Think. Prevent. Live.

Keep Our Children Safe

The Oklahoma Child Death Review Board
2013 Annual Report

Includes the 2014 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.

LEGISLATIVE FISCAL RECOMMENDATIONS

Office of the Chief Medical Examiner (OCME)

Continue support of the OCME goals to improve and maintain infrastructure. Policy changes are ineffective without 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 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.

Policy changes are ineffective without a financial commitment by the state of Oklahoma to affect positive change.

POLICY RECOMMENDATIONS

Hospitals

- All delivery hospitals should adopt a policy regarding in-house safe sleep and provide education on safe sleep after delivery but prior to discharge from hospital. The education should include statistics on sleep related deaths. The Oklahoma Child Death Review Board (CDRB) reviewed and closed 103 (37.1%) deaths related to unsafe sleep environments in 2013.
- All hospitals should have a written policy to notify the Oklahoma Department of Human Services Child Welfare division of unexpected child deaths.

Law Enforcement

- Increase the depth of suicide investigations to include mental, medical and social history (i.e. past history of attempts, medications, counseling, note of intention, social media, psychiatric diagnosis, family history of attempts/deaths, stressors, relationship status).
- Enforce child passenger safety laws, including appropriate seat restraint use. The CDRB reviewed and closed 43 cases that involved motor-vehicles and found seat restraint use to be at less than 30%.

Recommendations

- Document sobriety testing results in the Oklahoma Uniform Traffic Collision Report submitted to the Department of Public Safety.
- Adopt the Center for Disease Control's Sudden Unexpected Infant Death Investigation (SUIDI) protocols. The CDRB reviewed and closed 113 (40.6%) infant deaths in 2013; 99 (35.6%) of these were related to unsafe sleep environments and 93 (33.5%) had an "Undetermined" Manner of Death.
- Adopt a policy to notify the OKDHS Child Welfare division of unexpected child deaths.

Legislative

- Enact legislation banning the use of hand-held devices while operating a motor vehicle.
- Enhance child passenger safety laws, including appropriate seat restraint use.

OCME

- Adopt the Center for Disease Control's SUIDI protocols. The CDRB reviewed and closed 113 (40.6%) infant deaths in 2013; 99 (35.6%) of these were related to unsafe sleep environments and 93 (33.5%) had an "Undetermined" Manner of Death.

OKDHS

- Adopt a policy directing workers to connect a referral to a case number upon assignment of the referral.
- Adopt policy ensuring referrals assigned as an "Assessment" include a finding as to the allegation(s) and risk(s) reported.

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.
- Seventeen letters to the Office of the Chief Medical Examiner (OCME):
    - Recommending the Cause of Death and/or the Manner of death be amended;
    - Requesting a death certificate be filed on eight cases;
    - Inquiring if additional substances identified in toxicological studies contributed to the death and if so, please amend the Report of Autopsy to reflect as such;
    - Inquiring if an influenza finding contributed to the death and if so, please amend the Report of Autopsy to reflect as such;
    - Requesting date of death be corrected;
    - Inquiring as to why Child Death Review Board (CDRB) inquiries were unanswered;
    - Inquiring if the eyes were sectioned and examined during the autopsy as well as the measurements of a bruise;
    - Requesting explanation of how a finding may have contributed to a death as well as requested an additional review of the physical findings;
    - Inquiring if bacterial/viral testing was conducted;
    - Inquiring how Manner of Death was determined.
    - Reminding OCME of statutory obligation to autopsy persons who die while in state custody.
- Twenty letters to the Oklahoma Department of Human Services/Child Welfare Division (OKDHS/CW):
    - Requesting synopsis of a child's placement;
    - Requesting follow up with family to ensure safety measures were put in place;
    - Requesting an administrative review to ensure sibling safety;
    - Commending a thorough investigation;
    - Requesting OKDHS request the Oklahoma State Bureau of Investigation investigate a death;
    - Recommending grief counseling be offered in every death investigation and documentation of such;
    - Requesting an administrative review for possible amendment of investigative finding;
    - Requesting explanation on how two cases were connected;
    - Requesting information on OKDHS's plan for addressing apparent backlog of investigations;
    - Expressing the CDRB's concern with the Department's handling of referrals prior to the death and the status of mother's compliance with Family Centered Services case;
    - Making a formal referral on a death that was not referred to OKDHS/CW;
    - Requested further efforts be conducted to locate missing file;
    - Addressing the CDRB's concern for lack of follow through on appropriateness of placement of a child;
    - Inquiring as to the status of a child care home;
    - Inquiring as to why an alleged perpetrator had access to a near death victim;
    - Expressing CDRB's opinion that referral was inappropriately screened out.
    - Requesting policy on enforcement of Team Decision Making meeting, approval process for

Board Actions and Activities

pyschological medication for children in custody, INT hearing procedures, and copies of forms used to submit information to the courts;
    - Requesting Final Determination;
    - Recommending procedure be implemented to assure referrals are case connected immediately upon assignment;
    - Expressing CDRB's opinion that the handling of the family's entire case was inadequate.
- Thirteen letters to District Attorneys: inquiring if charges were filed, requesting review of a case for possible charges; requesting promoted use of the Centers for Disease Control's Sudden Unexpected Infant Death Investigation (CDC SUIDI) protocols; requesting promoted use of joint response by law enforcement and OKDHS/CW; advising of amended autopsy and requesting consideration of charges; inquiring why an alleged perpetrator had access to a near death victim; and requesting caregivers be polygraphed.
- Fourteen letters to law enforcement agencies: recommending increased thoroughness of child death investigations and/or utilization of the CDC SUIDI protocols; recommending policies and procedures include notification to OKDHS/CW of unexpected child deaths; inquiring as to why two potential witnesses were not interviewed; commending the use of toxicology screen on caregiver; requesting policies and procedures for sharing investigative reports; recommending a written record be maintained when responding to child death scenes; inquiring if additional records were available; recommending all unattended child deaths be investigated; and requesting caregivers be polygraphed.
- Four letters to the Oklahoma Commission on Children and Youth (OCCY): requesting result of case referred to the Office of Juvenile System Oversight (OJSO); requesting OCCY subpoena school records; referring two cases to the OJSO for review of OKDHS/CW's involvement with the case, status of a foster home, and appropriateness of patient/therapist relationship.
- Five letters to hospitals: recommending policies and procedures include notification to law enforcement and/or OKDHS/CW of unattended/unexpected child deaths and that documentation of such be included on the post-mortem checklist; recommending behavioral health unit have specific policies and procedures in place for making official referrals to OKDHS/CW in cases of suspected abuse and/or neglect; and recommending behavioral health unit increase training of professionals in the assessment and treatment of childhood Post Traumatic Stress Disorder and integration of trauma-focused treatment into inpatient program for youth with trauma related symptomology.
- Letter to the Speaker of the House, the President Pro Tem, the Chairs of the Appropriations Committee of the Oklahoma State Senate and House of Representatives expressing the need for an upgraded facility for the Office of the Chief Medical Examiner.
- Joint letter with the Domestic Violence Fatality Review Board to author of House Bill 1063 voicing both Board's support for home visitation programs.
- Letter to the District Attorney's Council requesting assistance with unanswered inquiries.
- Letter to involved judges regarding the CDRB's concern with lack of follow through by the courts on appropriateness of child's placement.
- Letter to private attorney inquiring as to why an alleged perpetrator had access to a near death victim.
- Letter to the Department of Public Safety advising them of a traffic fatality that was not investigated by law enforcement.
- Follow up correspondence to various entities (Juvenile Bureau, private water park, hospital, fire department, Oklahoma Highway Patrol) regarding lack of response to the CDRB's inquiries.

Cases Closed 2013

The Oklahoma Child Death Review Board is comprised of five review teams. The total number of deaths reviewed and closed in 2013 by all five teams is 278. The year of death for these cases ranged from 2005 to 2013.

