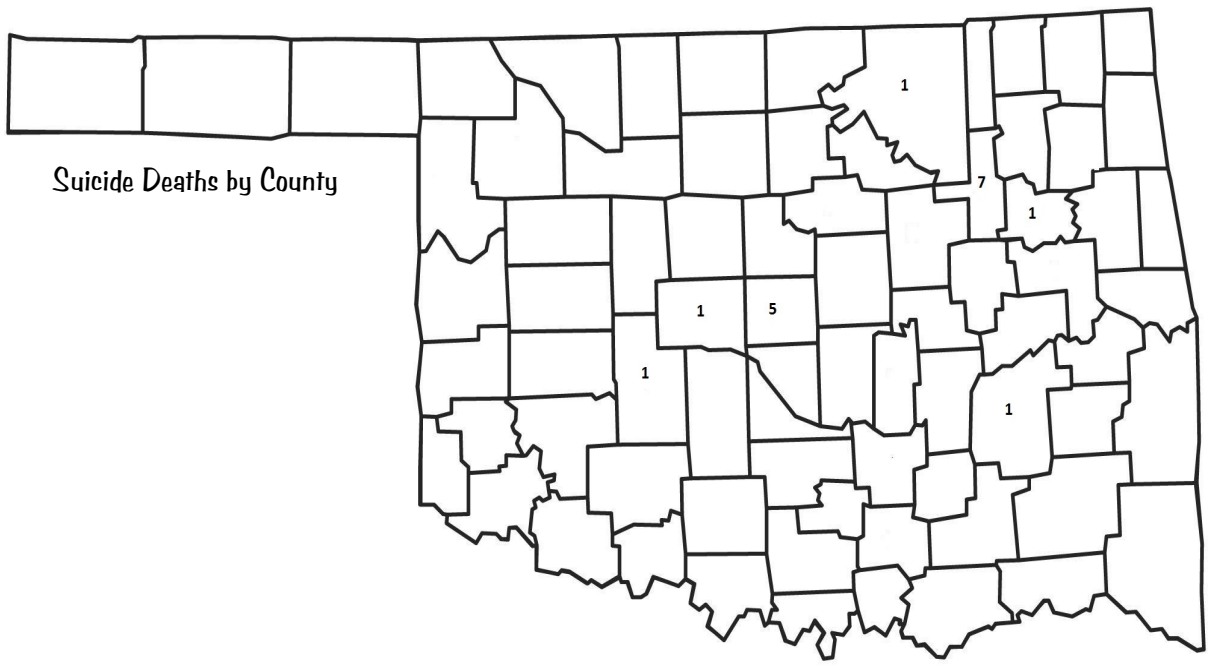
The Board reviewed and closed 17 deaths in 2012 whose manner of death was ruled Suicide.
Four (23.5%)were noted to have problems in school.
Five (29.4%) were noted to have had previous mental health treatment while three (17.6%) were receiving mental health services at the time of death.
Three (17.6%) were noted to be on medication for mental health at the time of death.
Three (17.6%) were noted to have a history of substance abuse.
Five (29.4%) were noted to have a history of child maltreatment.

Mechanism of Death		
Method	**Number**	**Percent**
Firearm	11	64.7%
Asphyxia	6	35.3%

