STATE OF WYOMING

CHILD MAJOR INJURY/FATALITY REVIEW TEAM

EIGHTH ANNUAL REPORT

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Mission Statement

The Child Fatality Major Injury Review Team (CFMIRT) seeks to improve Wyoming communities' responses to major injuries and fatalities in cases of child maltreatment.

The Child Fatality Major Injury Review Team will actively advocate for child victims of maltreatment and provide recommendations for change through prevention, intervention, training, education, legislation, and public policy.

Purpose and Responsibilities

The Child Fatality Major Injury Review Team shall:

1. Review case files of all Wyoming child fatalities and major injuries due to abuse and/or neglect.

2. Identify factors and predictors appearing in cases of child maltreatment which result in major injury or the death of a child(ren);

3. Review information that might change the response of the system so child maltreatment occurring in similar circumstances might be prevented;

4. Gain information which can be utilized in the modification and/or development of laws, policies, and procedures to protect children;

5. Actively advocate for child victims of maltreatment and provide recommendations for change through prevention, intervention, training, education, legislation and public policy.

6. Develop a yearly statistical report identifying trends in major injury due to maltreatment and fatal maltreatment and make recommendations which may include needed actions, development of preventive programs, or training recommendations addressing statewide issues.

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History of Child Death Review

National:

In 1995, The United States Advisory Board on Child Abuse and/or Neglect concluded child abuse and/or neglect fatalities and near fatalities could not be significantly reduced or prevented without more complete information about why these deaths and injuries occur. It was widely acknowledged that many child abuse and/or neglect deaths were under reported and/or misclassified. Professionals, scholars, and officials around the nation agreed that a system of comprehensive Child Death Review (CDR) teams could make a difference. Though these reviews initially centered on fatalities and other serious injuries due to child abuse and/or neglect, there has been a national movement to enhance the role of the CDR to review all preventable child deaths and major injuries. At this time, the scope of the CDR in surrounding states incorporates all child fatalities; Wyoming continues to pursue this option.

Wyoming:

The Wyoming Child Major Injury/Fatality Review Team was established by the Department of Family Services (DFS) in December, 1997 under the authority provided in the Child Protective Services Act, W.S.14-3-201 through 14-3-215. It was originally established with the purpose of reviewing child deaths due to abuse and/or neglect, but was expanded to include major injuries in 1999. The purpose of this team is to provide a systemic view of issues facing Wyoming and to provide a well-rounded review of the system issues surrounding the cases. Child major injury and fatality cases are submitted for review to the team by the local DFS offices as per procedure outlined in its rules, regulations and policies. The team meets monthly to review cases and fulfill its mission to improve the response to major injuries and fatalities in cases of child maltreatment in Wyoming, to actively advocate for child victims of maltreatment and to provide recommendations for system change through prevention, intervention, training, education, legislation, and public policy. These recommendations are compiled and published in an annual report. This document represents the eighth annual report published by this team.

The Department of Health continues to collaborate with the Department of Family Services on reviewing child deaths and major injuries. This collaboration has involved discussion with legislators and proposed legislation. Unfortunately, during the 2006 Legislative Session the proposed legislation change to relocate the team to the Department of Health, to review all child fatalities did not pass. Without this legislative change, Wyoming can only review child deaths and major injuries reported to the Department of Family Services.

The Wyoming Child Fatality Major Injury Review Team continues to advocate for the move to the Department of Health. This move would allow for a more systemic approach to issues of child death and major injuries throughout the state. The ability to review all cases would provide more detailed data regarding child death and major injuries throughout the state. At this time, the only notification the team receives are those cases brought to the attention of the Department of Family Services as a result of suspected abuse or neglect.

Observed Trends in Child Major Injuries/Fatalities/Risk Factors

The CFMIR team has observed the following trends in its recommendations since 1998:

Shaken Baby Syndrome continues to be a cause of fatalities and major injuries in cases of abuse and/or neglect in Wyoming. The CFMIR team has made many recommendations concerning Shaken Baby Syndrome, emphasizing the importance of education. Included in these recommendations has been to provide education to young men and women and emergency medical providers on the effects as well as symptoms of Shaken Baby Syndrome. It is the team's hope to foster development of innovative strategies preventing deaths and devastating major injuries that occur as a result of this syndrome.

