OCCY Board Update

June 25, 2021

Child Abuse Prevention Act
§63-1-227 through 1-227.9

- Prepare and implement a comprehensive state plan for the planning and coordination of child abuse prevention programs and services and for the establishment, development and funding of such programs and services, and to revise and update said plan pursuant to the provisions of Section 1-227.3 of this title;
- The Oklahoma Commission on Children and Youth shall review and approve the comprehensive state plan and any subsequent revisions of said plan,

- The plan shall include but not be limited to:
  - Specific proposals for the implementation of the comprehensive state plan which would promote the efficient use of staff, funds and other resources on the state level and improve the coordination and integration of state goals, activities and funds for the prevention of child abuse and neglect, particularly with regard to primary and secondary prevention of child abuse and neglect;
  - Specific proposals detailing the interagency provision of services to all populations at risk of committing child abuse. Services, especially those directed at high-risk populations including, but not limited to, those populations in which parental drug and/or alcohol abuse, mental illness and domestic abuse are an issue, shall be specifically addressed.

Child Abuse Prevention Act §63-1-227 through 1-227.9

- The Office of Child Abuse Prevention and the Oklahoma Commission on Children and Youth shall at least annually review the state plan and make any necessary revisions based on changing needs and program evaluation results not less than every five (5) years.

- The Office of Child Abuse Prevention shall provide adequate opportunity for appropriate private and public agencies and organizations and private citizens and consumers to participate at the local level in the development of the state plan.

Updates

- Biannual Meetings & Collaborations
- Surveys
- Data Collection
- Pandemic Response

Moving Forward

- Upcoming Survey July 2021
- Next Biannual State Plan Meeting: October 14, 2021
- Focus Areas:
  - More Community and Family Involvement
  - Addressing Gaps in Prevention Continuum
  - Begin Preparation for Next Plan Cycle

Beth Martin

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Oklahoma Child Death Review Board

2021 Annual Recommendations

Oklahoma Commission on Children and Youth

Commission Meeting

June 25, 2021

OKLAHOMA
COMMISSION ON
CHILDREN AND YOUTH

Oklahoma Child Death Review Board

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

Mission Statement:

The mission of the Oklahoma Child Death Review Board is to reduce the number of preventable deaths through a multidisciplinary approach to case review. Through case review, the Child Death Review Board collects 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.

Oklahoma Child Death Review Board

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

Quick Facts:

- 1989 Oklahoma Child Abuse Study Commission
- Statutorily Created/Sunset Reviewed
- Definition of “Child Protection System”
- Annual Data and Recommendations
- Oklahoma State Plan for Children’s Services

Oklahoma Child Death Review Board

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

2019 Data

Total Deaths Reviewed and Closed

N = 136

MANNER	NUMBER	PERCENT
Accident	59	43.3%
Unknown	31	22.8%
Suicide	19	14.0%
Homicide	18	13.2%
Natural	9	6.6%

Oklahoma Child Death Review Board

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

2019 Data

Accidents

N = 59

INJURY TYPE	NUMBER	PERCENT
Vehicular	31	52.5%
Asphyxia	15	25.4%
Drowning	9	15.3%
Fire	1	1.7%
Firearm	1	1.7%
Hypoxic Ischemic Encephalopathy*	1	1.7%
Poisoning/OD	1	1.7%

2019 Data

Unknown/Could Not Be Determined

N = 31

- Twenty-five (82.6%) were one year of age or less.
- Twenty-one (67.7%) were determined to be related to unsafe sleep environment; in an additional three cases, the role of the sleep environment as a contributory factor was unable to be determined.
- Two (6.5%) were due to injuries from firearms but the intent of the shooter was unable to be determined.
- Four (12.9%) were suspicious for child maltreatment, including but not limited to abusive head trauma, lack of supervision and prenatal drug exposure.

