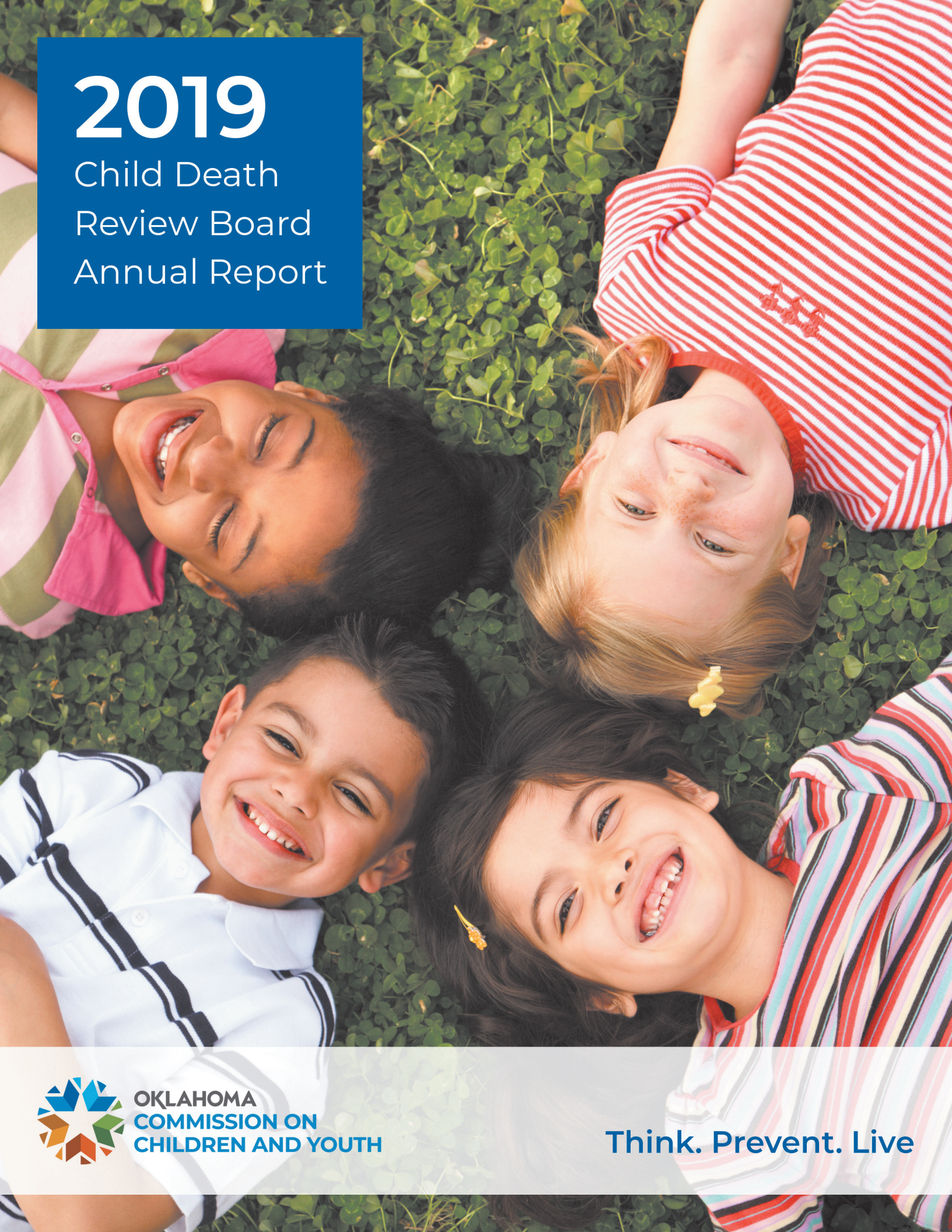

2019 Child Death Review Board Annual Report

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

Think. Prevent. Live

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The Oklahoma Child Death Review Board

History

In 1991, the Oklahoma legislature recognized the need for a multidisciplinary 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. With this information, they developed recommendations to improve policies, procedures, and practices within and between the agencies that serve the children of Oklahoma.

The Child Death Review Board (CDRB) at the Oklahoma Commission on Children and Youth (OCCY) 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.

Mission

The mission of the Oklahoma Child Death Review Board is to reduce the number of preventable deaths by utilizing 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.

