State of Wyoming

Child Major Injury/Fatality Review Team

Seventh Annual Report

November 2005

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Mission Statement

The Child Fatality Major Injury Review Team 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 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 CDR to review all preventable child deaths. Most other states have expanded their review to include all child deaths. Wyoming is in the process of expanding the Child Major Injury/Fatality Review (CMIFR) team to include all child deaths.

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. 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 and regulations and policies. The team meets monthly to review cases and fulfill its mission to improve Wyoming communities' responses to major injuries and fatalities in cases of child maltreatment, 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 seventh annual report published by this team.

The Department of Health has begun reviewing its availability to house the team. Upon possible statute passage, money allocation and department support, the Child Major Injury/Fatality Review Team will be relocated to the Department of Health. The purpose of this move is to facilitate review of all child deaths in the State of Wyoming. Presently, the only cases referred to the team for review come from abuse and/or neglect cases from the Department of Family Services.

Observed Trends in Child Major Injuries/Fatalities/Risk Factors

The CMIFR 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 CMIFR 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

In 2004, of the 12 cases reviewed, two were due to blunt force trauma, three to Shaken Baby Syndrome, and two were sexual abuse.

1. During 2004 there were 8 cases reviewed where the victim was under the age of one.

    a. A seven-month old baby received a skull fracture when he fell off of a sofa. Both parents were seventeen years old. The father never admitted to wrong doing and neither the Department of Family Services nor the District Attorney's office was able to reach a finding.

    b. A fifty-six day old child was hospitalized for bilateral subdural hematomas and retinal hemorrhages. The Denver Children's Hospital is insistent abuse caused the injuries, although the parents report that they were caused by the vacuum assisted delivery.

    c. A three-month old child was dropped on a rocking chair and suffered multiple broken bones. The father admitted to snapping the child up and it resulted in Shaken Baby Syndrome.

    d. A seventeen-month old child died from blunt force trauma when his mother's boyfriend lost his temper. The boyfriend "kicked" open the bedroom door and the door hit the child. The force of the door stopped his breathing.

    e. A six-month old little boy died from blunt force trauma when he fell of a couch. The family has a history of domestic violence as well as drug abuse.

    f. A ten-month old girl was admitted to the hospital for being unresponsive. The mother's boyfriend reported that the child fell off of the couch. He was acquitted of any wrongdoing.

    g. Four-month old child victim suffered several injuries when shaken by her biological father.

    h. A two-month old boy suffered a fractured skull, broken rib, and bruising to the face when his father knocked him into a wall. The father indicates he was rushing down the hall and "fell" into the wall. This child is now blind. The mother has a history of drug abuse.

2. Two of the twelve cases reviewed were major injuries occurred from lack of supervision while using an ATV machine.

    a. Two brothers were riding ATV's at their mother's house when they lost control of the vehicle. The parents insist the children were not supposed to be riding without supervision or a helmet. However, they were able to obtain the keys and began to ride. The boys were twelve and six years old.

3. Two cases reviewed involved sexual assault.

   a. A ten-year-old girl reported her step-father for sexually abusing her. Upon confrontation the man disappeared for a few days. He was later found hung to death in the garage. It was indicated he committed suicide. Since the perpetrator is deceased, no finding was made.

   b. A three-year-old female was admitted to the hospital with facial bruising. Later examination found sexual abuse trauma as well as previous broken bones.

Child Maltreatment Related Deaths in Wyoming

Introduction

Child fatalities are the most tragic consequence of maltreatment. 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 will explore the nature and scope of child maltreatment fatalities and major injuries in Wyoming.

