Oklahoma Child Death Review Board

2024 ANNUAL RECOMMENDATIONS

June 21, 2024

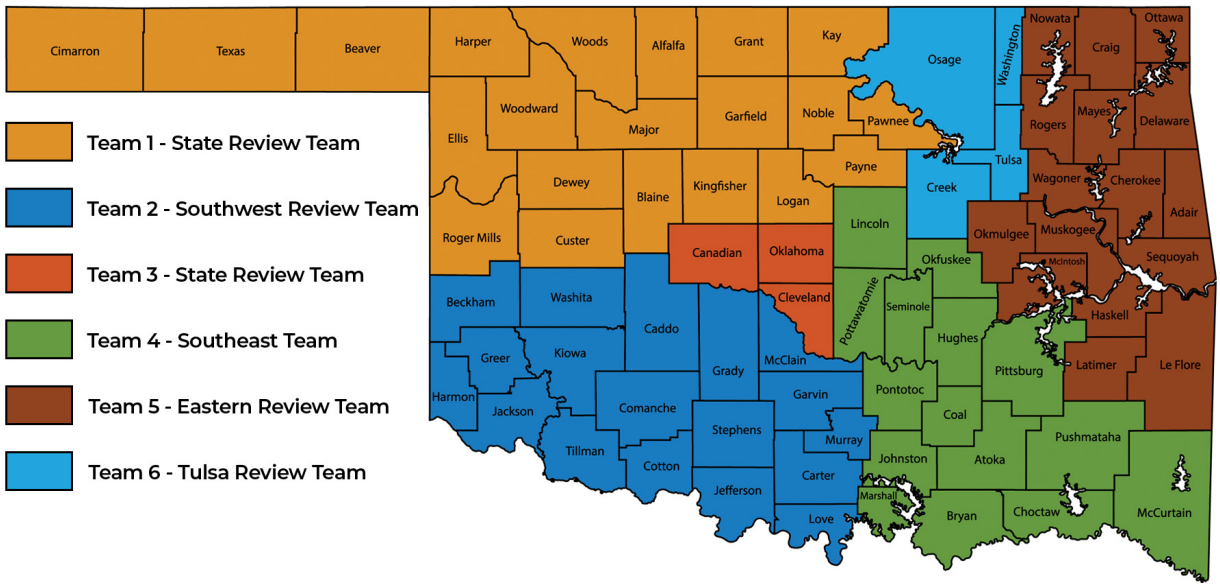
Overview

In 1991, the Oklahoma legislature recognized the need for a multidisciplinary process for systemically reviewing and learning from the non-natural deaths of our state's children and responded through the creation of the Child Death Review Act. This legislation created the Child Death Review Board (CDRB) within the Oklahoma Commission on Children and Youth (OCCY).

Since its inception, the CDRB has reviewed thousands of cases involving the deaths of Oklahoma's children from birth through age 17. Although individual case details are confidential, de-identified and aggregated results have allowed the CDRB to collect statistical data and identify preventable risks and harms to children within our state systems. Our state CDRB contributes to the National Fatality Review – Case Reporting System (ncfrp.org) to collaborate in the large-scale examination and dissemination of child death data in support of child safety and protection.

Child death review data informs the development of annual recommendations to improve policies, procedures, and practices within (and between) the agencies that protect and serve the children of Oklahoma. The CDRB strongly believes that through the provision of, and subsequent action on, these recommendations, lives are saved, families are strengthened, and agencies who serve to safeguard Oklahoma's children are supported in a manner that assists them in performing their duties.

The Board comprises five review teams that cover all 77 counties: The State Team, the Eastern Regional Review Team, the Southeastern Regional Review Team, the Southwestern Regional Review Team and the Tulsa Regional Review Team.



The Oklahoma Child Death Review Board would like to acknowledge the exceptional commitment of our former program manager, Ms. Lisa Rhoades, to the protection of our state's children and families. In 2023, Ms. Rhoades completed her time with the program after dedicating the majority of her professional career to serving and leading the CDRB. We thank Ms. Rhoades for her tireless commitment to ensuring that our communities learn and grow from the tragedy of child death so that we may create safer tomorrows for Oklahoma's future generations.

