2018

CHILD DEATH REVIEW BOARD

ANNUAL REPORT

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

THINK. PREVENT. LIVE.

THE OKLAHOMA CHILD DEATH REVIEW BOARD: HISTORY AND MISSION

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 nearly 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.

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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.

TABLE OF CONTENTS

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

CHILD DEATH REVIEW BOARD: 2019 ANNUAL RECOMMENDATIONS

The following are the 2019 annual recommendations of the Oklahoma Child Death Review Board as submitted to the Oklahoma Commission on Children and Youth.

FISCAL (Legislative)

In 2018, 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. 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. The state needs a strong infrastructure that fosters safe communities, preserves families, and supports the health of thriving children. To support this infrastructure, Oklahoma must mandate certain tax regulations and appropriations to ensure adequate revenue generation. When budget cuts are necessary, family strengthening services must be exempt from the cuts. The restoration of preventative programs and services that were previously cut from the state's budget, must be considered, if Oklahoma is to fulfill its commitment to the preservation of the health and wellbeing of its children and families.

LEGISLATION

The CDRB reviewed and closed 39 traffic related deaths in 2018, 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 2018. Thirty-one (54.4%) of the sleep-related deaths reviewed in 2018 were co-sleeping with an adult and/or another child.
- 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

• Continued on Page 4 •

CHILD DEATH REVIEW BOARD: ACTIONS AND ACTIVITIES

The following are the formal actions taken by the CDRB in 2018:

- 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.

closed 87 (43.1% of all cases) infant death cases in 2018; 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 2018, 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 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.

• Continued on Page 5 •

- 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 2018 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.

CASES CLOSED IN 2018

The Oklahoma Child Death Review Board is comprised of five review teams. The total number of deaths reviewed and closed in 2018 by all five teams is 132. The year of death for these cases ranged from 2010 to 2018.

2018 Deaths Reviewed

Manner	Number	Percent
Accident	59	44.7
Homicide	11	8.3
Natural	8	6.1
Suicide	14	10.6
Unknown	40	30.3

Race	Number	Percent
African American	21	15.9
American Indian	9	6.8
Asian	1	0.8
Multi-Race	38	28.8
White	63	47.7

Gender	Number	Percent
Males	86	65.2
Females	46	34.8

Ethnicity	Number	Percent
Hispanic (Any Race)	19	14.4
Non-Hispanic	113	85.6

- Ninety-five (72.0%) were referred to Child Welfare for investigation; 31 (32.6% of the 95) were substantiated as to the allegations.
- Thirty-four (25.8%) had at least one previous Child Welfare referral prior to the death.
- Twenty-three (17.4%) had a history of previous out-of-the-home placement, either voluntarily or court-ordered.
- Twelve (9.0%) had an open Child Welfare case at the time of death.

BREAKDOWN: CASES BY MANNER OF DEATH

ACCIDENTS

The board reviewed and closed 59 death cases in 2018 whose manner of death was ruled an accident, also known as unintentional injuries.

Type	Number	Percent
Vehicular	26	44.1
Asphyxia	14*	23.7
Drowning	9	15.3
Poisoning/ Overdose	3	5.0
Hyperthermia	3	5.0
Fire	1	1.7
Dragging by Animal	1	1.7
Complications of Hypoxic Ischemic Encephalopathy (Traumatic toilet birth w/prolonged exposure to H2O)	1	1.7

Race		
African Amer.	7	11.9
Amer. Indian	4	6.8
Multi-race	16	27.1
White	32	54.2

Ethnicity	Number	Percent
Hispanic/ Any Race	8	13.6
Non-Hispanic	51	86.4

Gender	Number	Percent
Males	8	71.2
Females	17	28.8

- Vehicular deaths continue to be the top mechanism of death for this category.
- 100% of the asphyxia deaths were related to unsafe sleep environments.
- The fire incident did have a smoke detector, unknown if it was functioning at the time of the incident.

*One of the asphyxia deaths had "unsafe sleep" as the cause, this was translated into "asphyxia" for data analysis purposes at the time of review with consultation with the National Center. A separate case had "Other significant conditions included prone sleeping position; history of premature delivery" included in the diagnosis—coded as unsafe sleep. All 14 of the asphyxia deaths were related to the sleep environment.

HOMICIDE

The board reviewed and closed 11 death cases in 2018 whose manner of death was ruled a homicide.