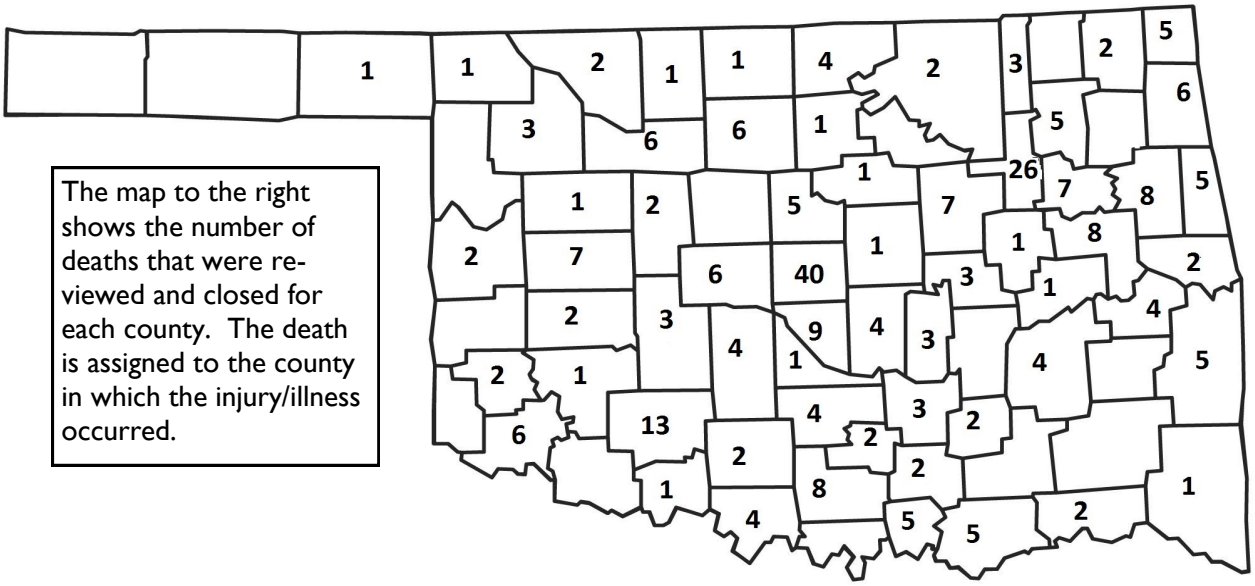
2013 Deaths Reviewed		
Manner	**Number**	**Percent**
Accident	97	34.9%
Homicide	33	11.9%
Natural	24	8.6%
Suicide	21	7.6%
Unknown	103	37.1%

Race		
African American	35	12.6%
American Indian	47	16.9%
Asian	2	0.7%
Multi-race	27	9.7%
White	167	60.1%

Gender	Number	Percent
Males	185	66.5%
Females	93	33.5%

Ethnicity	Number	Percent
Hispanic (any race)	23	8.3%
Non-Hispanic	255	91.7%

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.



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 Oklahoma Department of Human Services (OKDHS) 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 OKDHS.

The manner of death for the seven children in foster care include: one accident, one suicide, one homicide and four undetermined.

Additionally, there were 24 (8.6%) cases that had an open Child Welfare case at the time of death. Those manners of death include: one natural, four accident, one suicide, three homicides, and 15 undetermined.

Number of Cases with Previous Involvement in Selected State Programs

Agency	Number	Percent of All Deaths
Oklahoma Health Care Authority	216	77.7%
OKDHS—TANF	178	64.0%
OKDHS - Child Support Enforcement	128	46.0%
OKDHS - Child Welfare	91	32.7%
OKDHS - Food Stamps	27	9.7%
OKDHS - Disability	24	8.6%
Office of Juvenile Affairs	19	6.8%
OKDHS - Foster Care	7	2.5%
OKDHS - Child Care Assistance	3	1.1%
OSDH - Children First	3	1.1%
OKDHS - Emergency Assistance	0	N/A
OSDH - Office of Child Abuse Prevention	0	N/A

Accidents

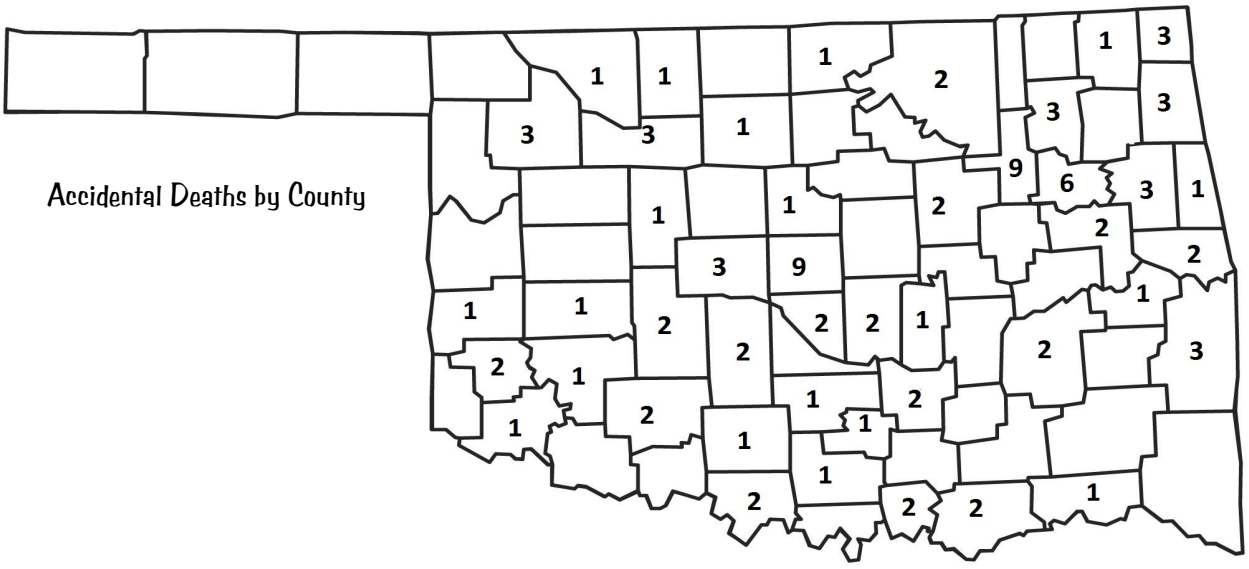
The Board reviewed and closed 97 deaths in 2013 whose manner of death was ruled Accident, also known as Unintentional Injuries. Vehicular deaths continue to be the top mechanism of death for this category.

Mechanism of Death		
Type	**Number**	**Percent**
Vehicular	43	43.2%
Drowning	23	24.2%
Fire	10	10.5%
Asphyxia	6	6.3%
Tornado*	5	5.3%
Firearm	5	5.3%
Poisoning/O.D.	3	3.1%
Crush	1	1.1%
Exposure	1	1.1%

Race		
African American	8	8.2%
American Indian	15	15.5%
Multi-race	8	8.2%
White	66	68.1%

