Oklahoma Child Death Review Board Recommendations
Submitted to the Oklahoma Commission on Children and Youth
May 2005

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 five 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 2004. 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, drowning, fire, natural causes, firearms, and child abuse/neglect**. A more in-depth report of the 2004 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 2003 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 2004, the Board reviewed a **total** of 398 deaths: of these, 120 (30.2%) involved motor vehicles. One hundred five (105) deaths were non-pedestrian related and of these, 43 (41%) were unrestrained. The driver was cited for driving under the influence in 13 (12.4%) cases. Drivers aged 17 years and younger were involved in 57 (54.3%) 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:

- Passing H.B. 1653, which strengthens Oklahoma's graduated drivers licensing system to include restrictions on teen drivers and the number of unlicensed and/or younger passengers allowed and the hours a teen can drive on the road.
- 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.
- Passing S.B. 799, which would increase the fines for drivers transporting unrestrained children to be comparable with fines for unrestrained drivers. This bill would also earmark the funding from that fine for child passenger safety education, administered through the Oklahoma Highway Safety Office.
- 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.

Drownings

Key Findings

In 2004 the Oklahoma Child Death Review Board reviewed 28 deaths due to drowning. This represents 7.0% of the total deaths reviewed. Nineteen (67.9%) occurred in a natural body of water; four (14.3%) occurred in a residential pool or hot tub.

Recommendations

In order to reduce the number of deaths due to drowning, the Board recommends:

- The State Department of Health's Injury Prevention Services Division should develop and distribute public service ads highlighting the dangers that flash-flooded natural bodies of water pose to curious children and adolescents.
- Continued distribution of the State Department of Health's Injury Prevention Services Division informational brochures on pool/hot tub safety.
- All pool/hot tub retailers in Oklahoma should be bound by law to distribute information on pool/hot tub safety to new pool/hot tub owners at the time of sale or installation of any new pool/hot tub.

Firearm Related Deaths

Key Findings

In 2004, the Board reviewed and closed 28 fatalities that were firearm related. This represents 7.0% 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; and, subsequent 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.
- Compliance with and enforcement of the Bryar Wheeler Act.
- Continued support for Project Safe Child, a gunlock giveaway program based out of Lt. Governor Mary Fallin's Office.

Fires

Key Findings

In 2004 the Oklahoma Child Death Review Board reviewed 19 deaths due to fires. This number represents 4.8% of the total deaths reviewed. In 13 (68.4%) of the cases there was not a working smoke detector present in the residence.

Recommendations

In order to reduce the number of fire related deaths, the Board recommends:

- Establishment of an educational/ community outreach grant open to all fire departments in Oklahoma that would enable each department to engage in smoke detector giveaway/installment programs, and would also enable the departments to partner with the Oklahoma Safe Kids Coalition to provide juvenile cooking classes and home safety inspections.

Natural Causes

Key Findings

In 2004 the Oklahoma Child Death Review Board reviewed 91 deaths due to natural causes. Of those deaths, 73 (80.2%) children were under a year old.

Recommendations

In order to reduce the number of natural deaths, the Board recommends:

- Expanding the Oklahoma State Department of Health's Children First Program to cover all first time mothers and to extend the enrollment period to include mothers who do not enroll by the 28th week of pregnancy.
- Creation of prevention programs to include those not eligible for the Children's First program.
- Expand hospital educational programs to include information on available programs and newborn safety issues (i.e. safe sleeping issues) prior to discharge.

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 2004 the Board reviewed and closed 48 (12% of the total number reviewed and closed) cases that were concluded by the Board to have been a result of child abuse/neglect: 41 of these were also ruled abuse/neglect by the Oklahoma Department of Human Services, Child Welfare. Additionally, 165 (41.5%) 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.
- Continued funding of the Oklahoma State Health Department's primary and secondary prevention programs.
- 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.