Think. Prevent. Live.

Keep Our Children Safe

The Oklahoma Child Death Review Board
2016 Annual Report

Includes the 2017 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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Table of Contents

Recommendations

The following are the 2017 annual recommendations of the Oklahoma Child Death Review Board as submitted to the Oklahoma Commission on Children and Youth.

In 1991 the Oklahoma legislature recognized the need for a multi-disciplinary review of how Oklahoma's children were dying and created the Child Death Review Act. Since that time, many professionals have convened and reviewed almost 7,000 cases of child deaths to collect 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. The Child Death Review Board (CDRB) strongly believes that through the implementation of these recommendations, lives will be saved, families strengthened and those agencies that serve to safeguard Oklahoma's children are supported in a manner that assists them in performing their duties.

The CDRB submits recommendations on an annual basis that could potentially reduce the number of children dying in Oklahoma each year. With the current fiscal crisis, we anticipate more children dying if the state does not provide the resources to do what needs to be done to protect our most vulnerable citizens and our future, our children.

The CDRB is providing the following recommendations:

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. Budget cuts will not provide Oklahomans with the financial commitment necessary to provide strong infrastructure, safe communities, and healthy thriving children.

LEGISLATION

The CDRB reviewed and closed 35 traffic related deaths in 2016, with 32 victims being in a vehicle (i.e. does not include pedestrian/ATV deaths). Of these 32, over one-third (37.5%) were not utilizing a safety restraint.

- Expand the current seat restraint legislation to include backseat passengers.
- Increase the fine for those ages 13 and over not using seat restraints to $100 for the first offense and $500 for subsequent offenses.
- Expand anti-texting legislation to only permit use of hand-free devices while operating a motor vehicle and the violation upgraded to a primary offense.

Recommendations

- Enact legislation that increases the age to get a license to 17 years of age.
- Enact legislation that increases the age to get a permit to 16 years of age.
- Extend the intermediate driver's license period to one full year.

POLICY

Hospitals

- The CDRB reviewed and closed 73 (37.6% of all deaths reviewed) deaths related to unsafe sleep environments in 2016. 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, most importantly the dangers of co-sleeping. Sixty-eight percent of the sleep-related deaths reviewed in 2016 were co-sleeping with an adult and/or another child.
- All birthing hospitals should have a written policy to implement, with fidelity, the Period of *PURPLE*® Crying abusive head trauma prevention program.
- All hospitals should have a written policy to notify the OKDHS Child Welfare division of unexpected child deaths.

Law Enforcement

- Expand suicide investigations to include medical, psychiatric, and social history (i.e. past history of attempts, medications, counseling, note of intent, social media, psychiatric diagnosis, family history of attempts/deaths, stressors, relationship status, school performance, peer relations, gender identity) in reports. The CDRB reviewed and closed 27 (13.9%) cases of suicide and a majority did not collect this information, which is vital to prevention efforts.
- Increase enforcement of child passenger safety laws, including appropriate seat restraint use. The CDRB reviewed and closed 35 cases that involved motor-vehicles. The CDRB found improper seat restraint use to be 37.5%.
- 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 84 (43.3% of all cases) infant death cases in 2016; of these, 55 (64.7% of the infant deaths) 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.
- Ensure all child death investigations are conducted jointly with OKDHS/Child

Recommendations

Welfare.

Office of the Chief Medical Examiner

- Adopt the Center for Disease Control's SUIDI protocols. As stated previously, the CDRB reviewed and closed 85 (43.3%) infant death cases in 2016; of these 85 infant deaths, 55 (64.7% of infant deaths) 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

- Ensure all children in OKDHS custody receive timely child behavior health screenings to determine the need for trauma-informed, evidence-based mental health treatment assessment and treatment services.
- Ensure all children and families served by OKDHS programs have access to trauma-informed, evidence-based mental health assessment and treatment services.
- Enforce use of the Center for Disease Control's SUIDI protocols for OKDHS death investigations.

Oklahoma Department of Mental Health and Substance Abuse Services

- Ensure trauma-informed, evidence-based mental health assessment and treatment resources are available for children and adults across Oklahoma.
- Extend professional training and consultation in trauma-informed, evidence-based mental health assessment and treatment for Oklahoma Community Mental Health Providers.

Oklahoma State Department of Health

- Ensure the continuation of the Office of Child Abuse Prevention and support with appropriate funding.

