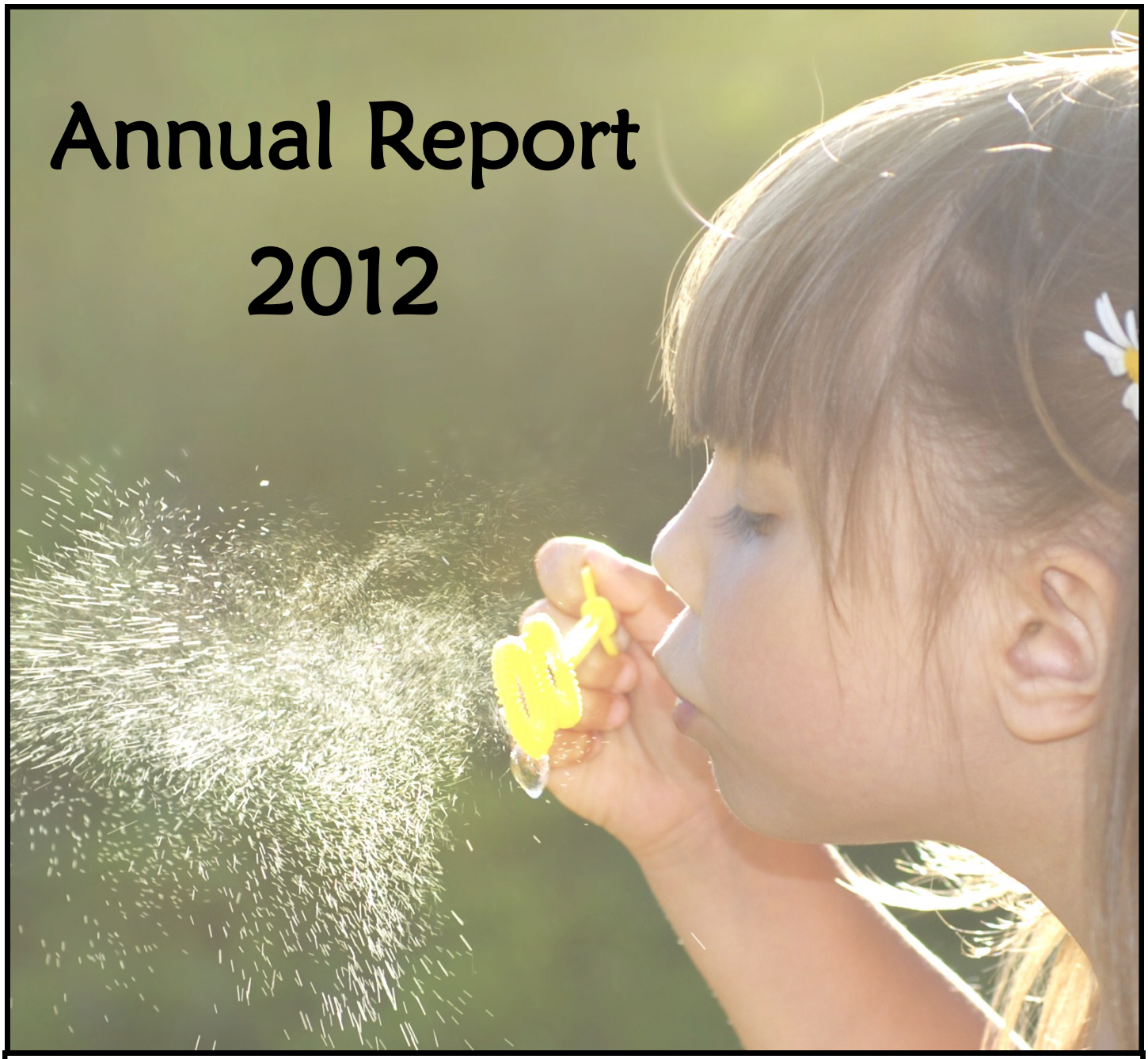
Annual Report 2012



Wyoming Child Death Review & Prevention Team

Wyoming
Child Death Review and Prevention Team

Mission:

We seek to improve Wyoming communities' prevention of and responses to major injuries and fatalities in cases of child maltreatment. We will evaluate visible trends in Wyoming's child fatalities and actively advocate for child victims of maltreatment and make recommendations for change through prevention, intervention, training, education, legislation and public policy.

