Think. Prevent. Live.

Keep Our Children Safe

The Oklahoma Child Death Review Board
2015 Annual Report

Includes the 2016 CDRB Recommendations

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.

Acknowledgements

The Oklahoma Child Death Review Board would like to thank the following agencies for their assistance in gathering information for case reviews:

The Police Departments and County Sheriffs' Offices of Oklahoma

Department of Public Safety
Office of the Chief Medical Examiner
Oklahoma Department of Human Services
Oklahoma State Bureau of Investigation
Oklahoma State Department of Health - Vital Statistics

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Recommendations

The following are the 2016 annual recommendations of the Oklahoma Child Death Review Board as submitted to the Oklahoma Commission on Children and Youth.

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. Since that time, many professionals convened and reviewed over 6,700 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 may 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 submits recommendations on an annual basis that could potentially reduce the number of children dying in Oklahoma each year. With the current fiscal crisis, we anticipate more children dying if the state does not provide the resources to do what needs to be done to protect our most vulnerable citizens and our future, our children.

FISCAL (Legislative)

Those state agencies that serve to safeguard Oklahoma's children require adequate funding in order to perform their duties. Oklahoma needs to make certain tax regulations and reforms are in place that ensure revenue will not be reduced and a budget that can be balanced. A stand-still budget, much less budget cuts, will not provide Oklahoma with the foundation it needs to build capacity nor to provide strong infrastructure, safe communities and healthy, thriving children. Agency improvement and policy changes are ineffective without a financial commitment by the state of Oklahoma to affect positive change.

LEGISLATION

The CDRB reviewed and closed 83 traffic related deaths in 2015, with 57 victims being in a vehicle (i.e. does not include pedestrian/bicycle/motorcycle/ATV). Of these 57, over half (56.6%) were not utilizing a safety restraint.

- Expand the current seat restraint legislation to include backseat passengers.
- Increase the fine for those ages 13 and over not using seat restraints to $100 for

Recommendations

the first offense and $500 for subsequent offenses.
- Enact legislation banning the use of hand-held devices while operating a motor vehicle and the use to be a primary offense.
- Enact legislation that increases the age to get a license to 17 years of age.
- Enact legislation that increases the age to get a permit to 16 years of age.
- Extend the intermediate driver's license period to one full year.

POLICY

Hospitals

- All delivery hospitals should adopt a policy regarding in-house safe sleep and provide education on safe sleep after delivery but prior to discharge from hospital. The education should include statistics on sleep related deaths. The CDRB reviewed and closed 112 (31.4%) deaths related to unsafe sleep environments in 2015.
- All hospitals should have a written policy to notify the OKDHS Child Welfare division of unexpected child deaths.
- All birthing hospitals should have a written policy to implement, with fidelity, the Period of *PURPLE*® Crying abusive head trauma prevention program.

Law Enforcement

- Increase the depth of suicide investigations to include mental, medical 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). The CDRB reviewed and closed 21 (5.9%) cases of Suicide and a majority did not have this information collected.
- Enforce child passenger safety laws, including appropriate seat restraint use. The CDRB reviewed and closed 83 cases that involved motor-vehicles, 57 of which were applicable to seat restraint use, and found seat restraint use to be 40%.
- Adopt the Center for Disease Control's Sudden Unexpected Infant Death Investigation (SUIDI) protocols, including scene recreation and use of photographs. The CDRB reviewed and closed 152 (43.0%) infant death cases in 2015; of these, 107 (70.4%) 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.
- Adopt a policy to notify the OKDHS Child Welfare division of unexpected child deaths.

Recommendations

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

Office of the Chief Medical Examiner

- Adopt the Center for Disease Control's SUIDI protocols. As stated previously, the CDRB reviewed and closed 152 (43.0%) infant death cases in 2015; of these 152 infant deaths, 107 (70.4%) 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 identified.
- Adopt a policy to notify the OKDHS Child Welfare division of unexpected 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 Department of Human Services

- Ensure all children in custody are referred and treated by a Trauma Focused Cognitive Behavioral Therapist.
- Adopt the Center for Disease Control's SUIDI protocols for Child Welfare death investigations.

