# 2020 Child Death Review Board Annual Report

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

Think. Prevent. Live

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# The Oklahoma Child Death Review Board

## History

In 1991, the Oklahoma legislature recognized the need for a multidisciplinary review of how Oklahoma's children were dying and created the Child Death Review Act. Since that time, many professionals have convened and reviewed nearly 7,000 cases of child deaths to collect statistical data and system failure information. With this information, they developed recommendations to improve policies, procedures, and practices within and between the agencies that serve the children of Oklahoma.

The Child Death Review Board (CDRB) at the Oklahoma Commission on Children and Youth (OCCY) 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.

## Mission

The mission of the Oklahoma Child Death Review Board is to reduce the number of preventable deaths by utilizing 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.

# Why were so few cases reviewed and closed during 2020?

## Work from Home

The COVID-19 pandemic affected the CDRB in unprecedented ways – just as it did with so many government programs. Like in other state agencies, OCCY staff, including the CDRB staff, had to transition from working in the office to working from home. That transition meant the typical ways of record management and case reviews were no longer appropriate. Prior to COVID-19, the CDRB operated with a paper-and-pencil process with most records received in paper form, and then provided at the CDRB meetings for the Board to review.

The system had to be changed to allow for a very secure, digital format. Developing and implementing this process was slow because the entire state had to do the same. Challenges also existed because not all Board members are state employees and therefore, not everyone had access to the same virtual meeting platforms and virtual sharing tools. However, a more robust and efficient system was implemented once solutions were found. Much of this new system is still used today even though meetings are now held in person.

## Challenges Related to Meetings

By statute, the CDRB is required to comply with the Open Meeting Act and requirements include having a quorum gathered at one location for the meeting. In-person meetings were halted at the beginning of the pandemic. After the Public Health Emergency was declared by Governor Stitt and meetings could be held on virtual platforms, the CDRB still had to develop a secure system to electronically share the confidential records with the Board members.

In addition, it was difficult to make quorum to hold meetings even if the meetings were virtual. So many Board members were sick with COVID-19, caring for loved ones with COVID-19, or their work priorities changed during the pandemic. They were not available or could not commit to participating by the deadline needed for inclusion on the agenda as required by the Public Health Emergency Executive Order.

Lastly, when virtual meetings were held, the lack of reliable broadband internet and a strong technology infrastructure kept meetings from occurring or running smoothly. These problems were especially difficult for the rural Board members.

## Bright Spots

While there were definite obstacles to preparing and reviewing, there were positives during this year. In addition to identifying and developing a more modernized review system, another staff person was hired. With additional funding from the legislature, OCCY was able to bring on a second staff person during SFY 2020 which doubled the CDRB staff size. Due to budget cuts over the years, there had been only one staff person serving in the CDRB department since 2015. This individual was solely responsible for requesting and gathering records, preparing cases, and completing the necessary follow up for each case for all five review teams which comprise the Board. Over the years, the caseload began to stack up and a backlog grew.

# 2021 Annual Recommendations

The following are the 2021 annual recommendations of the Oklahoma Child Death Review Board as submitted to the Oklahoma Commission on Children and Youth and are based on cases reviewed and closed in 2020.

## 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. Thirty-nine out of 46 birthing hospitals across Oklahoma provide 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 expanding this program to all birthing hospitals in Oklahoma so that caregivers may acquire skills that keep their infant safe.**

## Unsafe Sleep

In 2019, 30% (45 out of 136) of the total cases reviewed and closed by the CDRB involved an infant death. Out of the 45 infant death reviews, 34 (75.6%) of the deaths were due to an unsafe sleep environment. Three additional deaths were also suspected to have been caused by an unsafe sleep environment. These deaths 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 completed to determine what if any education is provided to parents and other caregivers of infants and by whom. Once the scan is completed, the Board recommends providing safe sleep education in areas of the state where it is lacking.**

## Suicide

Identifying strategies to reduce suicides has been difficult for the CDRB because law enforcement investigation reports often lack key information. Knowing about the decedent's family history of suicide, previous suicide attempts, mental health history, the use of behavioral health medications, and information gleaned from a suicide note can be very helpful in both the individual investigation as well as developing prevention efforts.