Method	Number	Percent
Physical Abuse	5	45.5
Firearm	4	36.3
Scalding	1	9.1
Stabbing	1	9.1

Gender	Number	Percent
Males	7	63.6
Females	4	36.4

Race		
African Amer.	3	27.3
Amer. Indian	1	9.1
Multi-race	1	9.1
White	6	54.5

Ethnicity	Number	Percent
Hispanic/ Any Race	2	18.2
Non-Hispanic	9	81.8

- All five physical abuse deaths were due to abusive head trauma, at a minimum; three of these also included additional physical trauma to other parts of the body.
- Four (80%) of the physical abuse cases were infants.

UNKNOWN

The board reviewed and closed 40 death cases in 2018 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 Amer.	2	14.3
Multi-race	7	28.6
White	5	57.1

Ethnicity	Number	Percent
Hispanic/ Any Race	0	0
Non-Hispanic	14	100

Gender	Number	Percent
Males	12	85.7
Females	2	14.3

- All 40 (100%) were one year of age or less.
- 36 (90%) were determined to be related to unsafe sleep environment.
- The remaining four (10%) were suspicious for child maltreatment, including lack of supervision and prenatal drug exposure.

BREAKDOWN: CASES BY MANNER OF DEATH

NATURAL

The board reviewed and closed eight deaths in 2018 whose manner of death was ruled natural.

Illness/Disease	Number	Percent
Respiratory Infection(s)	3	37.5
Seizure	2	25.0
Abnormal Vascular Formation	1	12.5
Inflammatory Disease	1	12.5
Neoplastic Disease	1	12.5

Race	Number	Percent
African Amer.	1	12.5
Amer. Indian	1	12.5
Asian	1	12.5
Multi-race	2	25.0
White	3	37.5

Ethnicity	Number	Percent
Hispanic/ Any Race	2	25.0
Non-Hispanic	6	75.0

Gender	Number	Percent
Males	5	62.5
Females	3	37.5

SUICIDE

The board reviewed and closed 11 death cases in 2018 whose manner of death was ruled homicide.

Method	Number	Percent
Firearm	13	92.9
Overdose	1	7.1

Gender	Number	Percent
Males	12	85.7
Females	2	14.3

Ethnicity	Number	Percent
Hispanic/ Any Race	0	0
Non-Hispanic	14	100

Race	Number	Percent
African Amer.	2	14.3
Multi-race	7	28.6
White	5	57.1

- Six (42.9%) had a history of suspected child maltreatment; one (7.1%) had a history of out-of-home placement but it is unknown if this was due to child maltreatment.
- Four (28.6%) had threatened suicide; in nine (64.3%) cases this information was not collected during the investigation.
- Five (35.7%) left a note of intention.
- Three (21.4%) cases noted family discord was occurring in the child's home.
- Two (14.3%) cases noted an argument with parent(s) had recently occurred.
- Two (14.3%) cases noted an argument with significant other had recently occurred.
- Two (14.3%) cases indicated a history of school problems.
- One (7.1%) case noted a recent breakup with significant other.
- One (7.1%) had a history of self-mutilation; in 13 (92.9%) cases this information was not collected during the investigation.
- One (7.1%) had a previous suicide attempt; in 11 (78.6%) 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.

BREAKDOWN: SELECT CAUSES OF DEATH

TRAFFIC-RELATED DEATHS

The board reviewed and closed 26 traffic related death cases in 2018 ruled an "accident".

DEMOGRAPHICS

Race	Number	Percent
African Amer.	1	3.8
Amer. Indian	2	7.7
Multi-race	6	23.1
White	17	65.4

Ethnicity	Number	Percent
Hispanic (Any Race)	4	15.4
Non-Hispanic	22	86.4

Gender	Number	Percent
Males	19	73.1
Females	7	26.9

- There was no helmet use for the ATV fatalities; the dirt bike occupant was utilizing a helmet incorrectly.
- Eight were roll overs.

VEHICLE OF DECEDENT

Vehicle	Number	Percent
Car	7	26.9
Pedestrian	4	15.4
Pick-up	3	11.5
SUV	5	19.2
Van	1	3.8
ATV	3	11.5
Boat	1	3.8
Skateboard	1	3.8
Non-street Legal Dirt Bike	1	3.8

POSITION OF DECEDENT

Position	Number	Percent
Rear Passenger	6	23.1
Pedestrian	4	15.4
Operator	8	30.8
Skateboard	1	3.8
Front Passenger	5	19.2
Boat Passenger	1	3.8
Unknown	1	3.8

CONTRIBUTING FACTORS*

Factor	Number	Percent
Speeding**	8	30.8
Drug/ Alcohol Use	6	23.1
Reckless Driving	5	19.2
Driver Distraction	3	11.5

*Not every fatality had a known/documented contributing factor

**Includes unsafe speed for conditions.

USE OF SAFETY RESTRAINTS

Seatbelt or Carseat	Number	Percent
Properly Restrained	4	15.4
Not Properly Restrained	11	42.3
Unknown	1	3.8
Not Applicable (Pedestrian/ATVs)	10	38.5

"As an Oklahoma law enforcement officer knowing the CDRB reviews each death or near-death case in our state gives me peace of mind that if I make a mistake during my investigation there are professionals reviewing the work I have done - and will hold me accountable."