Through the years, the team has recognized the linkages between substance abuse and domestic violence in child abuse cases. In addition, the team continues to observe an increase in young perpetrators who are the biological parents and perpetrators with low education level. Over the years the caregivers substantiated on for abuse and/or neglect have gotten younger. Many of these individuals have struggled educationally and have not been provided a healthy support system.

Representative Cases

During CY 2005, of the 12 cases reviewed, five were the result of Shaken Baby Syndrome, 2 were the result of car accidents, 1 was an unknown cause, 1 was a drowning, and 1 was accidental suffocation. There were three fatalities and nine major injuries reviewed. The cases reviewed consisted of incidents which occurred in 2003, eight which occurred during 2004 and two which occurred in 2005.

1. During 2005 there were 8 cases reviewed where the victim was under the age of one, three of which were fatalities.

    a. A nine-month old little girl was found drowned in the family bathtub. Her father left her alone to bath in the tub while the mother was not at home. The coroner's office did not complete an autopsy. As a result there is no information to inform the team if the child had suffered other forms of abuse or neglect. Neglect was substantiated and a consent decree was completed.

    b. A five-week old little girl was taken to the hospital because she was unresponsive. During the medical exam it was determined she suffered from a major injury of subdural hemotoma, which is indicative of Shaken Baby Syndrome. The family has a history of substance abuse as well as domestic violence. The child was taken into protective custody and remained out of the home for one year. Upon return home, she subsequently suffered another major injury. The allegations against the father were substantiated. There were no criminal charges filed.

    c. Five month old twin boys were taken to the hospital with major injuries. The medical exam determined one of the boys to have suffered from Shaken Baby Syndrome. The biological parents received a substantiation for both boys. The parents have a history of substance abuse as well as prior DFS involvement. At the time of the review it was indicated the parents will relinquish their parental rights to these children. There were no criminal charges filed.

    d. A five-month old little boy died from Shaken Baby Syndrome when he was left alone with his biological father while his mother was at work. The parents both admit to a history of substance abuse. The child had been taken to the hospital several times over the previous months but no connection was made during those visits. An autopsy was completed and the coroner ruled his death as non-accidental trauma resulting form Shaken Baby Syndrome. The perpetrator was found guilty and sentenced to fourteen to twenty-one years in prison.

    e. A three-month old little boy was found dead at his babysitters. It is believed the child suffocated from improper placement in his crib for feeding and sleeping. The child was placed in a crib with multiple blankets and his bottle propped up for feeding. When the sitters

checked on him, he was blue. Law Enforcement did not feel an autopsy was necessary so none was completed. The coroner stated his death was the result of accidental suffocation. There is extensive substance abuse history with the parents and babysitters. The siblings of this child had been in placement with DFS for Methamphetamine use by the parents. DFS advocated for this child to be removed from the home at birth but the physician did not feel this was necessary. The neglect allegations against the babysitters were substantiated. There were no criminal charges filed.

f. A four-month old little girl and siblings were taken into protective custody when she suffered a major injury at the hands of her uncle. The uncle had been the known babysitter of the children. There was no court involvement in this case because the County Attorney did not feel as thought there was enough information to prosecute. The children were returned to mom. There were no criminal charges filed.

g. A newborn baby was placed in protective custody when he and his mother tested positive for Methamphetamine at his birth. The mother sought treatment and the child was subsequently returned to his mother while she was in treatment. The allegations against mom were substantiated. There were no criminal charges filed.

2. Two of the twelve cases reviewed were major injuries occurring during vehicle accidents.

a. A fourteen year old girl was riding in the back of a van with her biological parents. There were no seats or seatbelts in the back of the van. The van was involved in an accident and the young girl was thrown from the van and sustained numerous injuries. The family has an extensive history with the Department of Family Services and the allegations of abuse were substantiated. Criminal charges were pending at the time of the review.

b. A 22-month old little girl was found at the scene of an automobile accident where her father had been killed. It was estimated she had been on the side of the road with her father for 30 hours until she was discovered. There was no autopsy completed on the father so cause of his death is unknown. The father had an extensive substance abuse history as well as domestic violence. The child was fine and released from care to her biological mother.

