Think. Prevent. Live.

Keep Our Children Safe

The Oklahoma Child Death Review Board
2014 Annual Report

Includes the 2015 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 case reviews:

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 2014 annual recommendations of the Oklahoma Child Death Review Board as submitted to the Oklahoma Commission on Children and Youth.

FISCAL (Legislative)

Those state agencies that serve to safeguard Oklahoma's children require adequate funding in order to perform their duties. Oklahoma needs to make certain tax regulations and reforms are in place that ensure revenue will not be reduced and a budget that can be balanced. A stand-still budget, much less budget cuts, will not provide Oklahoma with the foundation it needs to build capacity nor to provide strong infrastructure, safe communities and healthy, thriving children. Agency improvement and policy changes are ineffective without a financial commitment by the state of Oklahoma to affect positive change.

Office of the Chief Medical Examiner (OCME)

Provide the OCME with funding to continue OCME improvement goals and maintain infrastructure, including but not limited to additional OCME investigators.

- The Board reviewed and closed 112 infant deaths in 2014, of these, 80 (71.4%) had an Undetermined Manner of Death. The Board is of the opinion that had an OCME investigator conducted a more extensive scene investigation, a more definitive Manner of Death may be determined.

The Oklahoma Child Death Review Board (CDRB) supports the OCME's funding request.

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. Stable funding is also necessary to ensure continuity of support services provided by the OKDHS.

- Ninety-five (32.0%) death cases had a child welfare referral prior to the death.
- Sixty (20.2%) death cases were due to abuse and/or neglect.
- Twenty-eight of the 42 near death cases (66.7%) the child maltreatment allegation(s) were substantiated.
- Twenty-seven (64.3%) of the near death cases had a child welfare referral prior to the near death.
- Twenty-nine of the near deaths (69.0%) had a sibling with a child welfare referral prior to the near death.
- Two hundred two (68.0%) of the deaths had accessed assistance through the Temporary Aid for Needy Families (TANF) program; 40 (95.2%) of the near deaths had accessed TANF.
- One hundred thirty-three (44.8%) of the death cases had accessed OKDHS's Child Support Enforcement services; 32 (76.2%) of the near deaths accessed this program.

The CDRB supports OKDHS's funding request of $713,143,886.

Recommendations

Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS)

Provide the ODMHSAS with funding to support the mental health and substance abuse treatment needs of children and caregivers, including ensuring treatment beds for those children whose delinquency is deemed to be in need of mental health treatment.

- Six (4.8%) of the 124 unintentional deaths were due to accidental overdose or acute intoxication.
- Nine (21.4%) of the 42 near deaths were accidental overdoses/acute intoxications.
- Forty-four (14.8%) death cases had at least one caregiver with a history of substance abuse.
- Forty-one (13.8%) had at least one caregiver with a history of being a victim of child maltreatment.
- Twelve (4.0%) had a caregiver with a mental illness.
- Nine (3.0%) were born drug exposed.

While these caregiver and drug exposed infant numbers may seem relatively low, the information is not available on 100% of the cases, therefore, it can be deduced that the numbers are actually higher.

The CDRB supports the ODMHSAS's funding request of $141,104,999.

Oklahoma Health Care Authority (OHCA)

Provide the OHCA with enough funding to provide children and families with medical care, including screening services. One hundred ninety-six (66.0%) death cases were of children who relied on SoonerCare for their medical coverage; 30 (71.4%) of the near death cases had SoonerCare.

The CDRB supports the OHCA's funding request of $120,501,441.

Office of Juvenile Affairs (OJA)

Provide OJA with funding to support juvenile delinquency prevention, reduction and treatment. The CDRB reviewed 20 (6.7%) cases where the child had OJA involvement.

The CDRB supports the OJA's funding request of $17,861,647.

Oklahoma State Department of Health (OSDH)

Provide the OSDH with funding to continue support for injury prevention and infant mortality reduction initiatives.

- One hundred twenty-four deaths (41.8% of the total deaths reviewed and closed) were a result of unintentional injury, with over 50% (69 or 55.6%) associated with motor-vehicles.
- One hundred twelve (37.7%) cases were infant deaths. Although Oklahoma has made some progress in reducing the infant mortality rate (6.8 per 1,000 live births in 2013), we still remain above the national rate (5.96 per 1,000 live births in 2013) and racial disparities are well above the national and state rate (16.5 per 1,000 live births in 2013 for African American infants).

Recommendations

- Eighty-nine deaths (30.0%) were related to unsafe sleeping environments.

The CDRB recommends OSDH's prevention programs continue to be appropriately funded.

- Sixty (20%) death cases were ruled child abuse and/or neglect by the CDRB and 28 (66.7%) of the 42 near death cases were substantiated by OKDHS.

The CDRB support the OSDH's funding request of $18,523,641.

Additionally, the CDRB supports the agency's request for $49,178,000 for a bond initiative to construct a new public health laboratory and retain accreditation and vital public health services. This would also support the efforts of the OCME in its duty to identify manner and cause of death for children.

- In 2013, the OSDH Public Health Laboratory received about 194,000 specimens and ran about 661,000 tests, including newborn screenings for genetic disorders for all babies born in Oklahoma. Additionally, the lab conducts tests for respiratory viruses and foodborne illnesses that can cause outbreaks.

LEGISLATION

The CDRB reviewed and closed 69 traffic related deaths in 2014, with 51 victims being in a vehicle (i.e. does not include pedestrian/bicycle/ATV/trailer bed deaths). Of these 51, almost half (49%) were not utilizing a safety restraint. Twenty (39.2%) were children under 4' 9" (or between the ages of 4 and 8 whose height is unknown) who were not in a booster seat; six of these twenty were in seat belts.

- Expand the current seat restraint legislation to include backseat passengers through age 17.
- Increase the fine for those aged 13 and over not using seat restraints to $100 for the first offense and $500 for subsequent offenses.
- Enact legislation banning the use of hand-held devices while operating a motor vehicle and the use to be a primary offense.
- Enhance legislation to require children up to age two to be in a rear facing car seat.
- Enhance car seat legislation to require children age two to four to be in a forward facing car seat.
- Enhance booster seat legislation to require children over 4 years of age and under 4' 9" to be in a booster restraint.

POLICY

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 CDRB reviewed and closed 89 (30%) deaths related to unsafe sleep environments in 2014.
- All hospitals should have a written policy to notify the OKDHS Child Welfare division of unexpected child deaths.
- All birthing hospitals should have a written policy to implement, with fidelity, the Period of *PURPLE*® Crying abusive head trauma prevention program.

Recommendations

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). The CDRB reviewed and closed 27 (9.0%) cases of Suicide and a majority did not have this information collected.
- Enforce child passenger safety laws, including appropriate seat restraint use. The CDRB reviewed and closed 69 cases that involved motor-vehicles, 51 of which were applicable to seat restraint use, and found seat restraint use to be 49.0%.
- Adopt the Center for Disease Control's Sudden Unexpected Infant Death Investigation (SUIDI) protocols, including scene recreation and use of photographs. The CDRB reviewed and closed 112 (37.7%) infant death cases in 2014; of these 112 infant deaths, 80 (71.4%) had an Undetermined Manner of Death. The Board is of the opinion that with the utilization of these protocols, a more definitive Manner of Death may be determined and prevention avenues may be identified.
- Adopt a policy to notify the OKDHS Child Welfare division of unexpected child deaths.
- All child death investigations should be worked jointly with OKDHS/Child Welfare.

Office of the Chief Medical Examiner

- Adopt the Center for Disease Control's SUIDI protocols. As stated previously, the CDRB reviewed and closed 112 (37.7%) infant death cases in 2014; of these, 80 (71.4%) had an Undetermined Manner of Death. The Board is of the opinion that with the utilization of these protocols, a more definitive Manner of Death may be determined and prevention avenues identified.
- Adopt a policy to notify the OKDHS Child Welfare division of unexpected child deaths.
- Adopt a policy that ensures all drug-exposed newborns that die within the first 30 days of life have the drug-exposure listed in the Report of Autopsy by Medical Examiner.

Oklahoma Department of Human Services

- Adopt a policy directing workers to connect a referral to a case number upon assignment of the referral.
- Ensure all children in custody have a Trauma Focused Cognitive Behavioral Therapist.
- All child death investigations should be worked jointly with Law Enforcement.
- Public operated shelters in Tulsa and Oklahoma City should not be closed without a comprehensive plan and resources in place to meet the needs of children who are removed and housed in the two shelters.

Oklahoma Department of Mental Health and Substance Abuse Services

- Create a Child Welfare liaison position to ensure children in custody and their caregivers are receiving appropriate mental health and substance abuse services.
- Extend the number of Trauma Focused Cognitive Behavioral Therapists available for children and families.

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.
- Fifteen letters to the Office of the Chief Medical Examiner
    - Three letters requesting a review of the case for possible amendment of Manner and/or Cause of Death.
    - Five letters requesting clarification of Report of Autopsy content.
    - Two letters recommending the OCME report unexpected child deaths to the Oklahoma Department of Human Services/Child Welfare Division and/or documentation of the assigned referral number.
    - Two letters requesting documented findings be included in the Other Significant Medical Conditions section of the Report of Investigation by Medical Examiner.
    - One letter requesting an update on the agency's policy regarding diagnosis sleep-related deaths.
    - One letter recommending all drug-exposed newborns that die within the first 30 days of life have the drug-exposure listed in the Other Significant Medical Conditions of the Report of Investigation by Medical Examiner.
    - One letter advising a previous recommendation regarding the OCME had been rescinded.