Oklahoma Child Death Review Board

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

2019 Data

Suicides

N = 19

INJURY TYPE	NUMBER	PERCENT
Firearm	11	57.9%
Asphyxia	6	31.6%
MVC	1	5.3%
OD	1	5.3%

Oklahoma Child Death Review Board

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

2019 Data

- Ten (52.6%) had a history of suspected child maltreatment.
- Two (11.1%) had a history of out-of-home placement; one (5.3%) case was currently in out-of-home placement, but it is unknown if this was due to child maltreatment vs. juvenile delinquency.
- Three (15.8%) had threatened suicide within the previous 30 days; in 13 (68.4%) cases this information was not collected during the investigation.
- Six (31.6%) had documentation of a recent crisis; 11 (57.9%) cases this information was not collected during the investigation.
- Four (21.1%) had a history of self-mutilation; in 14 (73.7%) cases this information was not collected during the investigation.
- Two (10.5%) had a previous suicide attempt; in 17 (89.5%) cases this information was not collected during the investigation.

Oklahoma Child Death Review Board

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

2019 Data

Homicides

N = 18

INJURY TYPE	NUMBER	PERCENT
Firearm	9	50.0%
Physical Abuse	5*	27.8%
Cross-bow	1	5.6%
Drowning	1	5.6%
Fire	1	5.6%
Stabbing	1	5.6%

2019 Data

Natural

N = 9

ILLNESS TYPE	NUMBER	PERCENT
Infectious Disease	3	33.3%
Asthma	2	22.2%
Cancer	1	11.1%
Cardiovascular	1	11.1%
Complications of Cerebral Palsey	1	11.1%
Complications of Prematurity	1	11.1%

2019 Data

Sleep-Related

N = 35

MANNER	NUMBER	PERCENT
Undetermined	21	61.8%
Accidental	14	41.2%

2019 Data

Sleep-Related

Position When Placed

MANNER	NUMBER	PERCENT
Unknown	13	37.1%
On Back	11	31.4%
On Stomach	6	17.1%
On Side	5	14.3%

2019 Data

Sleep-Related

Position When Found

MANNER	NUMBER	PERCENT
On Stomach	13	37.1%
On Back	10	28.6%
Unknown*	7	20.0%
On Side	4	11.4%%
Not on the Surface	1	2.9%

Oklahoma Child Death Review Board

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

2019 Data

Sleep-Related

Sleeping Location:

LOCATION	NUMBER	PERCENT
Adult Bed	20	57.1%
Crib	4	11.4%
Couch	3	8.6%
Floor	2	5.7%
Air mattress	1	2.9%
Futon	1	2.9%
Playpen	1	2.9%
Bouncy Chair	1	2.9%
Unknown*	1	2.9%
Unknown**	1	2.9%

Sleeping Arrangement:

ARRANGEMENT	NUMBER	PERCENT
Alone	14	40.0%
With Adult and/or Other Child	20	57.1%
Unknown**	1	2.9%

2019 Data

Sleep-Related – Additional Information:

- Seventeen (48.6%) had a crib/bassinette available in the home; four (11.4%) did not and crib availability was unknown for 14 (40.0%) cases.
- Seventeen (48.6%) cases had at least one caregiver with a documented history of drug and/or alcohol abuse; in six (17.1%) cases this information is not addressed on any caregiver in investigative reports.
- Four (11.4%) of these deaths occurred in a sleep space designed for infant sleep (e.g., crib).
- Five (14.3%) were exposed to secondhand smoke; for 20 (57.1%) cases, this information is not addressed in investigative reports. Ten (28.6%) were not exposed to secondhand smoke.
- One (2.9%) case the supervisor is documented as being under the influence of drugs or alcohol at the time of the incident. In an additional eight (22.9%) cases, the supervisor's condition is not addressed in investigative reports.
- One (2.9%) death was noted as to having occurred when a caregiver fell asleep during feeding; in four (11.4%) cases, however, this information is not addressed in investigative reports.