Ethnicity	Number	Percent
Hispanic (any race)	9	9.3%
Non-Hispanic	88	90.7%

Gender	Number	Percent
Males	65	67.0%
Females	32	33.0%



Homicides

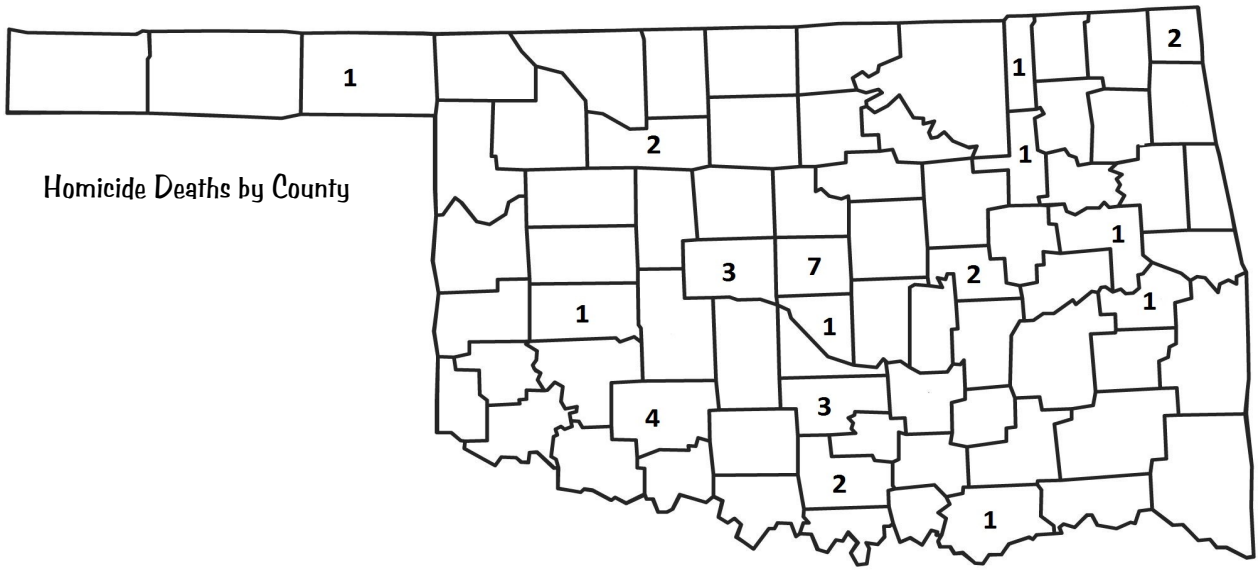
The Board reviewed and closed 33 deaths in 2013 whose manner of death was ruled Homicide.
Nine (27.3%) occurred as a result of domestic violence related family annihilations.

Mechanism of Death		
Method	**Number**	**Percent**
Abusive Trauma	13	39.4%
Firearm	11	33.3%
Asphyxia	4	12.1%
Stabbed	2	6.1%
Assault (not abuse)	1	3.0%
Starvation	1	3.0%
Fire	1	3.0%

Race		
African American	6	18.2%
American Indian	3	9.1%
Asian	1	3.0%
Multi-Race	8	24.2%
White	15	45.5%

Ethnicity	Number	Percent
Hispanic (any race)	4	12.1%
Non-Hispanic	29	87.9%

Gender	Number	Percent
Males	23	69.7%
Females	10	30.3%



Homicide Deaths by County

Naturals

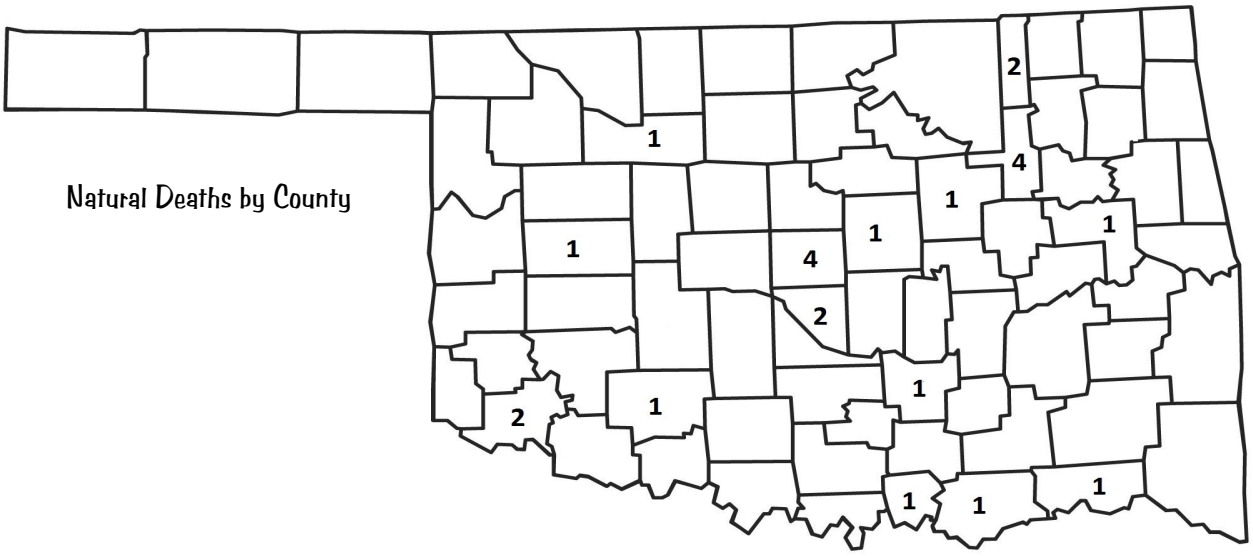
The Board reviewed and closed 24 deaths in 2013 whose manner of death was ruled Natural.

Mechanism of Death		
Illness/Disease	**Number**	**Percent**
SIDS	8	33.3%
Cardiovascular	3	12.5%
Pneumonia	3	12.5%
Asthma	2	8.3%
Congenital Anomaly	2	8.3%
Neurological	1	4.2%
Obstructive Tonsillar Hypertrophy	1	4.2%
Prematurity	1	4.2%
Rocky Mountain Spotted Fever	1	4.2%
Sepsis	1	4.2%
Sickle Cell Disease	1	4.2%

Race		
African American	5	20.8%
American Indian	2	8.3%
Asian	1	4.2%
Multi-Race	4	16.7%
White	12	50.0%

Ethnicity	Number	Percent
Hispanic (any race)	3	12.5%
Non-Hispanic	21	87.5%

Gender	Number	Percent
Males	11	45.8%
Females	13	54.2%



Suicides

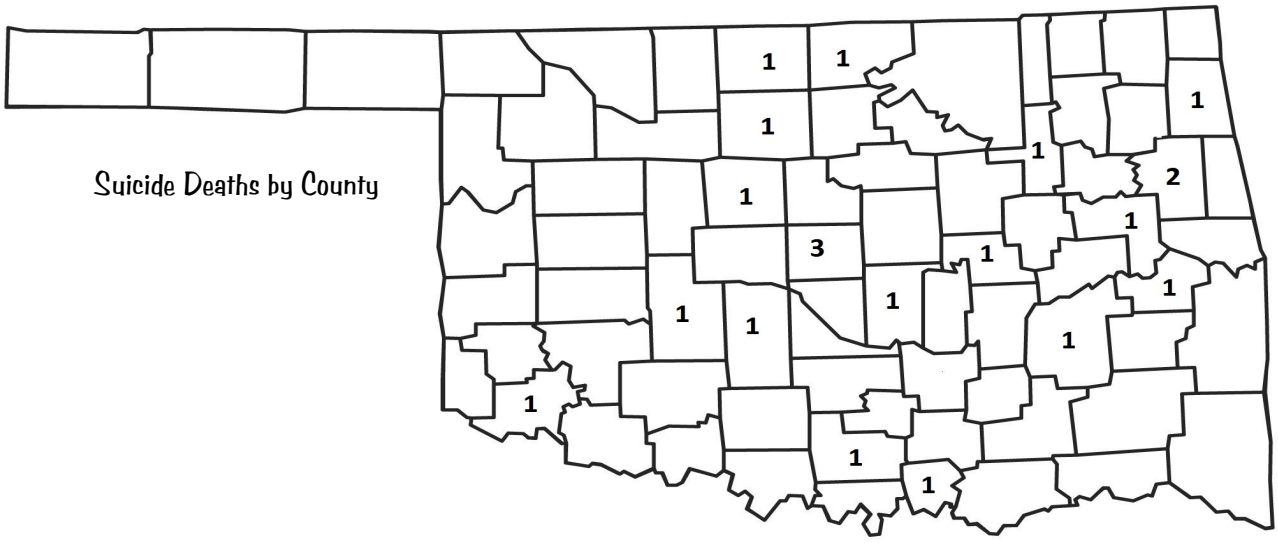
The Board reviewed and closed 21 deaths in 2013 whose manner of death was ruled Suicide.
Seven (33.3%) were noted to have problems in school, in 12 (57.1%) cases this information was not collected.
Eight (38.1%) were noted to have had previous mental health treatment, in 11 (52.4%) cases this information was not collected.
Six (28.6%) were receiving mental health services at the time of death, in 11 (52.4%) cases this information was not collected.
Three (14.3%) were noted to be on medication for mental health at the time of death, in 13 (61.9%) cases this information was not collected.
Five (23.8%) were noted to have a history of substance abuse, in 12 (57.1%) cases this information was not collected.
Thirteen (61.9%) were noted to have a history of child maltreatment.
Nine (42.9%) left a suicide note, in one (4.8%) case this information was not collected.
Four (19.0%) had a history of prior attempts, in eight (38.1%) cases this information was not collected.
Two (9.5%) had a family history of suicide, in 15 (71.4%) cases this information was not collected.