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 2002. 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. Some cases may be reported to law enforcement as murder, never coming to the attention of the Department of Family Services (DFS). 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 the United States, 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

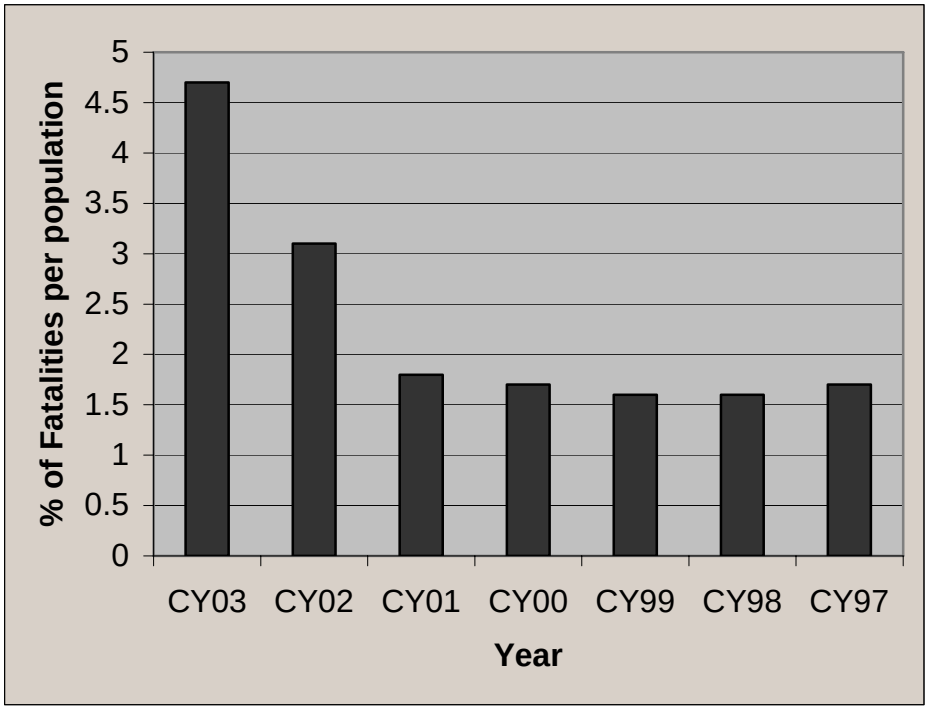
(Source: Child Maltreatment Reports 1997 through 2003)

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 Fatality Rates per 100,000 Children



(Source: Wyoming NCANDS Report, 2003)

Wyoming Findings 2003

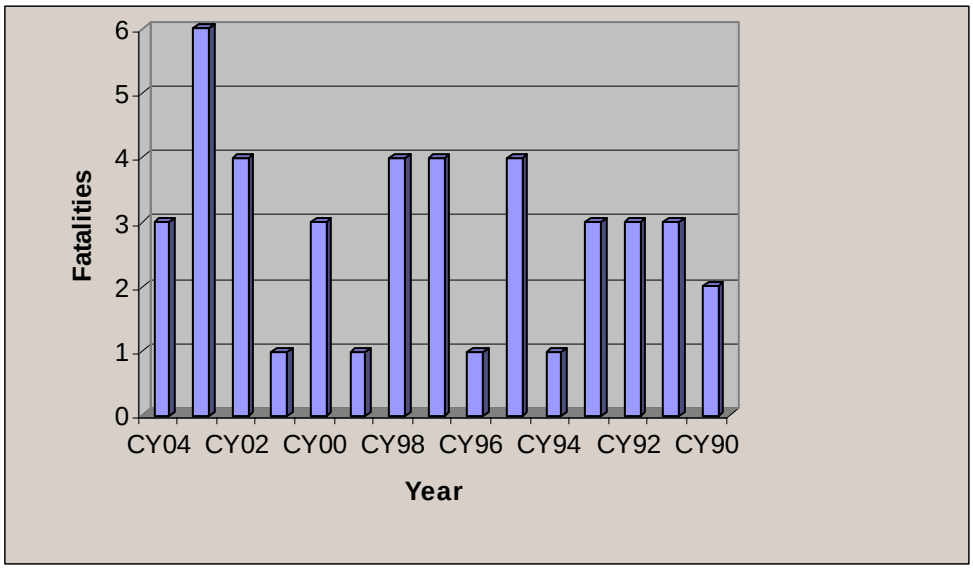
- DFS offices around the state received 7,247 referrals alleging that children have been abused and/or neglected
- 4,243 children were the subject of a report referred for investigation or assessment
- Children in the age group birth to 3 years accounted for 198 of the victims
- Four children died as a result of child abuse and/or neglect