Oklahoma Department of Mental Health and Substance Abuse Services

- Ensure appropriate treatment resources are available for persons suffering from mental health and substance abuse issues.
- Create a Child Welfare liaison position to ensure children in custody and their caregivers are receiving appropriate mental health and substance abuse services.
- Extend the number of Trauma Focused Cognitive Behavioral Therapists available for children and families.

Oklahoma State Department of Health

- Restore and increase funding to the Office of Child Abuse Prevention.

Board Actions and Activities

Include but are not limited to:

- Five letters to District Attorneys regarding status of criminal charges
- Ten letters to the Oklahoma Department of Human Services:
  - Three letters concerning surviving siblings (i.e. type of therapy child receiving)
  - One letter regarding delay of completion of investigative reports
  - One letter notifying the Department of a death
  - One letter requesting court orders be available in KIDS
  - One letter requesting a state level review for possible identification of pattern of maltreatment and possible amendment of investigative findings
  - One letter requesting information in the Findings screen match the information in the Report to District Attorney summary
  - One letter requesting a foster home be re-evaluated for safety
  - One letter inquiring if the agency conducted a review of the foster agency after the death of a child
- Two letters to medical facilities:
  - One letter recommending the facility refer all unnatural deaths to the OCME
  - One letter recommending the facility notify law enforcement and OKDHS of unexpected child deaths
- Eleven letters to law enforcement:
  - Eight letters recommending a change in policies and procedures to include notifying CW of unexpected child deaths and/or use the SUIDI protocols
  - One letter of commendation
  - One letter recommending use of a Mutual Aid Agreement with local medical emergency service providers
  - One letter recommending the department complete the Oklahoma Official Traffic Collision Report and submit the report to the Department of Public Safety on all motor-vehicle related fatalities
- One letter to a fire department inquiring if they notified law enforcement of death and if a Mutual Aid Agreement is in place with local law enforcement.
- One letter to a foster care agency inquiring if they conducted a review of their P&P regarding approval and monitoring of foster homes after a child death and if so, were any changes implemented as a result. And what special considerations were made, if any, for applicants with CW history and/or on active military duty.
- Four letters to the Office of the Chief Medical Examiner:
  - Inquiring regarding Manner Of Death
  - Inquiring regarding Cause Of Death
  - Inquiring if OCME notified OKDHS and if so, requested associated referral number
  - Recommending OCME notify OKDHS of unexpected child death

Cases Closed 2015

The Oklahoma Child Death Review Board is comprised of five review teams. The total number of deaths reviewed and closed in 2015 by all five teams is 357. The year of death for these cases ranged from 2009 to 2015.

2015 Deaths Reviewed		
Manner	**Number**	**Percent**
Accident	155	43.4%
Homicide	22	6.2%
Natural	35	9.8%
Suicide	21	5.9%
Unknown	124	34.7%

Gender	Number	Percent
Males	214	59.9%
Females	143	40.1%

Race		
African American	40	11.2%
American Indian	47	13.2%
Asian	3	0.8%
Multi-race	32	9.0%
Pacific Islander	2	0.6%
White	233	65.3%

Ethnicity	Number	Percent
Hispanic (any race)	38	10.6%
Non-Hispanic	319	89.4%

Government Involvement

The chart below indicates a child's involvement in government sponsored programs, either at the time of death or previous to the time of death.
The Oklahoma Department of Human Services (OKDHS) Child Welfare cases are those children who had an abuse and/or neglect referral ***prior*** to the death incident. It does not reflect those child deaths that were investigated by the OKDHS.
Additionally, there were 28 (7.8%) cases that had an open Child Welfare case at the time of death. including three children in foster care; the manners of death for those children were natural, accident, and homicide.