In 2019, the CDRB review 19 suicides. The majority of the youth (78.9%) were male and ten out of the total were suspected to have been victims of child maltreatment. **The CDRB recommends that law enforcement investigations be more thorough and include the detailed information previously listed. Additionally, suicide investigation policies and procedures should require that the Oklahoma Department of Human Services be notified about the death.**

# Cases Closed in 2020

The Oklahoma Child Death Review Program at OCCY is comprised of a state team and four regional teams. The total number of cases reviewed and closed in 2020 by all five teams is 15.

## 2020 Deaths Reviewed

| Manner | Number | Percent |
|---|---|---|
| Unknown | 6 | 40.0% |
| Accident | 5 | 33.3% |
| Natural | 2 | 13.3% |
| Suicide | 1 | 6.7% |
| Homicide | 1 | 6.7% |

### Demographics

| Gender | Number | Percent |
|---|---|---|
| Males | 11 | 73.4% |
| Females | 4 | 26.6% |
| **Ethnicity** | **Number** | **Percent** |
| Hispanic | 3 | 20.0% |
| Non-Hispanic | 12 | 80.0% |
| **Race** | **Number** | **Percent** |
| African American | 1 | 6.7% |
| American Indian | 2 | 13.3% |
| Asian | 1 | 6.7% |
| Multi-Race | 3 | 20.0% |
| White | 8 | 53.3% |

- Nine (60.0%) of the deaths were infants.
- Seven (46.7%) of the cases had at least one caregiver with child welfare history as a perpetrator.
- Five (33.3%) of the cases had a previous child welfare referral.
- Three (20.0%) of the cases had an open child welfare case at the time of death.
- Three (20.0%) of the cases had at least one caregiver with a history of drug/alcohol abuse; this information is unknown in six (40.0%) deaths.

# Cases by Manner of Death & Injury Types

## Accidents

The Boards reviewed and closed five deaths in 2020 whose manner of death was ruled as an "Accident", also known as "Unintentional Injuries".

### Mechanism of Death

| Type | Number | Percent |
|---|---|---|
| Asphyxia | 2 | 40.0% |
| Drowning | 2 | 40.0% |
| Vehicular | 1 | 20.0% |

### Demographics

| Race | Number | Percent |
|---|---|---|
| American Indian | 2 | 40.0% |
| Asian | 1 | 20.0% |
| Multi-Race | 2 | 40.0% |

| Ethnicity | Number | Percent |
|---|---|---|
| Non-Hispanic | 5 | 100.0% |

| Gender | Number | Percent |
|---|---|---|
| Males | 3 | 60.0% |
| Females | 2 | 40.0% |

- Two (40.0%) of the deaths were caused by asphyxia related to an unsafe sleep environment.
- Two (40.0%) of the deaths were due to drownings in natural bodies of water. In each death, a personal floatation device was not utilized.
- One (20.0%) vehicular death was caused by a driver in another car who was under the influence of drugs and alcohol. The child that died was utilizing a seat restraint.

# Homicides

The Boards reviewed and closed one case in 2020 whose manner of death was ruled as a “Homicide”.

## Mechanism of Death

| Method | Number | Percent |
| --- | --- | --- |
| Not Specified | 1 | 100.0% |

## Demographics

| Race | Number | Percent |
| --- | --- | --- |
| Multi-Race | 1 | 100.0% |

| Ethnicity | Number | Percent |
| --- | --- | --- |
| Non-Hispanic | 1 | 100.0% |

| Gender | Number | Percent |
| --- | --- | --- |
| Males | 1 | 100.0% |

## Naturals

The Boards reviewed and closed two cases in 2020 whose manner of death was ruled as a "Natural".