Regional Child Fatalities, 2003

State	*Total Child Fatalities*	*Rate per 100,000 children*
Wyoming	*8*	*6.61*
Colorado	27	2.34
Idaho	2	.54
Montana	3	1.39
Nebraska	16	3.63
South Dakota	5	2.56
Utah	9	1.21
**National data*	*1,177*	*2.00*

(Source: Child Maltreatment Report, 2003)

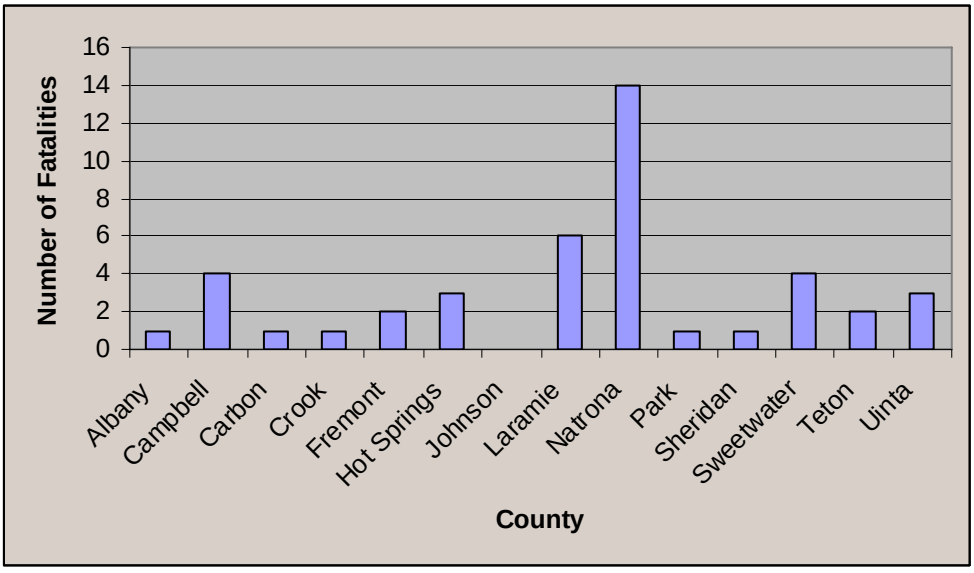
Wyoming Child Fatalities by Year



(Source: Wyoming WYCAPS data)