Race		
American Indian	2	11.8%
White	15	88.2%

Gender	Number	Percent
Males	13	76.5%
Females	4	23.5%

Ethnicity	Number	Percent
Hispanic (any race)	0	-
Non-Hispanic	17	100%



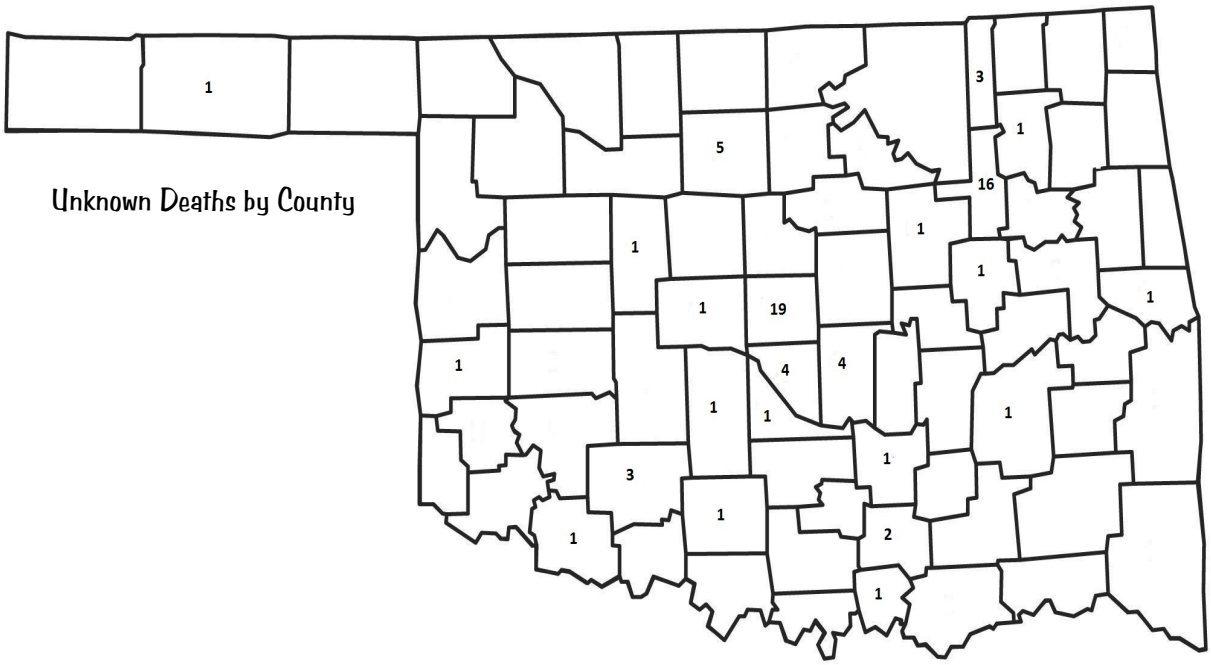
Unknown

The Board reviewed and closed 71 deaths in 2012 ruled Unknown. A death is ruled Unknown by the pathologist when there are no anatomical findings discovered at autopsy to explain the death.
Sixty-five (91.5%) were 2 years of age or younger.
Sixty-one (85.9%) were less than 1 year of age.
Fifty-nine (83.1%) involved questionable safe sleeping environments.
Four (5.6%) were suspicious for trauma.

Race		
African American	6	8.5%
American Indian	11	15.5%
Multi-Race	8	11.2%
White	46	64.8%

Ethnicity	Number	Percent
Hispanic (any race)	10	14.1%
Non-Hispanic	61	85.9%

Gender	Number	Percent
Males	45	63.4%
Females	26	36.6%



Traffic Related Deaths

The Board reviewed and closed 55 accidental deaths in 2012 related to traffic.
For the motorcycle deaths, both were wearing helmets; the go-cart death did not utilize a helmet.

Vehicle of Decedent

Vehicle	Number	Percent
Car	24	43.7%
Pedestrian	11	20.0%
Pick-up	7	12.7%
SUV	6	11.0%
Horse-Drawn Buggy	2	3.6%
Skateboard	2	3.6%
Motorcycle	2	3.6%
Go-Cart	1	1.8%

Use of Safety Restraints

Seatbelt/Car Seat Use	Number	Percent
Properly Restrained	9	22.5%
Not Properly Restrained	31	77.5%
Not Applicable	15	-

Race

African American	5	9.1%
American Indian	12	21.8%
Multi-race	1	1.8%
White	37	67.3%

Activity of Decedent

Position	Number	Percent
Front Passenger	9	16.3%
Rear Passenger	10	18.2%
Operator	15	27.3%
Pedestrian	11	20.0%
Unknown Passenger Placement	6	11.0%
Skateboarder	2	3.6%
Tailgate	1	1.8%
Bed of Pick-up	1	1.8%

Ethnicity	Number	Percent
Hispanic (any race)	5	9.1%
Non-Hispanic	50	90.9%

Gender	Number	Percent
Males	26	47.3%
Females	29	52.7%

Drowning Deaths

The Board reviewed and closed 19 accidental deaths in 2012 due to drowning.
One (5.3%) of the drowning victims had a personal floatation device available to them.
Six (31.6%) were one year of age or younger.

Location of Drowning		
Location	**Number**	**Percent**
Private, Residential Pool	6	31.5%
Open Body of Water (i.e. creek, river, pond, lake)	8	42.1%
Bathtub	3	15.8%
Decorative Pond	1	5.3%
Toilet	1	5.3%

Type of Residential Pool (N=6)		
Type of Pool	**Number**	**Percent**
Above Ground	4	66.7%
In Ground	2	33.3%

Type of Open Body of Water (N=8)		
Open Body	**Number**	**Percent**
Lake	4	50.0%
Creek	2	25.0%
Pond	2	25.0%

Race		
African American	3	15.8%
American Indian	2	10.5%
Multi-Race	2	10.5%
White	12	63.2%

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

Gender	Number	Percent
Males	13	68.4%
Females	6	31.6%

Sleep Related Deaths

The Board reviewed and closed 73 deaths that were related to sleep environments. These include unintentional asphyxiations, Sudden Infant Death Syndrome, and Unknown manners of death where the pathologist noted the sleep environment was a possible contributor to the death.
Four (5.5%) deaths occurred when mother fell asleep during breastfeeding.
Other locations include: car seat, bouncy seat, air mattress, dresser drawer, chair, and a port-a-crib.
Less than 1/4 (24.7%) of these deaths occurred in a sleep space designed for infant sleep (i.e. crib or bassinette). Forty-four (60%) had a crib available in the home.

Manner of Death for Sleep Related Deaths

Manner	Number	Percent
Accidental	6	8.2%
Natural (SIDS)	8	11.0%
Undetermined	59	80.8%

Position of Infant When Placed to Sleep

Position	Number	Percent
On Back	33	45.2%
On Side	10	13.7%
On Stomach	11	1.4%
Unknown*	19	26.0%

Position of Infant When Found

Position	Number	Percent
On Back	16	21.9%
On Side	8	11.0%
On Stomach	33	45.2%
Unknown*	16	21.9%

Sleeping Arrangement of Infant

Sleeping Arrangement	Number	Percent
Alone	50	68.5%
With Adult and/or Other Child	23	31.5%

Race

African American	7	9.6%
American Indian	14	19.2%
Asian	1	1.4%
Multi-race	9	12.3%
White	42	57.3%

Ethnicity	Number	Percent
Hispanic (any race)	9	12.3%
Non-Hispanic	64	87.7%

Gender	Number	Percent
Males	48	65.8%
Females	25	34.2%

Sleeping Location of Infant

Location	Number	Percent
Adult Bed	38	52.1%
Crib	13	17.8%
Bassinette	5	6.9%
Couch	5	6.9%
Playpen	4	5.5%
Floor	2	2.7%
Other	5	6.9%

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

Firearm Deaths

The Board reviewed and closed 17 deaths in 2012 due to firearms.