Oklahoma Child Death Review Board

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

2019 Data

Child Maltreatment

N = 31

MANNER	NUMBER	PERCENT
Accident	15	48.4%
Homicide	6	19.4%
Undetermined	6	19.4%
Natural	3	9.7%
Suicide	1	3.2%

2019 Data

Child Maltreatment

Additional Information:

- Five (16.1 %) cases were ruled abuse only; two (6.5%) cases were ruled abuse and neglect; and 24 (77.4%) cases were ruled neglect only.
- Ten (38.5%) of the 26 neglect cases included lack of supervision.
- Twelve (46.2%) of the 26 neglect cases included failure to protect from hazards.
- Five (71.4%) of the seven abuse cases included abusive head trauma.
- Fifteen (48.4%) cases had a previous referral for alleged child maltreatment.
- Five (16.1%) had an open Child Welfare case at the time of death.
- Two (6.4%) children were in formal foster care at the time of death.

2019 Data

Child Maltreatment

Additional Information:

- Eighteen (58.1%) cases had at least one caregiver with a documented child welfare history as an alleged perpetrator; in six (33.3%) of these, both caregivers had child welfare history as an alleged perpetrator.
- Sixteen (51.6%) had at least one parent on Medicaid.
- Fifteen (48.4%) had at least one caregiver receiving TANF.
- Eleven (35.5%) had at least one caregiver with a reported history of substance abuse; in five (16.1%) cases both caregivers had a reported history of substance abuse.
- Nine (29.0%) cases the caregiver was documented to have a history of domestic violence as a victim.
- Six (19.4%) had at least one caregiver with a documented child welfare history as a victim; in one (3.2%) case, both caregivers had a history as a victim.
- Three (9.7%) cases the caregiver was documented to have a history of domestic violence as a perpetrator.

Oklahoma Child Death Review Board

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

2019 Data

Near Deaths

N = 106

INJURY	NUMBER	PERCENT
Physical Abuse	32	30.2%
Poisoning/ O.D.	28	26.4%
Natural Illness	19	17.9%
Vehicular	6	5.7%
Asphyxia	5	4.7%
Fire/Burn	4	3.8%

INJURY	NUMBER	PERCENT
Drowning	3	2.8%
Inorganic Failure to Thrive	3	2.8%
Dog Attack	2	1.9%
Fall*	2	1.9%
Firearm	2	1.9%

2019 Data

Near Deaths

Additional Information:

- Seventy-five (70.8%) were alleged to be neglect, 23 (21.7%) alleged abuse and neglect, and eight (7.5) alleged abuse only.
- 98 (92.5%) had at least one biological parent as the alleged perpetrator.
- 67 (63.2%) had an associated TANF case.
- 62 (58.5%) were on Medicaid.
- 60 (56.6%) had a sibling with a previous child welfare referral; 16 of the 60 (26.7%) were substantiated.
- Fifty-seven (53.8%) were substantiated by OKDHS as to the allegations; 26 of these (45.6%) resulted in a treatment plan, of which, 17 of these 26 (65.4%) cases resulted in reunification; another three (5.3 % of the 57) resulted in immediate termination of parental rights, therefore, no treatment plan was initiated.

2019 Data

Near Deaths

Additional Information:

- Forty-four (41.5%) had a previous child welfare referral; 11 of the 44 (25.0% of 44/10.4% of all near deaths) were substantiated.
- Thirty (93.8%) of the 32 physical abuse cases were attributed to abusive head trauma; two of these also involved a simultaneous, separate type of inflicted injury.
- Twenty-six (24.5%) were associated with a Child Support Enforcement case.
- Thirteen (12.3%) sustained a chronic condition as the result of the near-death incident (e.g., vision impairment).
- Two (1.9%) were either currently in state custody or had a history of having previously been in state custody.

Recommendations

Oklahoma Child Death Review Board

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

Abusive Head Trauma

In 2010, the Preparing for a Lifetime, It's Everyone's Responsibility Infant Mortality Reduction Initiative created the Infant Injury Workgroup charged with recruiting hospitals to provide, free-of-charge, the Period of PURPLE© Crying, an abusive head trauma prevention education program.

In 2019, the Board reviewed and closed four deaths and 30 near deaths that were attributed to abusive head trauma, occurring in both metropolitan areas, as well as rural. There are currently 39 of 46 birthing hospitals across the state that provide this education, through the Preparing for a Lifetime; It's Everyone's Responsibility Infant Injury Workgroup.

