Oklahoma Child Death Review Board Recommendations
Submitted to the Oklahoma Commission on Children and Youth
May 2008

The following recommendations are based on the 378 death cases and 78 near death cases reviewed and closed in calendar year 2007. 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 89 cases (23.5% of all death cases reviewed) in 2007 involving motor vehicles.

Of these:

- Sixty-eight (76.4%) children were traveling in a car/van/pickup/SUV.
- Forty-six (51.7%) cases the driver was not tested for driving under the influence.
- Forty-two (61.8%) of the 68 children riding in a car/van/pick-up were unrestrained.
- Thirty-one (34.8%) involved drivers age 17 years or younger.
- Fifteen (22.1%) operators of vehicles were cited for driving under the influence.
- Eleven (12.4%) were pedestrians.
- Three (3.4%) were riding All-Terrain Vehicles (ATVs), with the youngest nine years of age and the oldest 15. None were utilizing a helmet. One occurred on private land, the remaining two occurred on public roadways.
- Two (2.2%) were riding a bicycle, with one utilizing 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.
- Legislation that bans the use of wireless hand-held telephone or electronic communication device by motor vehicle operators.
- Strengthening of the booster seat legislation to include use up to age 8.
- 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

- Enforcement of child passenger safety restraint laws, which include fines for drivers transporting unrestrained children.

- 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.

Unsafe Sleep Practices

Key Findings

There were a total of 105 (27.8%) deaths where unsafe sleeping practices contributed to the death.

Of these:

- Seventy-six (20.1% of all deaths/72.4% of sleep related deaths) were ruled Unknown manner of death, with the Medical Examiner stating unsafe sleep conditions might have contributed to the death.
- Twelve (3.2% of all deaths/11.4% of sleep related deaths) were ruled Accidental deaths with sleep conditions contributing to accidental suffocation/asphyxia.
- Twenty-seven (7.1% of all deaths/16.2% of sleep related deaths) deaths were classified as SIDS. Of those 27 cases, four of the children were sharing the same sleep surface with an adult or sibling. Regarding sleep position, 11 children were sleeping on their stomach, six were on their backs, four were sleeping on their side, and it was unknown as to the sleep position of six 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:

- The Office of the Chief Medical Examiner and law enforcement agencies should adopt the Centers for Disease Control's model policy for investigation and classification of Sudden Unexpected Infant Deaths (SUID) and Sudden Infant Death Syndrome (SIDS), including the use of scene recreation and digital photography. The methods currently utilized do not adequately provide the opportunity to distinguish accidental overlay (smothering) from undetermined causes.
- Affordable childbirth classes should be available to all expectant mothers and address safe sleep issues prior to birth. Scholarships should also be available to those who cannot afford classes.
- Education on safe sleep environments should also be provided to families after delivery but prior to discharge.
- Education on safe sleep environments should be provided to families at the first well-child visit.
- Distribute cribs for low-income families.
- All hospitals in Oklahoma should adopt a policy regarding in-house safe sleep issues.

Drowning

Key Findings

In 2007 the Oklahoma Child Death Review Board reviewed 27 deaths due to drowning.

Of these:

- Nine (33.3%) occurred in a natural body of water. Of these, four were in lakes, four were in a river and one was in a farm pond.

- Ten (37.0%) occurred in a residential swimming pool and all but one were residents or visitors of the home where the pool was located
- Five (18.5%) occurred in a bathtub
- One (6.3%) occurred in an apartment pool
- One (6.3%) occurred in a ditch
- One (6.3%) occurred in an abandoned well.
- Fourteen (51.9%) were 4 years of age and younger (nine of these were age two)
- Nine (33.3%) were 5 through 12 years of age
- Four (14.8%) were 13 years of age 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:

- Increase access to swimming lessons for all children.
- Fund and distribute the "water watcher" badges that promote appropriate and responsible adult supervision of children around water.
- EMS/National Weather Service include a warning regarding the dangers of flash floods in weather alerts.

Fires

Key Findings

In 2007 the Oklahoma Child Death Review Board reviewed 18 deaths due to fires. Of these:

- Nine fires were responsible for the 18 deaths.
- Only one (11.1%) of the nine fire incidents had a working smoke detector present in the residence.
- Two (22.2%) of the nine fire incidents 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:

- Smoke alarm give away programs should include carbon monoxide detectors.
- Increased penalties for homeowners who do not provide smoke alarms for rental houses.

Child Abuse/Neglect Deaths

Key Findings

In 2007 the Board reviewed and closed 34 cases that were concluded by the Board to have been a result of child abuse or child neglect. Fifteen (44.1%) 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 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.
- 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.

Agency Specific Recommendations

Oklahoma Safe Kids Coalition

- 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.
- 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.
- 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.

Oklahoma Child Death Review Board

- Promotion and establishment of funding for the Oklahoma Child Death Review Board's Think. Prevent. Live campaign that addresses (or will address) water, fire, wheeled activities, sleep, and child abuse/neglect best practices.