Board Actions and Activities

The following are the formal actions taken by the CDRB in 2016:

- Thirteen letters to law enforcement:
  - Five recommending improvement of scene investigation and utilization of the CDC's Sudden Unexplained Infant Death Investigation protocols.
  - Four recommending the agency notify OKDHS/Child Welfare when responding to an unexpected child death.
  - Two inquiring as to the specific OKDHS/Child Welfare referral number they would have received when making a death referral to Child Welfare.
  - One inquiring if the case was still open.
  - One inquiring if charges had been submitted to the District Attorney.
- Eight letters to Oklahoma Department of Human Services:
  - Two letters referring cases to Child Welfare for investigation.
  - One letter inquiring about services provided to a family.
  - One letter inquiring about policy(ies) for communication between agencies for dually involved children and procedure for enforcement.
  - One requesting the agency to review a family's prior history for missed opportunities for intervention.
  - One requesting response(s) to the Office of Juvenile System Oversight.
  - One requesting the State Office review a case to assess safety of children in an open Child Protection System case.
  - One requesting the agency consider askinging the Oklahoma State Bureau of Investigation investigate a case.
- Two letters to the Oklahoma Commission on Children and Youth referring cases to the Office of Juvenile System Oversight.
- One letter to a District Attorney inquiring if OKDHS had requested the District Attorny to request OSBI investigate a case.
- One letter to a fire department recommending the department notify the OKDHS/CW when arson is suspected in the death of a child.
- One letter to a mental health provider recommending utilization of specific standardized, evidence-based practices for working with juveniles who have experienced trauma.
- One letter to the Office of the Chief Medical Examiner inquiring if additional information would lead to the amendment of the manner of death and/or cause of death.
- One letter to the Office of Juvenile Affairs inquiring about policy(ies) for communication between agencies for dually involved children and procedure for enforcement.

Cases Closed 2016

The Oklahoma Child Death Review Board is comprised of five review teams. The total number of deaths reviewed and closed in 2016 by all five teams is 194. The year of death for these cases ranged from 2008 to 2016.

2016 Deaths Reviewed		
Manner	**Number**	**Percent**
Accident	71	36.6%
Homicide	21	10.8%
Natural	15	7.7%
Suicide	27	13.9%
Unknown	60	30.9%

Gender	Number	Percent
Males	123	63.4%
Females	104	36.6%

Race		
African American	22	11.3%
American Indian	11	5.7%
Asian	1	0.5%
Multi-race	43	22.2%
Native Hawaiian/ Pacific Islander	2	1.0%
White	115	59.3%

Ethnicity	Number	Percent
Hispanic (any race)	29	14.9%
Non-Hispanic	165	85.1%

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.
Additionally, there were 21 (10.8%) cases that had an open Child Welfare case at the time of death, including two children in foster care. The manners of death for those children were Natural and Suicide.
Another 15 (7.7%) had a history of foster care placement previous to the death.

Number of Cases with Involvement in Selected State Programs

Agency	Number	Percent of All Deaths
Oklahoma Health Care Authority	129	66.5%
OKDHS - TANF	118	60.8%
OKDHS - Child Support Enforcement	93	47.9%
OKDHS - Child Welfare	68	35.1%
OKDHS - Disability	13	6.7%
Office of Juvenile Affairs	11	5.7%
OKDHS - Foster Care	2	1.0%
OSDH - Office of Child Abuse Prevention	0	--
OSDH - Children First	0	-

Accidents

The Board reviewed and closed 71 deaths in 2016 whose manner of death was ruled Accident, also known as Unintentional Injuries.

Mechanism of Death		
Type	**Number**	**Percent**
Vehicular	35	49.3%
Asphyxia	16	22.5%
Drowning	11	15.5%
Poisoning/OD	3	4.2%
Animal Attack	2	2.8%
Crushing	1	1.4%
Fire	1	1.4%
Exposure	1	1.4%
Weapon	1	1.4%

Race		
African American	5	7.0%
American Indian	4	5.6%
Multi-race	13	18.3%
Native Hawaiian/ Pacific Islander	1	1.4%
White	48	67.6%

Ethnicity	Number	Percent
Hispanic (any race)	15	21.1%
Non-Hispanic	56	78.9%

Gender	Number	Percent
Males	46	64.8%
Females	25	35.2%

- Vehicular deaths continue to be the top mechanism of death for this category.
- Thirteen of the asphyxia deaths were related to unsafe sleep environments.
- The batteries had been removed from the smoke alarm in the one fire death and the fire ignition source was never identified.

Homicides

The Board reviewed and closed 21 deaths in 2016 whose manner of death was ruled Homicide.