2020 Annual Recommendations

The following are the 2020 annual recommendations of the Oklahoma Child Death Review Board as submitted to the Oklahoma Commission on Children and Youth and are based on cases reviewed and closed in 2019.

Legislative

Appropriations

With regard to Oklahoma's fiscal outlook, there has not been an increase in financial appropriations for agencies that serve children and families and many of these agencies continue to struggle to fulfill their obligations. Rather than maintaining a flat budget, the CDRB recommends legislative leaders appropriately fund those agencies, and support programs to create a strong infrastructure that fosters healthy and thriving children as well as preserve families and safe communities.

Recommended Legislation

The CDRB reviewed and closed 26 cases of traffic-related deaths in 2019, with 16 victims being in a vehicle (i.e. does not include pedestrian/ATV/dirt bike/boat deaths). Of these 16, only four (25.0%) were documented as utilizing a seat restraint. To reduce these types of deaths, the CDRB recommends the legislature:

- Expand the age requirement of the Oklahoma Mandatory Seat Belt Use Act (47 O.S. § 12-416-420) from eight to 17.
- Modify the anti-texting law (47 O.S. § 11-901d) to only allow drivers to use hands-free devices while operating a motor vehicle and upgrade violations of this law to a primary offense.
- Require joint death investigations between law enforcement and child welfare for all unexpected (i.e., the cause was not obvious before investigation) child deaths.

Furthermore, the Board recommends that the legislature conduct an interim study regarding preventable child deaths caused by drownings, traffic accidents, unsafe sleep, firearms, and more. The study should include an assessment and analysis of the state's expenditures caused by the events.

Policy

Hospitals

- All birthing facilities shall adopt a policy regarding in-house safe sleep practices and provide education on safe sleep after delivery, but prior to discharge. A bi-annual audit of the safe sleep education should be completed. The education shall be based on the most recent by the American Academy of Pediatrics recommendations regarding safe sleep and include statistics on sleep-related deaths, and most importantly, the dangers of co-sleeping.
- All birthing hospitals shall have a written policy to implement, with fidelity, the Period of PURPLE® Crying abusive head trauma prevention program.
- All medical facilities shall have a written policy to notify the Oklahoma Human Services (OKDHS) Child Welfare Division of unexpected or implausibly explained child deaths.

Law Enforcement

- Adopt a policy to notify the OKDHS Child Welfare Division of all 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 death investigations and documentation to include medical, psychiatric, and social history (i.e., past history of attempts, medications, counseling, note of intent, social media, family history of attempts/deaths, stressors, relationship status, school performance, peer relations, sexual orientation and gender identity). The CDRB reviewed and closed 14 cases of suicide (10.9% of all cases reviewed and closed) and many of the reports reviewed did not collect this information.

- Adopt the Center for Disease Control and Prevention's Sudden Unexplained Infant Death Investigation (SUIDI) protocols, including scene recreation and use of photographs. The CDRB reviewed and closed 62 infant death cases (47.0% of all cases) in 2018; of these, 38 (61.3%) reported as an Undetermined Manner of Death. The CDRB 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. The CDRB reviewed and closed 21 cases of infant deaths (33.9%) in which law enforcement agencies had utilized, at a minimum, the SUIDI form for their collection of infant death information.

- Increase enforcement of child passenger safety laws, including appropriate seat restraint use. The CDRB reviewed and closed 26 traffic related deaths in 2018, with 16 victims being in a vehicle (i.e., does not include pedestrian/ATV/dirt bike/boat deaths). Of these 16, only four (25.0%) 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.

Oklahoma Administrative Office of the Courts

- Provide evidenced-based continuing legal education regarding child fatalities at the annual judicial conference.

Oklahoma Board of Child Abuse Examination

- Assist in the training of Oklahoma's medical providers in all aspects of pediatric injury prevention, identification, and treatment, including but not limited to education on trauma-informed mental health, child maltreatment, safe sleep, suicide, and child fatality-associated issues.

Oklahoma Commission on Children and Youth

- Allocate funding to reestablish the Office of Planning and Coordination to assist with the facilitation of these recommendations.

- Increase the number of Full Time Equivalent (FTE) employees supporting the Oklahoma Child Death Review Board Program from two FTE to three FTE.

Oklahoma Department of Education

- Implement a policy requiring public, private, and online schools to notify OKDHS: when a child is known to be receiving critical services through an individualized health plan, is withdrawn from school, and there is suspicion of neglect. Once notified, a plan can be established to provide continuing services outside the education setting and ensure the safety of the child.

