Oklahoma Child Death Review Board 2017 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 have convened and reviewed almost 7,000 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 will 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 can be balanced. Budget cuts will not provide Oklahomans with the financial commitment necessary to provide strong infrastructure, safe communities, and healthy thriving children.

LEGISLATION

The CDRB reviewed and closed 35 traffic related deaths in 2016, with 32 victims being in a vehicle (i.e. does not include pedestrian/ATV deaths). Of these 32, over one-third (37.5%) 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 from $25 to $100 for the first offense and consideration of an increased fine for subsequent offenses.
- Expand anti-texting legislation to only permit use of hands-free devices while operating a motor vehicle and the violation upgraded to 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

- The CDRB reviewed and closed 73 (37.6% of all deaths reviewed) deaths related to unsafe sleep environments in 2016. All birthing 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, most importantly the dangers of co-sleeping. Sixty-eight percent of the sleep-related deaths reviewed in 2016 were co-sleeping with an adult and/or another child.
- All birthing hospitals should have a written policy to implement, with fidelity, the Period of *PURPLE*® Crying abusive head trauma prevention program.
- All hospitals should have a written policy to notify the OKDHS Child Welfare division of unexpected child deaths.

Law Enforcement

- Expand suicide investigations to include medical, psychiatric, 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, school performance, peer relations, gender identity) in reports reviewed. The CDRB reviewed and closed 27 (13.9%) cases of suicide and a majority did not collect this information, which is vital to identifying prevention efforts.
- Increase enforcement of child passenger safety laws, including appropriate seat restraint use. The CDRB reviewed and closed 35 cases involving motor vehicles. The CDRB found improper seat restraint use to be 37.5%.
- 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 84 (43.3% of all cases) infant death cases in 2016; of these, 55 (64.7% of the infant deaths) 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 85 (43.3%) infant death cases in 2016; of these 85 infant deaths, 55 (64.7% of the infant deaths) 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 written 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 OKDHS custody receive timely child behavior health screenings to determine the need for trauma-informed, evidence-based mental health treatment assessment and treatment services.
- Ensure all children and families served by OKDHS programs have access to trauma-informed, evidence-based mental health assessment and treatment services.
- Enforce use of the Center for Disease Control's SUIDI protocols for OKDHS death investigations.

Oklahoma Department of Mental Health and Substance Abuse Services

- Ensure trauma-informed, evidence-based mental health assessment and treatment resources are available for children and adults across Oklahoma.
- Extend professional training and consultation in trauma-informed, evidence-based mental health assessment and treatment for Oklahoma Community Mental Health Providers.

Oklahoma State Department of Health

- Ensure the continuation of the Office of Child Abuse Prevention and support with appropriate funding