Ms. Rhoades paved the way for the next generation of professionals to join our efforts at the CDRB. In December, Ms. Elizabeth "Lizz" Kaup, M.S., transitioned from her role as Case Manager to serve as our new Program Manager. She is joined in her efforts by Case Manager Joseph McGrath, B.A., new Case Manager Elly Kohs, J.D., and Administrative Programs Officer Christina Whatley. We appreciate the state's commitment to expanding our CDRB team so that we may more comprehensively, effectively, and efficiently meet our mission to reduce the number of preventable child deaths through multidisciplinary case review, data analysis, and the development of state recommendations.

2023 Oklahoma CDRB Case Review Outcomes

2023 was a time of transition for the CDRB team, related to both transitions in team leadership/membership and transitions from the COVID-19 era that were impacting CDRB system processes. Despite these challenges, our Board successfully reviewed 407 child death cases and 17 near-death cases, which is a significant increase over the prior three years and approximated pre-COVID-19 annual case closure numbers.

Oklahoma CDRB January - December 2023 Statistics

Total # of Child Death Cases Reviewed	407
Total # of Child Near Death Cases Reviewed	17
Total # of Child Death Cases Reviewed by Board:	
State Team	174
Tulsa Team	79
Eastern Team	75
Southwestern Team	53
Southeastern Team	26

2024 Oklahoma Child Death Recommendations

For 2024, the CDRB is focusing on selected categories of child deaths to guide our annual recommendations. These categories of child death were chosen due to their increasing (for some) and sustained (for others) frequency in occurrence within our state's population.

Selected Statistics for Child Death Cases Reviewed in 2023

Sleep-Related Death	174
Suicide	79
Firearm-Related Death	75
Accident	53
Homicide	26
Suicide	53
Sleep-Related Death	26

Sleep-Related Deaths

In 2023, the CDRB reviewed 95 infant sleep-related deaths (or Sleep-Related Sudden Unexpected Infant Deaths; SUID), comprising over 23% of all reviewed child deaths. In each of the 95 cases, an unsafe sleep environment was identified as a contributing factor.

For the time period of 2004 to 2019, the National Center for Fatality Review and Prevention reviewed 28,110 infant deaths entered into the National Fatality Review Case Reporting System that occurred while the infant was sleeping or in a sleep environment (https://ncfrp.org/center-resources/quick-looks/sleep-related-suid-deaths/). The NCFRP infographic below identifies sleep-related SUID characteristics of the cases reviewed:

Sleep-Related SUID Characteristics

Birthweight

Infants born preterm or with low birth weight are at increased risk of dying suddenly and unexpectedly.

- 25% were low birthweight
- 24% were born preterm

Smoking

Exposure to cigarette smoke during gestation or after birth places infants at greater risk; avoiding smoke and nicotine exposure exposure before and after birth is recommended.

- 49% of birthing parents smoked during pregnancy
- 49% of infants were exposed to secondhand smoke after birth

Sleep Surface

Infants should be placed on a firm, flat, non-inclined surface that meets Consumer Product Safety Commission safety standards. Of the 28,110 sleep-related SUIDs, infants were placed to sleep on these surfaces:

- 55% adult bed or mattress
- 23% crib, portable crib, or bassinet
- 12% couch, chair, cushion, or pillow
- 4% inclined sitting device
- 3% playpen or other play structure
- 2% makeshift bed
- 1% other surface or in a person's arm

Breastfeeding

Feeding infants human milk is associated with a reduced risk of SUID, and it is recommended that infants be fed human milk exclusively for the first six months, if possible.

- 58% were breastfed at least once
- 4% were breastfed at three months
- 1% were breastfed exclusively at three months

Source: https://ncfrp.org/center-resources/quick-looks/sleep-related-suid-deaths/

In response, the American Academy of Pediatrics updated its policy recommendations for reducing infant deaths in the sleep environment (Moon, Carlin & Hand, 2022). Examples of key infant safe sleep practice recommendations include:

- Supine positioning
- Use of a firm, non-inclined sleep surface
- Room sharing without bed sharing
- Avoidance of soft bedding and overheating
- Human milk feeding
- Avoidance of exposure to nicotine, alcohol, marijuana, opioids, and illicit drugs
- Routine immunizations
- Use of a pacifier

Readers are encouraged to review the updated 2022 American Academy of Pediatrics Task Force Report for their set of comprehensive recommendations.