Manner of Death for Firearm Victims		
Manner	**Number**	**Percentage**
Suicide	11	64.7%
Homicide	5	29.4%
Accident	1	5.9%

Race		
African American	4	23.5%
American Indian	2	11.8%
White	11	64.7%

Type of Firearm Used		
Type of Firearm	**Number**	**Percent**
Handgun	8	47.0%
Shotgun	4	23.5%
Hunting Rifle	2	11.8%
Assault Rifle	1	5.9%
Pen Gun	1	5.9%
Unknown	1	5.9%

Ethnicity	Number	Percent
Hispanic (any race)	0	-
Non-Hispanic	17	100%

Gender	Number	Percent
Males	14	82.4%
Females	3	17.6%

Fire Deaths

The Board reviewed and closed 11 deaths in 2012 due to fires. Six (54.5%) died of smoke inhalation; five (45.5%) died from both smoke inhalation and thermal injuries (burns).

Fire Ignition Source		
Source	**Number**	**Percent**
Space Heater	3	27.2%
Cigarette	2	18.2%
Electrical Wiring	1	9.1%
Stove	1	9.1%
Unknown	4	36.4%

Working Smoke Detector Present		
Detector	**Number**	**Percent**
Yes	5	45.4%
No	3	27.3%
Unknown	3	27.3%

Race		
American Indian	4	36.4%
White	7	63.6%

Ethnicity	Number	Percent
Hispanic (any race)	0	-
Non-Hispanic	11	100%

Gender	Number	Percent
Males	7	63.6%
Females	4	36.4%

Abuse/Neglect Deaths

The Board reviewed and closed 46 cases where it was determined that child maltreatment (abuse or neglect) caused or contributed to the death.
Ten (21.7%) cases were ruled abuse, 34 (73.9%) cases were ruled neglect, and two (4.4%) were ruled both.
Twenty (43.5%) cases had a previous referral for alleged child maltreatment; five (10.9%) had an open referral at the time of death
Nineteen (41.3%) cases had a caregiver with child welfare history as an alleged perpetrator.
Fourteen (30.4%) cases had a caregiver noted to have a history of domestic violence (either as a victim or a perpetrator).
Twelve (26.1%) cases had at least one caregiver with a history of substance abuse.

Manner of Death for Abuse/Neglect Cases		
Manner	**Number**	**Percent**
Accident	29	63.0%
Homicide	9	19.6%
Undetermined	8	17.4%

Race		
African American	4	8.7%
American Indian	3	6.5%
Multi-race	3	6.5%
White	36	78.3%

Gender	Number	Percent
Males	21	45.7%
Females	25	54.3%

Ethnicity	Number	Percent
Hispanic (any race)	7	15.2%
Non-Hispanic	39	84.8%

Near Deaths

The Board reviewed and closed 15 near death cases in 2012. 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.
Six (40.0%) were substantiated by OKDHS as to having been abuse and/or neglect.
Five (33.3%) had a previous referral that was investigated by OKDHS; seven (46.7%) had a sibling with a previous investigation.

Injuries in Near Death Cases		
Injury	**Number**	**Percent**
Physical Abuse	8	53.3%
Asphyxia	2	13.3%
Drowning	2	13.3%
Poison/Overdose	1	6.7%
Vehicular	1	6.7%
Fall	1	6.7%

Race		
African American	4	26.7%
American Indian	2	13.3%
White	9	60.0%

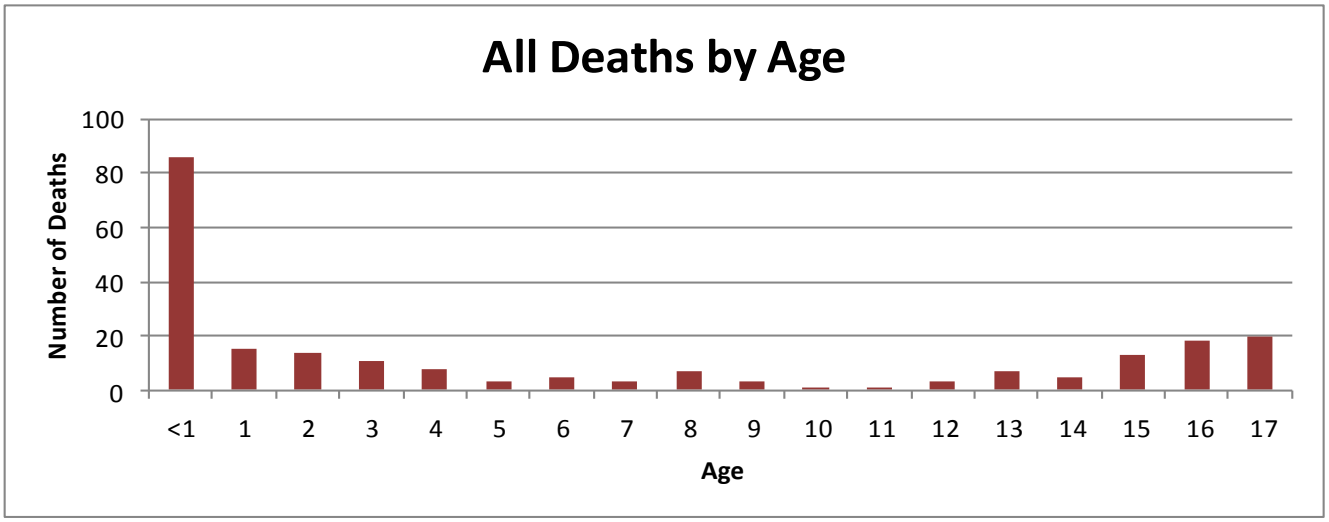
Ethnicity	Number	Percent
Hispanic (any race)	1	6.7%
Non-Hispanic	14	93.3%