The Board recommends this program continue to be funded and ensure all birthing hospitals provide this education in the expectation that caregivers may acquire skills that empower their capability to keep an infant safe.

Oklahoma Child Death Review Board

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

Unsafe Sleep

In 2019, infant deaths in Oklahoma totalled more than 30% of the deaths reviewed and closed (45 out of 136) by the CDRB. Of these, 34 (75.6%) were noted to be due to an unsafe sleep environment; in an additional three cases, this could not be determined but was not ruled out. These deaths are also occurring in both urban and rural areas.

To the Board's knowledge, there is limited instruction on infant safe sleep available for non-professional caregivers across the state, and recommend an environmental scan be conducted to determine what, if any, caregiver education is being provided and by whom. The Board further recommends safe sleep education be provided in 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 Child Death Review Board. This is due to investigation reports of suicide deaths lacking information such as a family history of suicide, previous attempts, mental health history, and use of behavioral health medications. It is often difficult to ascertain if the child even left a suicide note.

The Board recommends investigations conducted by law enforcement 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 Oklahoma Department of Human Services, Child Welfare division.

Questions?

Oklahoma Child Death Review Board

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

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OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

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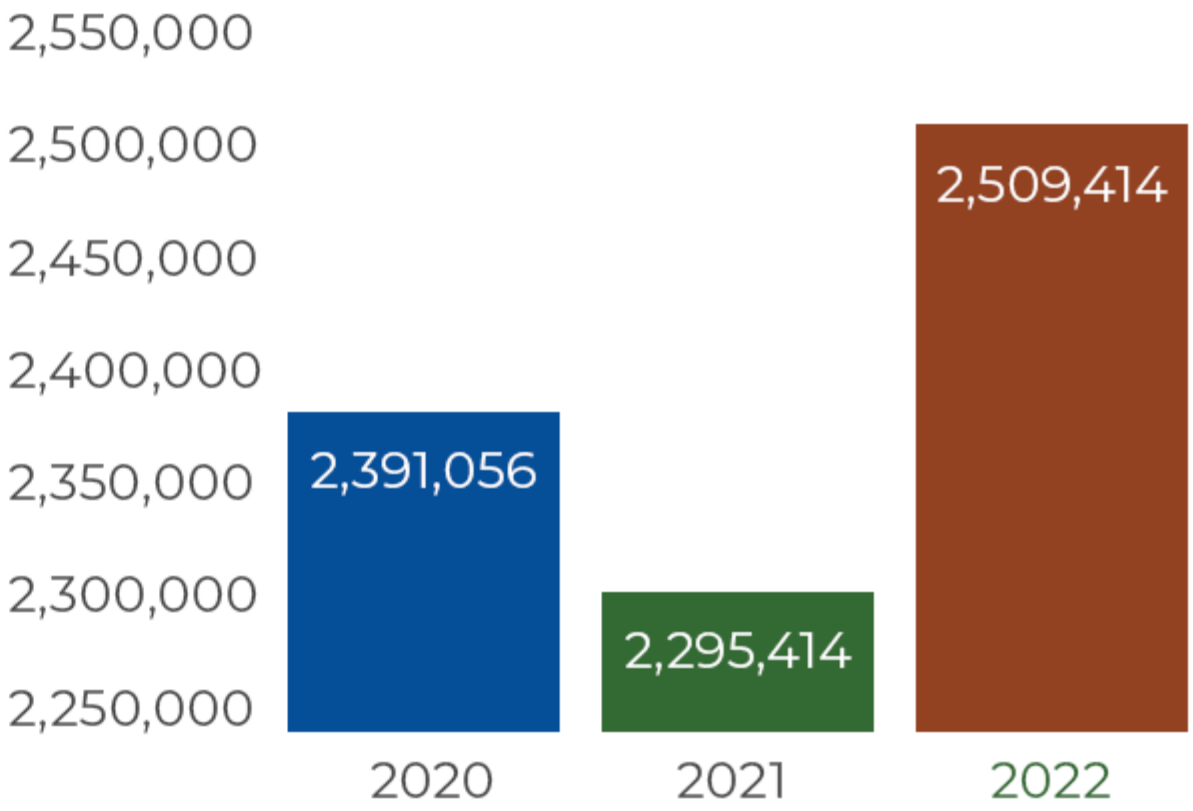
State Fiscal Year 2022 Budget Proposal