In Oklahoma, a 2022 environmental scan revealed deficits in available safe sleep education for nonprofessional caregivers statewide. Additionally, a trend has been emerging in unsafe sleep cases involving grandparents as caregivers/supervisors. As such, and to advance the 2022 AAP Safe Sleep Policy recommendations, **the CDRB *recommends:***

- ***Increased state-level financial support to continue and expand safe sleep education efforts across Oklahoma***
- ***Education efforts expand their target audience to include alternate caregivers, supervisors, and grandparents.***

Suicide

In 2023, the CDRB reviewed 54 child suicide deaths, comprising over 13% of all reviewed child deaths. This is a continuation of an increasing annual trend in child suicide deaths in the state of Oklahoma over multiple years and echoes a trend in pediatric suicide rates across the United States. Hedegard and colleagues (2018) identified a 41% increase in suicide rates among U.S. youth and young adults ages 15 to 24. Suicide has long been the second leading cause of death among youth and young adults ages 15 to 24 (Heron, 2017).

Research (e.g., Bilsen, 2018) is advancing our understanding of elevated risk factors for youth suicide, including mental health conditions (e.g., depression, substance abuse), stressful events (e.g., relationship break-up, bullying, trauma exposure), family history of trauma (e.g., suicide, abuse, neglect), personal history of suicidal ideation and attempts, and access to lethal means (e.g., firearms and drugs).

As reported in prior CDRB annual recommendations, law enforcement investigations commonly provide little youth and family information from which to identify relevant precursors to youth suicide. As a result, it is difficult to determine possible Oklahoma-based systemic factors that increase risk or are protective against suicidality in our state's youth. Our understanding of the factors increasing youth suicide risk in Oklahoma could be informed by expanded law enforcement investigations. Such efforts could collect critical information, including a family history of suicidality, youth suicidal ideation and self-harm history, youth mental health history, youth utilization of/adherence to prescribed psychotropic medications, and the presence of/content in youth pre-suicide communications.

Youth suicide case reviews are further hampered by law enforcement's failure to report youth suicides to the Oklahoma Department of Human Services - Child Welfare Division. This request by OKDHS was made of all Oklahoma law enforcement agencies in 2020. An increase by law enforcement to make such referrals can expand critical case data collection and ensure that surviving siblings and other family members have needed safety and support.

Specific to child suicide deaths, the CDRB *recommends:*

- ***All Oklahoma law enforcement agencies:***
    - ***Update policies and procedures to include notification of a suicide death to Oklahoma Human Services, Child Welfare division, for the determination of the needs of the family and to refer to any necessary services.***
    - ***Adopt a standardized child suicide reporting form to enhance and expand the quality and quantity of case investigations.***
    - ***Incorporate updated policies and procedures into officer training practices to support initial and ongoing adherence.***

Firearm-Related Death

In 2023, the CDRB reviewed 48 child deaths resulting from firearms, equally divided across homicide deaths (24) and suicide deaths (24). A trend across cases of youth suicide involved youth access to/use of a family member's (e.g., parent's) unsecured firearm within the family home.

As reported in the prior section, access to lethal means, including firearms, has been identified as a clear risk factor for child suicidality. Unfortunately, this has become an increasing trend in lethality choices for youth who complete suicide. Oklahoma child death data parallels child death data from other state partners, indicating the rise in the use of firearms as a mechanism for suicide.