Oklahoma Department of Mental Health and Substance Abuse Services

- Ensure trauma-informed, evidence-based behavioral/mental health assessment and treatment resources are available for infants, children and adults across Oklahoma.

- Extend professional training and consultation in trauma-informed, evidence-based behavioral/mental health screening, assessment, and treatment for Oklahoma community mental health providers and professionals who serve infants and children.

- Increase substance abuse treatment availability across the state.

Oklahoma Health Care Authority

- Increase reimbursements to medical providers for child maltreatment assessments to appropriately reflect the time and effort required.

Oklahoma Department of Human Services

- Ensure all child death investigations are conducted jointly with law enforcement.
- Encourage training and utilization of the Centers for Disease Control and Prevention's SUIDI protocols for OKDHS child death investigations.
- Expand suicide death investigations and documentation, to include medical, psychiatric, and social history.
- Ensure all children in OKDHS custody receive timely child behavioral/mental health screenings to determine the need for trauma-informed, evidence-based behavioral/mental health services.
- Ensure all children and families served by OKDHS programs have access to trauma-informed, evidence-based behavioral/mental health assessment and treatment services.

Cases Closed in 2019

The Oklahoma Child Death Review Program at OCCY is comprised of a state team and four regional teams. The total number of deaths reviewed and closed in 2019 by all five teams is 136. The year of death for these cases ranged from 2012 to 2017.

2019 Deaths Reviewed

Manner	Number	Percent
Accident	59	43.4%
Unknown	31	22.8%
Suicide	19	14.0%
Homicide	18	13.2%
Natural	9	6.6%

Demographics

Gender	Number	Percent
Males	95	69.9%
Females	41	30.1%

Race	Number	Percent
African American	14	10.3%
American Indian	11	8.1%
Asian	1	0.7%
Multi-Race	28	20.6%
White	82	60.3%

Ethnicity	Number	Percent
Hispanic	19	14.0%
Non-Hispanic	116	85.3%
Unknown	1	0.7%

- Forty-two (30.9%) of the cases involved at least one previous Child Welfare referral prior to the death.*
- Nineteen (14.0%) of the cases had a history of previous out-of-the-home placement, either voluntarily or court ordered.
- Fourteen (10.3%) of the cases had an open Child Welfare case at the time of death.

* Ongoing assessments of the data collected may result in the identification of additional cases with previous Child Welfare history.

Cases by Manner of Death & Injury Types

Accidents

The Boards reviewed and closed 59 cases in 2019 whose manner of death was ruled as an "Accident", also known as "Unintentional Injuries".

Mechanism of Death

Type	Number	Percent
Vehicular	31	52.5%
Asphyxia	15	25.4%
Drowning	9	15.3%
Fire	1	1.7%
Firearm	1	1.7%
Hypoxic Ischemic Encephalopathy	1	1.7%
Poisoning/Overdose	1	1.7%

Demographics

Race	Number	Percent
African American	7	11.9%
American Indian	3	5.1%
Asian	1	1.7%
Multi-Race	10	16.9%
White	38	64.4%

Ethnicity	Number	Percent
Hispanic	9	15.3%
Non-Hispanic	49	83.0%
Unknown	1	1.7%

Gender	Number	Percent
Males	43	72.9%
Females	16	27.1%

- Twelve (80.0%) of the asphyxia deaths were related to unsafe sleep environments.

Homicides

The Boards reviewed and closed 18 cases in 2019 whose manner of death was ruled as a "Homicide".

Mechanism of Death

Method	Number	Percent
Firearm	9	50.0%
Physical Abuse	5	27.8%
Crossbow	1	5.6%
Drowning	1	5.6%
Fire	1	5.6%
Stabbing	1	5.6%

Demographics

Race	Number	Percent
African American	4	22.2%
American Indian	1	5.6%
Multi-Race	4	22.2%
White	9	50.0%

Ethnicity	Number	Percent
Hispanic	1	5.6%
Non-Hispanic	18	94.4%

Gender	Number	Percent
Males	15	83.3%
Females	3	16.7%

- Four of the five (80.0%) physical abuse deaths were due to abusive head trauma and two (40.0%) were infants.

Naturals

The Boards reviewed and closed nine cases in 2019 whose manner of death was ruled as a “Natural”.