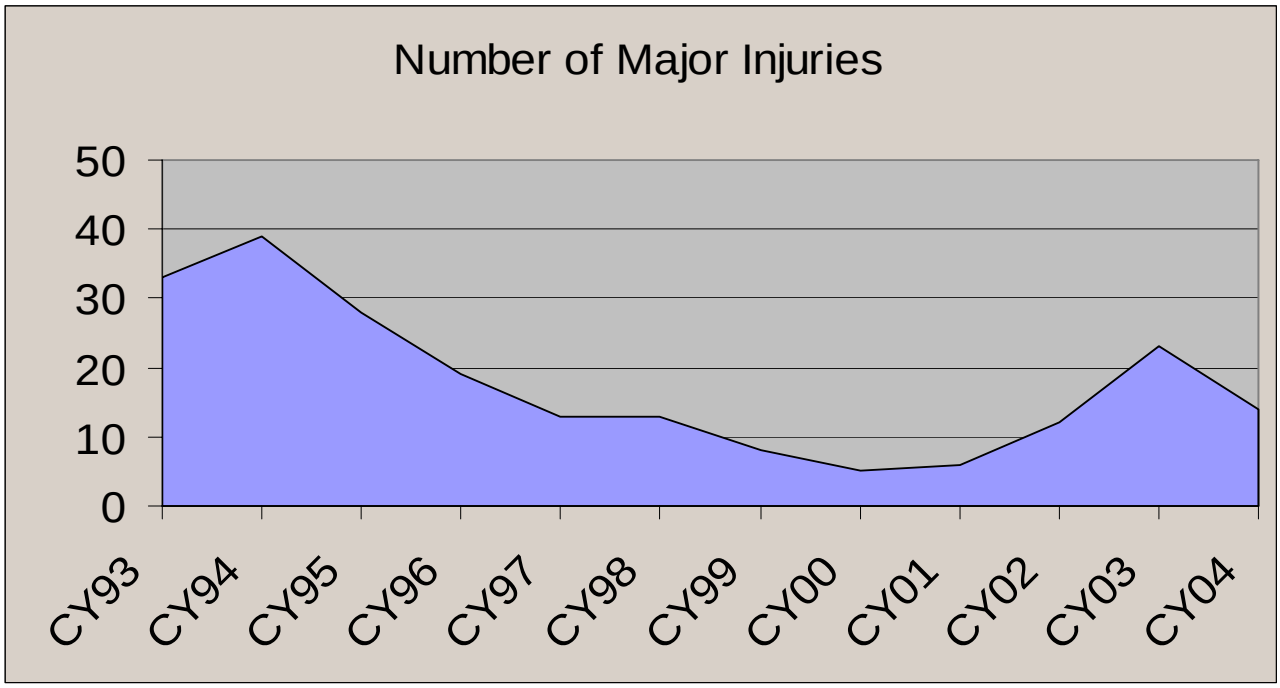
Demographics of Wyoming Fatalities

Fatalities by County 1990-December 2004



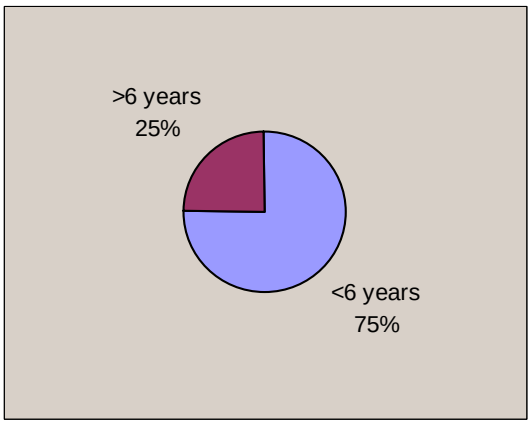
(Source: Wyoming WYCAPS data)

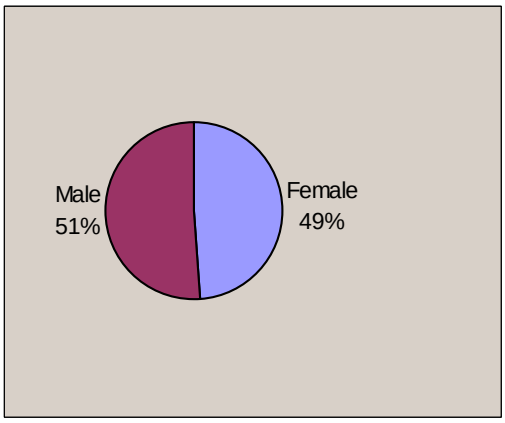
Wyoming Major Injuries



(NCANDS Data)

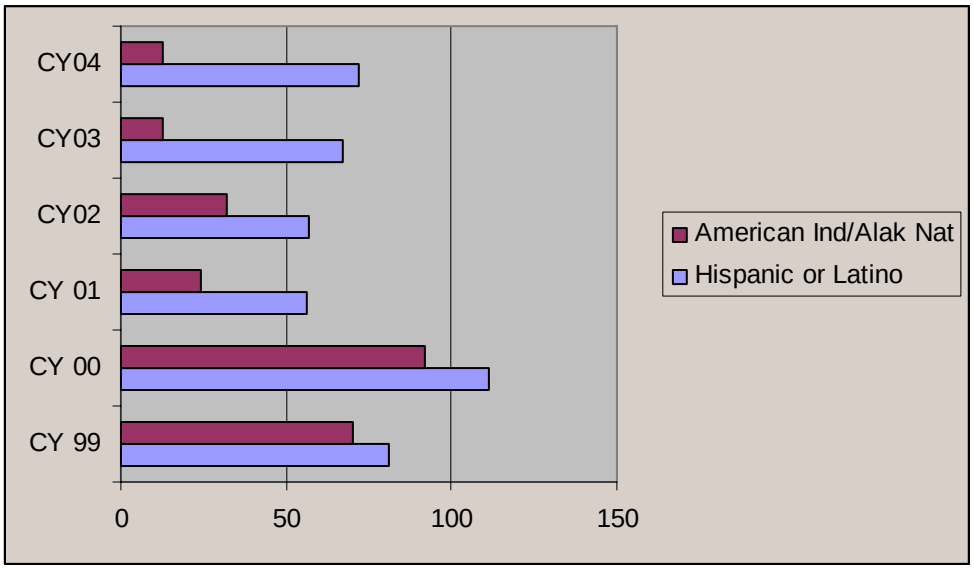
Characteristics of Victims 1990 - December 2004
In Relation to Fatalities