3. One case reviewed had an unknown cause.

A four-year old boy was admitted to the hospital with a fever and tenderness in the abdomen. When surgery was completed a perforated traverse colon was found which is indicative of a traumatic injury. At this time, no perpetrator has been discovered and the local office substantiated on an unknown individual. There were no criminal charges filed.

4. One case involved a six year old male.

   a. A six year old male was taken into protective custody when he was seen at the Emergency Room with a broken clavicle. The injury was not consistent with the described incident. The mother indicated she bumped him while moving furniture, however she told a neighbor she had pushed him down the stairs. The allegations of neglect and physical abuse were substantiated against both parents. There were no criminal charges filed.

Child Maltreatment Related Deaths in Wyoming

Introduction

The death of a child due to abuse and/or neglect is a tragedy felt not only by those who knew and loved the child, but also by the community at large. This report explores the nature and scope of child maltreatment fatalities and major injuries in Wyoming and provides recommendations on how to decrease these incidences.

Data Collection

The National Child Abuse and Neglect Data System (NCANDS) was established by the Department of Health and Human Services (DHHS) and is the primary source of national information on abused and neglected children. The Wyoming NCANDS report is compiled and submitted yearly based on data gathered from the Department of Family Services Wyoming Children Assistance and Protective System (WYCAPS).

Each year, the Children's Bureau within DHHS publishes an annual report and analysis of the most recent NCANDS data. The most recent NCANDS report, ***Child Maltreatment 2003***, shows data for 2003. The national and state data from this report, as well as WYCAPS information, will be used in this report.

It is important to note that efforts to collect and analyze data across states are hampered by wide variations in the way state child welfare agencies compile information. Nationally, there are no common definitions of child abuse and/or neglect, no common standard of proof of substantiation, and no common criteria for identifying that abuse and/or neglect was the cause of a child's death. For example, a child's drowning death due to a parent's poor supervision might be considered negligence in one state and simply a tragic accident in another. In Wyoming, such an incident would be considered a child maltreatment related fatality if the caregiver was found to be negligent. Therefore, comparing national statistics, given the variances, may reflect differences with how the data are collected and recorded and with definitions of maltreatment related fatalities. Additionally, it can be difficult to obtain and track information about maltreatment related child deaths. If law enforcement determines the case is an accidental situation, the Department of Family Services may not be notified. Some deaths involve very young children and occur at the hands of a sole caregiver in the privacy of the child's own home. Abusive or neglectful behavior may never be suspected or, if suspected, is difficult to prove. Therefore, reported numbers may undercount the actual incidence of child maltreatment fatalities in Wyoming, due to data collection problems and inconsistent definitions for what constitutes a death due to abuse and/or neglect. Further, the population of Wyoming is very small and the actual number of child deaths is also small which leads to wide variations in rates from year to year. **Caution should be used when interpreting rates, as numerators are less than 20.**

National Findings 2003

- CPS agencies receive more than 2.9 million referrals alleging that children have been abused and/or neglected each year
- Nationally, an estimated 906,000 children were victims of abuse and/or neglect
- Nationally, an estimated 1,500 children died from abuse and/or neglect
  (Source: Child Maltreatment Report, 2003)

National Fatality Rates

Year	Rate per 100,000 children
2003	2.0
2002	1.98
2001	1.81
2000	1.71
1999	1.62
1998	1.6
1997	1.7

(Source: Child Maltreatment Reports 1997 through 2003)