- Twenty-three letters to the Oklahoma Department of Human Services
    - One letter requesting referrals are connected to a case number upon receipt.
    - One letter recommending DHS educate workers on the heightened risk of additional suicide for relatives that have experienced a suicide of a family member, the need for mental health referrals for these families and recommending ensuring the referral is followed through on by the family.
    - One letter requesting a copy of the family's safety plan.
    - One letter inquiring as to the safety of a surviving sibling.
    - One letter inquiring if collaboration with a family's tribe was conducted to ensure services were provided to the family.
    - One letter inquiring what, if any, recommendations from the Office of Juvenile System Oversight, Oklahoma Commission on Children and Youth, were implemented.
    - One letter inquiring as to the delay in completing a death investigation and its associated Report to District Attorney.
    - One letter recommending an internal higher level of review when multiple reports on a child are received.
    - One letter requesting the status of a referral made by the CDRB.
    - Two letters expressing concern for lack of referring suspected crimes to a law enforce-

ment agency when information disclosed during CA/N investigations.
    - One letter expressing concern for policy not being followed regarding victim/alleged perpetrator being interviewed at the same time.
    - One letter requesting clarification of the investigation's findings, as the Report to District Attorney had two different findings documented.
    - Two letters requesting an administrative review of cases.
    - One letter questioning the appropriateness of the monitor in a Family Centered Services case.
    - One letter recommending the Termination of Parental Rights on a surviving sibling.
    - One letter recommending ensuring a family seeks the services that are recommended and documentation of such.
    - One letter requesting clarification of documentation of an investigative finding in the Case Contacts prior to the closing of an investigation.
    - One letter inquiring why a family with previous history was assigned a new case number.
    - One letter recommending specific guidelines for conducting allegations of medical neglect.
    - Two letters of commendation for exceptional investigations.

- Six letters to District Attorneys
    - Four letters inquiring if any charges were brought against person's involved in the case.
    - Two letters requesting additional investigation.

- Two letters to Hospitals
    - One letter recommending a hospital notify the Department of Human Services of an unexpected child death.
    - One letter advising of a missed medical diagnosis

- Nine letters to Law Enforcement Agencies
    - Two letters recommending the use of the CDC's SUIDI protocols.
    - Three letters recommending notifying OKDHS/CW of unexpected child deaths and/or conducting a joint response with OKDHS/CW.
    - One letter inquiring if the case was still open and was it referred to the District Attorney for any charges.
    - One letter recommending more information be collected in suicide investigations.
    - One letter recommending responding to a child death scene and write a report.
    - One letter of commendation for an exceptional investigation.

- Referred one case to the Oklahoma Commission on Children and Youth, Office of Juvenile System Oversight.

- Recommended a physician use the American Academy of Pediatrics' safe sleep guidelines when educating families.

Cases Closed 2014

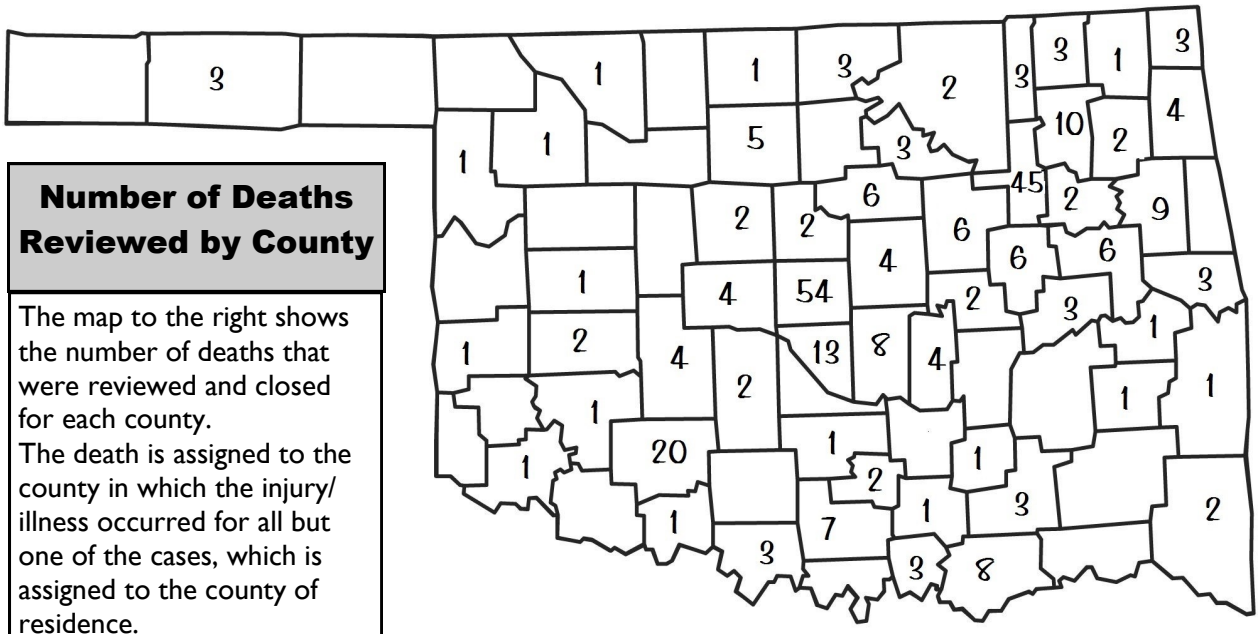
The Oklahoma Child Death Review Board is comprised of five review teams. The total number of deaths reviewed and closed in 2014 by all five teams is 297. The year of death for these cases ranged from 2005 to 2014.

2014 Deaths Reviewed		
Manner	**Number**	**Percent**
Accident	124	41.8%
Homicide	27	9.1%
Natural	30	10.1%
Suicide	27	9.1%
Unknown	89	29.9%

Race		
African American	43	14.5%
American Indian	35	11.8%
Asian	2	0.7%
Multi-race	36	12.1%
White	181	60.9%

Gender	Number	Percent
Males	176	59.3%
Females	121	40.7%

Ethnicity	Number	Percent
Hispanic (any race)	30	10.1%
Non-Hispanic	267	89.9%



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 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.

Additionally, there were 19 (6.4%) cases that had an open Child Welfare case at the time of death. Those manners of death include: five natural, four accident, one homicide, and nine undetermined, as ruled by the Office of the Chief Medical Examiner. There were four children in foster care at the time of death; those manners of death include two natural and two undetermined.

Number of Cases with Previous Involvement in Selected State Programs

Agency	Number	Percent of All Deaths
OKDHS - TANF	202	68.0%
Oklahoma Health Care Authority	196	66.0%
OKDHS - Child Support Enforcement	133	44.8%
OKDHS - Child Welfare	95	32.0%
OKDHS - Food Stamps	31	10.4%
OKDHS - Foster Care	27	9.1%
Office of Juvenile Affairs	20	6.7%
OKDHS - Disability	19	6.4%
OKDHS - Child Care Assistance	2	0.7%
OSDH - Start Right	1	0.3%
OKDHS - Emergency Assistance	1	0.3%
OSDH - Children First	0	-

Accidents

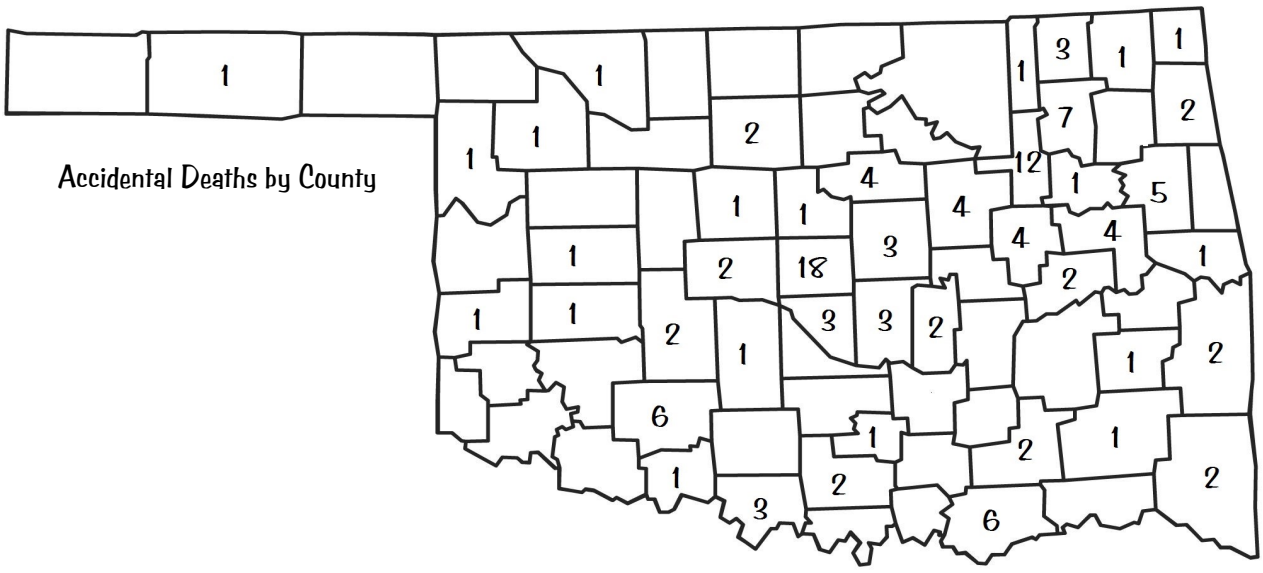
The Board reviewed and closed 124 deaths in 2014 whose manner of death was ruled Accident, also known as Unintentional Injuries. Vehicular deaths continue to be the top mechanism of death for this category.