### Mechanism of Death

| Illness/Disease | Number | Percent |
|---|---|---|
| Infectious Disease | 2 | 100% |

### Demographics

| Race | Number | Percent |
|---|---|---|
| White | 2 | 100.0% |

| Ethnicity | Number | Percent |
|---|---|---|
| Non-Hispanic | 2 | 100.0% |

| Gender | Number | Percent |
|---|---|---|
| Males | 2 | 100.0% |
| Females | 0 | 0.00% |

# Suicides

The Boards reviewed and closed one case in 2020 whose manner of death was ruled as a “Suicide”.

## Mechanism of Death

| Method | Number | Percent |
|---|---|---|
| Firearm | 1 | 100.0% |

## Demographics

| Race | Number | Percent |
|---|---|---|
| White | 1 | 100.0% |

| Ethnicity | Number | Percent |
|---|---|---|
| Non-Hispanic | 1 | 100.0% |

| Gender | Number | Percent |
|---|---|---|
| Males | 1 | 100.0% |
| Females | 0 | 0.00% |

- One case had a mental health diagnosis and had suffered recent crisis. No further specifications were documented.

# Unknown

The Boards reviewed and closed six deaths in 2020 ruled Unknown. A death is ruled "Unknown" by the pathologist when there are no physical findings discovered during the autopsy to definitively explain the death.

## Mechanism of Death

| Method | Number | Percent |
|---|---|---|
| Unknown | 6 | 100.0% |

## Demographics

| Race | Number | Percent |
|---|---|---|
| African American | 1 | 16.7% |
| White | 5 | 83.3% |

| Ethnicity | Number | Percent |
|---|---|---|
| Hispanic | 3 | 50.0% |
| Non-Hispanic | 3 | 50.0% |

| Gender | Number | Percent |
|---|---|---|
| Males | 4 | 66.7% |
| Females | 2 | 33.3% |

- All six of the deaths were related to unsafe sleep environments.

# Sleep-Related Deaths

The Boards reviewed and closed eight cases that were related to sleep environments.

## Manner of Death

| Manner | Number | Percent |
|---|---|---|
| Accidental | 6 | 75.0% |
| Undetermined | 2 | 25.5% |

## Sleeping Arrangement

| Manner | Number | Percent |
|---|---|---|
| With Adult and / or Other Child | 4 | 50.0% |
| Alone | 2 | 25.0% |
| Unknown+ | 2 | 25.0% |

## Sleeping Location

| Location | Number | Percent |
|---|---|---|
| Crib | 4 | 50.0% |
| Adult Bed | 2 | 25.0% |
| Chair | 2 | 25.0% |

## Sleeping Position

| Position | Number | Percent |
|---|---|---|
| Unknown+ | 3 | 37.5% |
| On Stomach | 2 | 25.0% |
| On Side | 2 | 25.0% |
| On Back | 1 | 12.5% |

# Sleep-Related Deaths (Continued)

## Sleeping Position When Found

| Position | Number | Percent |
|---|---|---|
| On Back | 3 | 37.5% |
| Unknown+ | 3 | 37.5% |
| On Side | 1 | 12.5% |
| Not on Surface | 1 | 12.5% |
| On Stomach | 0 | 0.00% |

## Demographics

| Race | Number | Percent |
|---|---|---|
| African American | 1 | 12.5% |
| American Indian | 1 | 12.5% |
| Multi-Race | 1 | 12.5% |
| White | 5 | 62.5% |

| Ethnicity | Number | Percent |
|---|---|---|
| Hispanic | 3 | 37.5% |
| Non-Hispanic | 5 | 62.5% |

| Gender | Number | Percent |
|---|---|---|
| Males | 5 | 62.5% |
| Females | 3 | 37.5% |

- Five (62.5%) of the cases had a crib available and exposed, one did not. This information is unknown for two deaths.
- Two (25%) of the cases involved children who were exposed to second-hand smoke. Three (37.5%) of the cases did not involve second-hand smoke. For the remaining three, this information is unknown.
- Two (25%) of the cases had a caregiver with a history of drug and/or alcohol abuse.
- One (12.5%) of the cases involved a parent who fell asleep while feeding the infant.