Mechanism of Death		
Method	**Number**	**Percent**
Asphyxia	11	52.4%
Firearm	10	47.6%

Race		
African American	1	4.8%
American Indian	3	14.3%
Multi-Race	2	9.5%
White	15	71.4%

Gender	Number	Percent
Males	17	81.0%
Females	4	19.0%

Ethnicity	Number	Percent
Hispanic (any race)	3	14.3%
Non-Hispanic	18	85.7%



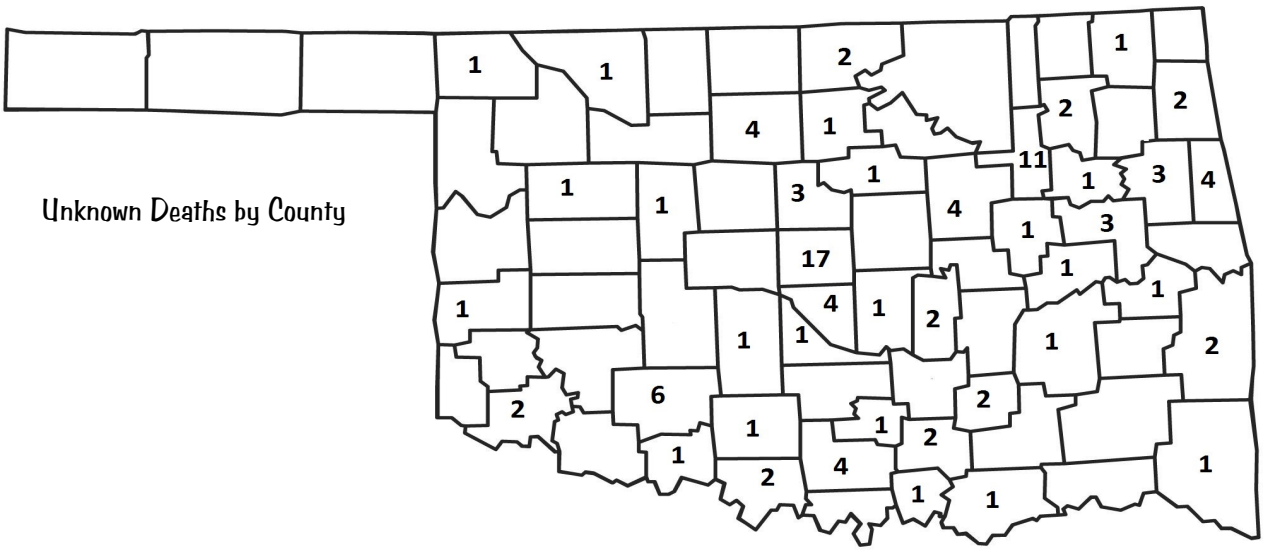
Unknown

The Board reviewed and closed 103 deaths in 2013 ruled Unknown. A death is ruled Unknown by the pathologist when there are no anatomical findings discovered at autopsy to definitively explain the death.
Ninety-nine (96.1%) were two years of age or younger.
Ninety-three (90.3%) were less than one year of age.
Eighty-nine (86.4%) were noted to be related to an unsafe sleep environment and another two (1.9%) were noted to be possibly-related to an unsafe sleep environment.
One (0.97%) was noted to be possibly related to an unsafe sleep environment but also had congenital malformations that may have also contributed to the death.
Three (2.9%) were suspicious for inflicted trauma.
One (0.97%) was suspicious for inflicted trauma but also drug toxicity related.
One (0.97%) was suspicious for inflicted trauma but was also found in an unsafe sleep environment.
Three (2.9%) were related to drug toxicity but the intentionality was unable to be determined.
One (0.97%) was possibly due to prenatal drug exposure.
One (0.97%) was possibly due to prematurity but also could have drowned.
One (0.97%) was possibly due to seizures.

Race		
African American	15	14.6%
American Indian	24	23.3%
Multi-Race	5	4.9%
White	59	57.3%

Ethnicity	Number	Percent
Hispanic (any race)	4	38.8%
Non-Hispanic	99	61.2%

Gender	Number	Percent
Males	69	67.0%
Females	34	33.0%



Traffic Related Deaths

The Board reviewed and closed 43 accidental deaths in 2013 related to traffic.
In the two motorcycle deaths, one was wearing a helmet.
In the two ATV deaths, one was wearing a helmet.

Vehicle of Decedent		
Vehicle	**Number**	**Percent**
Car	12	27.9%
SUV	10	23.3%
Pick-up	9	20.9%
Pedestrian	6	13.9%
All-Terrain Vehicle	2	4.7%
Motorcycle	2	4.7%
Van	2	4.7%

Activity of Decedent		
Position	**Number**	**Percent**
Front Passenger	7	16.3%
Rear Passenger	13	30.2%
Operator	14	32.6%
Pedestrian	6	13.9%
Unknown Passenger Placement	3	7.0%

Contributing Factors		
Factor	**Number**	**Percent**
Speeding	13	30.2%
Drug/Alcohol Use	6	14.0%
Driver Distraction	4	9.3%
Reckless Driving	3	7.0%
Driver Inexperience	3	7.0%
Driver Fatigue	2	4.7%

Use of Safety Restraints		
Seatbelt/Car Seat Use	**Number**	**Percent**
Properly Restrained	9	27.3%
Not Properly Restrained	24	72.7%
Not Applicable	10	-

Race		
African American	4	9.3%
American Indian	11	25.5%
Multi-race	2	4.7%
White	26	60.5%

Ethnicity	Number	Percent
Hispanic (any race)	5	11.6%
Non-Hispanic	38	88.4%

Gender	Number	Percent
Males	28	65.1%
Females	15	34.9%

Drowning Deaths

The Board reviewed and closed 23 accidental deaths in 2013 due to drowning. One (4.3%) of the drowning victims had a personal floatation device available to them. Four (17.4%) were one year of age or younger.

Location of Drowning		
Location	**Number**	**Percent**
Private, Residential Pool	14	60.9%
Open Body of Water (i.e. creek, river, pond, lake)	7	30.4%
Bathtub	2	8.7%

Race		
African American	2	8.7%
American Indian	2	8.7%
Multi-Race	4	17.4%
White	15	65.2%

Ethnicity	Number	Percent
Hispanic (any race)	2	8.7%
Non-Hispanic	21	91.3%

Type of Residential Pool (N=14)		
Type of Pool	**Number**	**Percent**
Above Ground	9	64.3%
In Ground	5	35.7%

Gender	Number	Percent
Males	16	69.6%
Females	7	30.4%

Type of Open Body of Water (N=7)		
Open Body	**Number**	**Percent**
Lake	4	57.1%
River	2	28.6%
Creek	1	14.3%

Sleep Related Deaths

The Board reviewed and closed 103 deaths that were related to sleep environments. These include unintentional asphyxiations, Sudden Infant Death Syndrome, and Unknown manners of death where the sleep environment was a possible contributor to the death.

Eleven (10.7%) deaths occurred when mother fell asleep during feeding (6 bottle, 4 breast, 1 unknown). Only 18 (16.5%) of these deaths occurred in a sleep space designed for infant sleep (i.e. crib/bassinette/port-a-crib), while sixty-two (60.2%) had a crib/bassinette/port-a-crib available in the home.