Mechanism of Death		
Type	**Number**	**Percent**
Vehicular	69	55.7%
Drowning	22	17.8%
Asphyxia	11	8.9%
Fire	6	4.8%
Poisoning/O.D.	6	4.8%
Firearm	4	3.2%
Hyperthermia	2	1.6%
Crush	1	0.8%
Animal Attack	1	0.8%
Unknown	1	0.8%
Fall	1	0.8%

Race		
African American	13	10.5%
American Indian	18	14.5%
Asian	1	0.8%
Multi-race	14	11.3%
White	78	62.9%

Ethnicity	Number	Percent
Hispanic (any race)	12	9.7%
Non-Hispanic	112	90.3%

Gender	Number	Percent
Males	68	54.8%
Females	56	45.2%



Homicides

The Board reviewed and closed 27 deaths in 2014 whose manner of death was ruled Homicide.

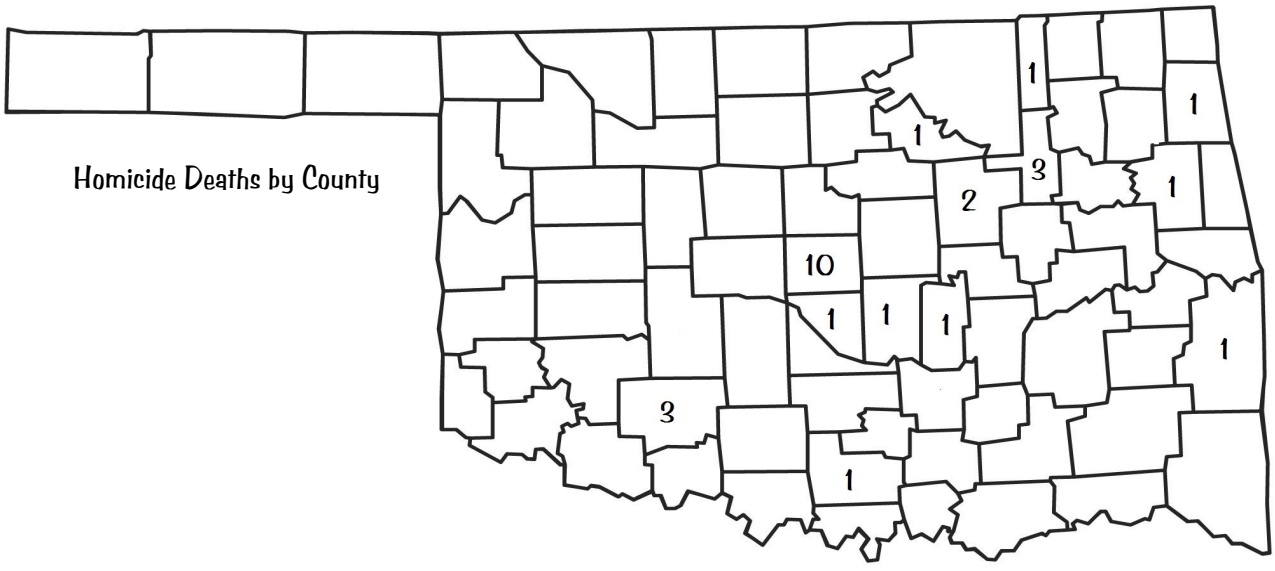
Six of the eight (75.0%) physical abuse homicides were due to abusive head trauma.

Mechanism of Death		
Method	**Number**	**Percent**
Firearm	13	48.1%
Physical Abuse	8	29.6%
Stabbing	2	7.4%
Asphyxia	1	3.7%
Drowning	1	3.7%
Fire	1	3.7%
Unknown	1	3.7%

Race		
African American	5	18.5%
American Indian	4	14.9%
Multi-Race	5	18.5%
White	13	48.1%

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

Gender	Number	Percent
Males	20	74.1%
Females	7	25.9%



Naturals

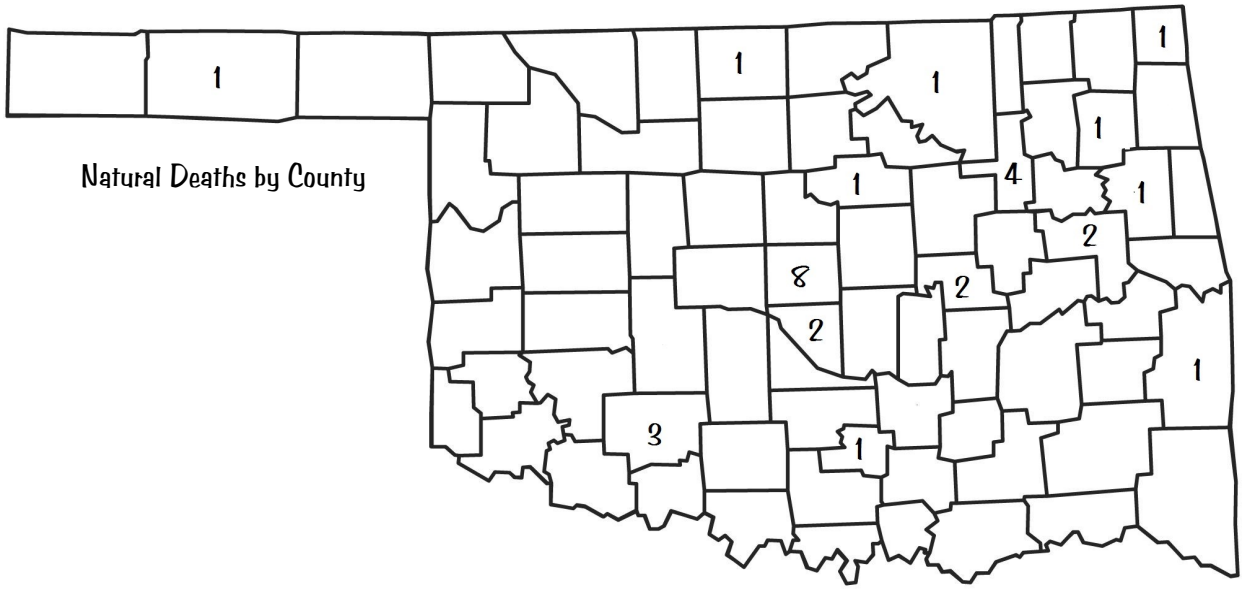
The Board reviewed and closed 30 deaths in 2014 whose manner of death was ruled Natural.

Mechanism of Death		
Illness/Disease	**Number**	**Percent**
Pneumonia	6	20.0%
Congenital Anomaly	5	16.7%
Other Infection	4	13.4%
SIDS	4	13.4%
Asthma	3	10.0%
Other Medical Conditions	3	10.0%
Cardiovascular	1	3.3%
Atelectasis	1	3.3%
Hepatomegaly	1	3.3%
Neurological	1	3.3%
Sepsis	1	3.3%

Race		
African American	9	30.0%
American Indian	2	6.6%
Multi-Race	5	16.7%
White	14	46.7%

Ethnicity	Number	Percent
Hispanic (any race)	6	20.0%
Non-Hispanic	24	80.0%

Gender	Number	Percent
Males	15	50.0%
Females	15	50.0%



Suicides

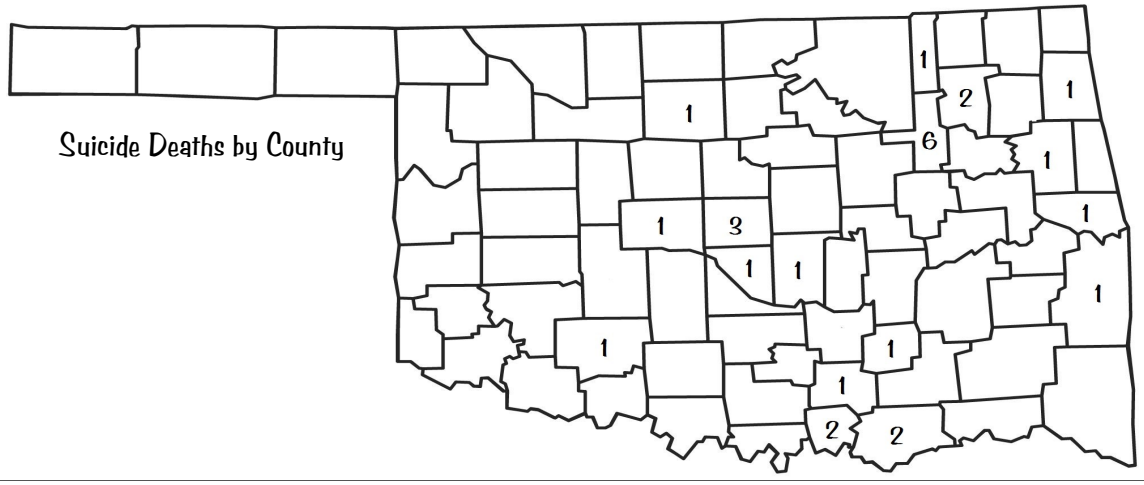
The Board reviewed and closed 27 deaths in 2014 whose manner of death was ruled Suicide.
Ten (37.0%) were noted to have a history of child maltreatment.
Ten (37.0%) had made threats of suicide, in 10 (23.8%) cases this information was not collected.
Nine (33.3%) left a suicide note, in three (11.1%) cases this information was not collected.
Seven (25.9%) were noted to have had previous mental health treatment, in 12 (44.4%) cases this information was not collected.
Seven (25.9%) were noted to have problems in school, in 14 (51.9%) cases this information was not collected.
Six (22.2%) were receiving mental health services at the time of death, in 10 (37.0%) cases this information was not collected.
Six (22.2%) had a history of prior attempts, in 12 (44.4%) cases this information was not collected.
Four (14.8%) were noted to be on medication for mental health at the time of death, in 14 (51.9%) cases this information was not collected.
Three (11.1%) had a family history of suicide, in 21 (77.8%) cases this information was not collected.
Three (11.1%) were noted to have a history of substance abuse, in 15 (55.6%) cases this information was not collected.