Number of Cases with Involvement in Selected State Programs

Agency	Number	Percent of All Deaths
Oklahoma Health Care Authority	275	77.0%
OKDHS - TANF	231	64.7%
OKDHS - Child Support Enforcement	170	47.6%
OKDHS - Child Welfare	92	25.8%
OKDHS - Disability	25	7.0%
OKDHS - Food Stamps	24	6.7%
Office of Juvenile Affairs	16	4.5%
OKDHS - Foster Care	3	0.8%
OKDHS - Child Care Assistance	2	0.6%

Accidents

The Board reviewed and closed 155 deaths in 2015 whose manner of death was ruled Accident, also known as Unintentional Injuries.

Mechanism of Death		
Type	**Number**	**Percent**
Vehicular	83	53.5%
Drowning	25	16.1%
Asphyxia	18	11.6%
Fire	16	10.3%
Weapon	6	3.9%
Poisoning/OD	4	2.6%
Storm Trauma	1	0.6%
Playground Injury	1	0.6%
Fall	1	0.6%

Race		
African American	12	7.7%
American Indian	19	12.3%
Asian	1	0.6%
Multi-race	11	7.1%
Pacific Islander	2	1.3%
White	110	71.0%

Ethnicity	Number	Percent
Hispanic (any race)	14	9.0%
Non-Hispanic	141	91.0%

Gender	Number	Percent
Males	96	61.9%
Females	59	38.1%

- Vehicular deaths continue to be the top mechanism of death for this category.

Homicides

The Board reviewed and closed 22 deaths in 2015 whose manner of death was ruled Homicide.

Mechanism of Death		
Method	**Number**	**Percent**
Firearm	10	45.5%
Physical Abuse	5	22.7%
Asphyxia	2	9.1%
Assault (Not Child Abuse)	2	9.1%
Incise Injury	2	9.1%
Unknown	1	4.5%

Race		
African American	4	18.2%
American Indian	4	18.2%
Multi-Race	1	4.5%
White	13	54.1%

Ethnicity	Number	Percent
Hispanic (any race)	3	13.6%
Non-Hispanic	19	86.4%

Gender	Number	Percent
Males	10	45.5%
Females	12	54.5%

- All five of the physical abuse deaths were due to abusive head trauma.

Naturals

The Board reviewed and closed 35 deaths in 2015 whose manner of death was ruled Natural.

Mechanism of Death		
Illness/Disease	**Number**	**Percent**
Infection - Other	11	31.4%
Cardiovascular	6	17.1%
Pneumonia	4	11.4%
Congenital Anomaly	3	8.6%
SUID	3	8.6%
Influenza	2	5.7%
Neurological	2	5.7%
Prematurity	2	5.7%
SIDS	2	5.7%

Race		
African American	7	20.0%
American Indian	6	17.1%
Multi-Race	6	17.1%
White	16	45.7%

Ethnicity	Number	Percent
Hispanic (any race)	3	8.6%
Non-Hispanic	32	91.4%

Gender	Number	Percent
Males	23	65.7%
Females	12	34.3%

Suicides

The Board reviewed and closed 21 deaths in 2015 whose manner of death was ruled Suicide.

Mechanism of Death		
Method	**Number**	**Percent**
Asphyxia	11	52.4%
Firearm	10	47.6%

Race		
African American	2	9.5%
American Indian	3	14.3%
Asian	1	4.8%
Multi-Race	3	14.3%
White	12	57.1%

Gender	Number	Percent
Males	16	76.2%
Females	5	23.8%

Ethnicity	Number	Percent
Hispanic (any race)	1	4.8%
Non-Hispanic	20	95.2%

- Thirteen (61.9%) had a history of child maltreatment.
- Eight (38.1%) had previously threatened suicide; in 10 (47.6%) cases this information was not collected.
- Seven (33.3%) left a note of intention; in six (28.6%) cases this information was not collected.
- Five (23.8%) had previous mental health treatment; in 15 (71.4%) cases this information was not collected.
- Four (19.0%) were currently receiving mental health treatment; in 16 (76.2%) cases this information was not collected.
- Three (14.3%) had a history of prior attempts; in 13 (61.9%) cases this information was not collected.
- Three (14.3%) had problems in school; in 16 (76.2%) cases this information was not collected.
- Three (14.3%) had a history of substance use/abuse; in 11 (52.4%) cases this information was not collected.
- Three (14.3%) had a history of self-mutilation; in 16 (76.2%) cases this information was not collected.
- Two (9.5%) had a family history of suicide; in 18 (85.7%) cases this information was not collected.
- Two (9.5%) were on mental health medications at the time of death: in 16 (76.2%) cases this information was not collected.