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

# Child Maltreatment

The Boards reviewed and closed two cases in which child maltreatment caused or contributed to the death.

## Manner of Death for Abuse / Neglect Cases

| Manner | Number | Percent |
|---|---|---|
| Accident | 1 | 50.0% |
| Homicide | 1 | 50.0% |

## Demographics

| Race | Number | Percent |
|---|---|---|
| Multi-Race | 2 | 100.0% |

| Ethnicity | Number | Percent |
|---|---|---|
| Hispanic | 2 | 100.0% |

| Gender | Number | Percent |
|---|---|---|
| Males | 2 | 100.0% |
| Females | 0 | 0.00% |

- Two (100%) of the children were fatally injured during the course of an open child welfare investigation.
- One (50%) of the CASES was a homicide due to physical abuse but did not include abusive head trauma.

# Near Deaths

The Boards reviewed and closed 59 near-death cases in 2020. A case is deemed a near death if the child was admitted to the hospital in serious or critical condition as a result of suspected abuse and/or neglect.

## Injuries in Near-Death Cases

| Location | Number | Percent |
|---|---|---|
| Failure to Thrive | 15 | 25.4% |
| Physical Abuse | 13 | 22.0% |
| Poisoning / Overdose | 13 | 22.0% |
| Vehicular | 4 | 6.8% |
| Fire / Burn | 4 | 6.8% |
| Drowning | 4 | 6.8% |
| Natural Illness | 3 | 5.1% |
| Firearm | 2 | 3.4% |
| Asphyxia | 1 | 1.7% |

## Demographics

| Race | Number | Percent |
|---|---|---|
| African American | 7 | 11.9% |
| American Indian | 7 | 11.9% |
| Asian | 1 | 1.7% |
| Multi-Race | 5 | 8.4% |
| White | 39 | 66.1% |

| Ethnicity | Number | Percent |
|---|---|---|
| Hispanic | 9 | 15.3% |
| Non-Hispanic | 50 | 84.7% |

| Gender | Number | Percent |
|---|---|---|
| Males | 32 | 54.2% |
| Females | 27 | 45.8% |

## Near Deaths (Continued)

- In eight (13.6%) of the cases, allegations of physical abuse were made.
- In 10 (16.9%) of the cases, allegations of physical abuse and neglect were made.
- Forty-one (69.5%) of the cases involved allegations of neglect.
- Thirty-one (52.5%) of the cases were substantiated by Oklahoma Human Services.
- Nineteen (61.3%) of the substantiations resulted in a court-ordered treatment plan.
- Sixteen (84.2%) of the 19 substantiated cases resulted in reunification of the child with at least one biological parent.
- Four (21.0%) of the 19 substantiated cases resulted in the termination of parental rights for at least one biological parent of the child.
- Thirty-four (57.6%) of the cases had a sibling with a previous child welfare referral. Sixteen of the near deaths (47.1%) were substantiated by Oklahoma Human Services.
- Thirty-one (52.5%) of the cases had a previous child welfare referral. Eight of the near deaths (25.8%) were substantiated.
- In 16 (27.1%) of the cases, the near-death experience resulted in a chronic condition for the child.
- In one (1.7%) poisoning case, it was also discovered that the poisoned child had a healing skull fracture.
- In one (1.7%) of the cases, the harmed child aged out of the foster care system before being permanently placed with a family.