State FY22 Appropriations

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

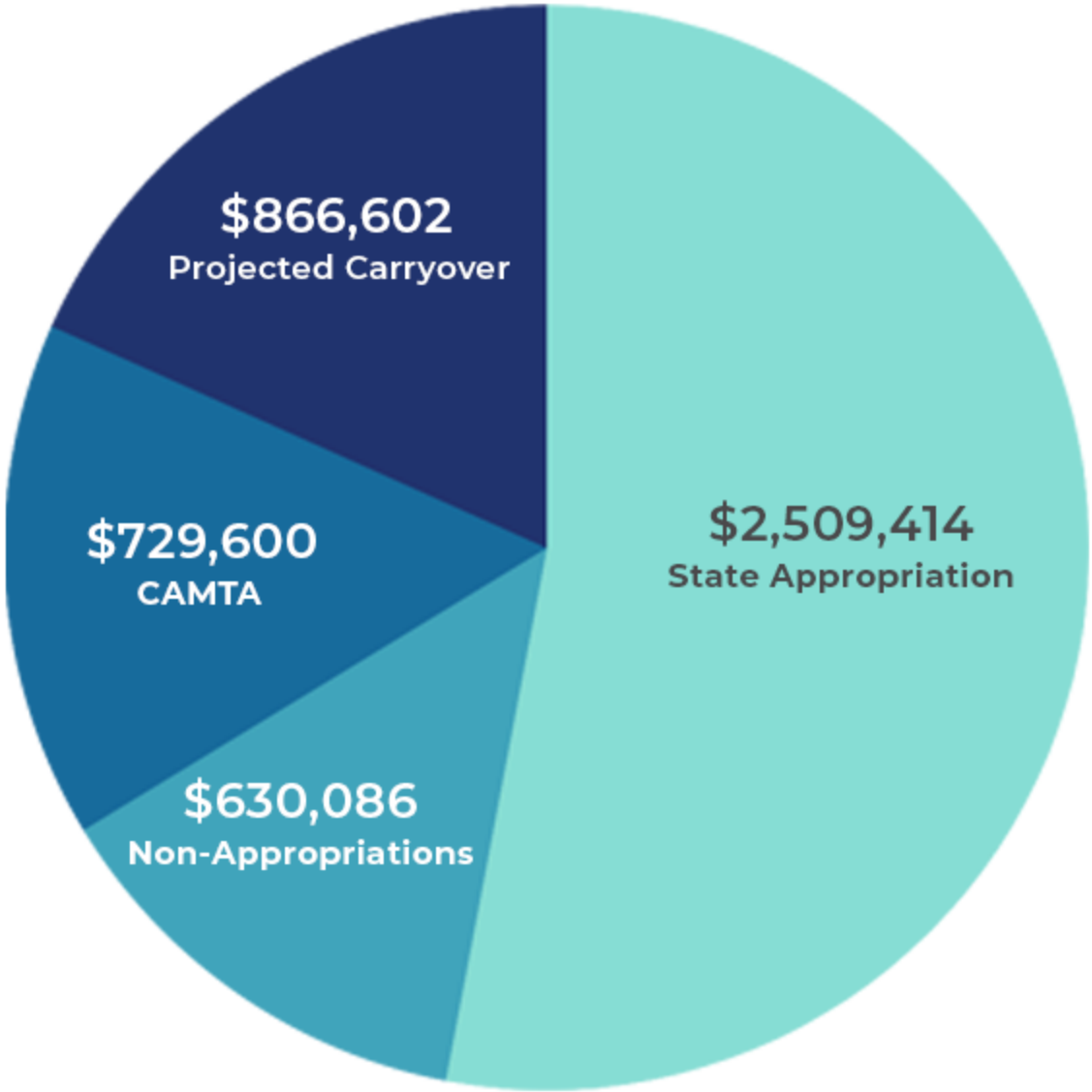
- **Increase of $214,000**
  - Community Development Planner • P&C
  - Case Manager • CDRB
  - Administrative Assistant • OJSO
- **90% of Appropriations is used to pay all agency personnel costs**