Mechanism of Death

Illness/Disease	Number	Percent
Infectious Disease	3	33.3%
Asthma	2	22.2%
Cancer	1	11.1%
Cardiovascular	1	11.1%
Complications of Cerebral Palsey	1	11.1%
Complications of Prematurity	1	11.1%

Demographics

Race	Number	Percent
African American	1	11.1%
Multi-Race	4	44.4%
White	4	44.4%

Ethnicity	Number	Percent
Hispanic	1	11.1%
Non-Hispanic	8	88.9%

Gender	Number	Percent
Males	7	77.8%
Females	2	22.2%

Suicides

The Boards reviewed and closed 19 cases in 2019 whose manner of death was ruled as a "Suicide".

Mechanism of Death

Method	Number	Percent
Firearm	11	57.9%
Asphyxia	6	31.6%
Motor Vehicle Crash	1	5.3%
Overdose	1	5.3%

Demographics

Race	Number	Percent
American Indian	2	10.5%
Multi-Race	4	21.1%
White	13	68.4%

Ethnicity	Number	Percent
Hispanic	3	15.8%
Non-Hispanic	16	84.2%

Gender	Number	Percent
Males	15	78.9%
Females	4	21.1%

- Four (21.1%) had a history of self-mutilation. In 14 (73.7%) cases, information regarding the history of self-mutilation was not collected during the investigation.
- Six (31.6%) had documentation of a recent crisis. In 11 (57.9%) cases, information regarding a recent crisis was not collected during the investigation.
- Ten (52.6%) had a history of suspected child maltreatment.
- Three (15.8%) had threatened suicide within the previous 30 days. In 13 (68.4%) cases, information determining if there was a threat of suicide in the previous 30 days was not collected during the investigation.
- Two (10.5%) had a previous suicide attempt. In 17 (89.5%) cases, information regarding if previous suicide attempts was not collected during the investigation.
- Two (11.1%) had a history of out-of-home placement; one (5.3%) case was currently in out-of-home placement, but it is unknown if this was due to child maltreatment or juvenile delinquency.

Unknown

The Boards reviewed and closed 31 cases in 2019 ruled Unknown. A death is ruled "Unknown" by the pathologist when there are no physical findings discovered during the autopsy to definitively explain the death.

Demographics

Race	Number	Percent
African American	2	6.5%
American Indian	5	16.1%
Multi-Race	6	19.4%
White	18	58.1%

Ethnicity	Number	Percent
Hispanic	5	16.1%
Non-Hispanic	16	83.9%

Gender	Number	Percent
Males	15	48.4%
Females	16	51.6%

- Twenty-five (82.6%) of unknown deaths involved children aged one year or less.
- Twenty-one (67.7%) of the unknown deaths were determined to be related to unsafe sleep environments; in an additional three cases, the role of the sleep environment as a contributing factor was unable to be determined.
- Two (6.5%) unknown deaths were due to injuries from firearms, but the intent of the shooters was unable to be determined.
- Four (12.9%) of unknown deaths were suspicious for child maltreatment, including but not limited to abusive head trauma, lack of supervision, and prenatal drug exposure.

Traffic-Related Deaths

The Boards reviewed and closed 31 cases of traffic-related deaths in 2019 ruled as an "Accident".

Contributing Factors*

Factor	Number	Percent
Speeding+++	14	45.2%
Drug / Alcohol Use	9	29%
Driver Distraction	8	25.8%
Reckless Driving	6	19.4%

+++ (Including unsafe speed for conditions)

Position of Decedent

Position	Number	Percent
Passenger	15	48.4%
Operator	10	32.3%
Unknown	1	3.2%

Use of Safety Restraints

Seatbelt / Car Seat Use	Number	Percent (Applicable Cases)
Not Properly Restrained	12	57.1%
Not Applicable++	10	---
Properly Restrained	7	33.3%
Unknown	2	9.5%

++ (Pedestrian / ATVs / Motorcycle)

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

Traffic-Related Deaths (Continued)

Type of Vehicle

Vehicle	Number	Percent
Car	11	35.5%
Sport-Utility Vehicle (SUV)	10	32.3%
Pedestrian	5	16..1%
All-Terrain Vehicle (ATV)	4	12.9%
Motorcycle	1	3.2%

Demographics

Race	Number	Percent
African American	2	6.5%
American Indian	1	3.2%
Asian	2	6.5%
Multi-Race	1	3.2%
White	25	80.6%

Ethnicity	Number	Percent
Hispanic	4	12.9%
Non-Hispanic	26	83.9%
Unknown	1	3.2%

Gender	Number	Percent
Females	7	22.6%
Males	24	77.4%

- No helmets were used in ATV and motorcycle fatalities.
- One pedestrian incident was farm related and involved a tractor.