Mechanism of Death		
Method	**Number**	**Percent**
Firearm	14	51.9%
Asphyxia	13	48.1%

Gender	Number	Percent
Males	21	77.8%
Females	6	22.2%

Race		
African American	1	3.7%
American Indian	3	11.1%
Asian	1	3.7%
Multi-Race	3	11.1%
White	19	70.4%

Ethnicity	Number	Percent
Hispanic (any race)	0	-
Non-Hispanic	27	100%



Unknown

The Board reviewed and closed 89 deaths in 2014 ruled Unknown. A death is ruled Unknown by the pathologist when there are no anatomical findings discovered at autopsy to definitively explain the death.

Eighty-eight (98.9%) were two years of age or younger.

Eighty (89.9%) were less than one year of age.

Seventy-five (84.3%) were noted to be related to an unsafe sleep environment, with another three (4.6%) noted to be possibly-related to an unsafe sleep environment.

Three (3.4%) were suspicious for inflicted trauma and not related to the sleeping environment.

Two (2.2%) were born prematurely due to maternal drug use.

Two (2.2%) were run over by a motor vehicle but not ruled "Accident" by the Office of the Chief Medical Examiner due to the circumstances surrounding the situations.

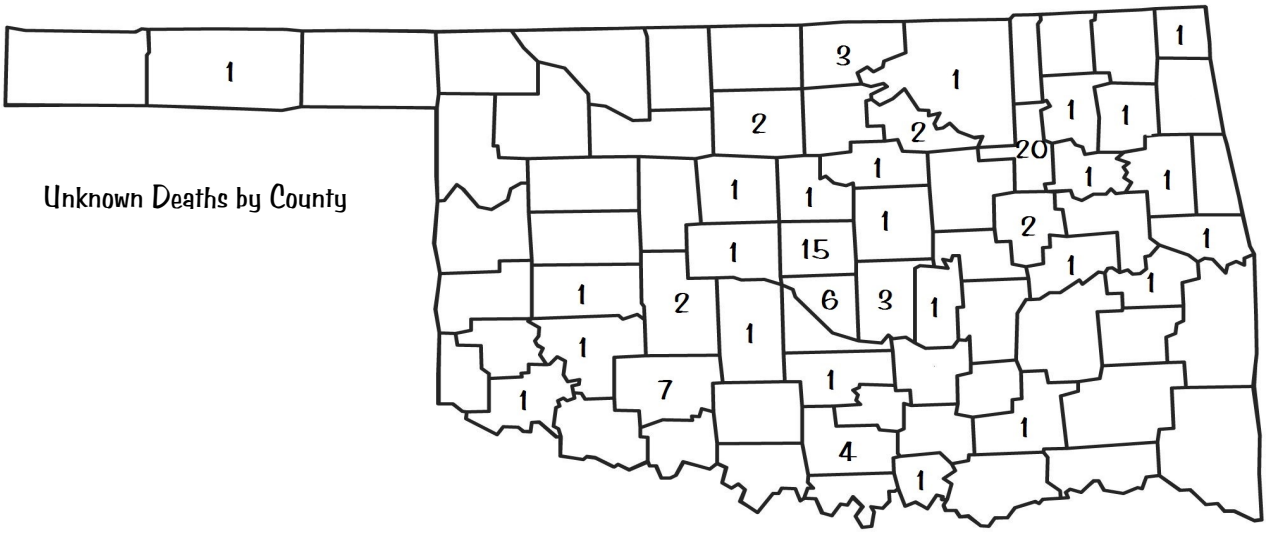
One (1.1%) was a result of probable hyperthermia but "heat related trauma" was listed only as an Other Significant Condition.

One (1.1%) was positive for methamphetamine at the time of death, indicating recent exposure, but the method and timeframe for exposure is unknown and the contribution, if any, of the methamphetamine exposure to the cause is unknown.

Race		
African American	15	16.9%
American Indian	8	9.0%
Multi-Race	9	10.1%
White	57	64.0%

Ethnicity	Number	Percent
Hispanic (any race)	10	11.2%
Non-Hispanic	79	88.8%

Gender	Number	Percent
Males	52	58.4%
Females	37	41.6%



Traffic Related Deaths

The Board reviewed and closed 69 traffic related deaths in 2014 ruled "Accident" by the Office of the Chief Medical Examiner.
The bicycle fatality was not utilizing a helmet.
In the four ATV deaths, one (25%) was wearing a helmet.

Vehicle of Decedent		
Vehicle	**Number**	**Percent**
Car	24	34.8%
SUV	18	26.1%
Pedestrian	12	17.4%
Pick-up	6	8.7%
All-Terrain Vehicle	4	5.8%
Van	3	4.4%
Bicycle	1	1.4%
Trailer Bed	1	1.4%

Position of Decedent		
Position	**Number**	**Percent**
Rear Passenger	27	39.1%
Front Passenger	15	21.8%
Operator	10	14.5%
Truck/Trailer Bed	2	2.9%
Unknown Passenger Placement	2	2.9%
Pedestrian	12	17.4%
Bicycle	1	1.4%

Gender	Number	Percent
Males	38	55.1%
Females	31	44.9%

Use of Safety Restraints		
Seatbelt/Car Seat Use	**Number**	**Percent**
Properly Restrained	26	51.0%
Not Properly Restrained	25	49.0%
Not Applicable	18	-

Contributing Factors*		
Factor	**Number**	**Percent**
Speeding (including unsafe speed for conditions)	25	36.2%
Drug/Alcohol Use	13	18.8%
Reckless Driving	12	17.4%
Driver Inexperience	9	13.0%
Ran Stop Sign/Light	7	10.1%
Driver Distraction	4	5.8%

Race		
African American	2	2.9%
American Indian	10	14.5%
Multi-race	8	11.6%
White	49	71.0%

Ethnicity	Number	Percent
Hispanic (any race)	6	8.7%
Non-Hispanic	63	91.3%

*Not every fatality had a known contributing factor.

Drowning Deaths

The Board reviewed and closed 22 accidental deaths in 2014 due to drowning. None of the drowning victims had a personal floatation device available to them. Eleven (50%) were three years of age or younger; five (22.7%) were one year of age.

Location of Drowning

Location	Number	Percent
Open Body of Water (i.e. creek/river/pond/lake)	10	31.8%
Private, Residential Pool	7	45.5%
Bathtub	4	18.2%
Hot tub	1	4.5%

Type of Residential Pool (N=7)

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

Type of Open Body of Water (N=10)

Open Body	Number	Percent
Pond	4	40.0%
Lake	3	30.0%
Creek	2	20.0%
River	1	10.0%

Race

African American	3	13.6%
American Indian	2	9.1%
Multi-Race	5	22.7%
White	12	54.6%

Ethnicity	Number	Percent
Hispanic (any race)	1	4.5%
Non-Hispanic	21	95.5%

Gender	Number	Percent
Males	15	68.2%
Females	7	31.8%

Sleep Related Deaths

The Board reviewed and closed 89 deaths that were related to sleep environments.
Five (5.6%) deaths occurred when a caregiver fell asleep during feeding (2 bottle/3 breast); an additional two (2.2%) were placed to sleep with a bottle propped.
Twenty-five (28.1%) of these deaths occurred in a sleep space designed for infant sleep (i.e. crib/ bassinette/cradle), while 45 (50.6%) had a crib/bassinette available in the home. For 35 (39.3%) cases, crib availability is unknown.
Eight (12.1%) were exposed to second hand smoke; for 78 (87.6%) cases, this information is unknown.

Manner of Death for Sleep Related Deaths

Manner	Number	Percent
Accidental	8	9.0%
Natural (SIDS/ hypoxia/pneumonia)	6	6.7%
Undetermined	75	84.3%

Position of Infant When Placed to Sleep

Position	Number	Percent
On Back	32	36.0%
On Side	5	5.6%
On Stomach	14	15.7%
Unknown*	38	42.7%

Position of Infant When Found**

Position	Number	Percent
On Back	13	14.8%
On Side	7	7.9%
On Stomach	35	39.8%
Unknown*	33	37.5%

**does not include one infant found feet up beside bed

Sleeping Arrangement of Infant

Sleeping Arrangement	Number	Percent
Alone	33	37.1%
With Adult and/or Other Child	47	52.8%
Unknown*	9	10.1%

Race

African American	14	15.7%
American Indian	12	13.5%
Asian	1	1.1%
Multi-race	7	7.9%
White	55	61.8%

Ethnicity	Number	Percent
Hispanic (any race)	8	9.0%
Non-Hispanic	81	91.0%

Gender	Number	Percent
Males	49	55.1%
Females	40	44.9%

Sleeping Location of Infant

Location	Number	Percent
Adult Bed	51	57.3%
Crib	14	15.7%
Bassinette	10	11.2%
Couch	9	10.1%
Car Seat	1	1.1%
Chair	1	1.1%
Cradle	1	1.1%
Floor	1	1.1%
Playpen	1	1.1%

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

Firearm Deaths

The Board reviewed and closed 31 deaths in 2014 due to firearms.