Projected SFY22 Revenue

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

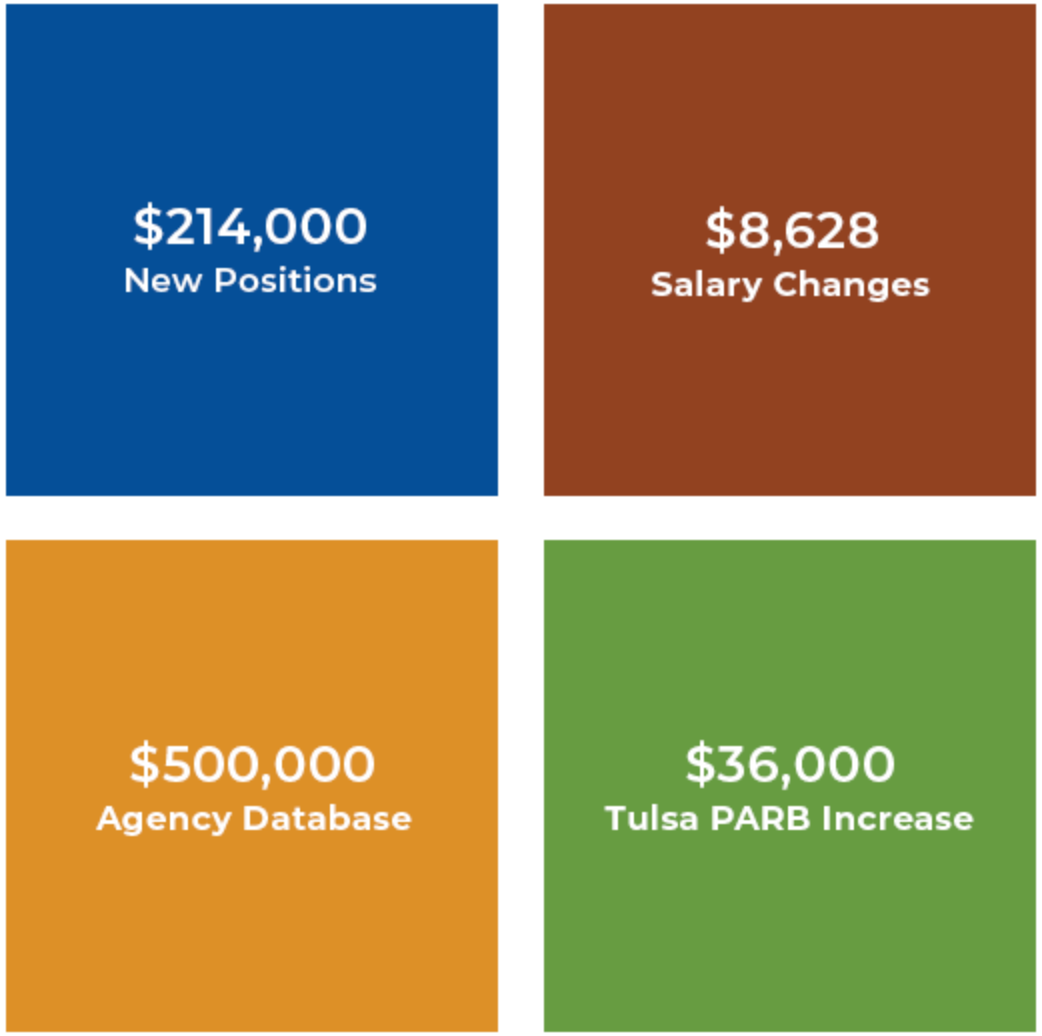
- **Projected SFY22 Revenue • $4,735,602**
  - State Appropriation • $2,509,414
  - Non-Appropriations • $630,086 (Title IV-E, CJA Grant, etc.)
  - CAMTA • $729,600
  - Projected Carryover • $866,602



