Think. Prevent. Live.

Keep Our Children Safe

The Oklahoma Child Death Review Board
2017 Annual Report

Includes the 2018 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 2018 annual recommendations of the Oklahoma Child Death Review Board (CDRB) as submitted to the Oklahoma Commission on Children and Youth.

FISCAL (Legislative)

A culture of budget cuts has left many public and private agencies powerless in their ability to provide the necessary services to Oklahoma's vulnerable population. In 2017, Oklahoma had one of the highest increases in child abuse cases in the nation and remains in the top five for child abuse related fatalities. Oklahoma must mandate certain tax regulations and appropriations that ensure and generate adequate revenue to support a strong infrastructure that fosters healthy and thriving children and preserves families and safe communities. If budget cuts are absolutely necessary, ensure family strengthening services are exempt from the cuts. Restoration of preventative programs and services that have been cut must be considered if Oklahoma is to fulfill its commitment to the preservation of the health and well-being of children and families.

LEGISLATION

The CDRB reviewed and closed 39 traffic related deaths in 2017, with 30 victims being in a vehicle (i.e. does not include pedestrian/motorcycle deaths). Of these 30, only one-third (33.3%) were documented as utilizing a seat restraint.

- Expand the current seat restraint legislation to include backseat passengers.
- Expand anti-texting legislation to only permit use of hands-free devices while operating a motor vehicle and the violation upgraded to a primary offense.

POLICY

District Attorney's Council

- Provide training for prosecutors involved in child maltreatment cases, including drug endangered children.

Hospitals

- All birthing hospitals will adopt a policy regarding in-house safe sleep practices and provide education on safe sleep after delivery but prior to discharge from hospital. The safe sleep education should be audited on at least a bi-annual basis. The education will be based on the most recent American Academy of Pediatrics recommendations regarding safe sleep and include statistics on sleep related deaths, most importantly the dangers of co-sleeping. The CDRB reviewed and closed 57 (28.2% of all deaths reviewed) deaths related to unsafe sleep environments in 2017. Thirty-one (54.4%) of the sleep-related deaths reviewed in 2017 were co-sleeping with an adult and/or another child.
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Recommendations

- All birthing hospitals will have a written policy to implement, with fidelity, the Period of *PURPLE*® Crying abusive head trauma prevention program.
- All hospitals will have a written policy to notify the OKDHS Child Welfare division of unexpected or implausibly explained child deaths.

Law Enforcement

- Adopt a policy to notify the OKDHS Child Welfare division of unexpected or implausibly explained child deaths.
- Ensure all child death investigations are conducted jointly with OKDHS/Child Welfare.
- Ensure that law enforcement has training on investigating child suicides and unexpected or implausibly explained child deaths.
- 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 reviewed. The CDRB reviewed and closed 14 (6.9%) cases of suicide and a majority did not collect this information, which is vital to identifying prevention efforts.
- Adopt the Center for Disease Control's Sudden Unexplained Infant Death Investigation (SUIDI) protocols, including scene recreation and use of photographs. The CDRB reviewed and closed 87 (43.1% of all cases) infant death cases in 2017; of these, 48 (55.2% 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.
- Increase enforcement of child passenger safety laws, including appropriate seat restraint use. The CDRB reviewed and closed 39 traffic related deaths in 2017, with 30 victims being in a vehicle (i.e. does not include pedestrian/motorcycle deaths). Of these 30, only one-third (33.3%) were documented as utilizing a seat restraint.

Office of the Chief Medical Examiner

- Adopt a written policy to notify the OKDHS Child Welfare division of unexpected or implausibly explained 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 Commission on Children and Youth

- Re-establish the Office of Planning and Coordination to assist with the facilitation of these recommendations.

Oklahoma Department of Education

- Implement a policy for when a child is known to be receiving critical services from school

Recommendations

are abruptly withdrawn, report the incident to OKDHS, so a plan for continuing services can be established.

Oklahoma Department of Human Services

- Ensure all child death investigations are conducted jointly with law enforcement.
- Encourage training and utilization of the Center for Disease Control's SUIDI protocols for OKDHS child death investigations.
- 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 reviewed. The CDRB reviewed and closed 14 (6.9%) cases of suicide and a majority did not collect this information, which is vital to identifying prevention efforts.
- 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.

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.
- Increase substance abuse treatment availability and stop reducing the already available treatment options across the state. In 2017 the CDRB reviewed 66 (30.2%) deaths where at least one parent had a history of substance abuse.