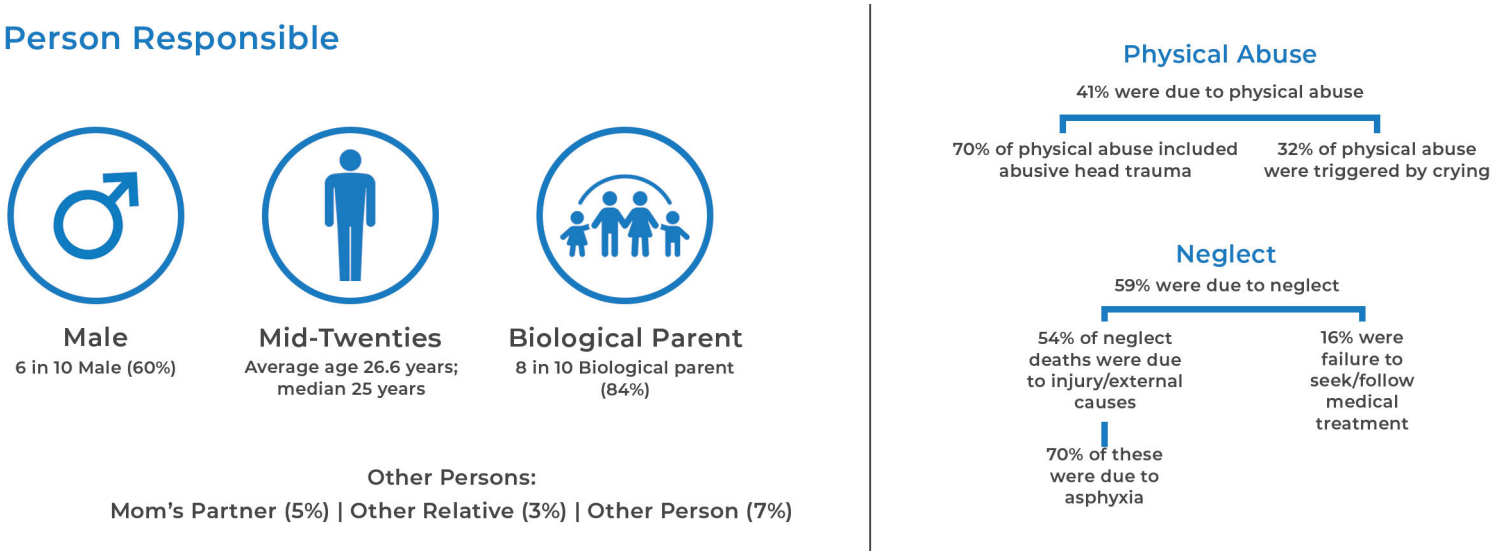
The CDRB recommends:

- ***State investment in educational campaigns and resource distribution (e.g., trigger lock giveaways) to expand adult securing of firearms in homes in which children reside***
- ***The Oklahoma legislature conduct an interim study to determine the mental health and economic costs associated with firearm deaths in our state.***

Abusive Head Trauma

In 2023, the Board reviewed 14 child deaths attributed to abusive head trauma, occurring in both metropolitan areas as well as rural.

For the time period of 2004 to 2017, the National Center for Fatality Review and Prevention reviewed over 4,600 infant child abuse and neglect deaths entered into the National Fatality Review Case Reporting System (https://ncfrp.org/center-resources/quick-looks/infant-can-deaths/). Within this group, 76% of infants were less than six months of age at the time of death, 75% experienced the abuse in their family home, 33% had evidence of prior abuse identified during their death investigation, 31% had a history of child maltreatment prior to death, 17% had an open child protective services case at the time of death. The NCFRP infographic below identifies additional infant child abuse and neglect characteristics of the cases reviewed:



Source: https://ncfrp.org/center-resources/quick-looks/infant-can-deaths/

The person most commonly responsible for infant death due to child abuse and neglect (84%) was a biological parent. 60% of the persons responsible were male. Of note, for the 41% of infants who died due to physical abuse, 70% of infants suffered 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.

The CDRB recommends:

- ***The Period of PURPLE® Crying program continue to be funded, and all Oklahoma birthing hospitals provide the education with the expectation that caregivers may acquire skills that empower their capability to keep an infant safe.***
- ***All birthing hospitals develop and abide by a written policy to implement, with fidelity, the Period of PURPLE® Crying abusive head trauma prevention program. Hospitals will additionally incorporate updated policies and procedures into employee onboarding and ongoing training practices to support adherence.***
- ***Enhanced state investment in educational campaigns such as "Think, Prevent, Live" to enhance child abuse prevention.***

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Heron, M. Deaths: Leading Causes for 2017. National Vital Statistics Reports, Vol. 68(6). Hyattsville, MD. National Center for Health Statistics, 2019.

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