Oklahoma Child Death Review Board Recommendations
Submitted to the Oklahoma Commission on Children and Youth
May 2004

The Oklahoma Child Death Review Board (CDRB) was legislatively created in 1991 and is required by statute to review the deaths and near deaths of children under the age of 18. The citation for statutes governing the powers and responsibilities of the Child Death Review Board are found in Title 10, Section 1150.1 through 1150.5 of the Oklahoma Statutes.

Experts from a range of backgrounds serve on one of three teams across the state to review the deaths and 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 following recommendations are based on the cases reviewed and closed in calendar year 2003. In the past, CDRB recommendations have addressed multiple manners and causes of death. This year, the Board has focused on deaths due to **motor vehicles, firearms, and child abuse/neglect**. A more in-depth report of the 2003 findings will be available in the near future; however, please feel free to visit http://okcdrb.ouhsc.edu to view or download a copy of the 2002 annual report.

Motor Vehicle Related Deaths

Key Findings

From the Board's inception, motor vehicle related fatalities have consistently been the leading cause of unintentional death among children 17 years of age and younger. In 2003, the Board reviewed a **total** of 292 deaths: of these, 89 (30.5%) involved motor vehicles. Eighty-six were non-pedestrian related and of these, 46 (53.5%) were unrestrained. The driver was cited for driving under the influence in 11 (12%) cases. Drivers aged 17 years and younger were involved in 40 (46.5%) cases. Although exact numbers are unavailable at this time, the Board is extremely concerned about the number of motor vehicle collisions that occur with two or more teenaged occupants.

Recommendations

In order to reduce the number of motor vehicle related fatalities, the Oklahoma Child Death Review Board recommends:

- Strengthening Oklahoma's graduated drivers licensing system to include restrictions on teen drivers and the number of unlicensed and/or younger passengers allowed.
- Mandatory field sobriety testing of drivers in motor vehicle accidents resulting in a child fatality and/or a critical or serious injury to a child.
- Increasing fines for drivers transporting unrestrained children to be comparable with fines for unrestrained drivers.
- Court sanctions and/or education prevention programs, such as drunk driving victim's panels should be strongly encouraged for first time and/or repeat offenders. Drug court, or a comparable drug and alcohol treatment program for repeat offenders should also be strongly encouraged.
- Provide mandated universal driver education classes for all high school and career tech students.

Firearm Related Deaths

Key Findings

In 2003, the Board reviewed and closed 18 fatalities that were firearm related. This represents 6.2% of the total deaths reviewed.

Recommendations

In order to reduce the number of firearm related fatalities, the Oklahoma Child Death Review Board recommends:

- Mandatory reporting by health care providers to the appropriate law enforcement agency of any/all gunshot wounds. Subsequently, mandatory reporting by law enforcement agencies to the Injury Prevention Services, Oklahoma State Department of Health of all gunshot wounds for review.
- Mandatory field sobriety testing of all individuals present during a firearm related fatality.
- Development of gun safety and avoidance programs, including implementation plans, with a particular emphasis on elementary aged children.
- Identification of secure visitation drop-off locations for the safe exchange of children in cases where the court has ordered visitation and a caregiver/parent has expressed to the court a concern over safety.

Child Abuse/Neglect Deaths

Key Findings

Reduction of child abuse/neglect deaths has remained a primary goal for the Oklahoma CDRB since its inception. In 2003 the Board reviewed and closed 29 (9.9% of the total number reviewed and closed) cases that were concluded by the Board to have been a result of child abuse/neglect: 22 (75.9%) of these were also ruled abuse/neglect by the Oklahoma Department of Human Services, Child Welfare. Additionally, 11 (37.9%) had previous child welfare involvement. Currently, Oklahoma's child welfare workers and supervisors carry an active caseload that is 2 to 3 times great than those recommended nationally by the Child Welfare League of America.

Recommendations

In order to reduce the number of deaths due to child abuse/neglect, the Oklahoma Child Death Review Board recommends:

- Provide the Oklahoma Department of Human Services with funding to hire additional child welfare staff to be in compliance with the recommended national standard issued by the Child Welfare League of America.
- Continue to fund the Oklahoma State Health Department's primary and secondary prevention programs (i.e. Children First, Child Guidance, Office of Child Abuse Prevention Programs, Oklahoma Parents as Teachers, and Safe Families).
- Increase child abuse prevention services that serve families that do not qualify for Children First but have been considered to be at high risk for abuse/neglect.