Mechanism of Death		
Method	**Number**	**Percent**
Physical Abuse	14	66.6%
Firearm	4	19.0%
Fire	1	4.8%
Poisoning	1	4.8%
Vehicular	1	4.8%

Race		
African American	4	19.0%
Asian	1	4.8%
Multi-Race	3	14.3%
White	13	61.9%

Gender	Number	Percent
Males	11	52.4%
Females	10	47.6%

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

- Eleven (78.6% of the abuse cases) of the physical abuse deaths were due to abusive head trauma.

Naturals

The Board reviewed and closed 15 deaths in 2016 whose manner of death was ruled Natural.

Mechanism of Death		
Illness/Disease	**Number**	**Percent**
Infection - Other	3	20.0%
Medical Condition - Other	3	20.0%
Congenital Anomoly	2	13.3%
Influenza	2	13.3%
Neurological/ Seizure Disorder	2	13.3%
Pneumonia	2	13.3%
Asthma	1	6.8%

Race		
African American	1	6.7%
Multi-Race	6	40.0%
White	8	53.3%

Ethnicity	Number	Percent
Hispanic (any race)	2	86.7%
Non-Hispanic	13	13.3%

Gender	Number	Percent
Males	12	80.0%
Females	3	20.0%

- Infection Other includes: Group A Strep, Sepsis, and viral infection with specific etiological agent not identified.
- Medical Condition Other includes: respiratory failure due to Cerebral Palsy, sequelae of Cerebral Palsy and Failure to Thrive, and gastro-intestinal infarct.

Suicides

The Board reviewed and closed 27 deaths in 2016 whose manner of death was ruled Suicide.

Mechanism of Death		
Method	**Number**	**Percent**
Firearm	12	44.4%
Asphyxia	11	40.7%
Overdose	4	14.8%

Race		
African American	1	3.7%
Multi-Race	6	22.2%
White	20	74.1%

Gender	Number	Percent
Males	15	55.6%
Females	12	44.4%

Ethnicity	Number	Percent
Hispanic (any race)	4	14.8%
Non-Hispanic	23	85.2%

- Seventeen (63.0%) had a history of suspected child maltreatment.
- Twelve (44.4%) had prior mental health treatment; in 14 (52.0%) cases this information was not collected during the investigation.
- Twelve (44.4%) had threatened suicide; in 10 (37.0%) cases this information was not collected during the investigation.
- Ten (37.0%) left a note of intention; in 2 (7.4%) cases this information was not collected during the investigation.
- Nine (33.3%) had problems in school; in 12 (44.4%) cases this information was not collected during the investigation.
- Eight (29.6%) had a history of self-mutilation; in 16 (59.3%) cases this information was not collected during the investigation.
- Seven (25.9%) had a previous suicide attempt; in 14 (52.0%) cases this information was not collected during the investigation.
- Six (22.2%) were actively participating in mental health treatment; in 15 (55.6%) this information was not collected during the investigation.
- Six (22.2%) had a history of substance use/abuse; in 14 (52.0%) cases this information was not collected during the investigation.
- Five (18.5%) were on mental health medication(s) at the time of death; in 18 (66.7%) cases this information was not collected during the investigation.
- Two (7.4%) cases the child did NOT have a familial history of suicide; in 25 (92.6%) cases this information was not collected during the investigation.

Unknown

The Board reviewed and closed 60 deaths in 2016 ruled Unknown. A death is ruled Unknown by the pathologist when there are no anatomical findings discovered at autopsy to definitively explain the death.

Race		
African American	11	18.3%
American Indian	7	11.7%
Multi-Race	15	25.0%
Native Hawaiian/ Pacific Islander	1	1.7%
White	26	43.3%

Ethnicity	Number	Percent
Hispanic (any race)	3	5.0%
Non-Hispanic	57	95.0%

Gender	Number	Percent
Males	39	65.0%
Females	21	35.0%

- Fifty-eight (96.7%) were two years of age or younger; 55 (91.7%) were less than one year of age.
- Fifty-five (91.7%) determined to be related to unsafe sleep environment.
- Three (5.0%) were suspicious for child maltreatment, including inflicted trauma, starvation, and maternal drug abuse.

Traffic Related Deaths

The Board reviewed and closed 35 traffic related deaths in 2016 ruled "Accident". There was no helmet use for in the ATV fatalities.

