

2013 Oklahoma Child Death Review Board Recommendations

FISCAL

Office of the Chief Medical Examiner (OCME)

Continue to support OCME goals to improve and maintain infrastructure.

Changes in policy are not enough, there needs to be a financial commitment by the state of Oklahoma to affect positive change.

Oklahoma Department of Human Services (OKDHS)

Continue to provide the OKDHS with funding to hire additional child welfare staff with a salary competitive with positions in other states to be in compliance with the recommended national standard issued by the Child Welfare League of America and in accordance with the Pinnacle Plan. Changes in policy are not enough, there needs to be a financial commitment by the state of Oklahoma to affect positive change.

POLICY

Motor Vehicle Collisions

- Legislation banning the use of hand-held devices.
- Enforcement and enhancement of child passenger safety laws, including seatbelt use.
- Sobriety testing results be documented in the Oklahoma Uniform Traffic Collision Report submitted to Department of Public Safety.

Safe Sleep

- All delivery hospitals should adopt a policy regarding in-house safe sleep, including education on safe sleep after delivery but prior to discharge from hospital and that the education include statistics on sleep related deaths.
- Adoption by law enforcement agencies and the OCME of the CDC's Sudden Unexpected Infant Death Investigation (SUIDI) protocols.

Reporting

- All hospitals and law enforcement agencies should have a policy in place to notify OKDHS/CW of unexpected child deaths.