Oklahoma Health Care Authority

- Reimburse medical providers for child maltreatment assessments.
- Reimburse medical and behavioral health providers for substance abuse assessments.

Oklahoma State Department of Health

- Support maternal, child and family health as a mandated public health area and prioritize and support appropriate funding of child abuse prevention as a core program that will improve health outcomes in our state and prevent child deaths.
- Promote and make available safe sleep practice education in all areas of the state through facilitation by public health social workers and health education staff.
- 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 2017:

- Ten letters total to law enforcement: recommending:
  - Notification to the Oklahoma Department of Human Services' Child Welfare (OKDHS/CW) division when investigating a child death;
  - Use of the Centers for Disease Control and Prevention's Sudden Unexpected Infant Death Investigation Reporting Form;
  - Work a child death investigation jointly with the OKDHS/CW;
  - Increase death scene investigation photography to include pictures of the location of the incident;
  - Increase thoroughness of child death investigations.
- One letter to law enforcement inquiring as to the progress of an investigation.
- One letter to law enforcement inquiring as to policy regarding follow up investigation when a victim in a motor vehicle collision is under 21 but has a blood alcohol level over the legal limit.
- One letter referring a case to the OKDHS/CW division.
- One letter to a District Attorney inquiring as to the potential for filing charges.
- One letter to the Office of the Chief Medical Examiner inquiring as to policy for the distribution of Reports of Investigation by Medical Examiner.
- One letter to the Oklahoma Commission on Children and Youth, Office of Juvenile System Oversight commending a thorough investigation.
- One letter to OKDHS recommending the agency's Child Welfare division work child deaths jointly with law enforcement.
- One letter to the Oklahoma Hospital Association inquiring if Oklahoma hospitals have a standard of practice of notification of child deaths to law enforcement and/or OKDHS/CW.

Cases Closed 2017

The Oklahoma Child Death Review Board is comprised of five review teams. The total number of deaths reviewed and closed in 2017 by all five teams is 202. The year of death for these cases ranged from 2012 to 2017.

2017 Deaths Reviewed		
Manner	**Number**	**Percent**
Accident	87	43.1%
Homicide	32	15.8%
Natural	18	8.9%
Suicide	14	6.9%
Unknown	51	25.2%

Race		
African American	24	11.9%
American Indian	13	6.4%
Asian	5	2.5%
Multi-race	48	23.8%
White	112	55.4%

Gender	Number	Percent
Males	124	61.4%
Females	78	38.6%

Ethnicity	Number	Percent
Hispanic (any race)	21	10.4%
Non-Hispanic	181	89.6%

- Eighty (39.6%) had at least one previous Child Welfare referral prior to the death.
- Twenty (9.9%) had a history of previous out-of-the-home placement, either voluntarily or court-ordered.
- Sixteen (7.9%) had an open Child Welfare case at the time of death.

Accidents

The Board reviewed and closed 87 deaths in 2017 whose manner of death was ruled Accident, also known as Unintentional Injuries.

Mechanism of Death		
Type	**Number**	**Percent**
Vehicular	39	44.8%
Drowning	18	20.7%
Asphyxia	16	18.4%
Fire	5	5.7%
Poisoning/OD	3	3.4%
Allergic Reaction	1	1.1%
Crushing	1	1.1%
Explosion	1	1.1%
Exsanguination	1	1.1%
Scalding	1	1.1%
Sports Injury	1	1.1%

Race		
African American	13	14.9%
American Indian	2	2.3%
Asian	3	3.4%
Multi-race	18	20.7%
White	51	58.6%

Ethnicity	Number	Percent
Hispanic (any race)	3	3.4%
Non-Hispanic	84	96.6%

Gender	Number	Percent
Males	59	67.8%
Females	28	32.2%

- Vehicular deaths continue to be the top mechanism of death for this category.
- Thirteen (81.3%) of the 16 asphyxia deaths were related to unsafe sleep environments.
- Only one of the fire incidents had a working smoke detector.

Homicides

The Board reviewed and closed 33 deaths in 2017 whose manner of death was ruled Homicide.

Mechanism of Death		
Method	**Number**	**Percent**
Physical Abuse	17	53.1%
Firearm	12	37.5%
Fire	2	6.3%
Poisoning	1	3.1

Race		
African American	5	15.6%
American Indian	1	3.1%
Asian	2	6.3%
Multi-Race	7	21.9%
White	17	53.1%

Gender	Number	Percent
Males	23	71.9%
Females	9	28.1%

Ethnicity	Number	Percent
Hispanic (any race)	6	18.7%
Non-Hispanic	26	81.3%

- Fourteen (82.4%) of the 17 physical abuse deaths were due to abusive head trauma.
- Nine (52.9%) of the 17 physical abuse cases were infants.