Manner of Death for Firearm Victims		
Manner	**Number**	**Percentage**
Suicide	14	45.2%
Homicide	13	41.9%
Accident	4	12.9%

Race		
African American	5	16.1%
American Indian	3	9.7%
Multi-Race	3	9.7%
White	20	64.5%

Type of Firearm Used		
Type of Firearm	**Number**	**Percent**
Handgun	18	58.0%
Hunting Rifle	6	19.4%
Shotgun	4	12.9%
Unknown	3	9.7%

Ethnicity	Number	Percent
Hispanic (any race)	2	6.5%
Non-Hispanic	29	93.5%

Gender	Number	Percent
Males	25	80.6%
Females	6	19.4%

Fire Deaths

The Board reviewed and closed 6 deaths in 2014 due to fires. Five (83.3%) died of smoke inhalation; one (16.7%) died from a combination of smoke inhalation and thermal injuries.

Fire Ignition Source		
Source	**Number**	**Percent**
Space Heater	4	66.6%
Electrical Wiring	1	16.7%
Unknown	1	16.7%

Working Smoke Detector Present		
Detector	**Number**	**Percent**
Yes	0	-
No	3	50.0%
Unknown	3	50.0%

Race		
African American	3	50.0%
Multi-Race	1	16.7%
White	2	33.3%

Ethnicity	Number	Percent
Hispanic (any race)	0	-
Non-Hispanic	6	100%

Gender	Number	Percent
Males	3	50.0%
Females	3	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.
Thirteen (21.7%) cases were ruled abuse, 45 (75.0%) cases were ruled neglect, and two (3.3%) were ruled both.
Nine of the 15 (60.0%) abuse cases were due to abusive head trauma.
Twenty-one (35.0%) cases had a previous referral for alleged child maltreatment; four (6.6%) had an open referral at the time of death.
Thirty-two (53.3%) cases had at least one caregiver with child welfare history as an alleged perpetrator; in twelve (20.0%) of these, both caregivers had child welfare history as an alleged perpetrator.
Twenty (33.3%) had at least one caregiver with a history of substance abuse.
Ten (16.7%) had a caregiver noted to have a history of domestic violence as a victim.
Nine (15.0%) cases had a caregiver noted to have a history of domestic violence as a perpetrator.
Six (10%) had a supervisor who was not a primary caregiver.

Manner of Death for Abuse/Neglect Cases

Manner	Number	Percent
Accident	26	43.4%
Homicide	14	23.3%
Natural	3	5.2%
Undetermined	17	28.3%

Race

African American	10	16.7%
American Indian	5	8.3%
Multi-race	10	16.7%
White	35	58.3%

Gender	Number	Percent
Males	33	55.0%
Females	27	45.0%

Ethnicity	Number	Percent
Hispanic (any race)	7	11.7%
Non-Hispanic	53	88.3%

Near Deaths

The Board reviewed and closed 42 near death cases in 2014. 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.

Four (9.5%) investigated for alleged abuse only; 10 (23.8%) for abuse and neglect; 28 (66.7%) for neglect only. Ten of the abuse cases were specific to abusive head trauma.

Twenty-nine (69.0%) had a sibling with a previous child welfare investigation, 14 (33.3%) were confirmed.

Twenty-eight (66.7%) were substantiated by OKDHS as to having been abuse and/or neglect.

Twenty-seven (64.3%) had a previous referral that was investigated by OKDHS, twelve (28.6%) of those were confirmed.

Thirty-six (85.7%) had at least one biological parent as the alleged perpetrator.

Injuries in Near Death Cases

Injury	Number	Percent
Physical Abuse	12	28.6%
Poison/Overdose	9	21.4%
Natural Illness	7	16.6%
Asphyxia	3	7.0%
Drowning	2	4.8%
Fall	2	4.8%
Firearm	2	4.8%
Dog Bite	1	2.4%
Electrocuted	1	2.4%
Failure to Thrive	1	2.4%
Fire/Burn	1	2.4%
Vehicular	1	2.4%

OKDHS Services in Near Death Cases

Service	Number	Percent
TANF	40	95.2%
CSE	32	76.2%
Medical	30	71.4%
Disability	9	21.4%
Foster Care	4	9.5%
Food Stamps	1	2.4%

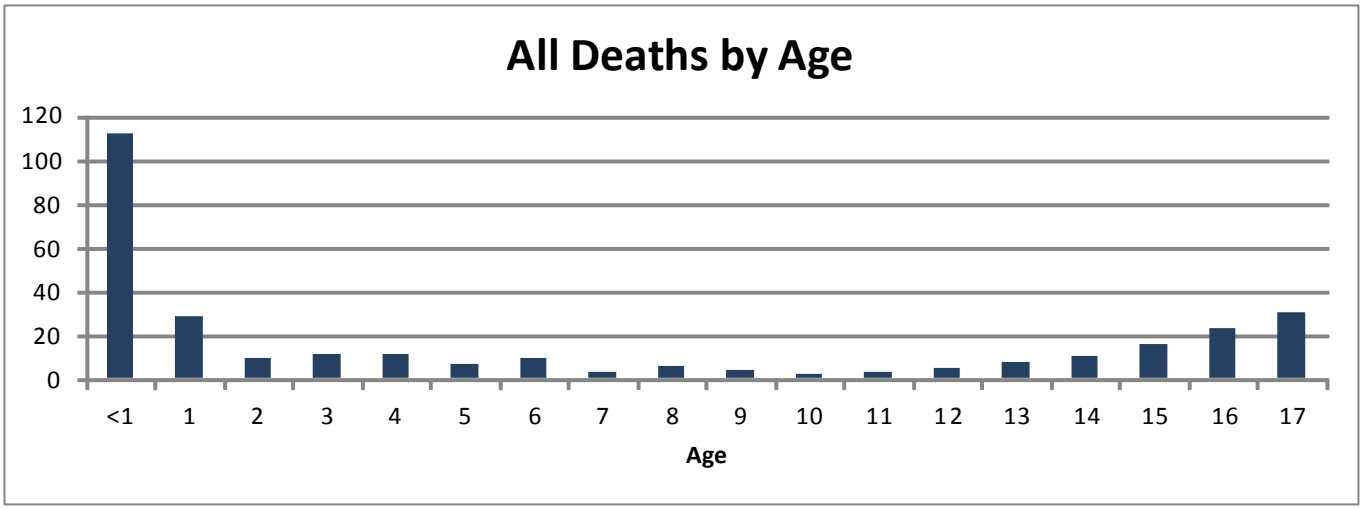
Race

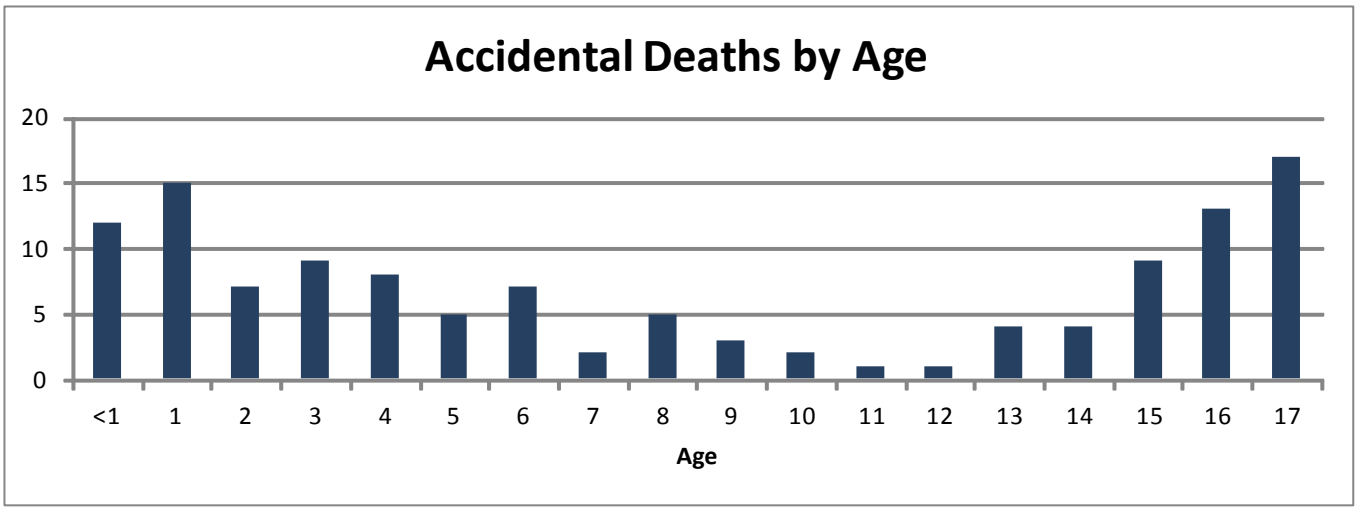
African American	9	21.4%
American Indian	8	19.0%
Asian	2	4.8%
Multi-Race	2	4.8%
White	21	50.0%

