# CHILD DEATH REVIEW BOARD: 2019 ANNUAL RECOMMENDATIONS

The following are the 2019 annual recommendations of the Oklahoma Child Death Review Board as submitted to the Oklahoma Commission on Children and Youth.

## FISCAL (Legislative)

In 2018, Oklahoma had one of the highest increases in child abuse cases in the nation and remains in the top five for child abuse related fatalities. A culture of budget cuts has left many public and private agencies powerless in their ability to provide the necessary services to Oklahoma's vulnerable population. The state needs a strong infrastructure that fosters safe communities, preserves families, and supports the health of thriving children. To support this infrastructure, Oklahoma must mandate certain tax regulations and appropriations to ensure adequate revenue generation. When budget cuts are necessary, family strengthening services must be exempt from the cuts. The restoration of preventative programs and services that were previously cut from the state's budget, must be considered, if Oklahoma is to fulfill its commitment to the preservation of the health and wellbeing of its children and families.

## LEGISLATION

The CDRB reviewed and closed 39 traffic related deaths in 2018, with 30 victims being in a vehicle (i.e. does not include pedestrian/motorcycle deaths). Of these 30, only one-third (33.3%) were documented as utilizing a seat restraint.

Expand the current seat restraint legislation to include backseat passengers.

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.

## POLICY

### District Attorney's Council

Provide training for prosecutors involved in child maltreatment cases, including drug endangered children.

### Hospitals

All birthing hospitals will adopt a policy regarding in-house safe sleep practices and provide education on safe sleep after delivery but prior to discharge from hospital. The safe sleep education should be audited on at least a bi-annual basis. The education will be based on the most recent American Academy of Pediatrics recommendations regarding safe sleep and include statistics on sleep related deaths, most importantly the dangers of co-sleeping. The CDRB reviewed and closed 57 (28.2% of all deaths reviewed) deaths related to unsafe sleep environments in 2018. Thirty-one (54.4%) of the sleep-related deaths reviewed in 2018 were co-sleeping with an adult and/or another child.

All birthing hospitals will have a written policy to implement, with fidelity, the Period of PURPLE® Crying abusive head trauma prevention program.

All hospitals will have a written policy to notify the OKDHS Child Welfare division of unexpected or implausibly explained child deaths.

### Law Enforcement

Adopt a policy to notify the OKDHS Child Welfare division of unexpected or implausibly explained child deaths.

Ensure all child death investigations are conducted jointly with OKDHS/Child Welfare.

Ensure that law enforcement has training on investigating child suicides and unexpected or implausibly explained child deaths.

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 14 (6.9%) cases of suicide and a majority did not collect this information, which is vital to identifying prevention efforts.

Adopt the Center for Disease Control's Sudden Unexplained Infant Death Investigation (SUIDI) protocols, including scene recreation and use of photographs. The CDRB reviewed and closed 87 (43.1% of all cases) infant death cases in 2018; of these, 48 (55.2% 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.

Increase enforcement of child passenger safety laws, including appropriate seat restraint use. The CDRB reviewed and closed 39 traffic related deaths in 2018, with 30 victims being in a vehicle (i.e. does not include pedestrian/motorcycle deaths). Of these 30, only one-third (33.3%) were documented as utilizing a seat restraint.

### Office of the Chief Medical Examiner

Adopt a written policy to notify the OKDHS Child Welfare division of unexpected or implausibly explained 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 Commission on Children and Youth

Re-establish the Office of Planning and Coordination to assist with the facilitation of these recommendations.

### Oklahoma Department of Education

Implement a policy for when a child is known to be receiving critical services from school are abruptly withdrawn, report the incident to OKDHS, so a plan for continuing services can be established.

### Oklahoma Department of Human Services

Ensure all child death investigations are conducted jointly with law enforcement.

Encourage training and utilization of the Center for Disease Control's SUIDI protocols for OKDHS child death investigations.

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 14 (6.9%) cases of suicide and a majority did not collect this information, which is vital to identifying prevention efforts.

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.

### 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.

Increase substance abuse treatment availability and stop reducing the already available treatment options across the state. In 2018 the CDRB reviewed 66 (30.2%) deaths where at least one parent had a history of substance abuse.

### Oklahoma Health Care Authority

Reimburse medical providers for child maltreatment assessments.

Reimburse medical and behavioral health providers for substance abuse assessments.

### Oklahoma State Department of Health

Support maternal, child and family health as a mandated public health area and prioritize and support appropriate funding of child abuse prevention as a core program that will improve health outcomes in our state and prevent child deaths.

Promote and make available safe sleep practice education in all areas of the state through facilitation by public health social workers and health education staff.

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