Naturals

The Board reviewed and closed 18 deaths in 2017 whose manner of death was ruled Natural.

Mechanism of Death		
Illness/Disease	**Number**	**Percent**
Infection - Other	6	33.3%
Pneumonia	4	22.2%
Medical Condition - Other	3	16.7%
Congenital Anomoly	2	11.1%
Influenza	2	11.1%
Asthma	1	5.6%

Race		
African American	2	11.1%
American Indican	3	16.7%
Multi-Race	4	22.2%
White	9	50.0%

Ethnicity	Number	Percent
Hispanic (any race)	7	38.9%
Non-Hispanic	11	61.1%

Gender	Number	Percent
Males	8	44.4%
Females	10	55.6%

- Infection Other includes: RSV, bronchiolitis, various streptococcus and staphylococcus species.
- Medical Condition Other includes: acute pyelonephritis and chronic tubulointerstitial and glomerular disease, cerebral palsey and its complications, complications of respiratory distress syndrome, snf peritoneal adhesions with an incarcerated internal hernia.

Suicides

The Board reviewed and closed 14 deaths in 2017 whose manner of death was ruled Suicide.

Mechanism of Death		
Method	**Number**	**Percent**
Firearm	9	64.3%
Asphyxia	4	28.6%
Overdose	1	7.1%

Race		
American Indian	2	14.3%
Multi-Race	4	28.6%
White	8	57.1%

Gender	Number	Percent
Males	12	85.7%
Females	2	14.3%

Ethnicity	Number	Percent
Hispanic (any race)	0	0
Non-Hispanic	14	100%

- Ten (71.4%) had a history of suspected child maltreatment.
- Two (14.3%) had threatened suicide; in five (35.7%) cases this information was not collected during the investigation.
- Five (35.7%) left a note of intention.
- Five (35.7%) had a history of self-mutilation; in nine (64.3%) cases this information was not collected during the investigation.
- Three (21.4%) had a previous suicide attempt; in five (35.7%) cases this information was not collected during the investigation.
- One (7.1%) case the child did NOT have a familial history of suicide; in 13 (92.9%) cases this information was not collected during the investigation.

Unknown

The Board reviewed and closed 51 deaths in 2017 ruled Unknown. A death is ruled Unknown by the pathologist when there are no physical findings discovered at autopsy to definitively explain the death.

Race		
African American	4	7.8%
American Indian	5	9.8%
Multi-Race	15	29.4%
White	27	52.9%

Ethnicity	Number	Percent
Hispanic (any race)	5	9.8%
Non-Hispanic	46	90.2%

Gender	Number	Percent
Males	23	45.1%
Females	28	54.9%

- Forty-nine (96.1%) were one year of age or less.
- Forty-two (82.4%) were determined to be related to unsafe sleep environment.
- Nine (17.6%) were suspicious for child maltreatment, including inflicted trauma, starvation, maternal drug abuse and inflicted maternal trauma.
- Five (9.8%) were premature births with maternal drug abuse histories.

Traffic Related Deaths

The Board reviewed and closed 39 traffic related deaths in 2017 ruled "Accident".

- There was no helmet use for the ATV, go-cart or motorcycle fatalities.

Race		
African American	4	10.2%
Asian	3	7.7%
Multi-Race	9	23.1%
White	23	59.0%

Ethnicity	Number	Percent
Hispanic (any race)	0	0
Non-Hispanic	39	100%

Gender	Number	Percent
Males	27	69.2%
Females	12	30.8%

Vehicle of Decedent		
Vehicle	**Number**	**Percent**
Car	9	23.1%
Pedestrian	9	23.1%
Pick-up	7	17.9%
SUV	5	12.8%
Van	4	10.2%
ATV	2	7.7%
Go-Cart	1	2.6%
Motorcycle	1	2.6%
Unknown	1	2.6%

Use of Safety Restraints		
Seatbelt/Car Seat Use	**Number**	**Percent**
Properly Restrained	10	38.5%
Not Properly Restrained	14	53.8%
Unknown	2	7.7%
Not Applicable (pedestrian/ATVs)	13	N/A

Position of Decedent		
Position	**Number**	**Percent**
Rear Passenger	13	33.3%
Pedestrian	9	23.1%
Operator	5	12.8%
Unknown	5	12.8%
Front Passenger	4	10.2%
In Utero	2	7.7%
ATV Bed	1	12.8%

Contributing Factors*		
Factor	**Number**	**Percent**
Speeding (including unsafe speed for conditions)	12	30.8%
Drug/Alcohol Use	11	28.2%
Reckless Driving	7	17.9%
Driver Distraction	2	7.7%

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

Drowning Deaths

The Board reviewed and closed 18 accidental deaths in 2017 due to drowning.