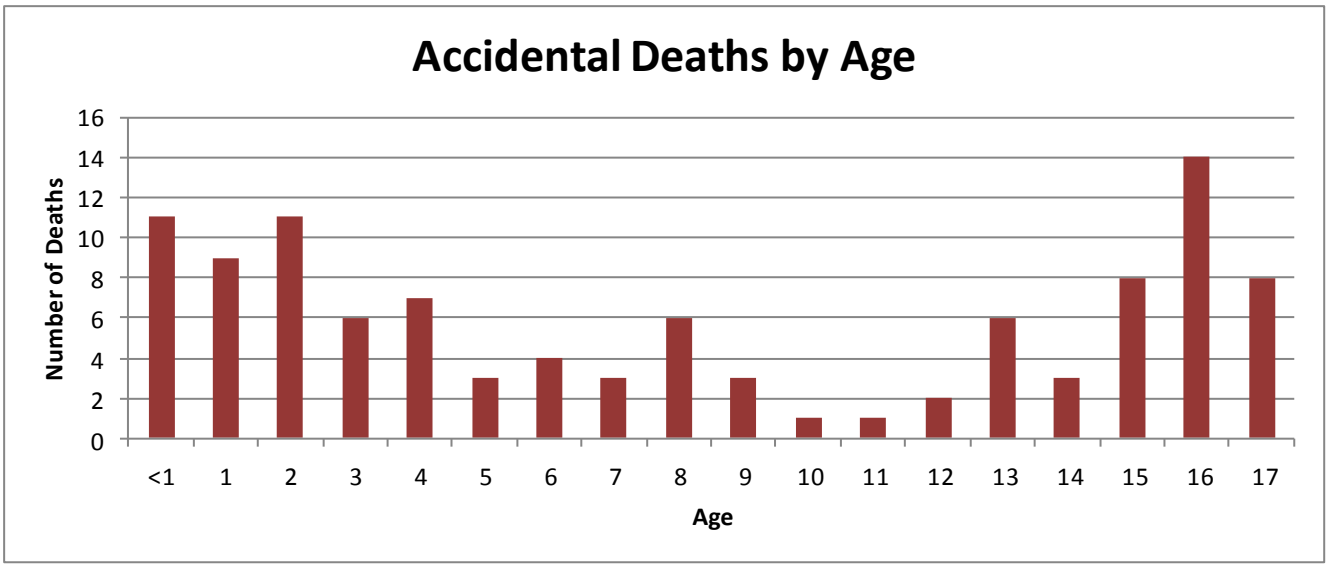
Gender	Number	Percent
Males	14	93.3%
Females	1	6.7%

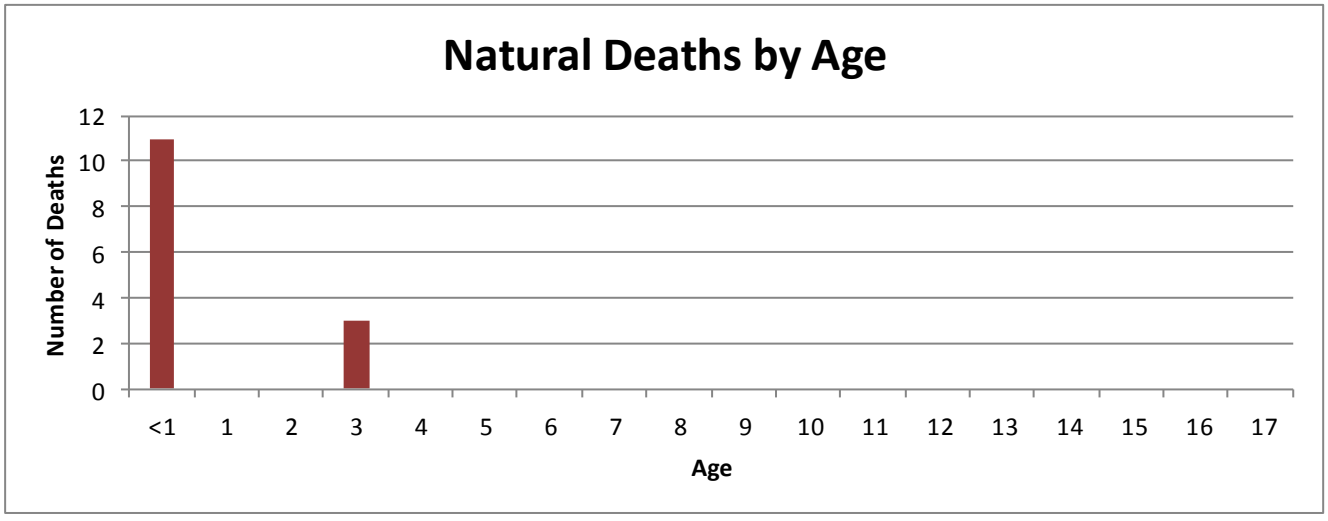
OKDHS Services in Near Death Cases		
Service	**Number**	**Percent**
TANF	11	73.3%
Medical*	9	60.0%
CSE	7	46.7%
Food Stamps	2	13.3%
Disability	2	13.3%
Foster Care	1	6.7%

