

## Oklahoma Child Death Review Board 2015 Recommendations

### 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.

### Office of the Chief Medical Examiner (OCME)

Provide the OCME with funding to continue OCME improvement goals and maintain infrastructure, including but not limited to additional OCME investigators.

- The Board reviewed and closed 112 infant deaths in 2014, of these, 80 (71.4%) had an Undetermined Manner of Death. The Board is of the opinion that had an OCME investigator conducted a more extensive scene investigation, a more definitive Manner of Death may be determined.

The Oklahoma Child Death Review Board (CDRB) supports the OCME's funding request.

### Oklahoma Department of Human Services (OKDHS)

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. Stable funding is also necessary to ensure continuity of support services provided by the OKDHS.

- Ninety-five (32.0%) death cases had a child welfare referral prior to the death.
- Sixty (20.2%) death cases were due to abuse and/or neglect
- Twenty-eight of the 42 near death cases (66.7%) the child maltreatment allegation(s) were substantiated.
- Twenty-seven (64.3%) of the near death cases had a child welfare referral prior to the near death.
- Twenty-nine of the near deaths (69.0%) had a sibling with a child welfare referral prior to the near death.
- Two hundred two (68.0%) of the deaths had accessed assistance through the Temporary Aid for Needy Families (TANF) program; 40 (95.2%) of the near deaths had accessed TANF.
- One hundred thirty-three (44.8%) of the death cases had accessed OKDHS's Child Support Enforcement services; 32 (76.2%) of the near deaths access this program.

The CDRB supports the OKDHS's funding request of \$713,143,886.

### **Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS)**

Provide the ODMHSAS with funding to support the mental health and substance abuse treatment needs of children and caregivers, including ensuring treatment beds for those children whose delinquency is deemed to be in need of mental health treatment.

- Six (4.8%) of the 124 unintentional deaths were due to accidental overdose or acute intoxication.
- Nine (21.4%) of the 42 near deaths were accidental overdoses/acute intoxications.
- Forty-four (14.8%) death cases had at least one caregiver with a history of substance abuse.
- Forty-one (13.8%) had at least one caregiver with a history of being a victim of child maltreatment.
- Twelve (4.0%) had a caregiver with a mental illness.
- Nine (3.0%) were born drug exposed.

While these caregiver and drug exposed infant numbers may seem relatively low, the information is not available on 100% of the cases, therefore, it can be deduced that the numbers are actually higher.

The CDRB supports the ODMHSAS's funding request of \$141,104,999.

### **Oklahoma Health Care Authority (OHCA)**

Provide the OHCA with enough funding to provide children and families with medical care, including screening services. One hundred ninety-six (66.0%) death cases were of children who relied on SoonerCare for their medical coverage; 30 (71.4%) of the near death cases relied SoonerCare.

The CDRB supports the OHCA's funding request of \$120,501,441.

### **Office of Juvenile Affairs (OJA)**

Provide OJA with funding to support juvenile delinquency prevention, reduction and treatment. The CDRB reviewed 20 (6.7%) cases where the child had OJA involvement.

The CDRB supports the OJA's funding request of \$17,861,647.

### **Oklahoma State Department of Health (OSDH)**

Provide the OSDH with funding to continue support for injury prevention and infant mortality reduction initiatives.

- One hundred twenty-four deaths (41.8% of the total deaths reviewed and closed) were a result of unintentional injury, with over 50% (69 or 55.6%) associated with motor-vehicles.
- One hundred twelve (37.7%) cases were infant deaths. Although Oklahoma has made some progress in reducing the infant mortality rate (6.8 per 1,000 live births in 2013), we still remain above the national rate (5.96 per 1,000 live births in 2013) and racial disparities are well above the national and state rate (16.5 per 1,000 live births in 2013 for African American infants).
- Eighty-nine deaths (30.0%) were related to unsafe sleeping environments.

The CDRB recommends OSDH's prevention programs continue to be appropriately funded.

- Sixty (20%) death cases were ruled child abuse and/or neglect by the CDRB and 28 (66.7%) of the 42 near death cases were substantiated by OKDHS.

The CDRB supports the OSDH's funding request of \$18,523,641.

Additionally, the CDRB supports the agency's request for \$49,178,000 for a bond initiative to construct a new public health laboratory and retain accreditation and vital public health services. This would also support the efforts of the OCME in its duty to identify manner and cause of death for children.

- In 2013, the OSDH Public Health Laboratory received about 194,000 specimens and ran about 661,000 tests, including newborn screenings for genetic disorders for all babies born in Oklahoma. Additionally, the lab conducts tests for respiratory viruses and foodborne illnesses that can cause outbreaks.

## **LEGISLATION**

The CDRB reviewed and closed 69 traffic related deaths in 2014, with 51 victims being in a vehicle (i.e. does not include pedestrian/bicycle/ATV/trailer bed deaths). Of these 51, almost half (49%) were not utilizing a safety restraint. Twenty (39.2%) were children under 4' 9" (or between the ages of 4 and 8 whose height is unknown) who were not in a booster seat; six of these twenty were in seat belts.

- Expand the current seat restraint legislation to include backseat passengers through age 17.
- Increase the fine for those aged 13 and over not using seat restraints to \$100 for 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.
- Enhance legislation to require children up to age two to be in a rear facing car seat.
- Enhance car seat legislation to require children age two to four to be in a forward facing car seat.
- Enhance booster seat legislation to require children over 4 years of age and under 4' 9" to be in a booster restraint.

## **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 89 (30%) deaths related to unsafe sleep environments in 2014.
- 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*<sup>®</sup> 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 intention, social media,

psychiatric diagnosis, family history of attempts/deaths, stressors, relationship status). The CDRB reviewed and closed 27 (9.0%) 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 69 cases that involved motor-vehicles, 51 of which were applicable to seat restraint use, and found seat restraint use to be 49.0%.
- 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 112 (37.7%) infant death cases in 2014; of these, 80 (71.4%) 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.
- All child death investigations should be worked 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 112 (37.7%) infant death cases in 2014; of these 112 infant deaths, 80 (71.4%) 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**

- Adopt a policy directing workers to connect a referral to a case number upon assignment of the referral.
- Ensure all children in custody have a Trauma Focused Cognitive Behavioral Therapist.
- All child death investigations should be worked jointly with Law Enforcement.
- Public operated shelters in Tulsa and Oklahoma City should not be closed without a comprehensive plan and resources in place to meet the needs of children who are removed and housed in the two shelters.

#### **Oklahoma Department of Mental Health and Substance Abuse Services**

- 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.