Unknown

The Board reviewed and closed 124 deaths in 2015 ruled Unknown. A death is ruled Unknown by the pathologist when there are no anatomical findings discovered at autopsy to definitively explain the death.

Race		
African American	15	12.1%
American Indian	15	12.1%
Asian	1	0.8%
Multi-Race	11	8.9%
White	82	66.1%

Ethnicity	Number	Percent
Hispanic (any race)	17	13.7%
Non-Hispanic	107	86.3%

Gender	Number	Percent
Males	69	55.6%
Females	55	44.4%

- One hundred fourteen (92.7%) were two years of age or younger; 107 (87.0%) were less than one year of age.
- Ninety-six determined to be sleep-related; another nine where the sleep environment may have contributed to the death but child also had other risk factors present (i.e. pre-existing health condition).
- Sixty-nine (56.0%) had an investigator from the OCME respond to the scene.
- Nine (7.3%) were suspicious for child maltreatment, including physical abuse, starvation, and maternal drug abuse.
- Four deaths the intent was unable to be determined (Accident vs. Suicide for three; Accident vs. Homicide for the fourth).

Traffic Related Deaths

The Board reviewed and closed 83 traffic related deaths in 2015 ruled "Accident" by the Office of the Chief Medical Examiner.
No proper helmet use for any of the ATV/Bicycle/Motorcycle fatalities.

Vehicle of Decedent

Vehicle	Number	Percent
Car	31	37.3
SUV	7	8.4
Pedestrian	13	15.7
Pick-up	18	21.7
All-Terrain Vehicle	9	10.9
Van	1	1.2
Bicycle	1	1.2
Trailer Bed	3	3.6

Position of Decedent

Position	Number	Percent
Rear Passenger	21	24.1
Front Passenger	13	15.7
Operator	31	37.3
Truck/Trailer Bed	3	3.9
Unknown Passenger Placement	1	1.2
Pedestrian	13	15.7
Bicycle	1	1.2

Gender	Number	Percent
Males	49	59.0%
Females	34	41.0%

Use of Safety Restraints

Seatbelt/Car Seat Use	Number	Percent
Properly Restrained	23	40.4%
Not Properly Restrained	34	56.6%
Not Applicable (pedestrians/motorcycles/ bicycles/ATVs)	26	--

Contributing Factors*

Factor	Number	Percent
Speeding (including unsafe speed for conditions)	26	31.3
Drug/Alcohol Use	16	19.3
Reckless Driving	6	7.2
Driver Inexperience	13	15.7
Ran Stop Sign/Light	9	10.8
Driver Distraction	7	8.4

Race

African American	4	4.8
American Indian	12	14.5
Asian	1	1.2
Multi-race	3	3.6
White	63	75.9

Ethnicity	Number	Percent
Hispanic (any race)	10	12.0%
Non-Hispanic	73	88.0%

*Not every fatality had a known/documented contributing factor.

Drowning Deaths

The Board reviewed and closed 25 accidental deaths in 2015 due to drowning.

Location of Drowning		
Location	**Number**	**Percent**
Open Body of Water (i.e. creek/river/pond/lake)	11	44.0%
Private, Residential Pool	12	48.0%
Bathtub	1	4.0%
Swimming area of natural falls water park	1	4.0%

Type of Residential Pool (N=12)		
Type of Pool	**Number**	**Percent**
Above Ground	4	33.3%
In Ground	4	33.3%
Not Documented	4	33.3%

Type of Open Body of Water (N=11)		
Open Body	**Number**	**Percent**
River	2	18.2%
Lake	6	54.5%
Creek	1	9.1%
Quarry	1	9.1%
Pond	1	9.1%

Race		
African American	2	8.0%
American Indian	3	12.0%
Multi-Race	2	8.0%
White	18	72.0%

Ethnicity	Number	Percent
Hispanic (any race)	2	8.0%
Non-Hispanic	23	92.0%

Gender	Number	Percent
Males	18	72.0%
Females	7	28.0%

- Two (8.0%) of the drowning victims had a personal floatation device available to them.
- Ten (40.0%) were three years of age or younger; five (20.0%) were one year of age or younger.