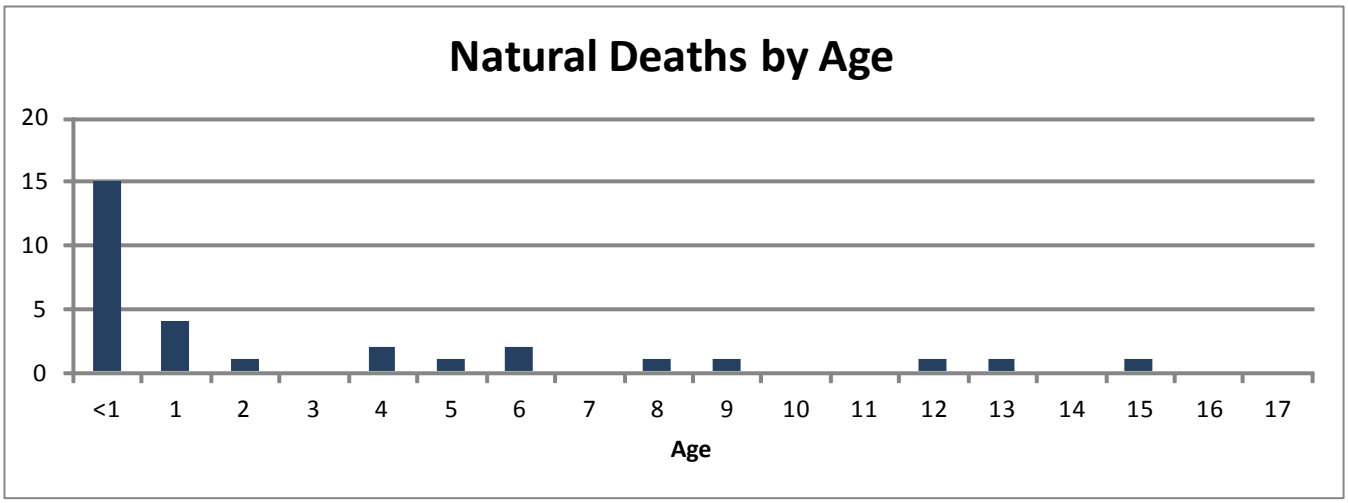
Gender	Number	Percent
Males	20	47.6%
Females	22	52.4%

