

2004 Citizen Review Panels Annual Report

The Citizen Review Panels (CRP) have comprehensively reviewed and evaluated the investigative, administrative, and judicial handling of child fatality cases, especially those cases involving child abuse/neglect and foster care. Many cases involve a potential combination of jurisdictions, such as interstate, federal-state, and state-tribal.

The Citizen Review Panels and staff reviewed reports from or participated on state committees. On these committees the CRP had staff and members or designees participate in subcommittees on systemic factors, safety outcomes, permanency outcomes and well being outcomes on child welfare services. In addition, the state and local Citizen Review Panels hold their own monthly and quarterly executive confidential review of child fatalities and near fatalities of children. These multi-disciplinary boards are responsible for reviewing the deaths of children in Oklahoma and providing statistical data and systems evaluation information to develop recommendations to improve the policies, procedures, and practices within and among agencies that protect and serve children.

The Citizen Review Panels and staff reviewed and assessed the following:

- Investigative, administrative and judicial handling of known and suspected instances of abuse and neglect;
- Safety assessment and prompt investigation on child abuse and neglect;
- Immediate steps taken to ensure child safety;
- Cooperation of law enforcement, courts, and appropriate state agencies in Child Protective Services;
- Expedited terminations of parental rights and permanency plans;
- Deaths and near deaths in foster care

Information used for review:

The following summarizes the reports and sources of information most frequently used by CRP members and staff when assessing investigative, administrative, and judicial handling of cases of child abuse and neglect:

- Reports generated by the automated Oklahoma Department of Human Services (OKDHS) information system
- The annual program and services reports from OKDHS, including a critical evaluation of outcomes into goals constituting the State's title IV-B Child and Family Services Plan
- Oklahoma OKDHS Annual Program and Services Report
- Oklahoma Child Death Review Board monthly meetings
- Oklahoma Child Death Review Board quarterly local team meetings
- Oklahoma Child Death Review Board Annual Report 2001
- Oklahoma Child Death Review Board Annual Report 2002
- Statistics generated from cases reviewed by the Oklahoma Child Death Review Board in 2003
- Oklahoma Child Abuse Prevention Task Force quarterly meetings
- Child Abuse Task Force Three Year Assessment
- Discussions, presentations, observations and recommendations of Citizen Review Panel members at the quarterly and monthly meetings.

Points of interest:

- Males continue to make up the majority of child deaths. In 2003 sixty-five percent of the deaths reviewed were male. In 2002 sixty-one percent were male; and in 2001 sixty-six percent were male.
- OKDHS involvement with families included: 106 (36%) families had previous medical assistance, 75 (26%) families had previous food stamp assistance, and 79 (27%) families had previous child support involvement.
- In 2003, the deaths of 292 children were reviewed and closed. Of these, 219 (75.0%) had received some type of assistance from OKDHS.
- The Temporary Aid to Needy Families (TANF) program had the highest frequency of involvement with 154 cases (52.7%).
- Child Protective Services had previous involvement with 89 (30.5%) families who lost a child. In 63 (21.6%) of the cases, the child who died had a previous abuse/neglect report.
- Three (1%) of the deaths involved children who were in foster care: One died of natural causes; one death was ruled accidental; and the other death was ruled homicide by the medical examiner's office.
- Accidental deaths made up 48.3% (141) of the cases reviewed; natural causes was the second leading cause of death, 29.1% (85); and undetermined was third at 9.6% (28). Suicides accounted for 5.8% (17) of the deaths reviewed and homicides made up 7.2% (21) of the deaths.
- Accidental deaths by cause: Vehicular – 89 (63%), Drowning – 21 (15%), Fire related – 11 (8%), Asphyxiation – 6 (4%), Poisoning – 5 (4%), Falls – 3 (2%), Firearm related – 2 (1%), Other - 4 (3%).

Continuing concerns of the Citizens Review Panels:

1. There is a problem of persistence of reunification when families have not responded to treatment and continue to lack the capacity or resources essential to parenting. Improved coordination of activity and expectations between child welfare staff and judges in several jurisdictions regarding child safety, timely realization of permanence and conformance with ICWA is an urgent need. Many judges and families have expressed concern that services, goals, and responsibilities are not readily understandable in the current treatment plan format.
2. The investigation of potential safe environments for children is hindered by the fact that DHS cannot release to any tribe or agency the child abuse and neglect history of any person who is applying to be a foster parent with any tribe or agency.
3. Approximately 15% of all children who have entered out of home placement re-entered foster care within 12 months of a prior foster care episode. In addition, the median length of stay for children in out of home placement in Oklahoma was 11.9 months. The Task Force has identified some reasons for re-entry or long stays for children in out of home placement. In many instances, family members have health, psychological or substance abuse issues; factors known produce environments that lead to neglect and abuse in homes. The resources to address these barriers are not readily available; more access to resources is needed for families at risk. Access to physicians, dentists and mental health clinicians are not readily available in many locales across the state. The lack of mental health treatment services has presented a significant obstacle to obtaining treatment for substance abuse services for children and families as well as treatment for emotionally and behaviorally disturbed children. Another factor that jeopardizes successful reunification not related to health care issues is the fact that parents often must miss work when meeting with the court or child welfare, which jeopardizes their employment/ income and their reunification plan.