Sleep Related Deaths

The Board reviewed and closed 112 deaths that were related to sleep environments.

Manner of Death for Sleep Related Deaths		
Manner	**Number**	**Percent**
Accidental	12	10.7%
Natural (SIDS/ hypoxia/pneumonia)	4	3.6%
Undetermined	96	85.7%

Race		
African American	12	10.7
American Indian	14	12.5
Asian	1	0.9
Multi-race	16	14.3
White	69	61.6

Position of Infant When Placed to Sleep		
Position	**Number**	**Percent**
On Back	39	34.8
On Side	22	19.6
On Stomach	16	14.3
Unknown*	35	31.3

Ethnicity	Number	Percent
Hispanic (any race)	14	12.5%
Non-Hispanic	98	87.5%

Gender	Number	Percent
Males	62	55.4%
Females	50	44.6%

Position of Infant When Found		
Position	**Number**	**Percent**
On Back	23	20.5
On Side	10	8.9
On Stomach	41	36.6
Unknown*	38	33.9

Sleeping Location of Infant		
Location	**Number**	**Percent**
Adult Bed	58	51.8%
Crib	25	22.3%
Couch	14	12.5%
Car Seat	3	2.7%
Air Mattress	2	1.8%
Chair	2	1.8%
Playpen	2	1.8%
Bassinette	1	0.9%
Bouncy Seat	1	0.9%
Floor	1	0.9%
Swing	1	0.9%
Toddler Bed	1	0.9%
Unknown*	1	0.9%

Sleeping Arrangement of Infant		
Sleeping Arrangement	**Number**	**Percent**
Alone	44	39.3
With Adult and/or Other Child	65	58.0
Unknown*	3	2.7

*This information is unknown due to the lack of information collected by scene investigators

Sleep Related Deaths Cont.

- Fifty-nine (52.7%) had a crib/bassinette available in the home; 15 (13.4%) did not and crib availability was unknown for 38 (33.9%) cases.
- Twenty-seven (24.1%) were exposed to second hand smoke; for 79 (70.5%) cases, this information is unknown. Six (5.4%) were not exposed to second hand smoke.
- Twenty-Six (23.2%) of these deaths occurred in a sleep space designed for infant sleep (i.e. crib/bassinette).
- Seven (6.3%) deaths occurred when a caregiver fell asleep during feeding (3 bottle/4 breast).

Firearm Deaths

The Board reviewed and closed 25 deaths in 2015 due to firearms.

Manner of Death for Firearm Victims		
Manner	**Number**	**Percentage**
Suicide	10	40.0%
Homicide	10	40.0%
Accident	5	20.0%

Type of Firearm Used		
Type of Firearm	**Number**	**Percent**
Handgun	19	76.0%
Shotgun	3	12.0%
Assault Rifle	2	8.0%
Pellet Gun	1	4.0%

Race		
African American	5	20.0%
American Indian	3	12.0%
Asian	1	4.0%
Multi-Race	1	4.0%
White	15	60.0%

Ethnicity	Number	Percent
Hispanic (any race)	3	12.0%
Non-Hispanic	22	88.0%

Gender	Number	Percent
Males	19	76.0%
Females	6	24.0%

Fire Deaths

The Board reviewed and closed 16 deaths in 2015 due to unintentional fires.