Ethnicity	Number	Percent
Hispanic (any race)	4	9.5%
Non-Hispanic	38	90.5%

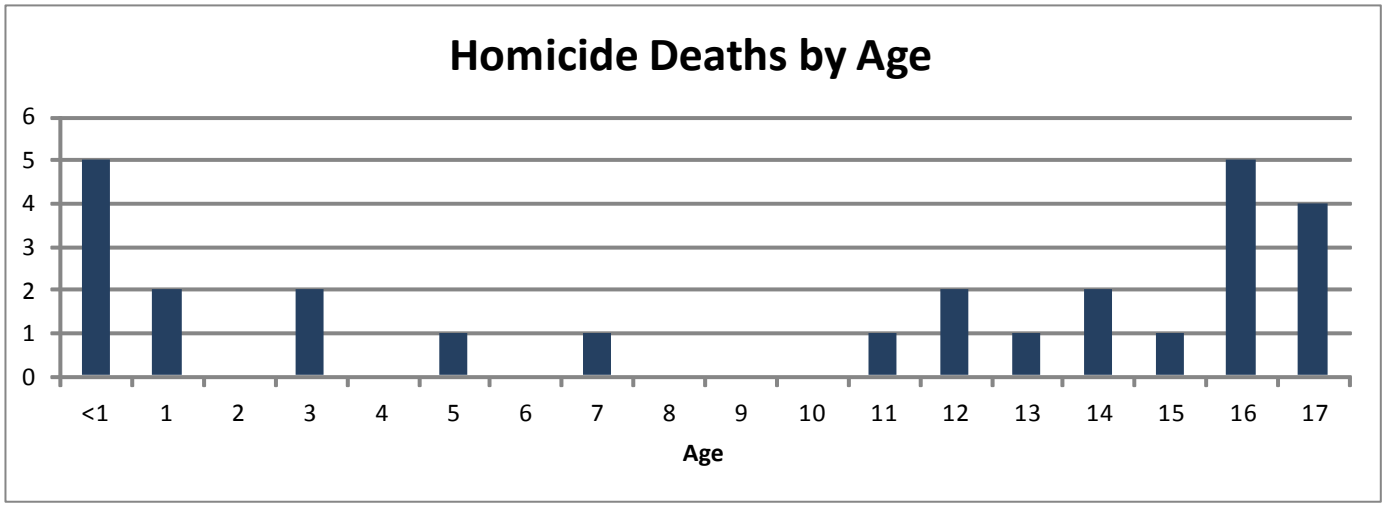
Age of Decedents by Manner

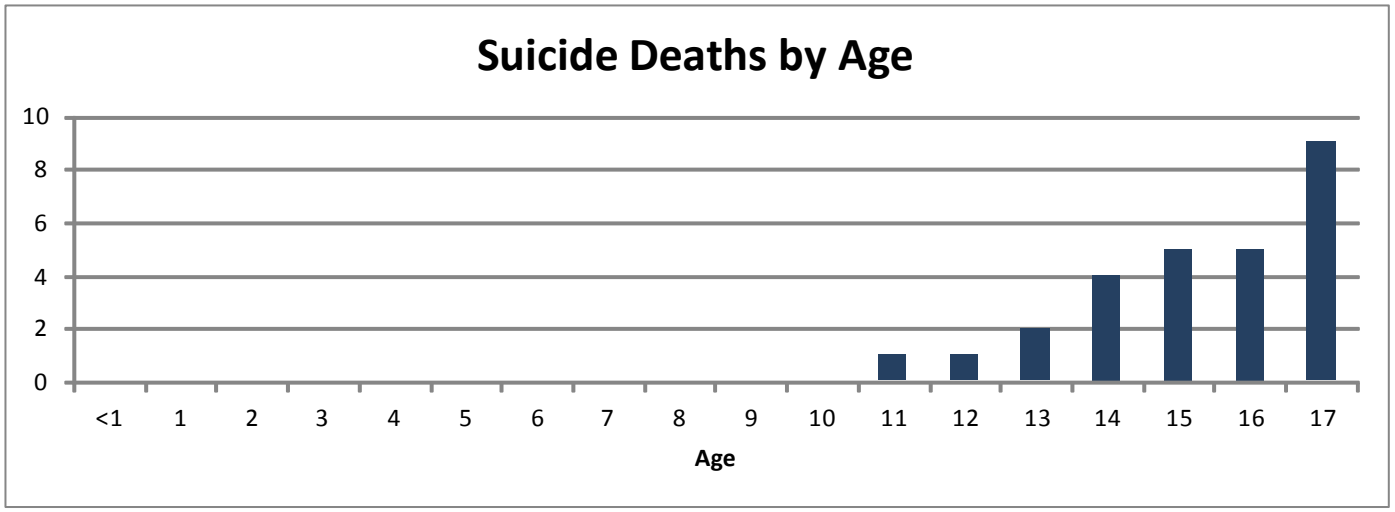


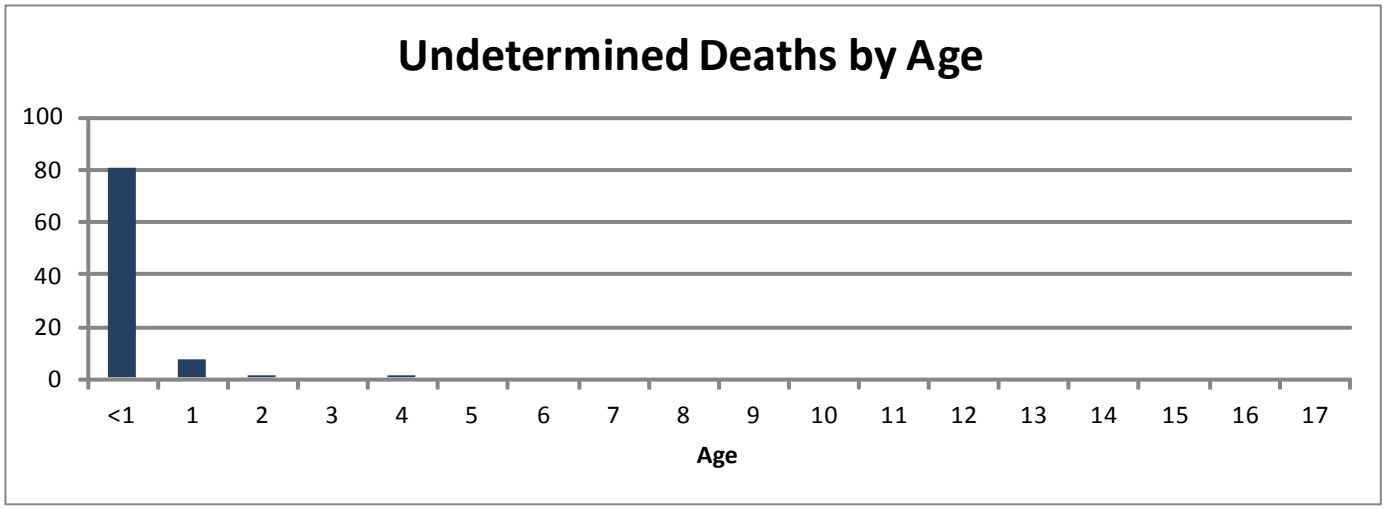




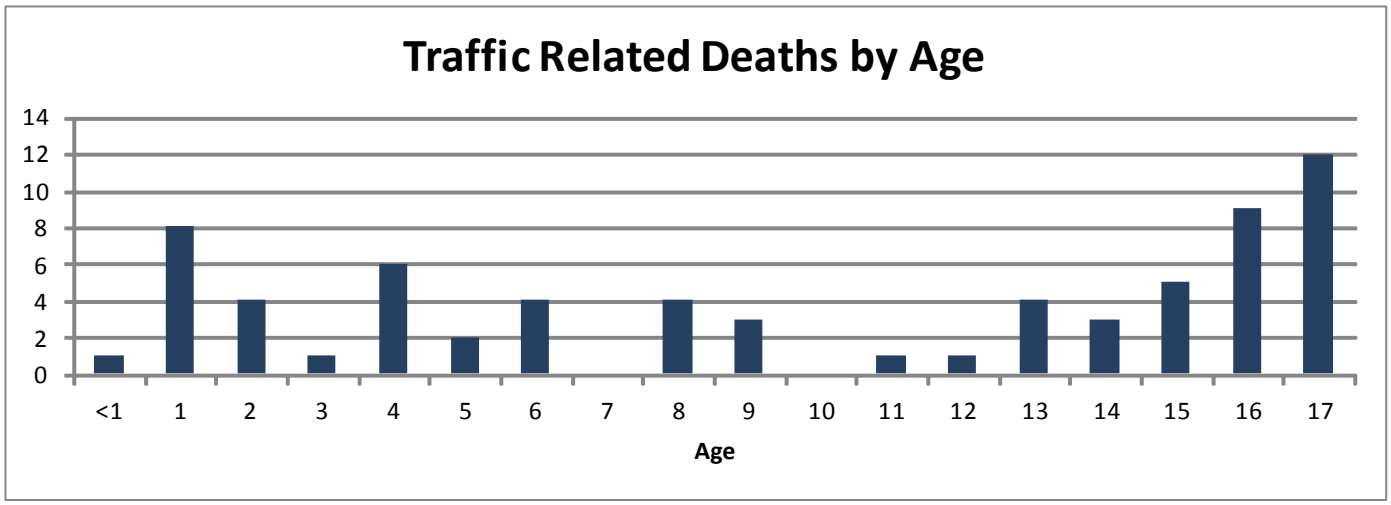
Age of Decedents by Manner

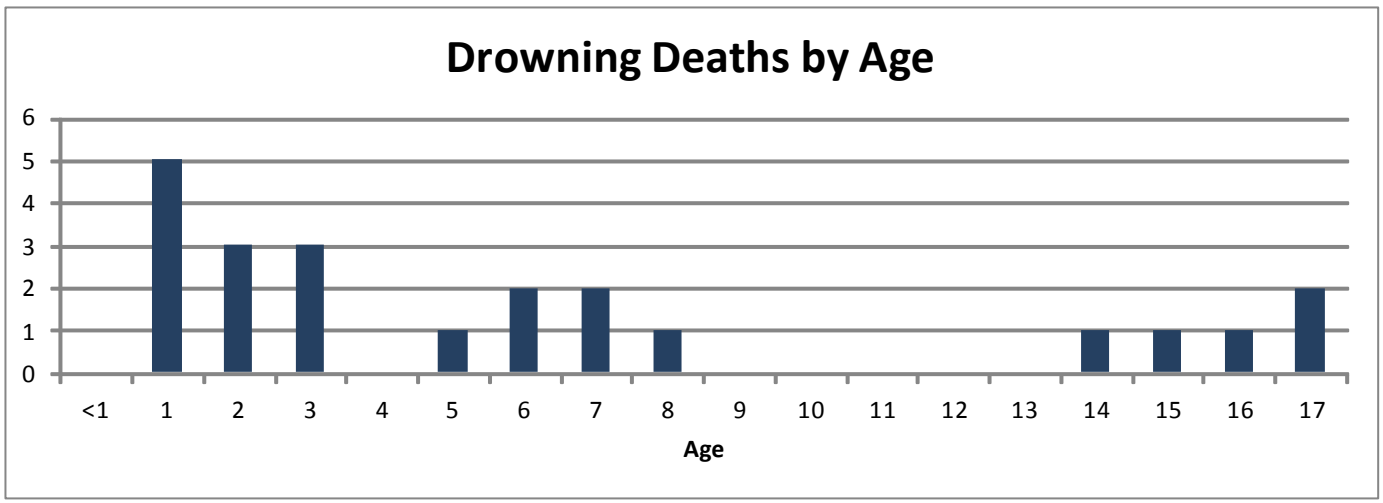


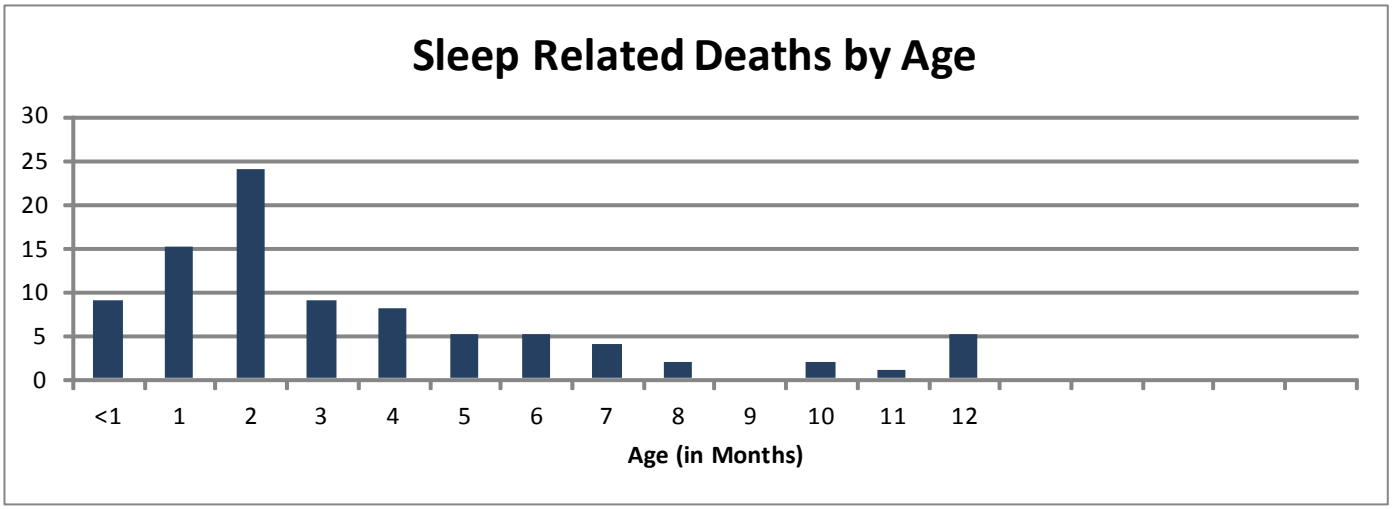




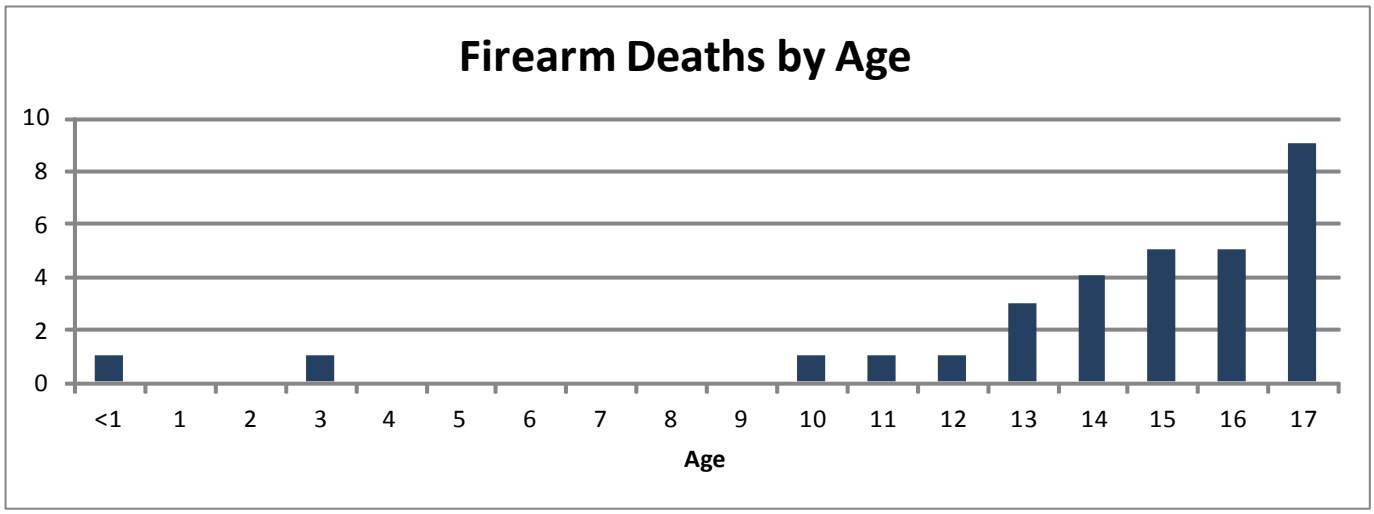
Age of Decedents by Select Causes

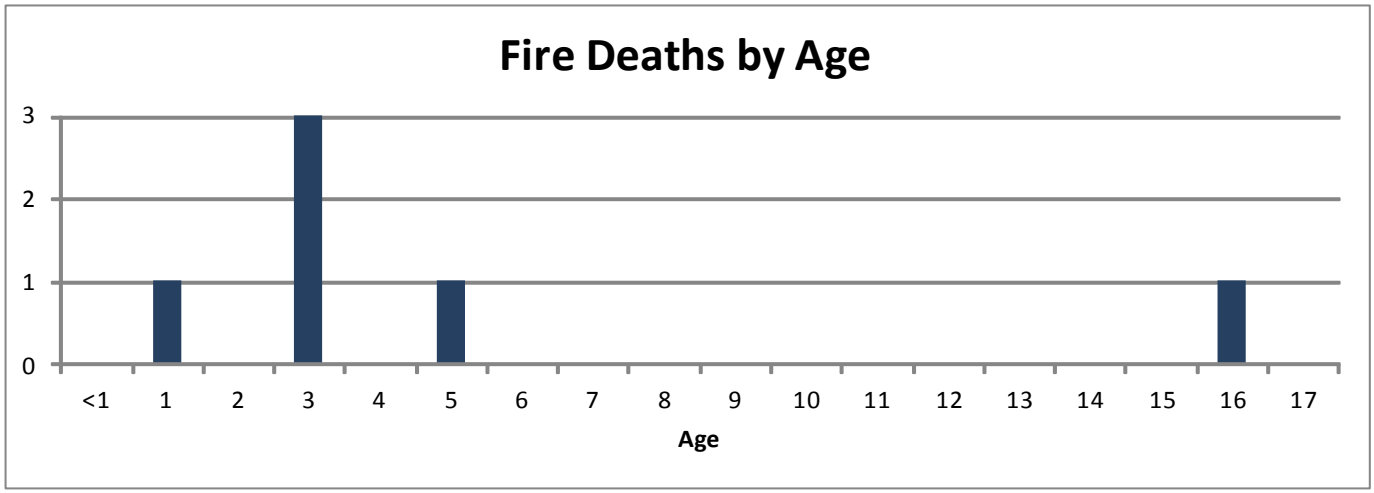


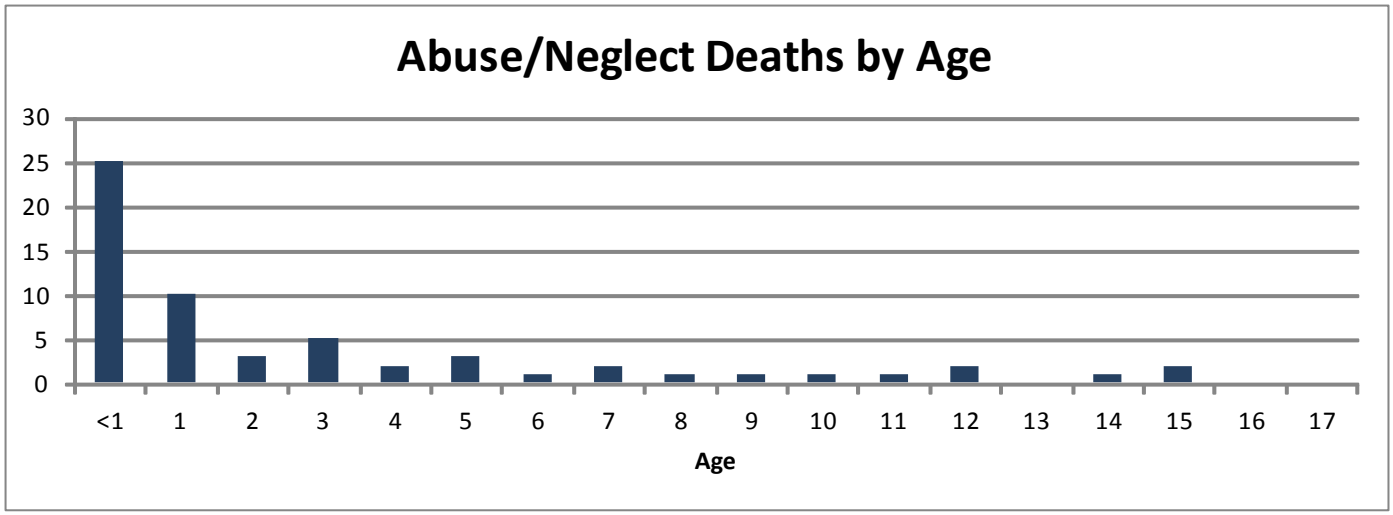




Age of Decedents by Select Causes







The 2014 Oklahoma State Child Death Review Board Members

Organization	Member	Designees
The Child Protection Committee of the Children's Hospital	*Ryan Brown, MD, John Stuemky, MD*	*Amy Baum, MSW, LCSW, Chair*
Office of Juvenile Affairs	*T. Keith Wilson, JD*	*Donna Glandon, JD, Vice-Chair*
OSDH, State Epidemiologist	*Kristy Bradley, DVM, MPH*	*Tina Johnson, MPH, RN*
Post Adjudication Review Board	*Jay Scott Brown, MA*	*Melanie Johnson, MCJ, MHR, LPC, LMFT, LADC*
American Academy of Pediatrics, OK. Chpt.	*Ryan Brown, MD*	
OSDH, Injury Prevention Services	*Sheryll Brown, MPH*	*Brandi Woods-Littlejohn, MCJ*
Oklahoma District Attorney's Council	*Susan Caswell, JD*	*Jennifer Austin, JD, Lori Puckett, J.D.*
Commissioner of Health	*Terry Cline, PhD*	*Carolyn Parks, MHR, RN, SANE A, SANE P*
Oklahoma State Bureau of Investigation	*Stan Florence, MS*	*Andi Grosvald Hamilton, MSW* *Charles Mackey, BS, Adam Whitney*
Oklahoma Health Care Authority	*Nico Gomez, MBA*	*Kenneth Goodwin, RN,* *Beverly Rupert, BSN, RN*
Indian Child Welfare	*Tracy Haney, BS*	
Oklahoma Court Appointed Special Advocate	*Angela Henderson, BS*	
OSDH, Office of Child Abuse Prevention	*Annette Wisk Jacobi, JD*	
Oklahoma Department of Human Services	*Ed Lake, MSW*	*Deborah Knecht, BA, Kristie Anderson, BA*
OSDH, Maternal and Child Health	*Joyce Marshall, MPH*	*Angela Dickson, MSW, LCSW, ACSW* *Alicia Lincoln, MSW, MSPH*
Oklahoma Osteopathic Association	*Julie Morrow, DO*	
Chief Child Abuse Medical Examiner	*Sara Passmore, DO, John Stuemky, MD*	
Office of the Chief Medical Examiner	*Eric Pfeifer, MD*	
Law Enforcement	*Lt. Miguel Ramos, BS, OCPD*	