(Source: WYCAPS data)

Characteristics of Victims 1999-2004
By Ethnicity



(Source: NCANDS Data)

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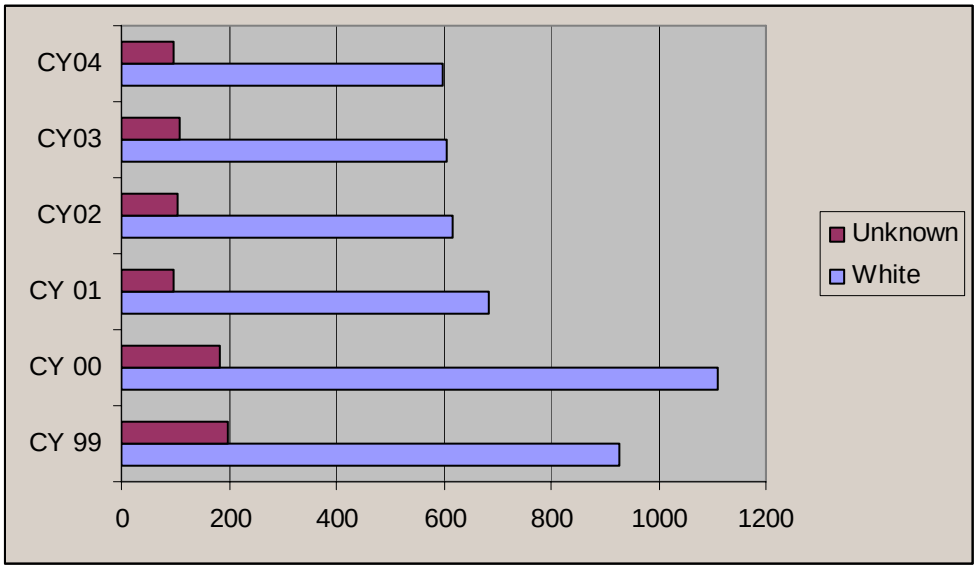
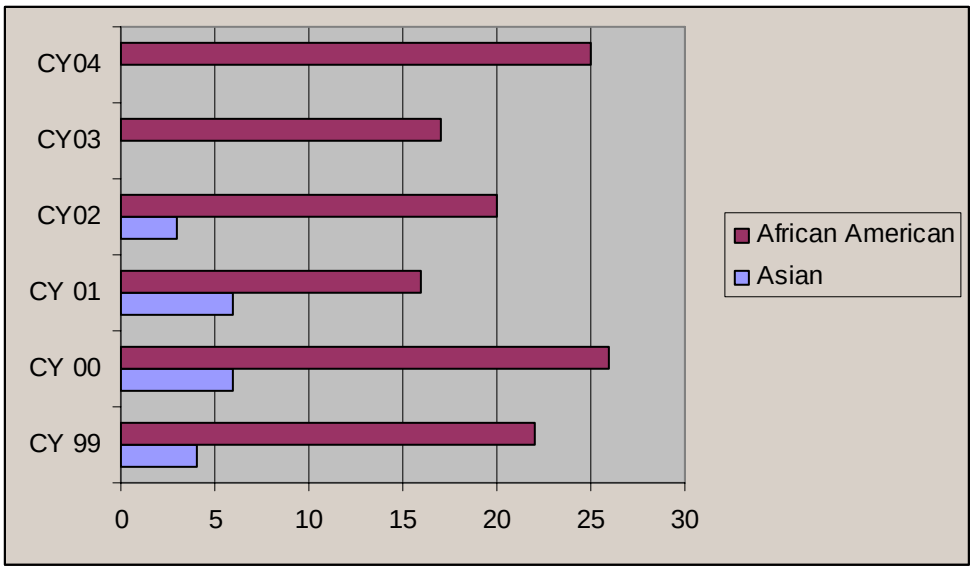