Thirty (29.1%) were exposed to second hand smoke but information is unknown for 67 (65.0%) cases.

Manner of Death for Sleep Related Deaths

Manner	Number	Percent
Accidental	6	5.8%
Natural (SIDS)	8	7.8%
Undetermined	89	86.4%

Position of Infant When Placed to Sleep

Position	Number	Percent
On Back	34	33.0%
On Side	18	17.5%
On Stomach	27	26.2%
Unknown*	24	23.3%

Position of Infant When Found

Position	Number	Percent
On Back	23	22.3%
On Side	38	36.9%
On Stomach	8	7.8%
Unknown*	34	33.0%

Sleeping Arrangement of Infant

Sleeping Arrangement	Number	Percent
Alone	43	41.7%
With Adult and/or Other Child	60	58.3%

Race

African American	18	17.5%
American Indian	22	21.4%
Multi-race	6	5.8%
White	57	55.3%

Ethnicity	Number	Percent
Hispanic (any race)	7	6.8%
Non-Hispanic	96	93.2%

Gender	Number	Percent
Males	66	64.1%
Females	37	35.9%

Sleeping Location of Infant

Location	Number	Percent
Adult Bed	66	64.1%
Crib	14	13.6%
Bassinette	4	3.9%
Couch	9	8.7%
Chair	3	2.9%
Playpen	2	1.9%
Car Seat	2	1.9%
Other	3	2.9%

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

Firearm Deaths

The Board reviewed and closed 25 deaths in 2013 due to firearms.

Manner of Death for Firearm Victims		
Manner	**Number**	**Percentage**
Homicide	11	44.0%
Suicide	10	40.0%
Accident	4	16.0%

Race		
African American	3	23.5%
Multi-Race	1	4.0%
White	21	84.0%

Type of Firearm Used		
Type of Firearm	**Number**	**Percent**
Handgun	16	64.0%
Hunting Rifle	6	24.0%
Shotgun	2	8.0%
Unknown	1	4.0%

Ethnicity	Number	Percent
Hispanic (any race)	3	12.0%
Non-Hispanic	22	88.0%

Gender	Number	Percent
Males	5	20.0%
Females	20	80.0%

Fire Deaths

The Board reviewed and closed 10 deaths in 2013 due to fires. One (10.0%) died of thermal injury; eight (80.0%) died of smoke inhalation; and one (10.0%) died from a combination of smoke inhalation and thermal injuries.

Fire Ignition Source		
Source	**Number**	**Percent**
Space Heater	4	40.0%
Cigarette	2	20.0%
Unknown	4	40.0%

Working Smoke Detector Present		
Detector	**Number**	**Percent**
Yes	1	10.0%
No	8	80.0%
Unknown	1	10.0%

Race		
American Indian	1	10.0%
Multi-Race	1	10.0%
White	8	8.0%

Ethnicity	Number	Percent
Hispanic (any race)	0	-
Non-Hispanic	10	100%

Gender	Number	Percent
Males	5	50.0%
Females	5	50.0%

Abuse/Neglect Deaths

The Board reviewed and closed 60 cases where it was determined that child maltreatment (abuse or neglect) caused or contributed to the death.
Twenty-six (43.3%) cases were ruled abuse, 34 (56.7%) cases were ruled neglect, and four (6.7%) were ruled both.
Twenty-four (40.0%) cases had a previous referral for alleged child maltreatment; eight (13.3%) had an open referral at the time of death.

Twenty-eight (46.7%) cases had at least one caregiver with child welfare history as an alleged perpetrator.
Twenty-four (40.0%) had at least one caregiver with a history of substance abuse.
Twenty (33/3%) had a caregiver noted to have a history of domestic violence as a victim.
Fifteen (25.0%) cases had a caregiver noted to have a history of domestic violence as a perpetrator.

Manner of Death for Abuse/Neglect Cases		
Manner	**Number**	**Percent**
Accident	19	31.7%
Homicide	23	38.3%
Natural	4	6.7%
Undetermined	14	23.3%

Race		
African American	4	6.7%
American Indian	12	6.5%
Asian	1	1.7%
Multi-race	12	20.0%
White	31	51.7%

Gender	Number	Percent
Males	42	70.0%
Females	18	30.0%

Ethnicity	Number	Percent
Hispanic (any race)	4	6.7%
Non-Hispanic	56	93.3%

Near Deaths

The Board reviewed and closed 29 near death cases in 2013. 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.
Eighteen (62.1%) were substantiated by OKDHS as to having been abuse and/or neglect.
Eleven (37.9%) had a previous referral that was investigated by OKDHS, three (10.3%) were confirmed.
Twelve (41.4%) had a sibling with a previous child welfare investigation, six (20.7%) were confirmed.

Injuries in Near Death Cases		
Injury	**Number**	**Percent**
Physical Abuse	15	51.7%
Poison/Overdose	4	13.8%
Firearm	2	6.9%
Natural Illness	2	6.9%
Asphyxia	1	3.45%
Crush	1	3.45%
Drowning	1	3.45%
Fall	1	3.45%
Fire/Burn	1	3.45%
Vehicular	1	3.45%

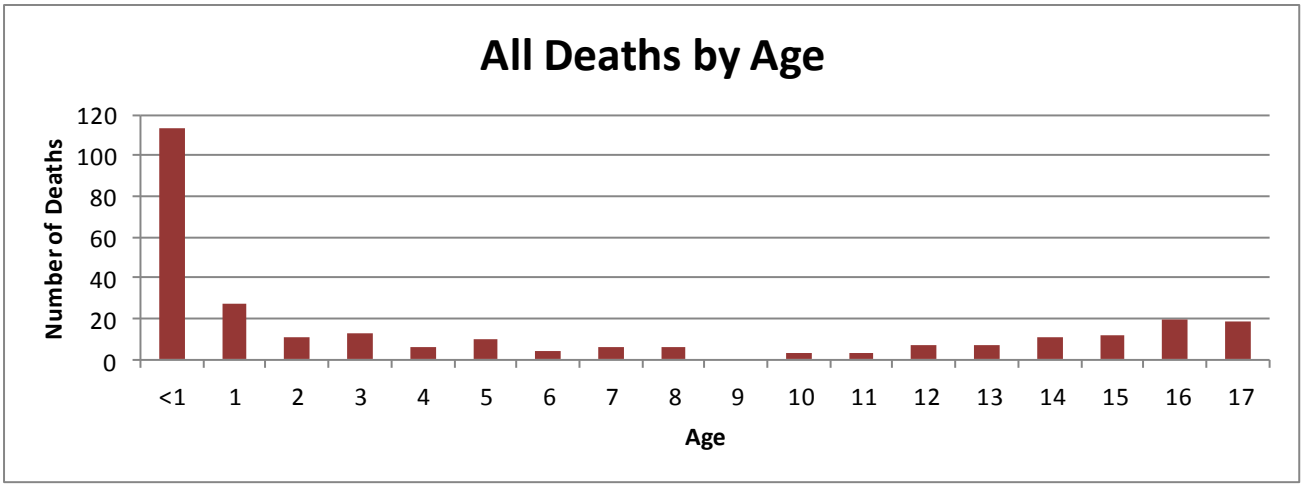
Race		
African American	3	10.3%
American Indian	2	6.9%
White	24	82.8%