Wyoming Fatality Rates

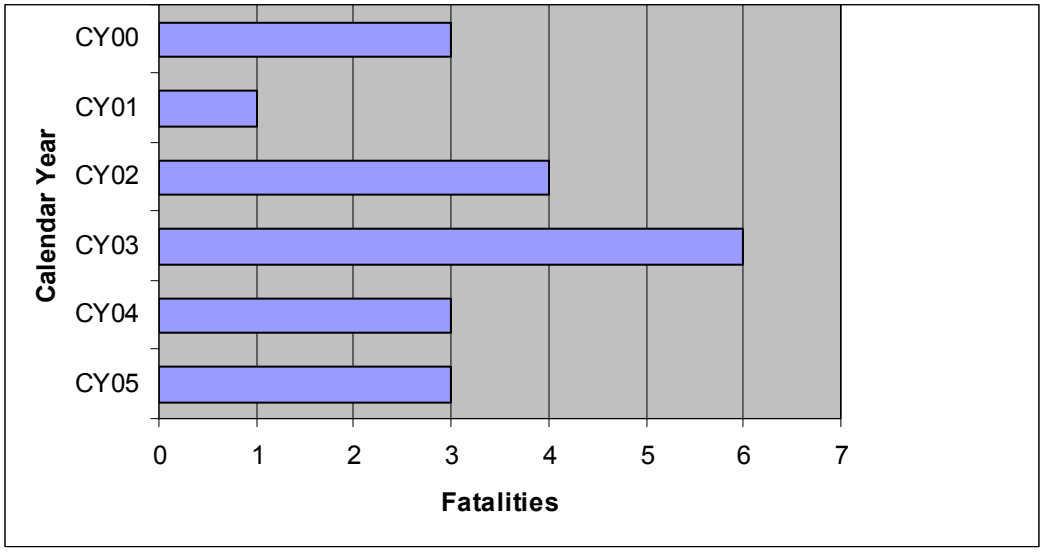
Year	Rate Per 100,000 children
2003	6.61
2002	2.45
2001	1.8
2000	1.7
1999	1.6
1998	1.6
1997	1.7

(Source: Child Maltreatment Reports 1997 through 2003.)

Wyoming Findings 2005

- DFS offices around the state received 7,399 referrals alleging that children have been abused and/or neglected
- 4,310 children were the subject of a report referred for investigation or assessment
- Children in the age group birth to 3 years accounted for 303 of the victims
- 1 child died as a result of child abuse and/or neglect

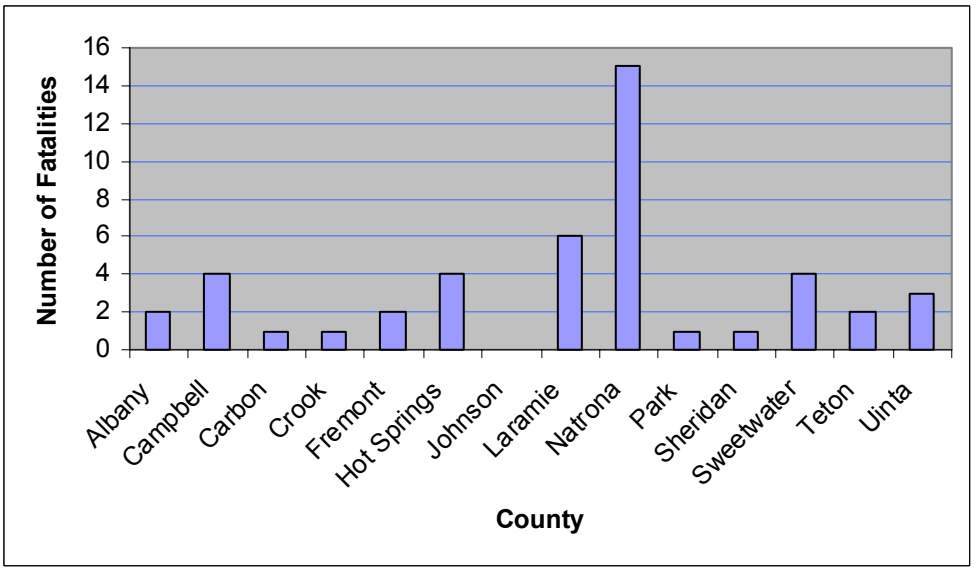
Wyoming Child Fatalities for the Previous Five Years



(Source: Wyoming WYCAPS data)