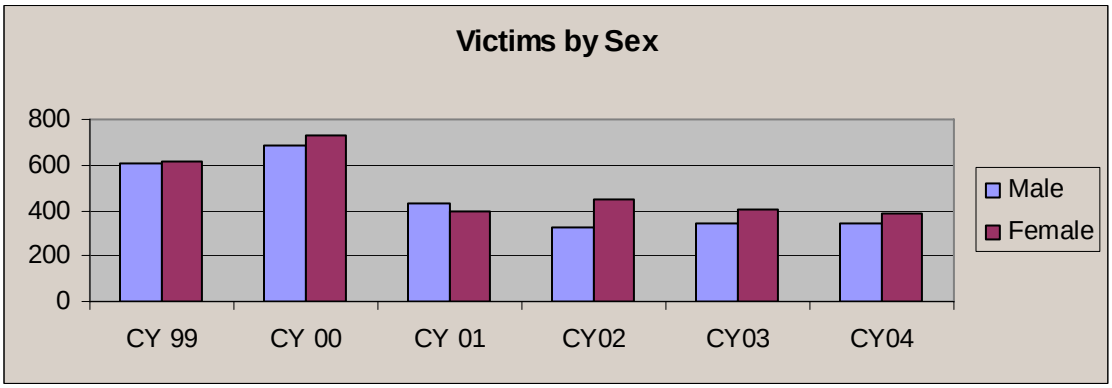
(Source: NCANDS Data)

Characteristics of Victims 1999-2004
By Ethnicity



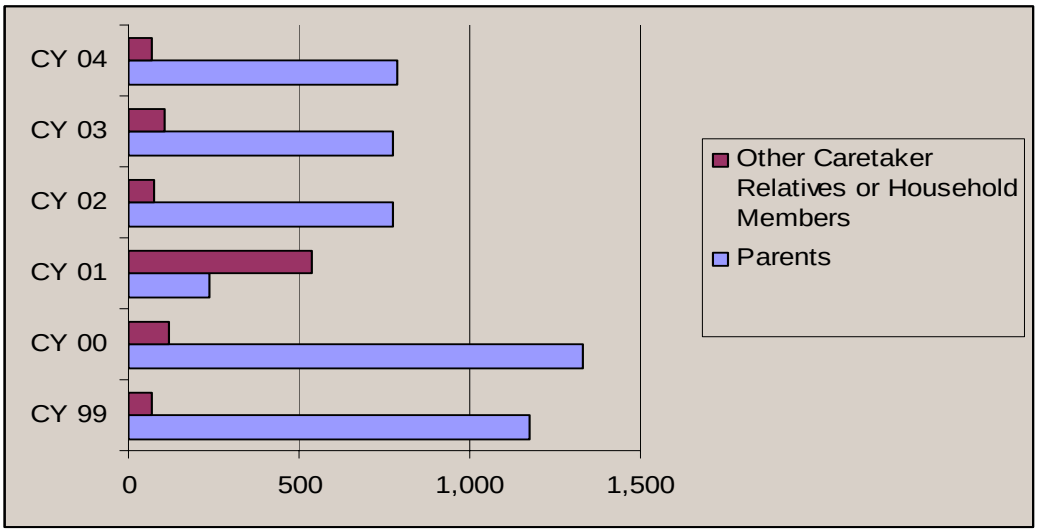
(Source: NCANDS data)