*number not verified with Oklahoma Health Care Authority

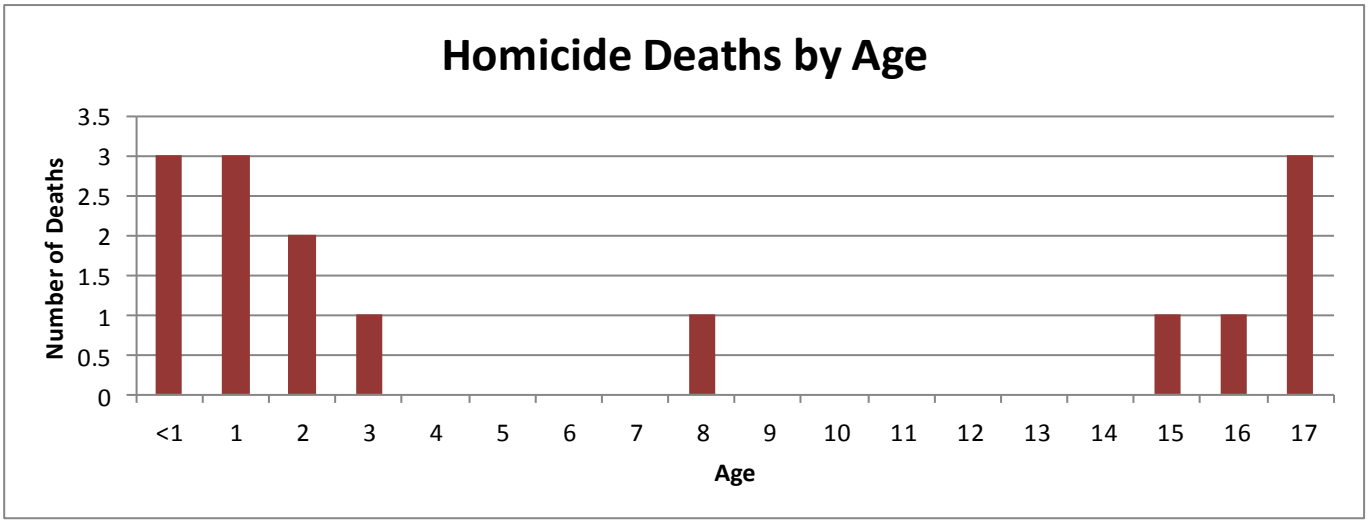
Age of Decedents by Manner

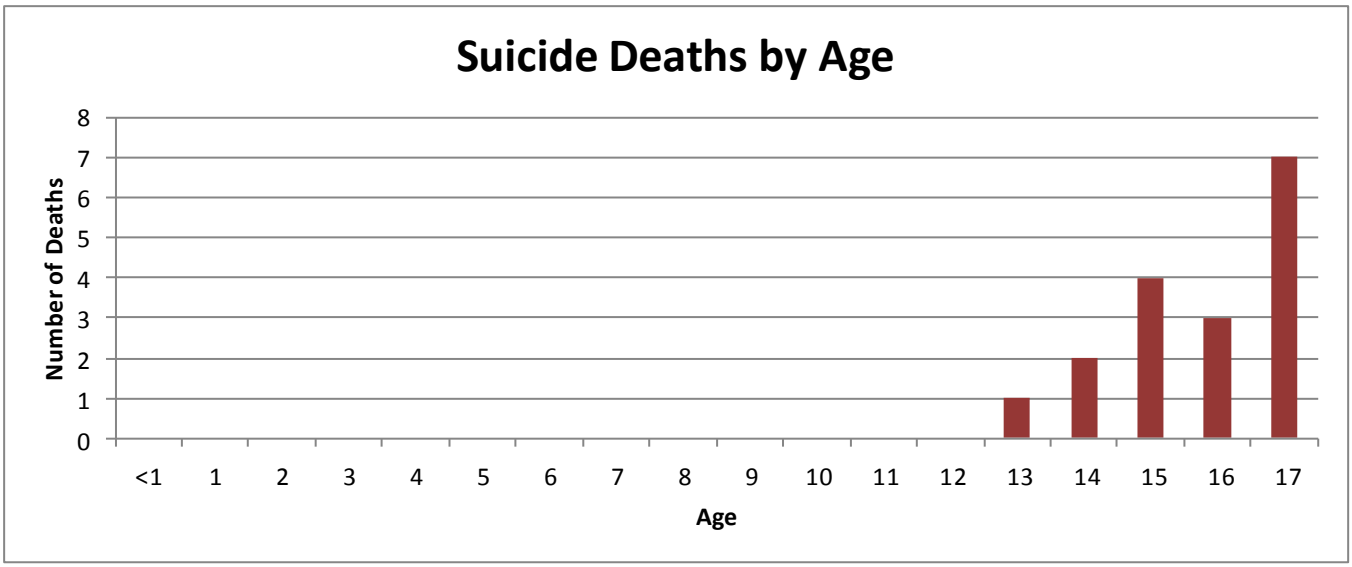