Projected SFY22 Expenditures

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

- **Projected SFY22 Expenditures • $4,623,133**
  - New Positions • $214,000
  - Salary Changes • $8,628
    - = Executive Director • Administration
    - = Executive Secretary • Administration
    - = Administrative Assistant II • P&C
  - Agency Database • $500,000
  - Tulsa County PARB Coordinator Contract Increase to $36,000



Summary of Project Carryover

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

- **Summary of Project Carryover • $866,602**
  - Juvenile Competency Evaluations • $50,000
  - Tulsa Co. PARB Coordinator Contract • $36,000
  - Travel, Training, & Other Various Department Costs $74,000
  - Agency Database • $500,000
  - Agency IT Costs • $35,000
  - Chief & Assistant Chief Child Abuse Examiner • $100,000

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

Proposed FY 2022 Budget

	Administration	Office of Juvenile System Oversight	Children's Endowment Fund	Office of Planning & Coordination	Post Adjudication Review Board	Freestanding Multidisciplinary Teams	Children's Justice Act Grant - CASA	Children of Incarcerated Parents	Juvenile Competency Evaluation	Board of Child Abuse Examination	Child Death Review Board	IT	TOTAL
	100002 8 FTE	100002 8 FTE	100040 1 Temp	100042 3 FTE	100043 2 FTE	100044 2 FTE	100045 0 FTE	100090 0 FTE	100301 0 FTE	100401 0 FTE	100681 3 FTE / 1 Temp	8800001 0 FTE	
Personnel	743,904	661,921	41,686	238,619	152,876	159,567	0	0	0	0	253,967	0	2,252,540
Professional Services	113,534	0	50,000	85,000	22,000	113,276	10,000	10,000	50,000	100,000	0	522,077	1,075,887
TOTAL PERSONNEL SERVICES	857,438	661,921	91,686	323,619	174,876	272,843	10,000	10,000	50,000	100,000	253,967	522,077	3,328,427
Travel Reimbursements	17,946	1,200	0	6,300	17,682	6,960	0	0	0	450	2,400	0	52,938
Travel Direct Purchase	12,190	15,287	300	20,810	32,562	63,310	0	0	0	0	3,756	0	148,215
Misc. Administrative Expenses	9,775	0	0	0	500	2,400	0	0	0	0	10,000	28,824	51,499
Rent Expense	95,924	0	0	5,500	0	7,370	0	0	0	0	0	42,488	151,282
Maintenance & Repair Expense	0	0	0	0	0	0	0	0	0	0	0	5,700	5,700
Specialized Supplies & Materials Expense	1,550	0	0	0	0	0	0	0	0	0	0	0	1,550
Production, Safety, & Security Expense	500	0	0	0	0	0	0	0	0	0	0	0	500
General Operating Expenses	6,800	0	0	0	0	2,800	0	0	0	0	0	100	9,700
Office Furniture & Equipment	23,000	1,500	0	1,200	900	900	0	0	0	0	1,200	24,022	52,722
Program Reimbursements, Litigation Cost	0	0	0	0	36,000	729,600	0	55,000	0	0	0	0	820,600
TOTAL OTHER EXPENSE	167,685	17,987	300	33,810	87,644	813,340	0	55,000	0	450	17,356	101,134	1,294,706
DIVISION/UNIT TOTALS	1,025,123	679,908	91,986	357,429	262,520	1,086,183	10,000	65,000	50,000	100,450	271,323	623,211	4,623,133
State Appropriation	927,359	661,921	0	265,513	152,876	159,567	0	0	0	0	253,967	88,211	2,509,414
Non-Appropriations (CJA Grant, Title IV-E)	209,033	17,987	91,986	87,536	64,494	149,050	10,000	0	0	0	0	0	630,086
CAMTA	0	0	0	0	0	729,600	0	0	0	0	0	0	729,600
Projected Carryover	0	0	0	4,380	45,150	47,966	0	65,000	50,000	100,450	18,656	535,000	866,602
TOTAL	1,136,392	679,908	91,986	357,429	262,520	1,086,183	10,000	65,000	50,000	100,450	272,623	623,211	4,735,702

Questions?