2014 Oklahoma Child Death Review Board Recommendations

FISCAL (Legislative)

Office of the Chief Medical Examiner (OCME)

Continue to support OCME goals to improve and maintain infrastructure.
Policy changes are ineffective without a financial commitment by the state of Oklahoma to affect positive change.

Oklahoma Department of Human Services (OKDHS)

Provide the OKDHS with funding to hire additional child welfare staff with a salary competitive with positions in other states to be in compliance with the recommended national standard issued by the Child Welfare League of America and in accordance with the Pinnacle Plan.
Policy changes are ineffective without a financial commitment by the state of Oklahoma to affect positive change.

POLICY

Hospitals

- All delivery hospitals should adopt a policy regarding in-house safe sleep and provide education on safe sleep after delivery but prior to discharge from hospital. The education should include statistics on sleep related deaths. The Oklahoma Child Death Review Board (CDRB) reviewed and closed 103 (37.1%) deaths related to unsafe sleep environments in 2013.
- All hospitals should have a written policy to notify the OKDHS Child Welfare division of unexpected child deaths.

Law Enforcement

- Increase the depth of suicide investigations to include mental, medical and social history (i.e. past history of attempts, medications, counseling, note of intention, social media, psychiatric diagnosis, family history of attempts/deaths, stressors, relationship status).
- Enforce child passenger safety laws, including appropriate seat restraint use. The CDRB reviewed and closed 43 cases that involved motor-vehicles and found seat restraint use to be at less than 30%.
- Document sobriety testing results in the Oklahoma Uniform Traffic Collision Report submitted to Department of Public Safety.
- Adopt the Center for Disease Control's Sudden Unexpected Infant Death Investigation (SUIDI) protocols. The CDRB reviewed and closed 113 (40.6%) infant deaths in 2013; 99 (35.6%) of these were related to unsafe sleep environments and 93 (33.5%) had an "Undetermined" Manner of Death.
- Adopt a policy to notify the OKDHS Child Welfare division of unexpected child deaths.

Legislative

- Enact legislation banning the use of hand-held devices while operating a motor vehicle.
- Enhance child passenger safety laws, including appropriate seat restraint use.

Office of the Chief Medical Examiner

- Adopt the Center for Disease Control's SUIDI protocols. The CDRB reviewed and closed 113 (40.6%) infant deaths in 2013; 99 (35.6%) of these were related to unsafe sleep environments and 93 (33.5%) had an "Undetermined" Manner of Death.

Oklahoma Department of Human Services

- Adopt a policy directing workers to connect a referral to a case number upon assignment of the referral.
- Adopt a policy ensuring referrals assigned as an "Assessment" include a finding as to the allegation(s) and risk(s) reported.