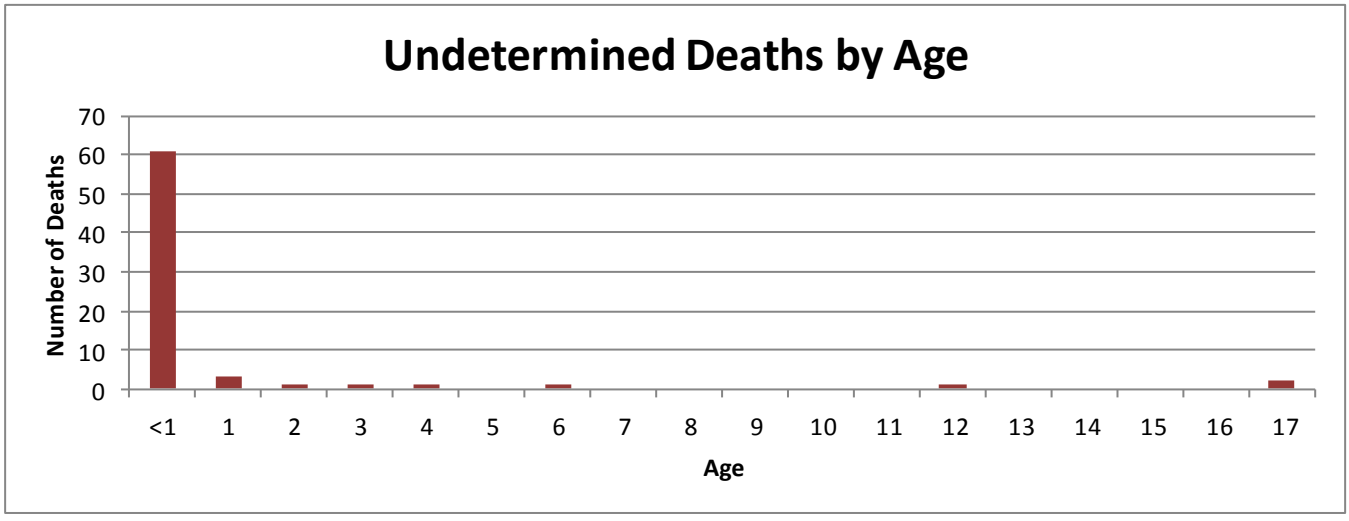




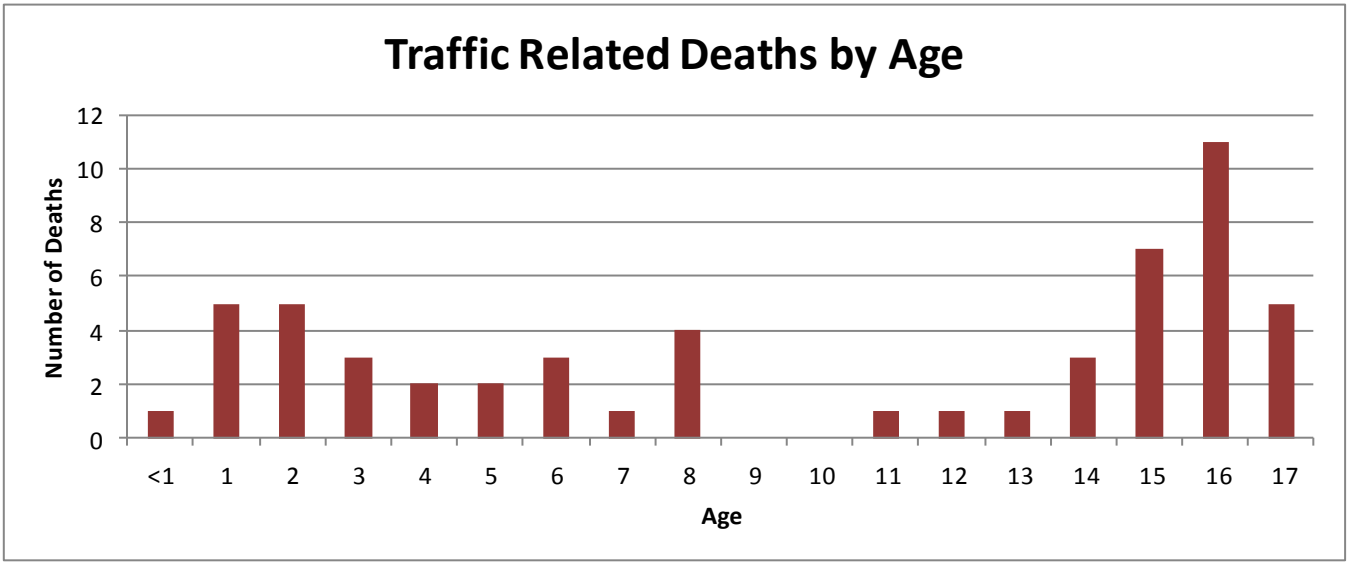
Age of Decedents by Manner

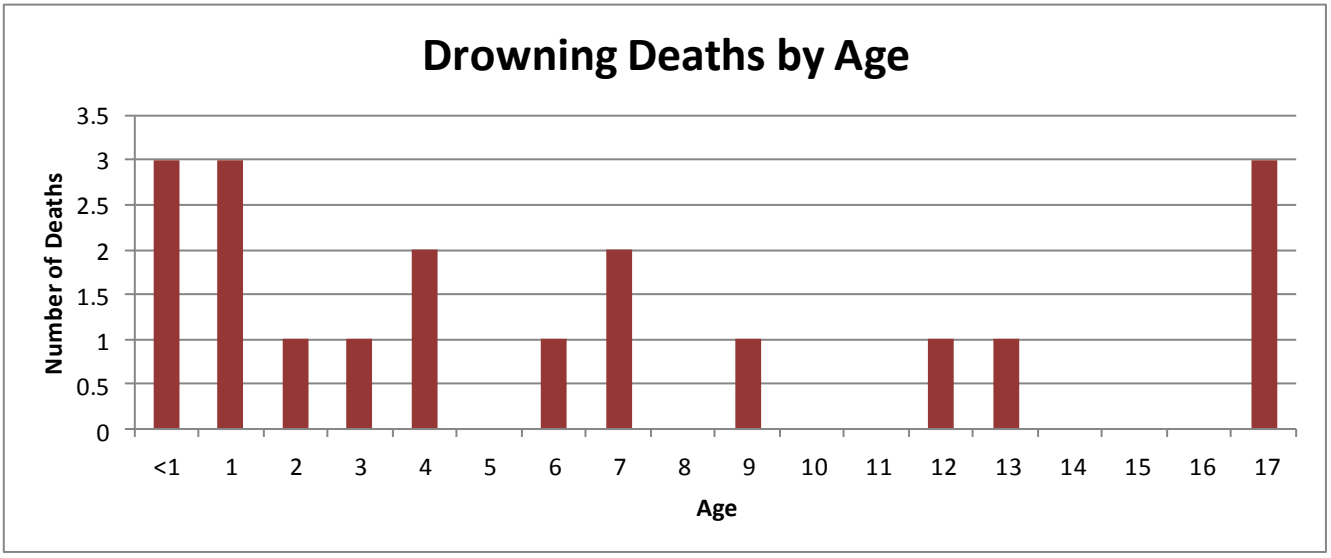