Drowning Deaths

The Boards reviewed and closed nine cases of accidental deaths in 2019 that were due to drowning.

Location of Drowning

Location	Number	Percent
Open Body of Water[++]	4	44.4%
Private, Residential Pool	4	44.4%
Bathtub	1	11.1%

[++] (i.e. creek / river / pond /lake)

Type of Open Body of Water (N=4)

Open Body	Number	Percent
Lake	3	75.0%
River	1	25.0%

Type of Residential Pool (N=4)

Type of Pool	Number	Percent
Above Ground	2	50.0%
In Ground	2	50.0%

Demographics

Race	Number	Percent
African American	1	11.1%
Multi-Race	1	11.1%
White	7	77.8%

Ethnicity	Number	Percent
Hispanic	2	22.2%
Non-Hispanic	7	77.8%

Gender	Number	Percent
Females	3	33.3%
Males	6	66.7%

- Eight (88.9%) of the drownings occurred in an open body of water or pool. Of these eight, only one (12.5%) had documentation indicating there was a personal flotation device available for the child; for one incident, this information was not documented.
- The children involved in these deaths ranged in age from one to 17 years.

Sleep-Related Deaths

The Boards reviewed and closed 35 cases that were related to sleep environments. This accounts for 33.0% of all the cases reviewed and closed in 2019.

Manner of Death

Manner	Number	Percent
Undetermined	21	60.0%
Accidental	14	40.0%

Sleeping Position When Found

Position	Number	Percent
On Stomach	13	37.1%
On Back	10	28.6%
Unknown[+]	7	20.0%
On Side	4	11.4%
Not on Surface	1	2.9%

Sleeping Arrangement

Manner	Number	Percent
Alone	14	40.0%
Unknown[++]	14	40.0%
With Adult and / or Other Child	20	57.1%

Sleeping Location

Location	Number	Percent
Adult Bed	20	57.1%
Crib	4	11.4%
Couch	3	8.6%
Floor	2	5.7%
Air Mattress	1	2.9%
Bouncy Chair	1	2.9%
Futon	1	2.9%
Playpen	1	2.9%
Unknown[+]	1	2.9%
Unknown[++]	1	2.9%

Sleeping Position

Position	Number	Percent
Unknown[++]	13	37.1%
On Back	11	31.4%
On Stomach	6	17.1%
On Side	5	14.3%

[++] This item is unknown based on the investigator's notation that it appeared the caregiver may have slept on the couch and speculated they may have slept there with the infant.

[+] This information is unknown due to the lack of information collected by scene investigators.

Sleep-Related Deaths (Continued)

Demographics

Race	Number	Percent
African American	3	8.6%
American Indian	3	8.6%
Multi-Race	10	28.6%
White	19	54.3%

Ethnicity	Number	Percent
Hispanic	3	8.6%
Non-Hispanic	32	91.4%

Gender	Number	Percent
Females	14	40.0%
Males	21	60.0%

- Five (14.3%) cases involved a child exposed to second hand smoke. Ten (28.6%) were not exposed to second hand smoke. In the remaining cases, it is not known whether the child was exposed to second-hand smoke.
- Four (11.4%%) of these deaths occurred in a product designed for infant sleep (i.e. crib).
- In one (2.9%) case, the caregiver is documented as being under the influence of drugs or alcohol at the time of the incident. In an additional eight (22.9%) cases, the caregiver's condition is not addressed in investigative reports.
- One (2.9%) death was noted as to having occurred when a caregiver fell asleep during feeding; in four (11.4%) cases, however, this information is not addressed in investigative reports.
- In seventeen (48.6%) cases, there was a crib/bassinet available in the home. In four cases (11.4%) no crib was available and in the remaining cases, it was unknown if a crib or bassinet was available.
- Seventeen (48.6%) cases had at least one caregiver with a documented history of drug and/or alcohol abuse; in six (17.1%) cases, this information is not addressed regarding any caregiver in investigative reports.

Firearm Deaths

The Boards reviewed and closed 23 cases in 2019 of deaths due to firearms.