Race		
African American	1	2.9%
American Indian	1	2.9%
Asian	1	2.9%
Multi-race	5	14.2%
White	27	77.1%

Ethnicity	Number	Percent
Hispanic (any race)	7	20.0%
Non-Hispanic	28	80.0%

Gender	Number	Percent
Males	24	68.6%
Females	11	31.4%

Vehicle of Decedent		
Vehicle	**Number**	**Percent**
Car	19	54.3%
SUV	5	14.3%
Pick-up	5	14.3%
Van	3	8.6%
ATV	2	5.7%
Pedestrian	1	2.9%

Use of Safety Restraints		
Seatbelt/Car Seat Use	**Number**	**Percent**
Properly Restrained	16	50.0%
Not Properly Restrained	12	37.5%
Unknown	4	12.5%
Not Applicable (pedestrian/ATVs)	3	--

Position of Decedent		
Position	**Number**	**Percent**
Rear Passenger	13	37.1%
Operator	11	31.4%
Front Passenger	10	28.6%
Pedestrian	1	2.9%

Contributing Factors*		
Factor	**Number**	**Percent**
Speeding (including unsafe speed for conditions)	16	45.7%
Reckless Driving	11	31.4%
Drug/Alcohol Use	8	22.9%
Driver Inexperience	6	17.1%
Driver Distraction	3	8.6%

*Not every fatality had a known/documented contributing factor.

Drowning Deaths

The Board reviewed and closed 11 accidental deaths in 2016 due to drowning.

Location of Drowning		
Location	**Number**	**Percent**
Open Body of Water (i.e. creek/river/pond/lake)	6	54.6%
Private, Residential Pool	4	36.4%
Bathtub	1	90.%

Race		
Multi-Race	2	18.2%
Native Hawaiian/ Pacific Islander	1	9.0%
White	8	72.8%

Type of Residential Pool (N=4)		
Type of Pool	**Number**	**Percent**
Above Ground	2	50.0%
In Ground	1	25.0%
Not Documented	1	25.0%

Ethnicity	Number	Percent
Hispanic (any race)	3	27.3%
Non-Hispanic	8	72.7%

Type of Open Body of Water (N=6)		
Open Body	**Number**	**Percent**
Lake	3	50.0%
River	3	50.0%

Gender	Number	Percent
Males	7	63.6%
Females	4	36.4%

- One (9.1%) child had a personal floatation device available; for one incident this information was not documented.
- Seven (63.6%) were between the ages of one year and five years.

Sleep Related Deaths

The Board reviewed and closed 73 deaths that were related to sleep environments.

Manner of Death for Sleep Related Deaths		
Manner	**Number**	**Percent**
Accidental	13	17.8%
Natural (SIDS/ hypoxia/pneumonia)	5	6.9%
Undetermined	55	75.3%

Position of Infant When Placed to Sleep		
Position	**Number**	**Percent**
On Back	37	50.7%
On Side	5	6.8%
On Stomach	16	21.9%
Unknown*	15	20.5%

Position of Infant When Found		
Position	**Number**	**Percent**
On Back	15	20.5%
On Side	7	9.6%
On Stomach	36	49.3%
Unknown*	15	20.5%

Sleeping Arrangement of Infant		
Sleeping Arrangement	**Number**	**Percent**
Alone	29	39.7%
With Adult and/or Other Child	44	60.3%

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

Race		
African American	12	16.4%
American Indian	7	9.6%
Multi-race	21	28.8%
Native Hawaiin/ Pacific Islander	1	43.8%
White	32	1.4%

Ethnicity	Number	Percent
Hispanic (any race)	2	2.7%
Non-Hispanic	71	97.3%

Gender	Number	Percent
Males	47	64.4%
Females	26	35.6%

Sleeping Location of Infant		
Location	**Number**	**Percent**
Adult Bed	39	53.4%
Crib	14	19.2%
Couch	7	9.6%
Bassinette	2	2.7%
Car Seat	2	2.7%
Floor	2	2.7%
Futon	2	2.7%
Bean Bag	1	1.4%
Bouncy Seat	1	1.4%
Chair	1	1.4%
Laundry Basket	1	1.4%
Swing	1	1.4%

Sleep Related Deaths Cont.

- Forty-nine (67.1%) had a crib/bassinette available in the home; 8 (11.0%) did not and crib availability was unknown for 16 (21.9%) cases.
- Twenty-two (30.1%) were exposed to second hand smoke; for 45 (61.6%) cases, this information is unknown. Six (8.2%) were not exposed to second hand smoke.
- Sixteen (21.9%) of these deaths occurred in a sleep space designed for infant sleep (i.e. crib/bassinette).
- Four (5.5%%) deaths occurred when a caregiver fell asleep during feeding (3 bottle/1 breast).
- Six (8.2%) cases documented the caregiver as being under the influence of drugs or alcohol; four of these six were sharing the sleep space with the child. In 30 (41.1%) cases, this information is not addressed in investigative reports.

