Oklahoma Child Death Review Board Recommendations
Submitted to the Oklahoma Commission on Children and Youth
May 2007

The following recommendations are based on the 345 death cases reviewed and closed in calendar year 2006. 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. There were a total of 106 cases (30.7% of 345) in 2006 involving motor vehicles.

Of these:

- Nineteen cases (17.9%) the driver was cited for driving under the influence.
- Eleven (10.4%) were pedestrians.
- Eighty-one (76.4%) children were traveling in a car/van/pickup/SUV.
- One (0.9%) was riding a bicycle--helmet use unknown.
- Drivers aged 17 years and younger were involved in 41 cases (38.7%).
- Fifty-four of the 81 (66.7%) children riding in a car/van/ pick-up were unrestrained.
- Nine (8.5%)were riding All-Terrain Vehicles (ATVs), with the youngest four years of age and the oldest 15.
- Of the nine riding ATVs, only one was wearing a helmet.

Recommendations

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

Legislative recommendations

- Mandatory 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.
- 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. Requirements should be statewide, including on private land.

Administrative recommendations

- Develop and disseminate a campaign that will promote the best practices related to booster seat usage.
- Provide, at no cost, driver education classes for all high school and career tech students.
- Increase accessibility and usage of drug courts and drug treatment programs.

- 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 of funding for the Safe Kids Oklahoma "Walk This Way" program which is aimed at reducing the number of child pedestrian injuries and fatalities.
- 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.

Unsafe Sleep Practices

Key Findings

There were a total of 72 (20.9%) deaths where unsafe sleeping practices contributed to the death.

Of these:

- Forty-seven (66.2%) were ruled Unknown manner of death, with the Medical Examiner stating unsafe sleep conditions might have contributed to the death.
- Three (4.5%) were ruled Accidental deaths due to overlay.
- Twenty-eight (42%) deaths were classified as SIDS. Of those 28 cases, eight of the children were sharing the same sleep surface with an adult or sibling, and four cases included the possibility of overlay, as ruled by the Medical Examiner. Regarding sleep position, 11 children were sleeping on their stomach, six were on their backs, three were sleeping on their side, and it was unknown as to the sleep position of eight of the children.

Recommendations

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

- Affordable childbirth classes should be available to all expectant mothers. The Board further recommends that the classes educate new parents on safe sleep issues, including utilization of the American Academy of Pediatrics recommendations for safe sleep.
- Distribute cribs for low income families

Drowning

Key Findings

In 2006 the Oklahoma Child Death Review Board reviewed 16 deaths due to drowning. Of these:

- Four (25.0%) occurred in a natural body of water. Of these, two were in lakes, one was in a river and one was in a creek
- Seven (43.8%) occurred in a residential swimming pool and all but one were residents or visitors of the home where the pool was located

- Four (25.0%) occurred in a bathtub
- One (6.3%) occurred in an apartment pool
- Eleven (68.8%) were 3 years of age and younger
- Three (18.8%) were 5 through 12 years of age
- Two (12.5%) were aged 13 or older

Recommendations

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

Legislative recommendations:

- 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.

Administrative recommendations:

- Promotion and establishment of funding for Safe Kids Oklahoma's water safety programs, which include the Wee Water Wahoo and Wacky Water Wahoo water safety training events and the Brittany Project, which provides loaner life jackets at Oklahoma Corps of Engineer lakes.
- 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.
- Encourage swimming lessons for all children.

Fires

Key Findings

In 2006 the Oklahoma Child Death Review Board reviewed 20 deaths due to fires. Of these:

- Six (30.0%) of the cases did not have a working smoke detector present in the residence.
- Ten (50%) cases investigators were unable to determine if a working smoke detector was present.

Recommendations

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

- Promotion and establishment of funding for Safe Kid's Oklahoma's burn prevention programs, which include the "Save-A-Life" smoke detector giveaway/installment programs, a fireworks safety campaign, a childcare providers burn education curriculum, and a "Change Your Battery" campaign.

Child Abuse/Neglect Deaths

Key Findings

In 2006 the Board reviewed and closed 50 cases that were concluded by the Board to have been a result of child abuse/neglect. Nine (18%) cases had previous child welfare referrals.

Currently, Oklahoma's child welfare workers and supervisors carry an active caseload that is 2 to 3 times greater 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:

- Increased funding of the Oklahoma State Health Department's primary and secondary prevention programs.
- Increased funding of the Department of Education Parents as Teachers program
- Increased funding of the Oklahoma Department of Human Services Comprehensive Home-Based Services program
- 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.
- 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 and with a salary competitive with positions in other states.
- Make court records pertaining to custody and guardianship available for public inspection after a child death.
- Create a medical team to review the medical records in child abuse/neglect cases and submit an opinion.