CHILD DEATH
REVIEW BOARD

OKLAHOMA CHILD DEATH REVIEW BOARD
2022 RECOMMENDATIONS

Due to the challenges resulting from the COVID-19 pandemic, the following recommendations are based on cases reviewed and closed by the Oklahoma Child Death Review Board (CDRB) Teams in the years 2020 and 2021. The combined total is 163 death cases and 132 near-death cases.

Abusive Head Trauma

In 2020 and 2021, the CDRB reviewed and closed nine death cases and 28 near-death cases that were alleged to be abusive head trauma (25 cases were substantiated allegations). All cases occurred in both rural and metropolitan areas.

In 2010, the *Preparing for a Lifetime, It's Everyone's Responsibility* Infant Mortality Reduction Initiative created an infant injury workgroup charged with recruiting hospitals to provide, free of charge, the Period of PURPLE® Crying, an abusive head trauma prevention education program. There are currently 40 out of 46 birthing hospitals across the state providing this education through the *Preparing for a Lifetime, It's Everyone's Responsibility* Infant Injury Workgroup.

It is recommended by the CDRB that this educational program should continue to be funded. It also recommends that all statewide birthing hospitals provide their patients with the program's educational resources. The expectation is that caregivers may acquire skills that empower them to keep an infant safe.

Unsafe Sleep

In 2020 and 2021, 80 out of 163 death cases reviewed and closed by the CDRB involved infant deaths. Additionally, 63 of the 163 cases were due to an unsafe sleep environment. Although it wasn't ruled out, the review of one of the cases could not determine if it was an unsafe sleep environment. All deaths occurred in both rural and metropolitan areas.

To the CDRB's knowledge, the availability of infant safe sleep education to statewide non-professional caregivers is limited. The CDRB recommends that an environmental scan should be conducted in order to determine what type of education is being provided to the non-professional caregivers as well as identify if someone is teaching it. If an area is identified by the scan to be lacking infant safe sleep education, the CDRB recommends that it should be provided educational resources.

Suicide

It has been difficult for the CDRB to identify prevention needs to reduce suicide deaths in Oklahoma. Difficulties stem from investigative reports lacking information such as the family history of suicide, previous suicide attempts, mental health history, the use of behavioral health medications, and whether or not a suicide note was left by the decedent. In 2020 and 2021, the CDRB reviewed and closed 14 suicide cases. Five of those cases did not have documentation on whether a suicide note was left by the decedent.

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The CDRB recommends that law enforcement investigations should include details such as the family history of suicide, previous suicide attempts, mental health history, the use of behavioral health medications, and whether or not a suicide note was left by the decedent. This information will assist the CDRB with the identification of resources needed for suicide prevention. The CDRB also recommends that suicide investigation policies and procedures should include notifying the Oklahoma Department of Human Services, Child Welfare Division of the suicide.

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