Oklahoma Psychological Association	*Susan Schmidt, PhD*	*Christina Cantrell, PhD*
Oklahoma Commission on Children and Youth	*Lisa L. Smith, MA*	*Jennifer Hardin, BS* *Penny Hill-Malone, MHR, LADC*
Oklahoma Bar Association	*G. Gail Stricklin, JD*	*Cindy Goble, JD*
Oklahoma Coalition Against Domestic Violence and Sexual Assault	*Jennifer Thomas, MA, LPC, CDSVRP*	
National Association of Social Workers, OK Chpt.	*Jon Trzcinski, LCSW, MSW*	
Oklahoma Department on Mental Health and Substance Abuse Services	*Terri White, MSW*	*Teresa Capps, MEd, LPC*
Oklahoma Medical Association	*Vacant*	
Oklahoma Emergency Technician Association	*Vacant*	

2014 Eastern Regional Review Team Members

Organization	Member
Muskogee County Health Department	*Tonya James, MS, CCPS, Chair*
Muskogee Public School	*Debbie Winburn, MEd, Vice-Chair*
Oklahoma Psychological Association	*Misty Boyd, PhD, MS*
Child Advocacy Center	*Hillary McQueen, BA*
Court Appointed Special Advocate	*Susie Massey, BBA*
Law Enforcement	*Coletta Peyton*
Department of Human Services	*Jeff Sanders, BS*

2014 Southeastern Regional Review Team Members

Law Enforcement	*J.R. Kidney, Chair*
District Attorney's Council	*Shelly Levisay, JD, Vice-Chair*
Oklahoma Department of Human Services	*Zane Gray, Jerrell Hoffman, BA*
Oklahoma State Health Department	*Carolyn Parks, MHR, RN, SANE A., SANE P.*
Citizen Potawatomi Nation	*La'Trenda Sanders*
Medical Professional	*John Stuemky, MD*

2014 Southwestern Regional Review Team Members

Court Appointed Special Advocate	*Alma Santiago Juanes, BS, Chair*
Office of Juvenile Affairs	*Donna Glandon, JD, Vice-Chair*
District Attorney's Council	*Jason Hicks, JD*
Oklahoma Department of Human Services	*Betty Johnson, BA*
Office of the Chief Medical Examiner	*Emma Prophet*
Law Enforcement	*Tommy Uptergrove,*

2014 Tulsa Regional Review Team Members

Child Abuse Network	*Rose Turner, LCSW, MSW, Chair*
Medical Professional	*Sara Passmore, DO, Vice-Chair*
Law Enforcement	*Eric Bentz, BS*
Children First, Wagoner County	*Sharon Konemann, MS, RN-BC*
Department of Humans Services	*Jessica Martin, BA*
District Attorney's Council	*Sarah McAmis, JD*
Safe Kids Tulsa	*Susan West, RN*