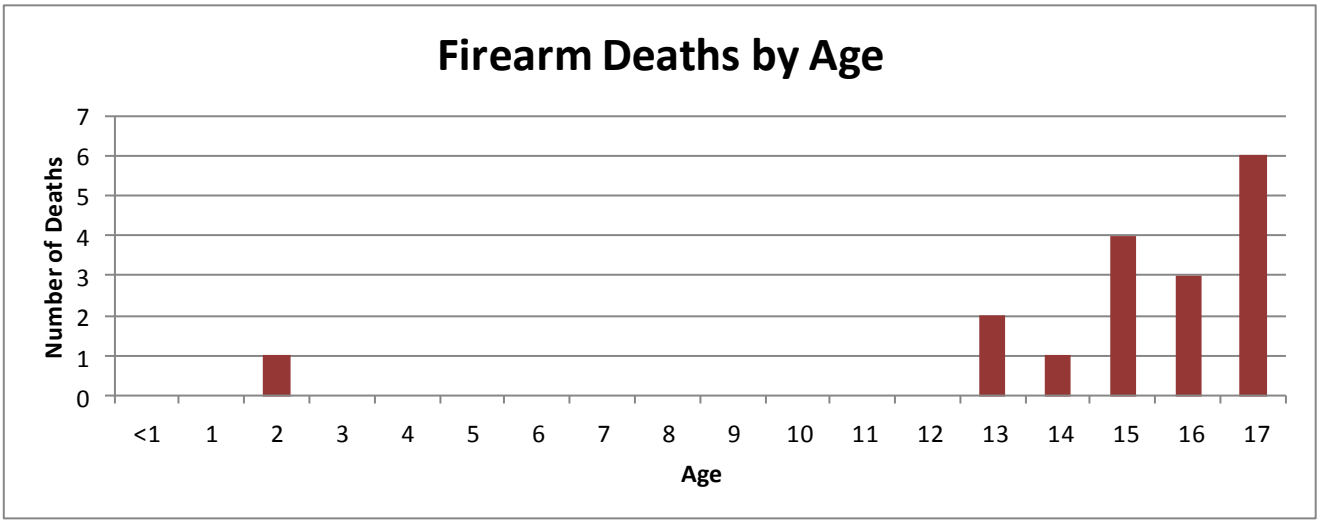




Age of Decedents by Select Causes







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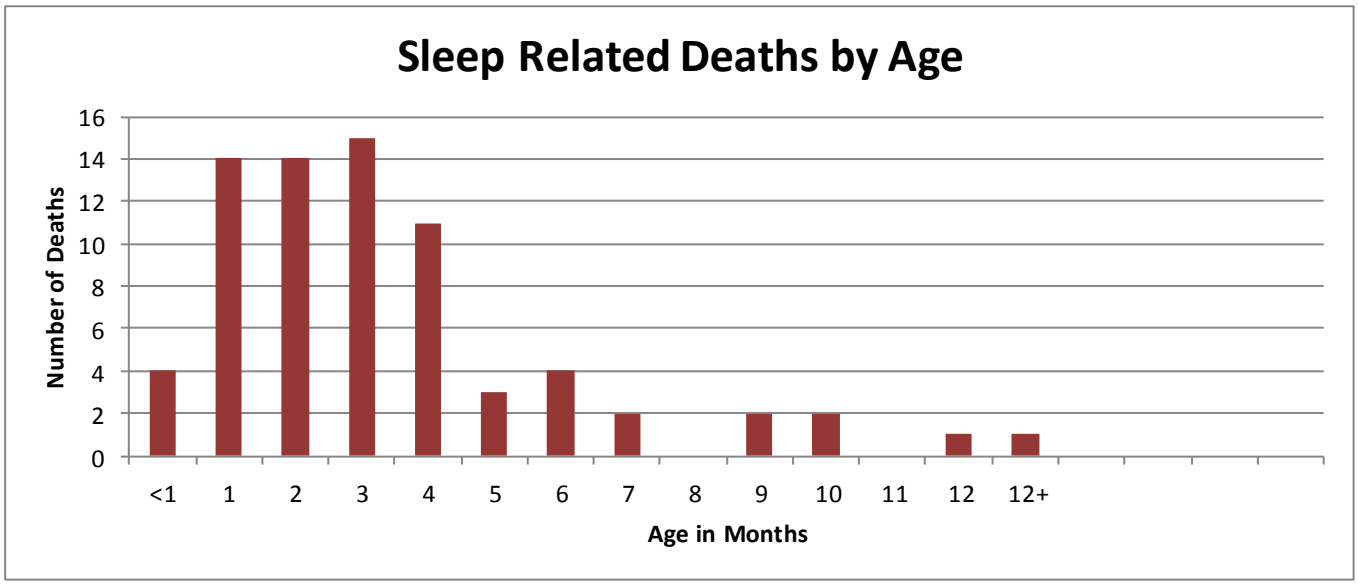