Location of Drowning		
Location	**Number**	**Percent**
Open Body of Water (i.e. creek/river/pond/lake)	8	44.4%
Private, Residential Pool	7	38.9%
Bathtub	2	11.1%
Swimming Area of a Natural Body of Water	1	5.6%

Race		
African American	2	11.1%
American Indian	2	11.1%
Multi-Race	4	22.2%
White	10	55.6%

Type of Residential Pool (N=7)		
Type of Pool	**Number**	**Percent**
Above Ground	4	57.1%
In Ground	3	42.9%

Ethnicity	Number	Percent
Hispanic (any race)	1	5.6%
Non-Hispanic	17	94.4%

Gender	Number	Percent
Males	13	72.2%
Females	5	41.2%

Type of Open Body of Water (N=8)		
Open Body	**Number**	**Percent**
Creek	3	37.5%
Pond	2	25.0%
River	2	25.0%
Lake	1	12.5%

- Sixteen (88.9%) of the drownings were not associated with a bathtub. Of these 16, only 1 (6.3%) child had a personal floatation device available; for one incident this information was not documented.
- Fourteen (77.8%) were between the ages of less than one year and five years.

Sleep Related Deaths

The Board reviewed and closed 57 deaths that were related to sleep environments. This accounts for 28.2% of all the cases reviewed and closed in 2017.

Manner of Death for Sleep Related Deaths		
Manner	**Number**	**Percent**
Accidental	13	22.8%
Natural	2	3.5%
Undetermined	42	73.7%

Race		
African American	4	7.0%
American Indian	6	10.5%
Multi-race	16	28.1%
White	31	54.4%

Position of Infant When Placed to Sleep		
Position	**Number**	**Percent**
On Back	27	47.4%
On Side	9	15.8%
On Stomach	10	17.5%
Unknown*	11	19.3%

Ethnicity	Number	Percent
Hispanic (any race)	7	12.3%
Non-Hispanic	50	87.7%

Position of Infant When Found		
Position	**Number**	**Percent**
On Back	17	29.8%
On Side	10	17.5%
On Stomach	19	33.3%
Unknown*	11	19.3%

Gender	Number	Percent
Males	28	49.1%
Females	29	50.9%

Sleeping Arrangement of Infant		
Sleeping Arrangement	**Number**	**Percent**
Alone	25	43.9%
With Adult and/or Other Child	31	54.4%
Unknown*	1	1.7%

Sleeping Location of Infant		
Location	**Number**	**Percent**
Adult Bed	26	45.6%
Crib	12	21.1%
Bassinette	8	14.0%
Couch	4	7.0%
Swing	2	3.5%
Bouncy Seat	1	1.7%
Futon	1	1.7%
Playpen	1	1.7%
Wooden Box	1	1.7%
Unknown	1	1.7%

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

Sleep Related Deaths Cont.

- Forty (70.2%) had a crib/bassinette available in the home; two (3.5%) did not and crib availability was unknown for 15 (26.3%) cases.
- Twenty-five (43.9%) cases had a caregiver with a documented history of drug and/or alcohol abuse.; in 15 (26.3%) cases this information is not addressed in investigative reports.
- Twenty (35.1%) of these deaths occurred in a sleep space designed for infant sleep (i.e. crib/bassinette).
- Nineteen (33.3%) were exposed to second hand smoke; for 31 (54.4%) cases, this information is not addressed in investigative reports. Seven (12.3%) were not exposed to second hand smoke.
- Six (10.5%) cases the caregiver is documented as being under the influence of drugs or alcohol at the time of the incident; three of these six were sharing the sleep space with the child. In 22 (38.6%) cases, this information is not addressed in investigative reports.
- Five (8.8%) deaths occurred when a caregiver fell asleep during feeding (3 bottle/2 breast); in four (7.0%) cases, this information is not addressed in investigative reports.

Firearm Deaths

The Board reviewed and closed 21 deaths in 2017 due to firearms.