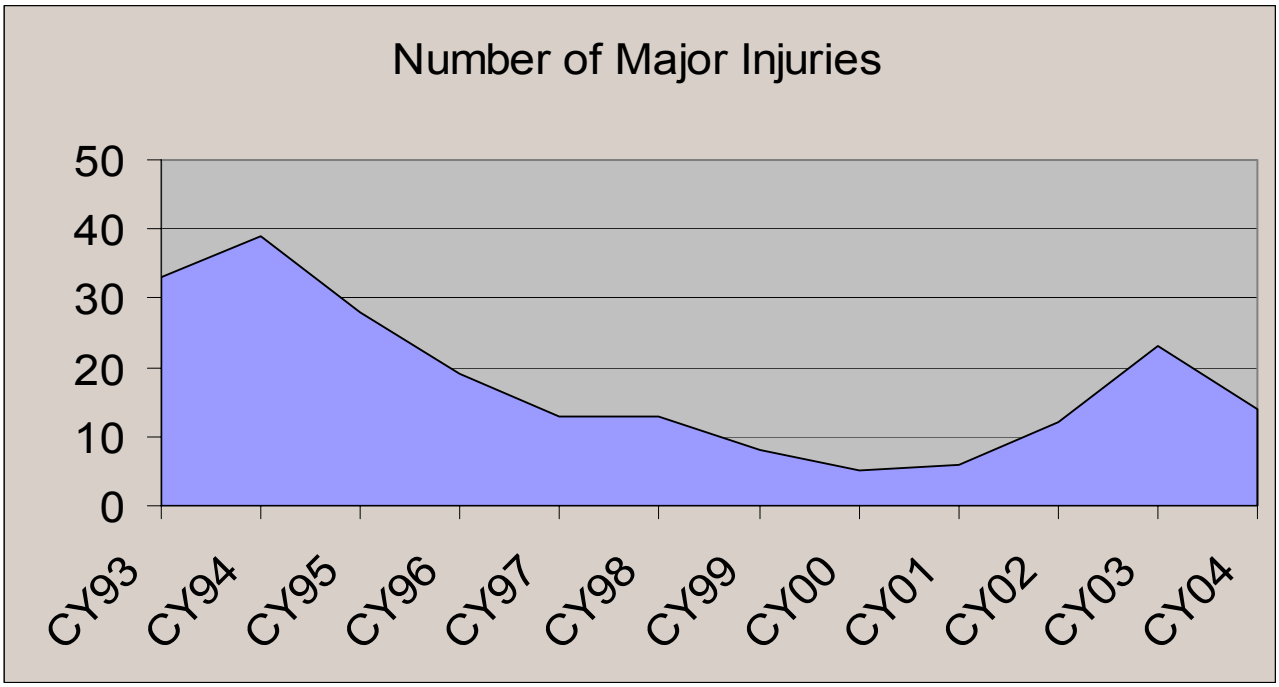
Demographics of Reviewed Wyoming Fatalities

Fatalities by County 1990-December 2005



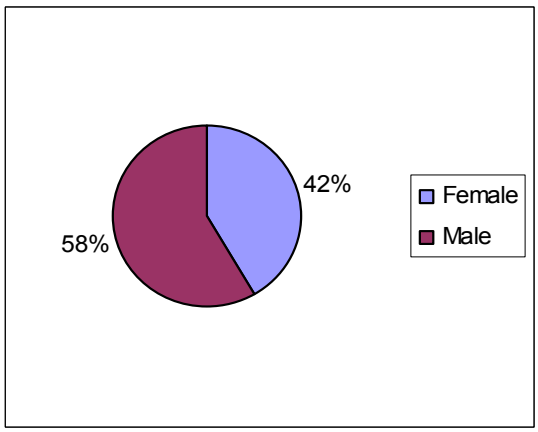
(Source: Wyoming WYCAPS data)

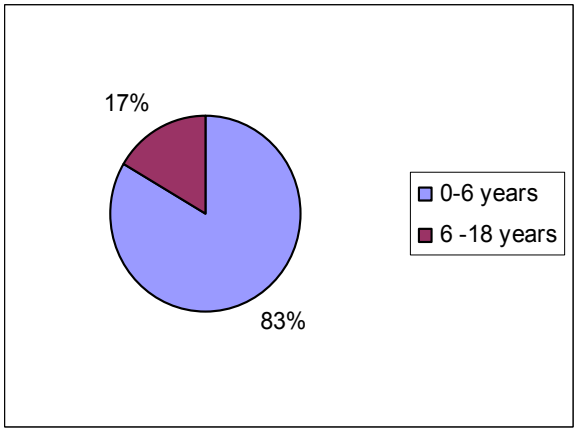
Wyoming Major Injuries



(NCANDS Data)