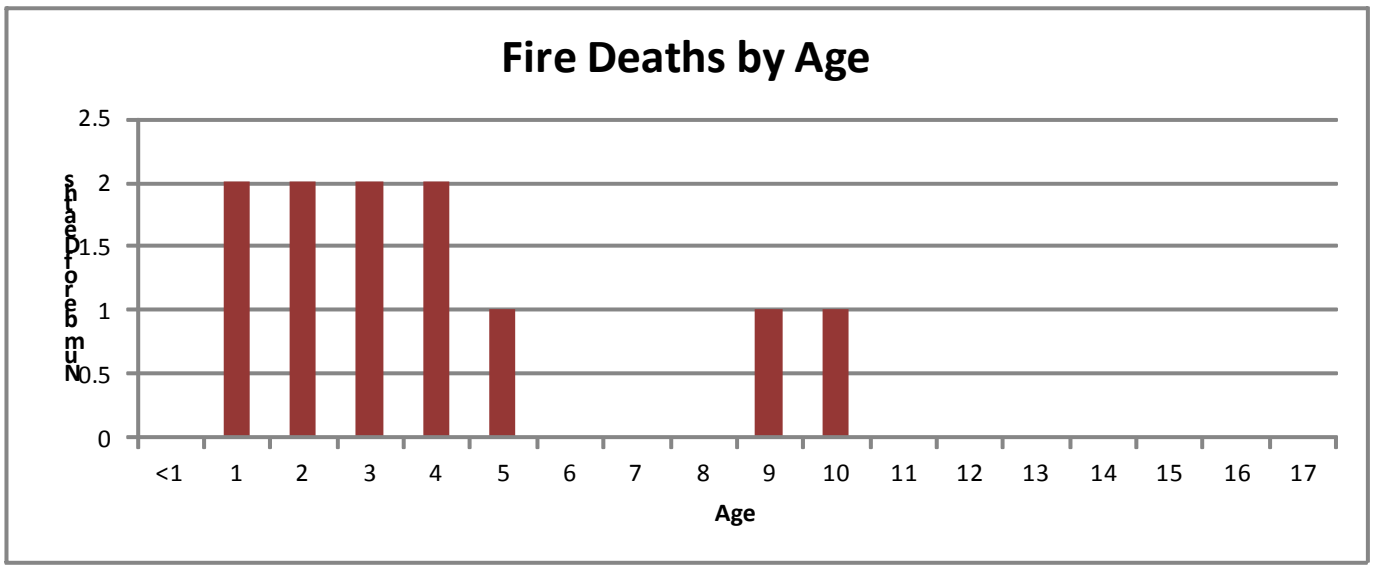

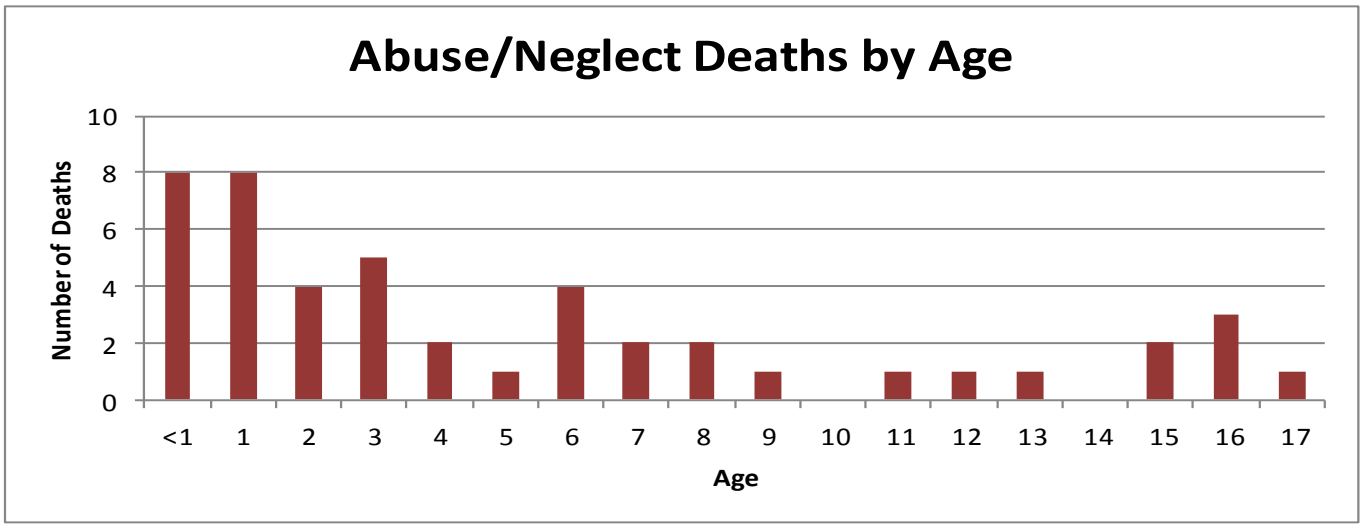

Resources

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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