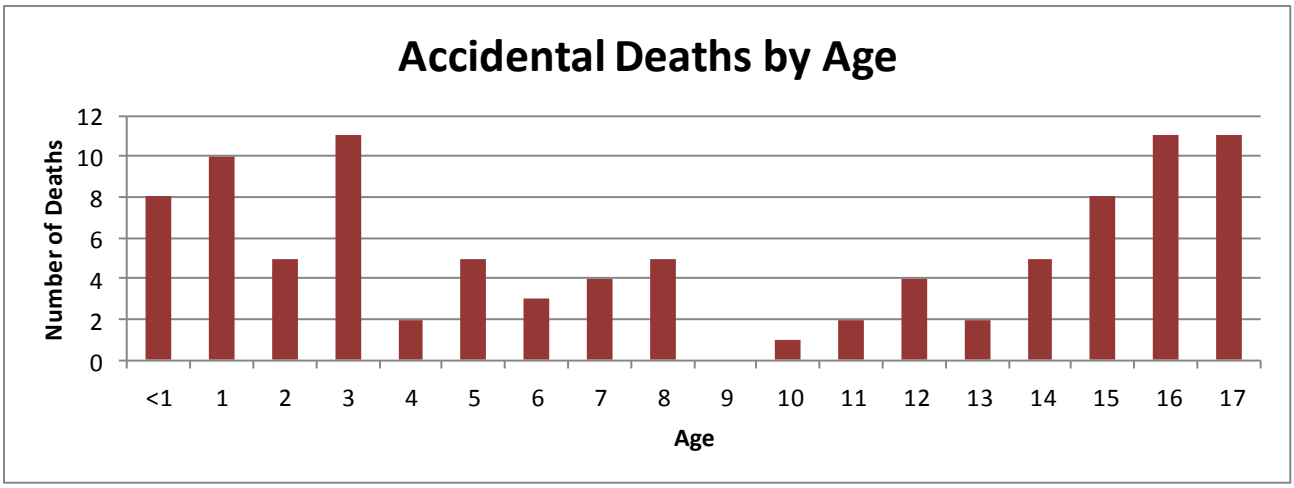
Ethnicity	Number	Percent
Hispanic (any race)	5	17.2%
Non-Hispanic	24	82.8%

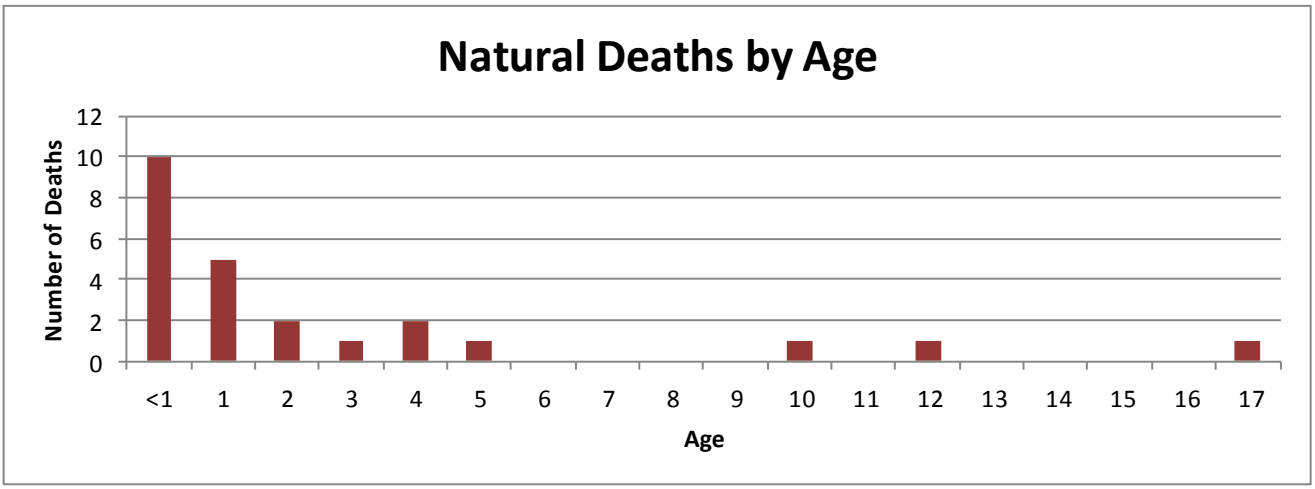
OKDHS Services in Near Death Cases		
Service	**Number**	**Percent**
TANF	26	89.7%
CSE	22	75.9%
Medical	11	37.9%
Food Stamps	0	N/A
Disability	2	6.9%
Foster Care	2	6.9%