Firearm Deaths

The Board reviewed and closed 17 deaths in 2016 due to firearms.

Manner of Death for Firearm Victims		
Manner	**Number**	**Percentage**
Suicide	12	70.6%
Homicide	4	23.5%
Accident	1	5.9%

Race		
Multi-Race	4	23.5%
White	13	76.5%

Ethnicity	Number	Percent
Hispanic (any race)	3	17.6%
Non-Hispanic	14	82.4%

Type of Firearm Used		
Type of Firearm	**Number**	**Percent**
Handgun	14	82.4%
Shotgun	2	11.8%
Hunting Rifle	1	5.8%

Gender	Number	Percent
Males	12	70.6%
Females	5	29.4%

Child Maltreatment

The Board reviewed and closed 39 (16.0%) cases where it was determined that child maltreatment (abuse and/or neglect) caused or contributed to the death.

Manner of Death for Abuse/Neglect Cases		
Manner	**Number**	**Percent**
Accident	15	38.5%
Homicide	15	38.5%
Natural	2	5.1%
Undetermined	7	17.9%

Race		
African American	7	17.9%
American Indian	2	5.1%
Asian	1	2.6%
Multi-race	6	15.4%
Native Hawaiian/ Pacific Islander	1	2.6%
White	22	56.4%

Gender	Number	Percent
Males	21	53.8%
Females	18	46.2%

Ethnicity	Number	Percent
Hispanic (any race)	7	17.9%
Non-Hispanic	32	82.1%

- Thirteen (33.3%) cases were ruled abuse, 23 (59.0%) cases were ruled neglect, and three (7.7%) were ruled both.
- Nineteen (48.8%) of the neglect cases were due to lack of supervision.
- Eleven (84.6%) of the 13 abuse cases were due to abusive head trauma.
- Although none were in formal foster care at the time of death, 7 (17.9%) had an open Child Welfare case.
- Seventeen (43.6%) cases had a previous referral for alleged child maltreatment.
- Twenty (51.3%) cases had at least one caregiver with child welfare history as an alleged perpetrator; in twelve (30.8%) of these, both caregivers had child welfare history as an alleged perpetrator.
- Seventeen (43.6%) had at least one caregiver with a child welfare history as a victim; in four (10.3%) cases, both caregivers had a history as a victim.
- Twenty-one (53.8%) had at least one caregiver with a history of substance abuse; seven (17.9%) cases both caregivers had a history of substance abuse.
- Seven (17.9%) cases had a caregiver noted to have a history of domestic violence as a perpetrator.
- Thirteen (33.3%) had a caregiver noted to have a history of domestic violence as a victim.

Near Deaths

The Board reviewed and closed 65 near death cases in 2016. A case is deemed near death if the child was admitted to the hospital diagnosed in serious or critical condition as a result of suspected abuse or neglect.

Injuries in Near Death Cases		
Injury	**Number**	**Percent**
Poison/Overdose	19	29.2%
Abusive Head Trauma	11	16.9%
Natural Illness	11	16.9%
Drowning	5	7.7%
Asphyxia	4	6.2%
Failure to Thrive/ Malnutrition	4	6.2%
Fall	3	4.6%
Fire/Burn	3	4.6%
Vehicular	3	4.6%
Incise Injury	1	1.5%
Scalding	1	1.5%

Race		
African American	6	9.2%
American Indian	5	7.7%
Asian	1	1.5%
Multi-race	12	18.5%
White	41	63.1%

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

Gender	Number	Percent
Males	40	61.5%
Females	25	38.5%

- Fifty-two (80.0%) were alleged to be neglect, nine (13.8%) alleged abuse and neglect, and four (6.2%) alleged abuse only.
- Thirty-one (47.7%) were substantiated by OKDHS as to the allegations.
- Fifty-nine (90.8%) had at least one biological parent as the alleged perpetrator.
- Forty-five (69.2%) of the near death victims had a previous child welfare referral; 16 (35.6% of the 45) were substantiated.
- Forty-four (67.7) had a sibling with a previous child welfare referral; 20 (45.5% of the 44) were substantiated.
- Twelve (18.5%) sustained a chronic condition as the result of the near death incident.
- Four (6.2%) were in foster care at the time of injury.
- Fifty-two (80.0%) had an associated TANF case.
- Forty-three (66.2%) were on Medicaid.
- Forty-three (66.2%) were associated with a Child Support Enforcement case.