OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

CHILD DEATH REVIEW BOARD

OKLAHOMA CHILD DEATH REVIEW BOARD 2020 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[1]. Since that time, many professionals have convened and reviewed almost 7,400 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 is promoting the following recommendations:

FISCAL (Legislative)

With regard to Oklahoma's fiscal outlook, there has not been an increase in financial appropriations for agencies that serve children and families and many agencies continue to struggle to fulfill their obligations. Rather than maintaining a flat budget, the CDRB recommends legislative leaders appropriately fund those agencies, and support programs to create a strong infrastructure that fosters healthy and thriving children and preserves families and safe communities.

LEGISLATION

The CDRB reviewed and closed 26 traffic related deaths in 2018, with 16 victims being in a vehicle (i.e. does not include pedestrian/ATV/dirt bike/ boat deaths). Of these 16, only 4 (25.0%) were documented as utilizing a seat restraint.

- Expand the current seat restraint legislation to include backseat passengers between the ages of eight (8) and seventeen (17).
- Expand anti-texting legislation to limit drivers to only being able to use hands-free devices while operating a motor vehicle and upgrade violations to a primary offense.

Additional legislative recommendations include:

- Require joint death investigations between law enforcement and child welfare for all unexpected (i.e., the cause was not obvious before investigation) child deaths.
- Conduct an interim study of preventable child deaths, including (but not limited to) drownings, traffic, unsafe sleep and firearms. The study should include a financial assessment and analysis of economic impact on the state due to hospitalizations and lost earnings (due to family members staying with the child instead of working).

POLICY

Hospitals

- All birthing facilities shall adopt a policy regarding in-house safe sleep practices and provide education on safe sleep after delivery but prior to discharge. A bi-annual audit of the safe sleep education should be completed. The education shall 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.
- All birthing hospitals shall have a written policy to implement, with fidelity, the Period of PURPLE® Crying abusive head trauma prevention program.

- All medical facilities shall have a written policy to notify the Oklahoma Human Services (OKDHS) Child Welfare Division of unexpected (i.e., cause of death not obvious before investigation) or implausibly explained child deaths.

Law Enforcement

- Adopt a policy to notify the OKDHS Child Welfare Division of unexpected (i.e., cause of death not obvious before investigation) 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 (i.e., cause of death not obvious before investigation) or implausibly explained child deaths.
- Expand suicide death investigations and documentation, to include medical, psychiatric, and social history (i.e., past history of attempts, medications, counseling, note of intent, social media, family history of attempts/ deaths, stressors, relationship status, school performance, peer relations, sexual orientation and gender identity) in reports reviewed. The CDRB reviewed and closed 14 (10.9% of all cases reviewed and closed) cases of suicide and many did not collect this information.
- Adopt the Center for Disease Control and Prevention's Sudden Unexplained Infant Death Investigation (SUIDI) protocols, including scene recreation and use of photographs. The CDRB reviewed and closed 62 (47.0% of all cases) infant death cases in 2018; of these, 38 (61.3% of the infant deaths) had an Undetermined Manner of Death. The CDRB 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. The CDRB reviewed and closed 21 cases (33.9% of the infant deaths) where law enforcement agencies had utilized, at a minimum, the SUIDI form for their collection of infant death information.
- Increase enforcement of child passenger safety laws, including appropriate seat restraint use. The CDRB reviewed and closed 26 traffic related deaths in 2018, with 16 victims being in a vehicle (i.e., does not include pedestrian/ATV/dirt bike/ boat deaths). Of these 16, only 4 (25.0%) 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 (i.e., cause of death not obvious before investigation) or implausibly explained child deaths.

Oklahoma Administrative Office of the Courts

- Provide evidenced-based child fatality-related continuing legal education at the annual judicial conference.

Oklahoma Board of Child Abuse Examination

- Assist in the training of Oklahoma's medical providers in all aspects of pediatric injury prevention, identification, and treatment, including (but not limited to) education on trauma-informed mental health, child maltreatment, safe sleep, suicide, and child fatality-associated issues.

Oklahoma Commission on Children and Youth

- Allocate funding to re-establish the Office of Planning and Coordination to assist with the facilitation of these recommendations.
- Increase the number of Full Time Equivalent (FTE) employees supporting the Oklahoma Child Death Review Board Program from two FTE to three FTE.

Oklahoma Department of Education

- Implement a policy requiring public, private, or online schools to notify OKDHS when a child who is known to be receiving critical services through an individualized health plan is withdrawn from school, and there is a suspicion of neglect, so a plan for continuing services outside the education setting and the safety of the child can be established.

Oklahoma Department of Mental Health and Substance Abuse Services

- Ensure trauma-informed, evidence-based behavioral/mental health assessment and treatment resources are available for infants, children and adults across Oklahoma.
- Extend professional training and consultation in trauma-informed, evidence-based behavioral/mental health screening, assessment, and treatment for Oklahoma community mental health providers and professionals who serve infants and children.
- Increase substance abuse treatment availability across the state.
- Ensure programs specific to infant mental health are available across the state.

Oklahoma Health Care Authority

- Increase reimbursements to medical providers for child maltreatment assessments to appropriately reflect the time and effort required for these evaluations.

Oklahoma State Department of Health

- Ensure availability of maternal, child, and family health programs.
- Promote and make available safe sleep practice education in all areas of the state.

Oklahoma Department of Human Services

- Ensure all child death investigations are conducted jointly with law enforcement.
- Encourage training and utilization of the Centers for Disease Control and Prevention's SUIDI protocols for OKDHS child death investigations.
- Expand suicide death investigations and documentation, to include medical, psychiatric, and social history (i.e., past history of attempts, medications, counseling, note of intent, social media, family history of attempts/deaths, stressors, relationship status, school performance, peer relations, sexual orientation and gender identity) in reports reviewed. The CDRB reviewed and closed 14 (10.9% of all cases reviewed and closed) cases of suicide and many did not collect this information.
- Ensure all children in OKDHS custody receives timely child behavioral/mental health screenings to determine the need for trauma-informed, evidence-based behavioral/mental health assessment and treatment services.
- Ensure all children and families served by OKDHS programs have access to trauma-informed, evidence-based behavioral/mental health assessment and treatment services.

[1] Oklahoma Title 10. Children, Chapter 51, Child Death Review Board, O.S. §, 1150-1150.6

This publication is issued by the Oklahoma Commission on Children and Youth as authorized by Annette Wisk-Jacobi, Executive Director. Copies have not been printed but are available through the agency's website.