J.R. Kidney
Chief, Tecumseh Police Department
CDRB - Southeastern Regional Review Team

BREAKDOWN: SELECT CAUSES OF DEATH

SLEEP-RELATED DEATHS

The board reviewed and closed 50 death cases that were related to sleep environments. This accounts for 37.9% of all the cases reviewed and closed in 2018.

DEMOGRAPHICS

Race	Number	Percent
African Amer.	9	18.0
Amer. Indian	3	6.0
Multi-race	15	30.0
White	23	46.0

Ethnicity	Number	Percent
Hispanic (Any Race)	5	10.0
Non-Hispanic	45	90.0

Gender	Number	Percent
Males	29	58.0
Females	21	42.0

MANNER OF SLEEP RELATED DEATHS

Manner	Number	Percent
Accidental	14	28.0
Undetermined	36	72.0

SLEEPING ARRANGEMENT OF INFANT

Sleeping Arrangement	Number	Percent
Alone	18	36.0
With Adult and/or Other Child	31	62.0
Unknown*	1	2.0

POSITION OF INFANT WHEN PLACED TO SLEEP

Position	Number	Percent
On Back	16	32.0
On Side	8	16.0
On Stomach	10	20.0
Unknown	16	32.0

POSITION OF INFANT WHEN FOUND

Position	Number	Percent
On Back	11	22.0
On Side	6	12.0
On Stomach	22	44.0
Unknown	11	22.0

SLEEPING LOCATION OF INFANT

Location	Number	Percent
Adult Bed	31	62.0
Crib	6	12.0
Bassinette	3	6.0
Couch	4	8.0
Bouncy Seat	1	2.0
Futon	1	2.0
Playpen	1	2.0
Unknown	2	4.0
Toddler Bed	1	2.0

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

CDRB Recommends:

All birthing hospitals need to adopt a policy regarding in-house safe sleep practices and provide education on safe sleep after delivery but prior to discharge from the 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 2018. Thirty-one (54.4%) of the sleep-related deaths reviewed in 2018 were co-sleeping with an adult and/or another child.

- Thirty-one (62.0%) had a crib/bassinette available in the home; six (12.0%) did not and crib availability was unknown for 13 (26.0%) cases.
- Thirty-six (72.0%) cases had at least one caregiver with a documented history of drug and/or alcohol abuse.; in four (8.0%) cases this information is not addressed on any caregiver in investigative reports.
- Nine (18.0%) of these deaths occurred in a sleep space designed for infant sleep (i.e. crib/bassinette).
- Twenty-three (46.0%) were exposed to second hand smoke; for 19 (38.0%) cases, this information is not addressed in investigative reports. Eight (16.0%) were not exposed to second hand smoke.
- Six (12.0%) cases the supervisor is documented as being under the influence of drugs or alcohol at the time of the incident; four of these six were sharing the sleep space with the child, one case it is not documented. An additional seven (14.0%) cases, supervisor condition is not addressed in investigative reports.
- Five (10.0%) deaths occurred when a caregiver fell asleep during feeding (all bottle fed); in three (6.0%) cases, this information is not addressed in investigative reports.

BREAKDOWN: SELECT CAUSES OF DEATH

FIREARM DEATHS

The board reviewed and closed 13 death cases in 2018 due to firearms.

DEMOGRAPHICS

Race	Number	Percent
African Amer.	1	7.7
Amer. Indian	1	7.7
Multi-race	4	30.8
White	7	53.8

Ethnicity	Number	Percent
Hispanic (Any Race)	2	15.4
Non-Hispanic	11	86.4

Gender	Number	Percent
Males	10	76.9
Females	3	23.1

MANNER OF DEATH FOR FIREARM VICTIMS

Manner	Number	Percent
Homicide	4	30.8
Suicide	8	61.5
Accident	1	7.7

TYPE OF FIREARM USED

Firearm Type	Number	Percent
Handgun	6	46.2
Hunting Rifle	4	30.8
Shotgun	2	15.8
Assault Rifle	1	7.7

"Young children sometimes shoot themselves or get shot by a sibling with a gun found in their own home. I know I live in Oklahoma – but secure your guns if you have them. Teaching your children not to mess with them is not enough. Almost all of the gun deaths I have reviewed, the parents thought they had done everything possible to teach their children gun safety and that the children didn't know where the guns were. You may not have a second chance if your child finds the gun."