Characteristics of Victims 1999-2004
By Gender



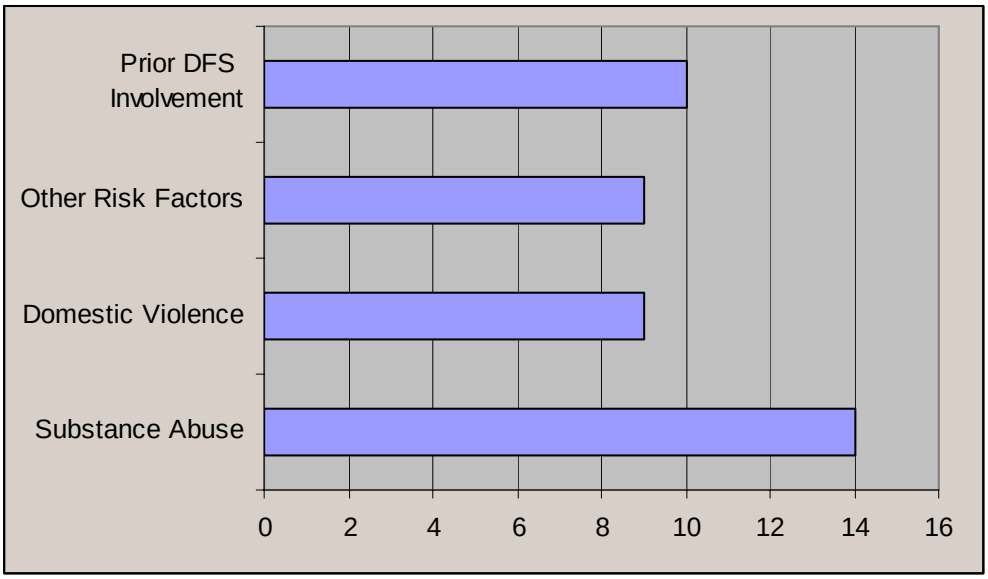
(Source: NCANDS data)

Characteristics of Perpetrators 1998-December 2004
In Relation to Victim



(Source: NCANDS data)

Characteristics of Perpetrators 1998-December 2004



(Source: WYCAPS data)

2004 Recommendations

Since January 2004, the CFMIR Team completed the reviews of twelve cases. Ten of them were major injuries and two were fatalities. 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

- All traffic crashes or incidents in a home where a child was injured should be reported to the Department of Family Services.

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 be encouraged to provide investigative reports to Department of Family Service workers on cases where major injuries or death occurred to children.
- Instances have surfaced where the CFMIR Team learned of a child being involved in a traffic crash or incident in the home where they were injured and no law enforcement report was furnished to DFS.
- There is a need for continued training to occur in a variety of issues, to include detection, investigation, and prosecution of child abuse cases.

Health Care/Medical

- EMT's should receive more training on Shaken Baby Syndrome and how to identify such situations.
- Protocol should be developed for the medical community to refer major injuries to the appropriate people.
- Coordinated response to major injuries between all agencies should be established.
- There is a need for continued training to occur in a variety of issues, to include detection, investigation, and prosecution of child abuse cases.

Department of Family Services

- The Department of Family Services should become proactive in educating young parents on how to parent appropriately.
- An educational program targeted at children with aggressive behaviors and/or substance abuse issues should be implemented.
- Increase and expand education for parents of premature infants through public service announcements.
- Cases of severe violence should receive a comprehensive clinical, psychological, and substance abuse assessments.
- There is a need for continued training to occur in a variety of issues, to include detection, investigation, and prosecution of child abuse cases.

Mental Health

- Cases of severe violence should receive a comprehensive clinical, psychological, and substance abuse assessments.

Legal System

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

Responses to 2003 Recommendations

The Sixth Annual Report published in October 2004, listed recommendations, which were generated from specific case review conducted in 2002 and 2003 as well as from reviews conducted since 1997. Some agencies chose to respond to these recommendations and have provided the following responses.

Department of Family Services

1. Recommendation: Department of Family Services case closure should be based on assessment and safety planning priorities. Incorporating a family-centered approach would improve case planning.

The Department of Family Services has implemented Family Partnership Conferences throughout the state. The projected goal is for all DFS employees, as well as other agencies, to be trained and fully functional by December 2006. The Family Partnership Conference implements a number of techniques, but primarily it utilizes the family-centered approach to work with families to assist them.

2. Recommendation: Available screening instruments should be evaluated.

A taskforce has been created and is formulating the appropriate assessment process for child abuse and/or neglect cases. This process involves the completion of a preliminary assessment of the family which will provide the caseworker with the ability to refer the family or an individual from the family for further assessment depending on the answers of the tool.

3. Recommendation: An education report is needed in the case file.

This has been implemented. A new educational assessment has been established and worked into the case management of all cases.