Gender	Number	Percent
Males	17	58.6%
Females	12	41.4%

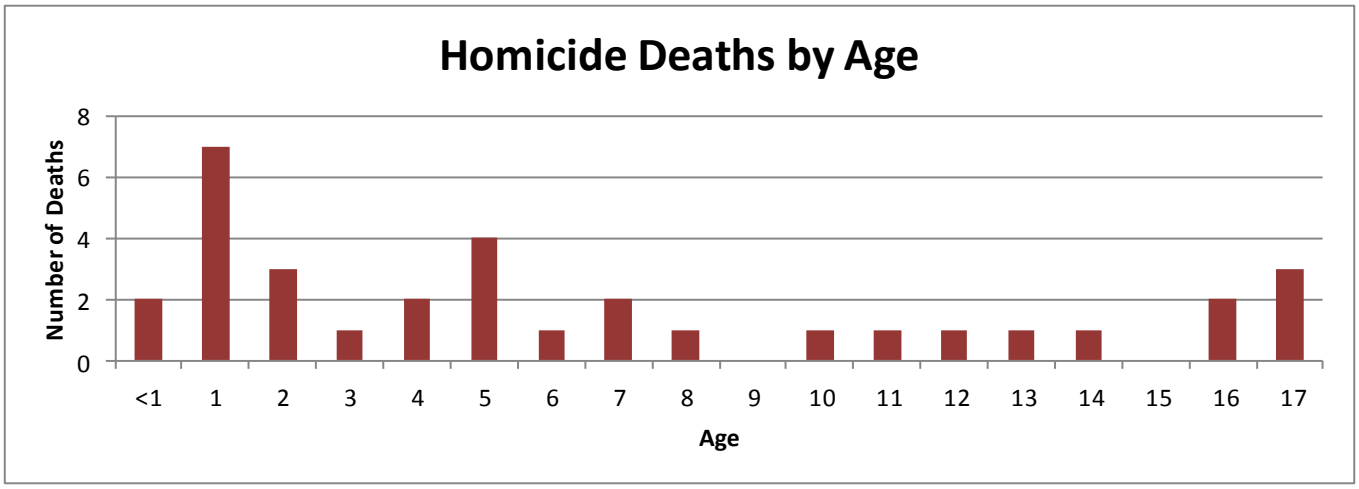
Age of Decedents by Manner

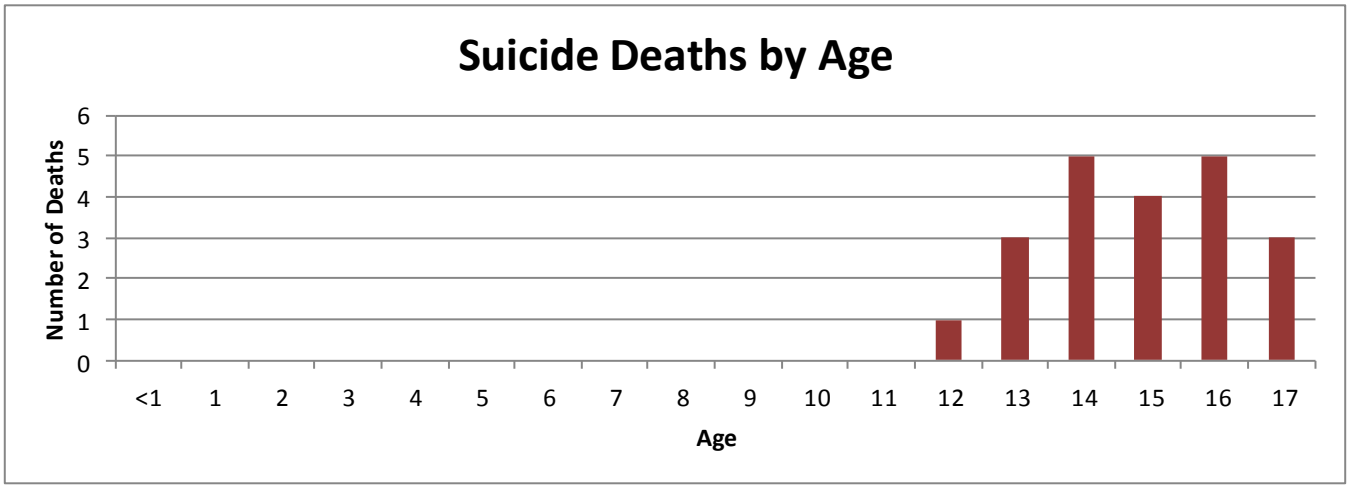


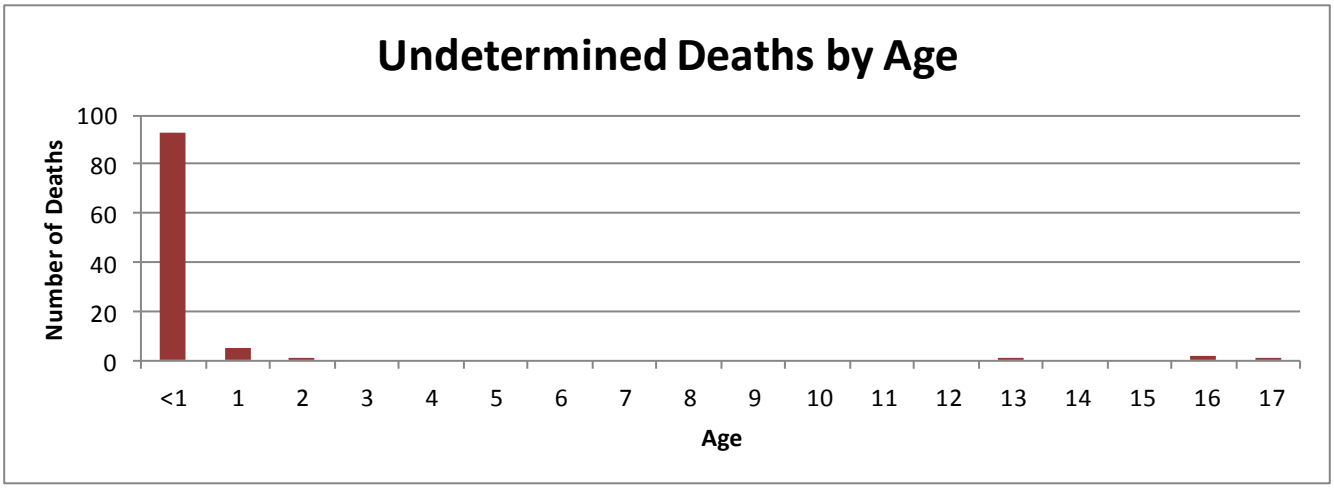




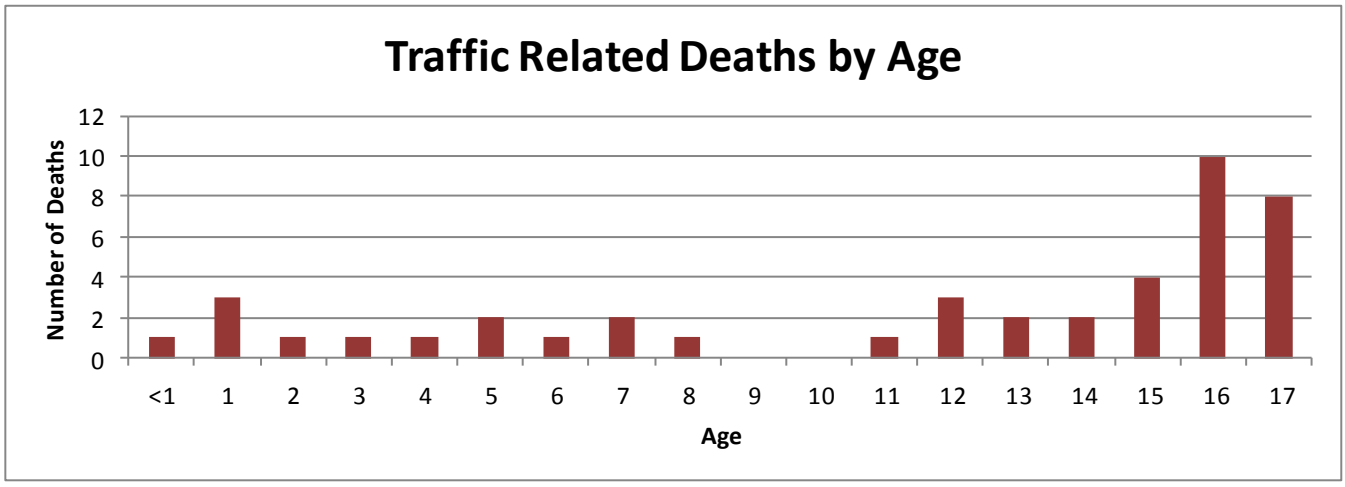
Age of Decedents by Manner

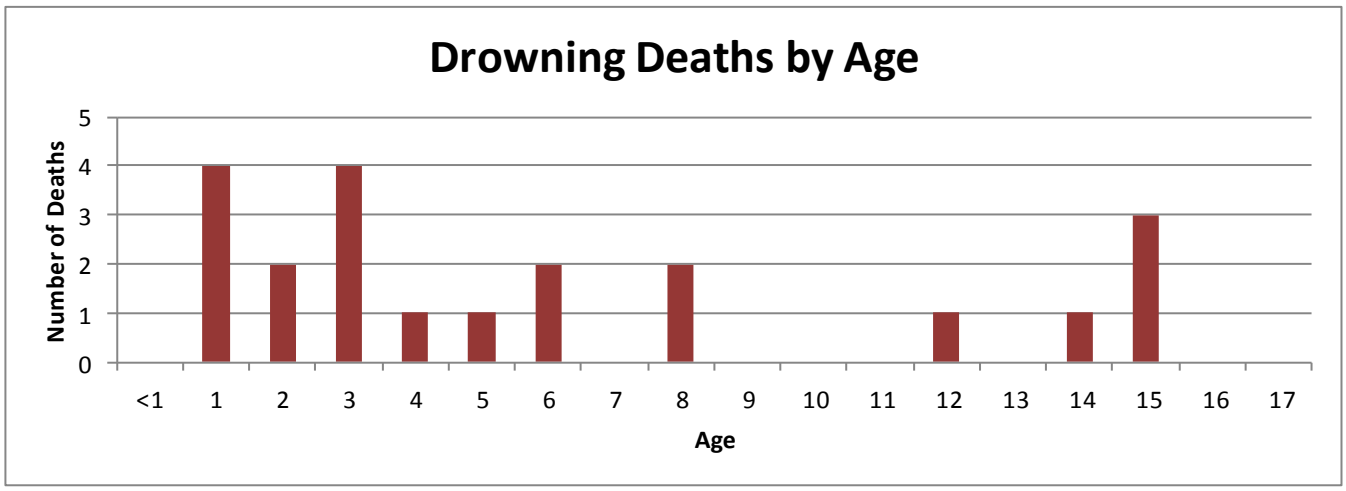