Amy Baum, Child Protection Team Coordinator
The Children's Hospital at OU Medical Center

DROWNING DEATHS

The board reviewed and closed 9 accidental death cases in 2018 due to drowning.

DEMOGRAPHICS

Race	Number	Percent
African Amer.	1	11.1
Multi-race	2	22.2
White	6	66.7

Ethnicity	Number	Percent
Hispanic (Any Race)	1	11.1
Non-Hispanic	8	88.9

Gender	Number	Percent
Males	8	88.9
Females	1	11.1

LOCATION OF DROWNING

Location	Number	Percent
Open Body of Water (creek/river/pond/lake)	1	11.1
Private/ Residential Pool	6	66.7
Bathtub	2	22.2

TYPE OF RESIDENTIAL POOL (N=6)

Pool Type	Number	Percent
Above Ground	2	33.3
In Ground	2	33.3
Unknown (Not Documented)	2	33.3

TYPE OF OPEN BODY OF WATER (N=1)

Open Body	Number	Percent
Pond	1	

- Seven (77.8%) of the drownings were not associated with a bathtub. Of these 7, only six (85.7%) had documentation indicating there was no personal floatation device available for the child; for one incident this information was not documented.

- The age range is one year to seven years of age.

BREAKDOWN: SELECT CAUSES OF DEATH

CHILD MALTREATMENT

The board reviewed and closed 24 (18.2%) cases where it was determined that child mal-treatment (abuse and/or neglect) caused or contributed to the death.

DEMOGRAPHICS

Race	Number	Percent
African Amer.	6	25.0
Amer. Indian	1	4.2
Multi-race	3	12.5
White	14	58.3

Ethnicity	Number	Percent
Hispanic (Any Race)	4	16.7
Non-Hispanic	20	83.3

Gender	Number	Percent
Males	16	66.6
Females	8	33.3

MANNER OF DEATH: ABUSE/NEGLECT CASES

Manner	Number	Percent
Accident	9	37.5
Homicide	7	29.2
Undetermined	8	33.3

- Four (16.7%) cases were ruled abuse only; three (12.5%) cases were ruled abuse and neglect; and 17 (70.8%) cases were ruled neglect only.
- Nine (37.5%) of the neglect cases included lack of supervision.
- Fourteen of the 17 neglect cases included failure to protect from hazards.
- Five of the 7 abuse cases included abusive head trauma.
- Two (8.3%) children were in formal foster care at the time of death
- Six (25.0%) had an open Child Welfare case at the time of death.
- Thirteen (54.2%) cases had a previous referral for alleged child maltreatment.
- Fourteen (58.3%) cases had at least one caregiver with a documented child welfare history as an alleged perpetrator; in nine of these, both caregivers had child welfare history as an alleged perpetrator.
- Nine (37.5%) had at least one caregiver with a documented child welfare history as a victim; in three (12.5%) cases, both caregivers had a history as a victim.
- Fourteen (58.3%) had at least one caregiver with a reported history of substance abuse; eight (33.3%) cases both caregivers had a reported history of substance abuse.
- Twelve (50.0%) cases the caregiver was documented to have a history of domestic violence as a perpetrator.
- Thirteen (54.2%) cases the caregiver was documented to have a history of domestic violence as a victim.
- All were referred to Child Welfare for investigation; 21 (87.5%) were substantiated by CW as to the allegations.
- Eighteen (75.0%) had at least one parent receiving TANF.
- Fifteen (62.5%) had at least one parent on Medicaid.

"The unique charge of fatality review teams is to dig into life events, events that society often asks us to look away from. Reviewing a death gives the community the opportunity to peel back layers of risk factors to identify opportunities for systems change."

Abby Collier
Director, National Center for Fatality Review & Prevention

BREAKDOWN: NEAR DEATHS

NEAR DEATHS

The board reviewed and closed 16 near death cases in 2018. 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.