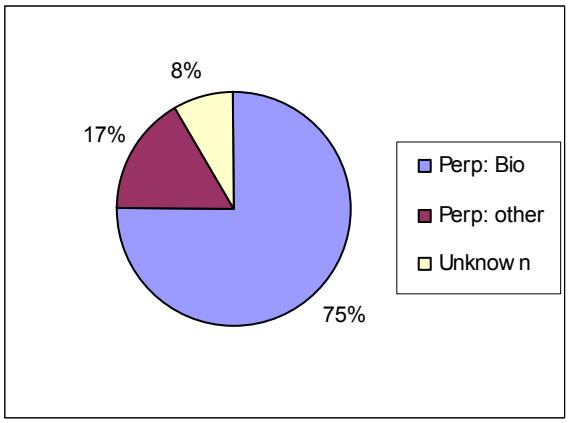
Characteristics of Victims
In Cases Reviewed in 2005





(Source: WYCAPS data)

Perpetrators in Cases Reviewed in 2005



Family Characteristics of Perpetrators In Cases Reviewed in 2005

(Source: WYCAPS data)

2005 Recommendations

Since January 2005, the CFMIR Team completed reviews of twelve cases, one from 2003, eight from2004 and two from 2005. Based on these and past comprehensive case reviews, the Team reports the following findings and recommendations, which are intended to help reduce child fatalities through enhanced policy development and service delivery within and among the agencies that serve child and families. Recommendations are grouped by social system.

Public Policy

- Those traffic crashes resulting from substance abuse where a child was injured should be reported to the Department of Family Services.
- If a death occurs in the vehicle accident an autopsy should be completed to determine appropriate cause of death.
- Increase the penalty for individuals convicted of child abuse.
- Establish in statute that an autopsy is to be completed on all "unexpected" deaths of a children, as well as define unexpected.
- Consent Decrees between the parents and district attorney should not be used in abuse/neglect cases.

Law Enforcement

- Law enforcement agencies need to document reported cases of suspected child abuse and/or neglect even if there is not enough evidence for prosecution.
- Law enforcement should receive in-depth training on how to recognize signs of abuse/neglect on child cases.
- Law enforcement receive training on recognition of scene evidence needed in identifying victims of Shaken Baby Syndrome.

Health Care/Medical

- Emergency room doctors should be better trained in identifying possible child abuse/neglect cases and the steps to report these cases to the proper authorities.
- Emergency room nurses should receive further training on identification and requirements of reporting child abuse and neglect.
- Provide clarification to local hospitals concerning reporting of child abuse/neglect and testifying, per HIPPA.
- Establish ER protocol for identifying Shaken Baby Syndrome signs and symptoms.

Department of Family Services

- The Department of Family Services should receive extensive training on identification of Shaken Baby Syndrome and the identification of it.
- DFS should receive further training on the appropriate information to provide to the local district or county attorney for possible prosecution.
- Activate monthly child protection teams throughout the state.
- DFS should train caseworkers in appropriate services for families, as well as how to determine if reunification is appropriate in specific cases.
- Establish protocol for continued monitoring of a family upon reunification.

Coroner

- Establish protocol that states ALL unexpected deaths of a child under the age of four should receive an autopsy.
- Establish required training for all coroner's surrounding abuse/neglect and Shaken Baby Syndrome.
- Establish continuing education requirement yearly for each coroner that incorporates child abuse/neglect cases including Shaken Baby Syndrome.

Legal System

- Train prosecuting attorneys on evidence based prosecution of child abuse and neglect cases.
- Consent decree's could be used on those cases identified as low risk for future abuse or neglect

Responses to 2004 Recommendations

The Seventh Annual Report published in November 2005, listed recommendations, which were generated from specific case review conducted in 2004. Some agencies chose to respond to these recommendations and have provided the following responses.

Department of Family Services

1. **Recommendation:** Cases of severe violence should receive a comprehensive clinical, psychological, and substance abuse assessments.

   The Department of Family Services has implemented a thorough assessment process for individuals and families assess their various mental health needs.

2. **Recommendation:** The Department of Family Services should become proactive in educating young parents on how to parent appropriately.

   The Department of Family Services has had all child protection workers trained in Triple P parenting. We have been supportive of this form of parenting and encourage our workers to implement the various strategies with their cases.

   The Child Fatality Major Injury Team has purchased a School Based Curriculum on Shaken Baby Syndrome and will offer during 2006 to purchase one for each school that requests it.

3. **Recommendation:** There is a need for continued training to occur in a variety of issues, to include detection, investigation, and prosecution of child abuse cases.

   The Department of Family Services continues to improve and implement various trainings on investigation of abuse/neglect cases.