Fire Ignition Source		
Source	**Number**	**Percent**
Cigarette	2	12.5%
Cigarette Lighter	2	12.5%
Electrical Wiring	2	12.5%
Power Strip	1	6.3%
Space Heater	2	12.5%
Stove	2	12.5%
Unknown	5	31.3%

Race		
African American	2	12.5%
American Indian	2	12.5%
Pacific Islander	2	12.5%
White	10	62.5%

Ethnicity	Number	Percent
Hispanic (any race)	1	6.2%
Non-Hispanic	15	93.8%

Working Smoke Detector Present		
Detector	**Number**	**Percent**
Yes	3	18.7%
No	7	43.8%
Unknown	6	37.5%

Gender	Number	Percent
Males	8	50.0%
Females	8	50.0%

- Five (31.3%) children died of smoke inhalation; 11 (%) died from a combination of smoke/products of combustion inhalation and thermal injuries.

Abuse/Neglect Deaths

The Board reviewed and closed 57 (16.0%) cases where it was determined that child maltreatment (abuse or neglect) caused or contributed to the death.

Manner of Death for Abuse/Neglect Cases		
Manner	**Number**	**Percent**
Accident	31	54.4
Homicide	10	17.5
Natural	2	3.5
Undetermined	14	24.6

Race		
African American	4	7.0
American Indian	10	17.5
Multi-race	5	8.8
Pacific Islander	2	3.5
White	36	63.2

Gender	Number	Percent
Males	29	50.9%
Females	28	49.1%

Ethnicity	Number	Percent
Hispanic (any race)	6	10.5
Non-Hispanic	51	89.5

- Seven (12.5%) cases were ruled abuse, 47 (82.1%) cases were ruled neglect, and three (5.4%) were ruled both.
- Twenty-six (53.0%) of the 47 neglect cases were due to lack of supervision.
- Four (40.0%) of the 10 abuse cases were due to abusive head trauma.
- Two (3.6%) were in foster care at the time of death.
- Fifteen (26.3%) cases had a previous referral for alleged child maltreatment; seven (12.3%) had an open referral at the time of death.
- Twenty-six (45.6%) cases had at least one caregiver with child welfare history as an alleged perpetrator; in twelve (21.1%) of these, both caregivers had child welfare history as an alleged perpetrator.
- Twenty (35.1%) had at least one caregiver with a child welfare history as a victim; in seven (12.3%) cases, both caregivers had a history as a victim.
- Seventeen (29.8%) had at least one caregiver with a history of substance abuse.
- Twelve (21.1%) cases had a caregiver noted to have a history of domestic violence as a perpetrator.
- Nine (15.8%) had a caregiver noted to have a history of domestic violence as a victim.
- Four (7.0%) had a caretaker who was not a primary caregiver.

Near Deaths

The Board reviewed and closed 95 near death cases in 2015. A case is deemed near death if the child was admitted to the hospital diagnosed in serious or critical condition as a result of suspected abuse or neglect.

Injuries in Near Death Cases		
Injury	**Number**	**Percent**
Physical Abuse	30	31.6%
Poison/Overdose	27	28.4%
Natural Illness	16	16.8%
Fire/Burn	5	5.3%
Vehicular	5	5.3%
Drowning	4	4.2%
Asphyxia	3	3.2%
Failure to Thrive	2	2.1%
Animal Attack	1	1.1%
Crush	1	1.1%
Substance Exposed Newborn	1	1.1%

Race		
African American	15	15.8%
American Indian	5	5.3%
Asian	1	1.1%
Multi-race	20	21.1%
White	54	56.8%

Ethnicity	Number	Percent
Hispanic (any race)	6	6.3%
Non-Hispanic	89	93.7%

Gender	Number	Percent
Males	55	57.9%
Females	40	42.1%

- Sixty-two (65.3%) were alleged to be neglect ; 28 (29.5%) alleged abuse and neglect; five (5.3%) alleged abuse only.
- Fifty-six (58.9%) were substantiated by OKDHS as to the allegations.
- Eighty-nine (93.7%) had at least one biological parent as the alleged perpetrator.
- Fifty (52.7%) had a sibling with a previous child welfare referral; 24 (48.0% of the 50) were substantiated.
- Forty-two (44.2%) of the near death victims had a previous child welfare referral; 16 (38.1% of the 42) were substantiated.