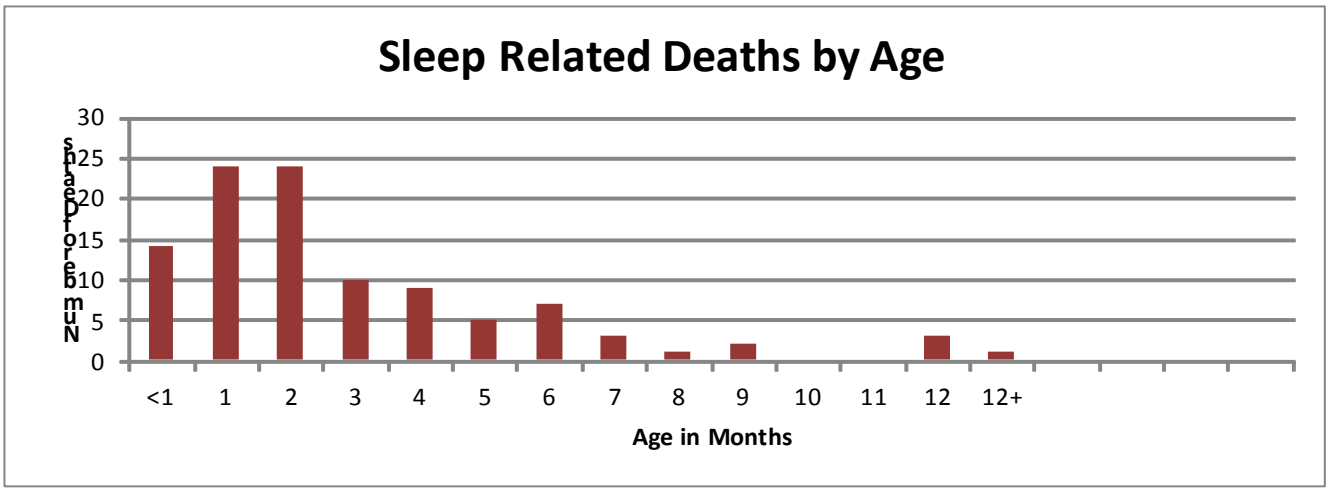




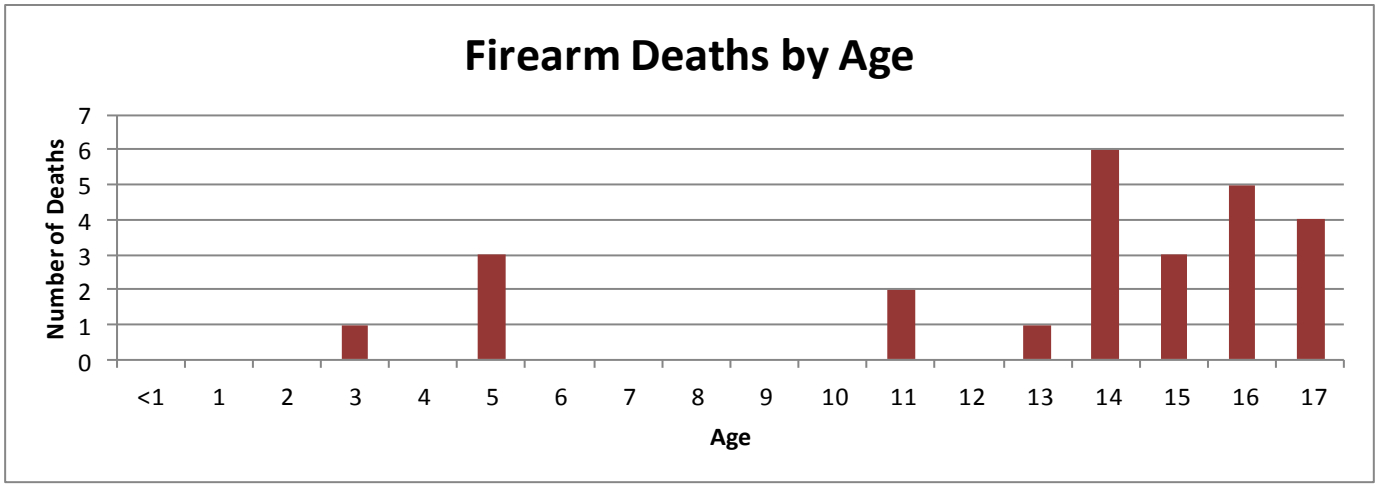
Age of Decedents by Select Causes

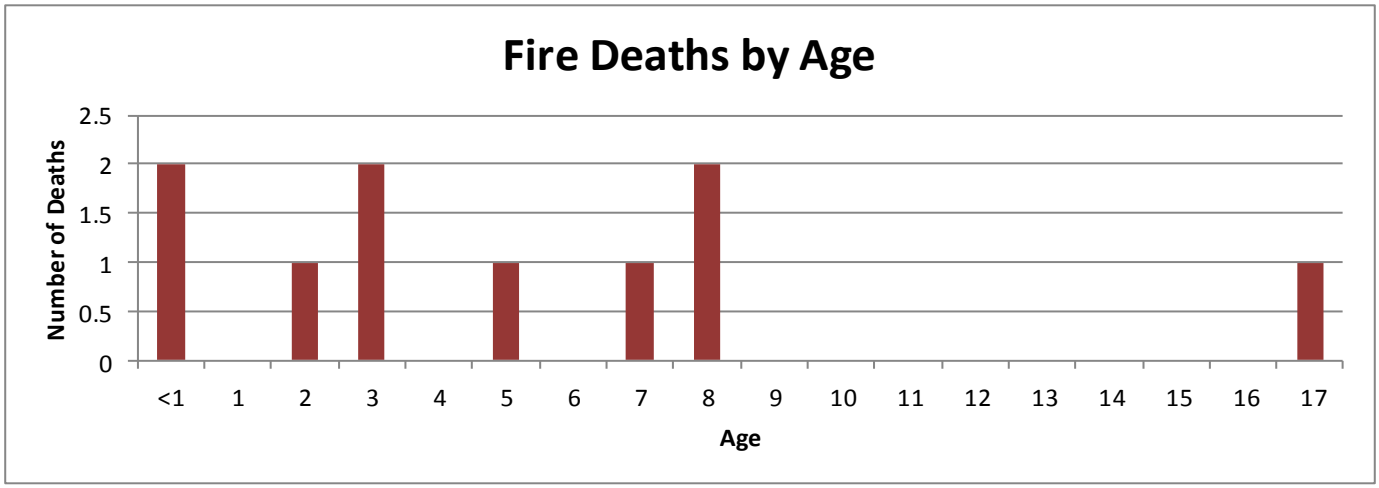


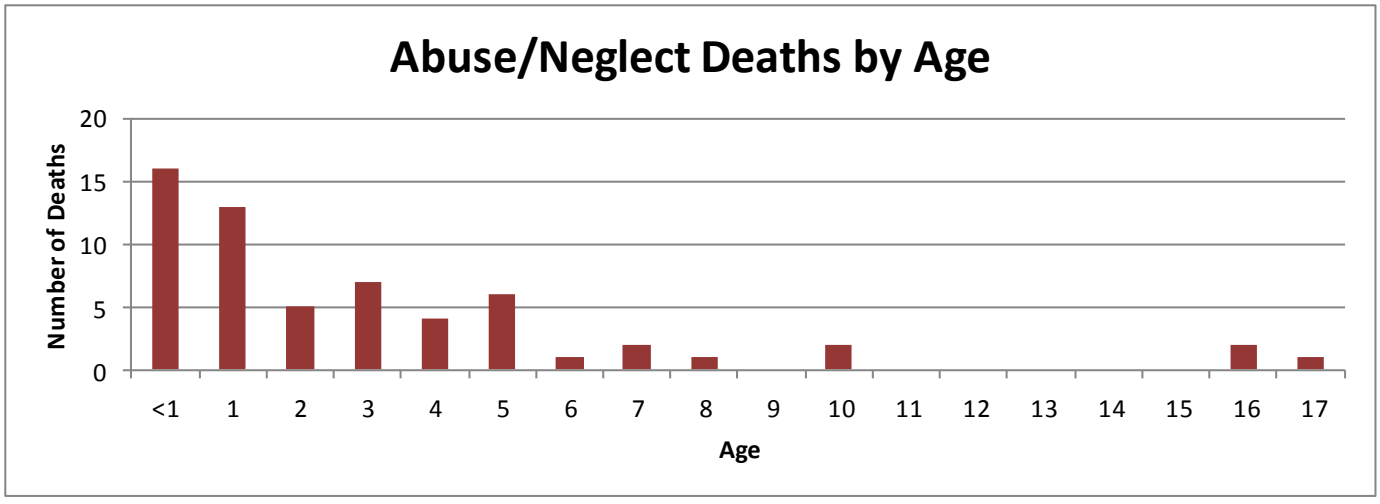




Age of Decedents by Select Causes







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

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