Oklahoma Child Death Review Board Recommendations
Submitted to the Oklahoma Commission on Children and Youth
May 2006

The following recommendations are based on the cases reviewed and closed in calendar year 2005. Recommendations this year are based on deaths due to **motor vehicles, drowning, unsafe sleep practices, fires, and child abuse/neglect**.

Motor Vehicle Related Deaths

Key Findings

From the Board's inception, motor vehicle related fatalities have consistently been the leading cause of death among children 17 years of age and younger. In 2005, the Board reviewed a **total** of 409 deaths: of these, 115 (28.1%) involved motor vehicles. 85 (73.9% of 115) children were traveling in a car/van/pickup/SUV and of these, 55 (64.7% of the 85) 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 continues to be 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:

- Enforcement of the Oklahoma Graduated Driver's License Law, which restricts the number of multiple passengers younger than 21 (other than family).
- 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.
- Enforcement of child passenger safety restraint laws, which fines drivers transporting unrestrained children.
- 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.
- Passage of All-Terrain Vehicle (ATV) legislation that contains elements requiring helmet use, prohibiting passengers, prohibiting drivers aged 12 and under, and requiring ATV safety training.
- Promotion and establishment of funding for the Safe Kids Oklahoma Child Passenger Safety Program. This program includes: providing car seats for low-income families; providing training and car seats for **every** child care center in the state starting July 2006; providing, through a loaner program, car seats for special needs children; piloting a program for providing car beds for babies born prematurely; and the "Please Be Seated" program which allows citizens the opportunity to send a card to Safe Kids with license plate information when a citizen has observed a child to be transported unrestrained. Safe Kids then contacts the family through a letter reminding them of the law and offering assistance for obtaining a car seat.
- Promotion and establishment funding for the Safe Kids Oklahoma bicycle safety program, which includes conducting bicycle safety rodeos and provided free helmets to groups who conduct bike safety education events utilizing Safe Kids curriculum.
- Promotion and establishment of funding for the Safe Kids Oklahoma "Walk This Way" program which is aimed at reducing the number of child pedestrian injuries and fatalities.

Unsafe Sleep Practices

Key Findings

There were 40 deaths in 2005 classified as SIDS. Of those 40 cases, 20 (50%) of the children were sharing the same sleep surface with an adult or sibling, and 16 (40%) of those 40 cases included the possibility of overlay. Regarding sleep position, six children were sleeping on their stomach, eight were sleeping on their side, and it was unknown as to the sleep position of 14 of the children.

Additionally, 67 undetermined deaths (non-SIDS) were reviewed by the board, with 36 (53.7%) attributed to unsafe sleep conditions.

Of the 12 accidental suffocation deaths reviewed and closed by the board, five (41.7%) were confirmed overlays during sleep as a result of bed sharing.

These three categories combined for 64 (15.6%) deaths due to unsafe sleeping practices.

Recommendations

In order to reduce the number of deaths of children due to unsafe sleeping conditions, the Oklahoma Child Death Review Board recommends:

- Require education about safe sleep practices to be included in child-birth preparation core curriculum
- Require hospitals in Oklahoma to educate new parents about safe sleep practices prior to discharge from the hospital
- Provide the Oklahoma State Department of Health (OSDH) with funding to create and distribute a "New Parent Kit" to all first time mothers who deliver in Oklahoma. A component of the "New Parent Kit" will include educational information about safe sleep practices
- Distribute cribs for low income families
- Continue educational efforts regarding safe sleep recommendations, American Academy of Pediatrics, through the OSDH Sudden Infant Death Syndrome (SIDS) Program.

Drowning

Key Findings

In 2005 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.

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.

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.