DEMOGRAPHICS

Race	Number	Percent
African Amer.	1	6.3
Pacific Islander	1	6.3
Multi-race	3	18.7
White	11	98.7

Ethnicity	Number	Percent
Hispanic (Any Race)	1	6.3
Non-Hispanic	15	93.7

Gender	Number	Percent
Males	10	62.5
Females	6	37.5

INJURIES IN NEAR DEATH CASES

Injury	Number	Percent
Physical Abuse	3	18.7
Poisoning/ Overdose	7	43.7
Natural Illness	5	31.3
Fire/Burn	1	6.3

- Twelve (75.0%) were alleged to be neglect, two (12.5%) alleged abuse and neglect and two (12.5%) alleged abuse only.
- Seven (43.7%) were substantiated by OKDHS as to the allegations; two (28.6% of the seven) resulted in a treatment plan, of which, only one case resulted in reunification; another two (28.6% of the seven) resulted in immediate termination of parental rights, therefore, no treatment plan was initiated.
- Three (18.7%) of the four physical abuse cases were attributed to abusive head trauma.
- Fifteen (93.8%) had at least one biological parent as the alleged perpetrator.
- Nine (56.3%) had a previous child welfare referral; seven (77.8% of the 9) were substantiated.
- Twelve (75.0%) had a sibling with a previous child welfare referral; seven (58.3% of the 12) were substantiated.
- Three (18.7%) sustained a chronic condition as the result of the near death incident.
- Four (25.0%) were either currently in state custody or had a history of having previously been in state custody.
- Eight (50.0%) had an associated TANF case.
- Ten (62.5%) were on Medicaid.
- Four (25.0%) were associated with a Child Support Enforcement case.

"I cherish the precious gift of Oklahoma's children. For those who survived a near death incident, I am extraordinarily grateful. For those who didn't make it, I am on a quest to ensure that their deaths are not in vain. The silent witness of those who died spurs me on to figure out how best to prevent what happened to them from happening to someone else."

Angela Henderson
Executive Director, CASA of Northeast Oklahoma
CDRB - Eastern Regional Review Team

CHILD DEATH REVIEW BOARD MEMBERS

American Academy of Pediatrics – Oklahoma Chapter
- Scott Melson, MD

Chief Child Abuse Medical Examiner
- Sarah Passmore, DO

Child Protection Committee of the Children's Hospital at OU Medical Center
- Ryan Brown, MD
- Amy Baum

National Association of Social Workers – Oklahoma
- Bonni Goodwin, LCSW

Office of the Chief Medical Examiner
- Eric Pfeifer, MD
- Lisa Barton, MD

Office of Juvenile Affairs
- Rachel Holt
- Donna Glandon

Oklahoma Bar Association
- Susan Damron, JD

Oklahoma Coalition Against Domestic Violence and Sexual Assault
- Jennifer Thomas

Oklahoma Commission on Children and Youth
- Annette Wisk Jacobi, JD
- Mark James
- Jennifer Hardin
- Matt Spruill

Oklahoma Court Appointed Special Advocate
- Tiffany Page, LCSW

Oklahoma District Attorneys Council
- Orvil Loge, JD

Oklahoma Department of Human Services
- Justin Brown
- Tricia Valera
- Marissa Edstedt

Oklahoma Department of Mental Health and Substance Abuse Services
- Carrie Slatton-Hodges
- Teresa Capps

Oklahoma Health Care Authority
- Kevin Corbett
- Jennifer Laizure

Oklahoma Osteopathic Association
- Laura Bode, DO

Oklahoma State Department of Health
- Gary Cox, JD
- Ann Benson, MSN, APRN, CNP

Oklahoma State Department of Health – Injury Prevention Services
- Tracy Wendling
- Brandi Woods-Littlehon
- Lorry Gail Malcolm

Oklahoma State Department of Health – Maternal Child Health Service
- Joyce Marshall, MPH
- Alicia Lincoln
- James Craig

Oklahoma State Department of Health – Office of Child Abuse Prevention
- Beth Martin, MA, CCC

Oklahoma State Department of Health – State Epidemiologist
- Aaron Wendelboe, PhD
- Shari Kinney

Oklahoma State Bureau of Investigation
- Ricky Adams
- Dannie Sanders
- Brenna Alavarez

Oklahoma State Medical Association
- Mary Ellen Stockett, MD

State Post Adjudication Review Board
- Cindy Nocton
- Melanie Johnson

Vacancies
- Member of an Emergency Medical Technician's Association
- Member of a Native American Tribe involved in the protection of Native American children
- A law enforcement officer

CHILD DEATH REVIEW BOARD TEAMS

Eastern Regional Review Team
- James Ables
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- Ashley Hopkins, MD, MPH
- Orvil Loge, JD
- Susan McComb
- Charla Miller

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- Carolyn Parks
- Cyndie Sanford
- Chuck Sullivan, JD

Southwestern Regional Review Team
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- Jason Hicks, JD
- Donna Glandon
- Diadra Lorseh, PA-C
- Sandra Martinez

Tulsa Regional Review Team
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- Sarah Passmore, DO
- Rose Turner, MSW, LSW
- Susan West

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