OKLAHOMA CHILD DEATH REVIEW BOARD 2021 RECOMMENDATIONS

The Child Death Review Board (CDRB) respectfully submits the following recommendations to the Oklahoma Commission on Children and Youth for consideration for inclusion in the State Plan for Children's Services:

Abusive Head Trauma

In 2010, the Preparing for a Lifetime, It's Everyone's Responsibility Infant Mortality Reduction Initiative created an Infant Injury Prevention Workgroup. The workgroup is charged with recruiting hospitals to provide (free-of-charge) an abusive head trauma prevention education program called the Period of PURPLE© Crying. There are currently 39 of 46 birthing hospitals across Oklahoma that provides this education.

In 2019, the CDRB reviewed and closed four deaths and 30 near-deaths attributed to abusive head trauma which occurred in both metropolitan and rural areas of Oklahoma.

The CDRB recommends continuing to fund this program as well as ensuring all birthing hospitals in Oklahoma provide this education with the expectation that caregivers may acquire skills that empower their capability to keep an infant safe.

Unsafe Sleep

In 2019, infant deaths in Oklahoma totaled more than 30% (45 out of 136) of the deaths reviewed and closed by the CDRB. Of the deaths reviewed, 34 (75.6%) were noted to be due to an unsafe sleep environment. Three additional deaths could not determine an unsafe sleep environment existed – however, it wasn't ruled out. All deaths reviewed occurred in both urban and rural areas of Oklahoma.

To the CDRB's knowledge, there is limited instruction on infant safe sleep available for non-professional caregivers across Oklahoma. The CDRB recommends an environmental scan be conducted to determine what (if any) caregiver education is being provided and by whom. The CDRB recommends areas identified by the scan as lacking safe sleep education to be provided educational resources as needed.

Suicide

Identifying prevention needs to reduce suicides has been difficult for the CDRB. This is due to investigation reports of suicide deaths from law enforcement lacking information such as a family history of suicide, previous suicide attempts, mental health history, and the use of behavioral health medications. It is often difficult to determine if the decedent left a suicide note.

The CDRB recommends investigations conducted by law enforcement to include the details previously listed in order to identify specific suicide prevention needs. Additionally, suicide investigation policies and procedures need to include notification of the death to the Oklahoma Department of Human Services.

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.