Oklahoma Child Death Review Board 2016 Recommendations

In 1991 the Oklahoma legislature recognized the need for a multi-disciplinary review of how Oklahoma's children were dying and created the Child Death Review Act. Since that time, many professionals convened and reviewed over 6,700 cases of child deaths 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 Child Death Review Board (CDRB) strongly believes that through the implementation of these recommendations, lives may be saved, families strengthened and those agencies that serve to safeguard Oklahoma's children are supported in a manner that assists them in performing their duties.

The CDRB submits recommendations on an annual basis that could potentially reduce the number of children dying in Oklahoma each year. With the current fiscal crisis, we anticipate more children dying if the state does not provide the resources to do what needs to be done to protect our most vulnerable citizens and our future, our children.

The CDRB is providing the following recommendations:

FISCAL (Legislative)

Those state agencies that serve to safeguard Oklahoma's children require adequate funding in order to perform their duties. Oklahoma needs to make certain tax regulations and reforms are in place that ensure revenue will not be reduced and a budget that can be balanced. A stand-still budget, much less budget cuts, will not provide Oklahoma with the foundation it needs to build capacity nor to provide strong infrastructure, safe communities and healthy, thriving children. Agency improvement and policy changes are ineffective without a financial commitment by the state of Oklahoma to affect positive change.

LEGISLATION

The CDRB reviewed and closed 83 traffic related deaths in 2015, with 57 victims being in a vehicle (i.e. does not include pedestrian/bicycle/motorcycle/ATV). Of these 57, over half (56.6%) were not utilizing a safety restraint.

- Expand the current seat restraint legislation to include backseat passengers.
- Increase the fine for those ages 13 and over not using seat restraints to $100 for the first offense and $500 for subsequent offenses.
- Enact legislation banning the use of hand-held devices while operating a motor vehicle and the use to be a primary offense.
- Enact legislation that increases the age to get a license to 17 years of age.
- Enact legislation that increases the age to get a permit to 16 years of age.
- Extend the intermediate driver's license period to one full year.

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 CDRB reviewed and closed 112 (31.4%) deaths related to unsafe sleep environments in 2015.
- All hospitals should have a written policy to notify the OKDHS Child Welfare division of unexpected child deaths.
- All birthing hospitals should have a written policy to implement, with fidelity, the Period of *PURPLE*® Crying abusive head trauma prevention program.

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 intent, social media, psychiatric diagnosis, family history of attempts/deaths, stressors, relationship status). The CDRB reviewed and closed 21 (5.9%) cases of Suicide and a majority did not have this information collected.
- Enforce child passenger safety laws, including appropriate seat restraint use. The CDRB reviewed and closed 83 cases that involved motor-vehicles, 57 of which were applicable to seat restraint use, and found seat restraint use to be 40%.
- Adopt the Center for Disease Control's Sudden Unexpected Infant Death Investigation (SUIDI) protocols, including scene recreation and use of photographs. The CDRB reviewed and closed 152 (43.0%) infant death cases in 2015; of these, 107 (70.4%) had an Undetermined Manner of Death. The Board is of the opinion that with the utilization of these protocols, a more definitive Manner of Death may be determined and prevention avenues may be identified.
- Adopt a policy to notify the OKDHS Child Welfare division of unexpected child deaths.
- Ensure all child death investigations are conducted jointly with OKDHS/Child Welfare.

Office of the Chief Medical Examiner

- Adopt the Center for Disease Control's SUIDI protocols. As stated previously, the CDRB reviewed and closed 152 (43.0%) infant death cases in 2015; of these 152 infant deaths, 107 (70.4%) had an Undetermined Manner of Death. The Board is of the opinion that with the utilization of these protocols, a more definitive Manner of Death may be determined and prevention avenues identified.
- Adopt a policy to notify the OKDHS Child Welfare division of unexpected child deaths.
- Adopt a policy that ensures all drug-exposed newborns that die within the first 30 days of life have the drug-exposure listed in the Report of Autopsy by Medical Examiner.

Oklahoma Department of Human Services

- Ensure all children in custody are referred and treated by a Trauma Focused Cognitive Behavioral Therapist.
- Adopt the Center for Disease Control’s SUIDI protocols for Child Welfare death investigations.

Oklahoma Department of Mental Health and Substance Abuse Services

- Ensure appropriate treatment resources are available for persons suffering from mental health and substance abuse issues.
- Create a Child Welfare liaison position to ensure children in custody and their caregivers are receiving appropriate mental health and substance abuse services.
- Extend the number of Trauma Focused Cognitive Behavioral Therapists available for children and families.

Oklahoma State Department of Health

- Restore and increase funding to the Office of Child Abuse Prevention.