Manner of Death for Firearm Victims		
Manner	**Number**	**Percentage**
Homicide	12	57.1%
Suicide	9	42.9%

Type of Firearm Used		
Type of Firearm	**Number**	**Percent**
Handgun	17	81.0%
Hunting Rifle	2	9.5%
Shotgun	1	4.8%
Unknown	1	4.8%

Race		
African American	3	14.3%
American Indian	1	4.8%
Asian	2	9.5%
Multi-Race	2	9.5%
White	14	61.9%

Ethnicity	Number	Percent
Hispanic (any race)	1	4.8%
Non-Hispanic	20	95.2%

Gender	Number	Percent
Males	19	90.5%
Females	2	9.5%

Child Maltreatment

The Board reviewed and closed 63 (30.7%) 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	29	46.0%
Homicide	22	34.9%
Natural	2	3.2%
Suicide	1	1.6%
Undetermined	9	14.3%

Race		
African American	9	14.3%
American Indian	2	3.2%
Asian	2	3.2%
Multi-race	16	25.4%
White	34	54.0%

Gender	Number	Percent
Males	42	66.7%
Females	21	33.3%

Ethnicity	Number	Percent
Hispanic (any race)	5	7.9%
Non-Hispanic	58	92.1%

- Eighteen (28.6%) cases were ruled abuse, 41 (65.1%) cases were ruled neglect, and four (6.3%) were ruled both.
- Sixteen (35.5%) of the 45 neglect cases were due to lack of supervision.
- Fourteen (63.6%) of the 22 abuse cases were due to abusive head trauma.
- One (1.6%) child was in formal foster care at the time of death and an additional six (9.5%) had an open Child Welfare case at the time of death.
- Thirty-two (50.8%) cases had a previous referral for alleged child maltreatment.
- Forty-five (71.4%) cases had at least one caregiver with a documented child welfare history as an alleged perpetrator; in 17 (27.0%) of these, both caregivers had child welfare history as an alleged perpetrator.
- Twenty-five (39.7%) had at least one caregiver with a documented child welfare history as a victim; in three (4.8%) cases, both caregivers had a history as a victim.
- Thirty-one (49.2%) had at least one caregiver with a reported history of substance abuse; twelve (19.0%) cases both caregivers had a reported history of substance abuse.
- Nineteen (30.2%) cases the caregiver was documented to have a history of domestic violence as a perpetrator.
- Twenty-four (38.1%) cases the caregiver was documented to have a history of domestic violence as a victim.
- Twelve (19.0%) were being supervised by someone other than a primary caregiver.
- Thirteen (20.6%) were not referred to Child Welfare for investigation at the time of the incident.

Near Deaths

The Board reviewed and closed 44 near death cases in 2017. A case is deemed near death if the child was admitted to the hospital in serious or critical condition as a result of suspected abuse and/or neglect.

Injuries in Near Death Cases		
Injury	**Number**	**Percent**
Physical Abuse	13	29.5%
Poisoning/O.D.	7	15.9%
Natural Illness	7	15.9%
Drowning	3	6.8%
Failure to Thrive	2	4.5%
Fall	2	4.5%
Firearm	2	4.5%
Fire/Burn	2	4.5%
Vehicular	2	4.5%
Crushing Injury	1	2.2%
Incise Injury	1	2.2%
Scalding	1	2.2%
Suffocation	1	2.2%

Race		
African American	8	18.2%
American Indian	1	2.2%
Multi-race	12	27.3%
White	23	52.3%

Ethnicity	Number	Percent
Hispanic (any race)	3	6.8%
Non-Hispanic	41	93.2%

Gender	Number	Percent
Males	29	65.9%
Females	15	34.1%

- Twenty-six (59.1%) were alleged to be neglect, 14 (31.8%) alleged abuse and neglect, and four (9.1%) alleged abuse only.
- Twenty-eight (63.6%) were substantiated by OKDHS as to the allegations; 13 (46.4% of the 28) resulted in a treatment plan.
- Thirteen (86.7%) of the 15 physical abuse cases were attributed to abusive head trauma.
- Thirty-nine (88.6%) had at least one biological parent as the alleged perpetrator.
- Twenty-one (47.7%) had a previous child welfare referral; eight (38.1% of the 21) were substantiated.
- Nineteen (43.2%) had a sibling with a previous child welfare referral; 10 (52.6% of the 19) were substantiated.
- Sixteen (36.4%) sustained a chronic condition as the result of the near death incident.
- Three (6.8%) had a history of having previously been in state custody.
- Twenty-seven (61.4%) had an associated TANF case.
- Twenty-three (52.3%) were on Medicaid.
- Nineteen (43.2%) were associated with a Child Support Enforcement case.
- Ten (22.7%) resulted in at least one biological parent's rights being terminated.