4. Child Welfare staff retention is identified as a primary need affecting many of the statewide investigations in allegations of child abuse and neglect. At this time fifty percent of Child Welfare staff have less than 2 years experience in the field, with 23% having less than one year. Achieving greater worker longevity is a critical component of future investigations and services provided by the state.
5. There is a need to improve the state's ICWA conformance, including but not limited to, improved and increased coordination/communication between the state and tribes. Also, there is a need to improve inconsistent practices with regard to the early identification of Native American status, tribal notification of hearings or the results of court proceedings, and efforts to secure culturally appropriate services.
6. There is a need for additional training to improve the investigative, administrative and judicial involvement of the state's multidisciplinary teams, law enforcement personnel, mental health professionals, judges, district attorneys, defense lawyers and child welfare workers, especially in the area of forensic interviewing, in all areas of child abuse and neglect including sexual victimization of children.

RECOMMENDATIONS:

Motor Vehicle Related Deaths:

Key Findings

In 2003, the Citizen Review Panel reviewed a **total** of 292 deaths: of these, 90 (30.8%) involved motor vehicles. Eighty-five were non-pedestrian related and of these, 36 (42%) were unrestrained. The driver was cited for driving under the influence in 11 (12%) cases. Drivers aged 17 years and younger were involved in 39 (45.9%) cases. Although exact numbers are unavailable at this time, the CRP is extremely concerned about the number of motor vehicle collisions that occur with two or more teenaged occupants.

Recommendations

In order to reduce the number of motor vehicle related fatalities, the Citizen's Review Panel recommends:

- Strengthening Oklahoma's graduated drivers licensing system to include restrictions on teen drivers and the number of unlicensed and/or younger passengers allowed.
- Mandatory field sobriety testing of drivers in motor vehicle accidents resulting in a child fatality and/or a critical or serious injury to a child.
- Increasing fines for drivers transporting unrestrained children to be comparable with fines for unrestrained drivers.
- Court sanctions and/or education prevention programs, such as drunk driving victim's panels should be strongly encouraged for first time and/or repeat offenders. Drug court, or a comparable drug and alcohol treatment program for repeat offenders should also be strongly encouraged.
- Provide mandated universal driver education classes for all high school and career tech students.

Firearm Related Deaths:

Key Findings

In 2003, the Panel reviewed and closed 18 fatalities that were firearm related. This represents 6.2% of the total deaths reviewed.

Recommendations

In order to reduce the number of firearm related fatalities, the Citizen's Review Panel recommends:

- Mandatory reporting by health care providers to the appropriate law enforcement agency of any/all gunshot wounds. Subsequently, mandatory reporting by law enforcement agencies to the Injury Prevention Services, Oklahoma State Department of Health of all gunshot wounds for review.
- Mandatory field sobriety testing of all individuals present during a firearm related fatality.
- Development of gun safety and avoidance programs, including implementation plans, with a particular emphasis on elementary aged children.
- Identification of secure visitation drop-off locations for the safe exchange of children in cases where the court has ordered visitation and a caregiver/parent has expressed to the court a concern over safety.

Child Abuse/Neglect Deaths:

Key Findings

In 2003 the CRP reviewed and closed 29 (9.9% of the total number reviewed and closed) cases that were concluded by the CRP to have been a result of child abuse/neglect: 22 (75.9%) of these were also ruled abuse/neglect by the Oklahoma Department of Human Services, Child Welfare. Additionally, 11 (37.9%) had previous child welfare involvement. Currently, Oklahoma's child welfare workers and supervisors carry an active caseload that is 2 to 3 times great than those recommended nationally by the Child Welfare League of America.

Recommendations

In order to reduce the number of deaths due to child abuse/neglect, the Citizen's Review Panel recommends:

- Provide the Oklahoma Department of Human Services with funding to hire additional child welfare staff to be in compliance with the recommended national standard issued by the Child Welfare League of America.
- Continue to fund the Oklahoma State Health Department's primary and secondary prevention programs (i.e. Children First, Child Guidance, Office of Child Abuse Prevention Programs, Oklahoma Parents as Teachers, and Safe Families).
- Increase child abuse prevention services that serve families that do not qualify for Children First but have been considered to be at high risk for abuse/neglect.