Manner of Death for Sleep Related Deaths

Manner	Number	Percent
Suicide	11	47.8%
Homicide	9	39.1%
Undetermined	2	8.7%
Accident	1	4.3%

Type of Firearm Used

Type of Firearm	Number	Percent
Handgun	20	87.0%
Hunting Rifle	1	4.3%
Unknown	1	4.3%
Assault Rifle	1	4.3%

Demographics

Race	Number	Percent
White	14	60.9%
African American	4	17.4%
Multi-Race	4	17.4%
American Indian	1	4.3%

Ethnicity	Number	Percent
Hispanic	5	8.7%
Non-Hispanic	16	91.3%

Gender	Number	Percent
Males	15	87.0%
Females	16	13.0%

Child Maltreatment

The Boards reviewed and closed 31 (22.8%) cases in which child maltreatment caused or contributed to the death.

Manner of Death for Abuse / Neglect Cases

Manner	Number	Percent
Accident	15	48.4%
Homicide	6	19.4%
Undetermined	6	19.4%
Natural	3	9.7%
Suicide	1	3.2%

Demographics

Race	Number	Percent
African American	4	12.9%
American Indian	2	6.4%
Multi-Race	6	19.4%
White	19	61.3%

Ethnicity	Number	Percent
Hispanic	5	16.1%
Non-Hispanic	26	83.9%

Gender	Number	Percent
Males	19	61.3%
Females	12	38.7%

- Five (16.1 %) cases were ruled as abuse only; two (6.5%) cases were ruled as abuse and neglect; and 24 (77.4%) cases were ruled as neglect only.
- Ten (38.5%) of the 26 neglect cases included lack of supervision.
- Twelve (46.2%) of the 26 neglect cases included failure to protect from hazards.
- Five (71.4%) of the seven abuse cases included abusive head trauma.
- Two (6.4%) children were in foster care at the time of death
- Five (16.1%) cases had an open Child Welfare case at the time of death.
- Fifteen (48.4%) cases had a previous referral for alleged child maltreatment.
- Eighteen (58.1%) cases had at least one caregiver with a documented child welfare history as an alleged perpetrator; in six (33.3%) of these cases, both caregivers had child welfare history as an alleged perpetrator.
- Six (19.4%) cases had at least one caregiver with a documented child welfare history as a victim; in one (3.2%) case, both caregivers had a history as a victim.
- Eleven (35.5%) cases had at least one caregiver with a reported history of substance abuse; in five (16.1%) cases, both caregivers had a reported history of substance abuse.
- In three (9.7%) cases, the caregiver was documented to have a history of domestic violence as a perpetrator.
- In nine (29.0%) cases, the caregiver had a documented history of domestic violence as a victim.
- Fifteen (48.4%) cases had at least one caregiver receiving Temporary Aid to Needy Families (TANF).
- Sixteen cases (51.6%) had at least one parent on Medicaid.

Near Deaths

The Boards reviewed and closed 106 near-death cases in 2019. A case is deemed a 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

Location	Number	Percent
Physical Abuse	32	30.2%
Poisoning / Overdose	28	26.4%
Natural Illness	19	17.9%
Vehicular	6	5.7%
Fire / Burn	4	3.8%
Inorganic Failure to Thrive	3	2.8%
Drowning	3	2.8%
Firearm	2	1.9%
Dog Attack	2	1.9%
Asphyxia	2	4.7%
Fall[++]	2	1.9%

[++] One near-death fall victim had extreme hypothermia.

Demographics

Race	Number	Percent
African American	14	13.2%
American Indian	3	2.8%
Multi-Race	26	24.5%
White	63	59.4%

Ethnicity	Number	Percent
Hispanic	13	12.3%
Non-Hispanic	93	87.7%

Gender	Number	Percent
Males	56	52.8%
Females	50	47.2%

Near Deaths (Continued)

- Seventy-five (70.8%) cases were alleged to be caused by neglect. Twenty-three (21.7%) cases were alleged to be caused by abuse and neglect; and eight cases (7.5) were alleged to have been caused by abuse only.

- Fifty-seven (53.8%) cases were substantiated by OKDHS due to allegations; 26 of these (45.6%) resulted in a treatment plan, of which, 17 of these 26 (65.4%) cases resulted in reunification; another three (5.3 % of the 57) resulted in immediate termination of parental rights.

- Thirty (93.8%) of the 32 physical abuse cases were attributed to abusive head trauma; two of these also involved a simultaneous attempted drowning.

- Ninety-eight (92.5%) cases had at least one biological parent named as the alleged perpetrator.