# CDRB Board Members, Teams, Staff

## 2020 CDRB State Board Members

Chair: Ryan Brown | Vice-Chair: Susan Schmidt

| Position | Member | Designee |
|---|---|---|
| Chair of the Child Protection Team of the Oklahoma Children's Hospital | Ryan Brown | Amy Baum* |
| Chief Child Abuse Medical Examiner | Mary Ellen Stockett | |
| Chief Executive Officer of the Oklahoma Health Care Authority | Kevin Corbett | Jennifer Laizure* |
| Chief Medical Examiner | Eric Pfeifer | Lisa Barton* |
| Chief of Injury Prevention Services of the State Department of Health | Tracey Wendling | Brandy Woods-Littlejohn* |
| Chief of Maternal and Child Health Services at the State Department of Health | Joyce Marshall | James Craig*<br>Alicia Lincoln* |
| Commissioner of Mental Health and Substance Abuse Services | Terri White/Carrie Slatton-Hodges | Teresa Capps* |
| Director of Department of Human Services | Justin Brown | Jennifer Postlewait*<br>Marissa Edstedt* Patricia Valera* |
| Director of the Office of Juvenile Affairs | Steven Buck/Rachel Holt | Donna Glandon* |
| Director of the Oklahoma State Bureau of Investigation | Ricky Adams | Dannie Sanders* |
| Office of Child Abuse Prevention | Beth Martin/Lorri Essary | Sherie Trice* |
| Oklahoma Commission on Children and Youth | Annette Wisk Jacobi | Matthew Spruill* Brittany Hunt Jassey*<br>Tameron Sessions* Keith Pirtle* |
| State Commissioner of Health | Gary Cox/Keith Reed | Ann Benson* Tina Johnson* |
| State Epidemiologist of the State Department of Health | Laurence Burnsed | |

*Designee

### Appointed by the Executive Director of OCCY

**Court-Appointed Special Advocate (CASA)**
Tiffany Page

**District Attorneys Council**
Orvil Loge/Michael Fields
Justin Kemp*

**Emergency Medical Technician (EMT)**
Vacant

**Oklahoma Bar Association**
Susan Damron

**Oklahoma Coalition or Association Against Domestic Violence and Sexual Assault**
Jennifer Thomas

**Oklahoma Indian Affairs Commission (ICWA)**
Vacant

**Oklahoma Psychological Association**
Susan Schmidt

**Pediatric Physician or Osteopath**
Scott Melson

**Representing Oklahoma Sheriffs and Peace Officers**
Vacant

**Representing Social Workers**
Bonni Goodwin

**State Post Adjudication Review Advisory Board**
Cindy Nocton

**Statewide Organization for Osteopaths**
Laura Bode

**Statewide Organization for Physicians**
Vacant

## 2019 Eastern Regional CDRB Team

**Court Appointed Special Advocate (CASA)**
Angela Henderson

**District Attorney, District 15**
Morgan Musjlakovich

**Licensed Mental Health Professional**
Vacant

**Medical Professional**
Ashley Hopkins

**Oklahoma Department of Human Services**
Susan McComb

**Law Enforcement**
James Ables

## 2019 Southeastern Regional CDRB Team

**District Attorney - District 18**
Chuck Sullivan

**Licensed Mental Health Professional**
Vacant

**Medical Professional**
Cyndie Sanford

**Oklahoma Department of Human Services**
Jerrell Hoffman

**Public Health / Birth Defects**
Carolyn Parks

**Law Enforcement**
J.R. Kidney

## 2019 Southwestern Regional CDRB Team

**Court Appointed Special Advocate (CASA)**
Vacant

**District Attorney - District 6**
Jason Hicks

**Law Enforcement**
John Byers

**Licensed Mental Health Professional**
Vacant

**Medical Professional**
Diadra Lorseh

**Office of Juvenile Affairs**
Donna Glandon

**Oklahoma Department of Human Services**
Sandra Martinez

## 2019 Tulsa CDRB Team

**District Attorney - District 14**
Steve Kunzweiler

**Domestic Violence Intervention Services**
Rose Turner

**Law Enforcement**
Penny Hamrick

**Licensed Mental Health Professional**
Kathryn LaFortune

**Medical Professional**
Sarah Passmore

**Oklahoma Department of Human Services**
Julie Merritt/Betsey Lambeth

**Safe Kids, Tulsa**
Susan West

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OKLAHOMA
COMMISSION ON CHILDREN AND YOUTH

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