- Forty-four (41.5%) children had a previous child welfare referral; 11 of the 44 (25.0% of 44/10.4% of all near-deaths) were substantiated.

- Sixty (56.6%) children had a sibling with a previous child welfare referral; 16 of the 60 (26.7%) children had substantiated cases.

- Thirteen (12.3%) children sustained a chronic condition as the result of the near-death incident (e.g. vision impairment).

- Two (1.9%) children were either currently in state custody or had a history of having previously been in-state custody.

- Sixty-seven (63.2%) cases had an associated TANF case.

- Sixty-two (58.5%) children were on Medicaid.

- Twenty-six (24.5%) cases were associated with a Child Support Enforcement case.

CDRB Board Members, Teams, Staff

2019 CDRB State Board Members

Chair: Ryan Brown | Co-Chair: Susan Schmidt

Chair of the Child Protection Team of the Oklahoma Children's Hospital	Ryan Brown	Amy Baum*
Chief Child Abuse Medical Examiner	Sarah Passmore	
Chief Executive Officer of the Oklahoma Health Care Authority	Becky Pasternik-Ickard	Jennifer Laizure*
Chief Medical Examiner	Eric Pfeifer	Edana Stroberg*
Chief of Injury Prevention Services of the State Department of Health	Brandi Woods-Littlejohn	Tracy Wendling*
Chief of Maternal and Child Health Services at the State Department of Health	Joyce Marshall	Alicia Lincoln*
Commissioner of Mental Health and Substance Abuse Services	Terri White	Teresa Capps*
Director of Department of Human Services	Edward Lake	Tricia Valera*
Director of the Office of Juvenile Affairs	Steven Buck	Donna Glandon*
Director of the Oklahoma State Bureau of Investigation	Ricky Adams	Andi Hamilton*
Office of Child Abuse Prevention	Beth Martin	
Oklahoma Commission on Children and Youth	Annette Wisk Jacobi	Matthew Spruill* Jennifer Hardin*
State Commissioner of Health	Tom Bates	
State Epidemiologist of the State Department of Health	Laurence Burnsed	Amanda Shoemate*

*Designee

Appointed by the Executive Director of OCCY

Court-Appointed Special Advocate (CASA)
Tiffany Page

District Attorney's Council
Orvil Loge

Emergency Medical Technician (EMT)
Vacant

Oklahoma Bar Association
Jennifer Irish

Oklahoma Coalition or Association Against Domestic Violence and Sexual Assault
Jennifer Thomas

Oklahoma Indian Affairs Commission (ICWA)
Vacant

Oklahoma Psychological Association
Susan Schmidt

Pediatric Physician or Osteopath
Scott Melson

Representing Oklahoma Sheriffs and Peace Officers
Tim Dorsey

Representing Social Workers
Ann Riley

State Post Adjudication Review Advisory Board
Cindy Nocton

Statewide Organization for Osteopaths
Laura Bode

Statewide Organization for Physicians
Vacant

2019 Eastern Regional CDRB Team

Court Appointed Special Advocate (CASA)
Angela Henderson

District Attorney, District 15
Orvil Loge

Licensed Mental Health Professional
Vacant

Medical Professional
Ashley Hopkins

Oklahoma Department of Human Services
Susan McComb

Law Enforcement
James Ables

2019 Southeastern Regional CDRB Team

District Attorney - District 18
Chuck Sullivan

Licensed Mental Health Professional
Vacant

Medical Professional
Cyndie Sanford

Oklahoma Department of Human Services
Jerrell Hoffman

Public Health / Birth Defects
Carolyn Parks

Law Enforcement
J.R. Kidney

2019 Southwestern Regional CDRB Team

Court Appointed Special Advocate (CASA)
Kim Davis

District Attorney - District 6
Jason Hicks

Law Enforcement
John Byers

Licensed Mental Health Professional
Vacant

Medical Professional
Laura White

Office of Juvenile Affairs
Donna Glandon

Oklahoma Department of Human Services
Sandra Martinez

2019 Tulsa CDRB Team

District Attorney - District 14
Steve Kunzweiler

Domestic Violence Intervention Services
Rose Turner

Law Enforcement
Penny Hamrick

Licensed Mental Health Professional
Kathryn LaFortune

Medical Professional
Sarah Passmore

Oklahoma Department of Human Services
Julie Merritt

Safe Kids, Tulsa
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