Vision:

To eliminate child major injuries and fatalities in Wyoming.

Team Members:

Allison Anderson
Wendy Applegarth
Judge Peter Arnold
Shad Bates
Dr. Kimberley Broomfield
Jacqueline Brown
Brenda Burnett
Ashley Busacker
Steve Corsi
Jennifer Davis
Janet Gerken
Lisa Gossert
Kelly Hamilton
Debra Hibbard
Lynn Huylar
Connie Jacobson
Lauri Lamm
Marty Luna
Diane MacPherson
Edward McAuslan
Kathy McCoole
Linda McElwain
Cpt. Derek Mickelson
Michael Reyes
Bill Stanton
Rep. Jeb Steward
Mariah Storey
Judge Wade Waldrip

Executive Committee:

Lynn Huylar, Chairperson
Shad Bates, Vice Chairperson
Diane MacPherson, Review and Evaluation Chair
Ashley Busacker, Data and Statistics Chair
Lauri Lamm, Department of Family Services
Debra Hibbard, Department of Family Services
Allison Anderson, Coordinator

Overview:

The Wyoming Child Death Review and Prevention Team (WCDRPT) is coordinated between the Wyoming Citizen Review Panel and Wyoming Department of Family Services. The team is a member of the Western Child Death Review Coalition and a participating state with the National Center for the Review and Prevention of Child Deaths.

In the last year, the WCDRPT has undergone a large re-structuring. The team was also re-named, formerly known as the Wyoming Child Major Injury and Fatality Review Team. The WCDRPT has expanded from strictly looking at cases involving Department of Family Services major injuries and fatalities at the hands of a caretaker, to examine themes in ALL child deaths in the state of Wyoming. There is not an investigation of any kind when looking at these additional fatalities. Instead, we examine the themes in data regarding all children that die of unnatural causes in our state. We also look at prevention aspects relating to these deaths and create strength-based recommendations to state, district, and local-level agencies and organizations as needed to help in providing the future prevention of these deaths. Part of the re-structuring also included a re-commitment from current team members and the replacement and addition of some new members to help reach a broad range of expertise on this topic.

The team is divided into two subcommittees. The Data and Statistics Committee gathers and evaluates data relating to unnatural child deaths and major injuries. The Review and Evaluation Committee reviews the Department of Family Service case files as required by statute. They also look at themes in child deaths and major injuries that have recently occurred or are not currently in a statistical formats. As a whole, the team establishes possibilities for why children are being injured or dying in Wyoming of unnatural causes and what we can do to better prevent them. Through more comprehensive recommendations and reporting, outside groups, agencies, and individuals will better understand what this team does and well as benefit from the strength-based approach it takes in its recommendations.

This new structure was approved at the first quarterly team meeting in February 2012. There were three other full team meetings held in 2012. We set a focus on six themes identified by the group as statistically high or of greater public concern. We submitted information on nine Department of Family Services case files into the National Center for the Review and Prevention of Child Deaths secure database. We also reviewed four Department of Family Services case files. Concerns and recommendations relating to the identified themes and case file reviews are addressed throughout this annual report.

Prevention:

The Wyoming Child Death Review and Prevention Team identified and focused on the following themes in unnatural child deaths and major injuries for 2012:

1. Shaken Baby Syndrome / Abusive Head Trauma
2. Safe Sleep / SIDS / Suffocation
3. Drug Overdoses
4. Fetal Alcohol Spectrum Disorder
5. Infant Burns / Scalding
6. Suicide / Bullying

Discussion and Recommendations of Identified Themes:

1. Shaken Baby Syndrome/Abusive Head Trauma (SBS/AHT) —

- There is inconsistent data statewide on the actual number of victims. The biggest reasons for this inconsistency are:
    - Lack of identification or acknowledgement of Shaken Baby Syndrome or Abusive Head Trauma as the primary (or even secondary) "Cause of Death" on death certificates. It may be ruled under another categorization.
    - Lack of knowledge about the true number of victims that survived being shaken. If not identified or reported, these children could grow up with further physical, emotional, or social problems.
    - In some cases, children have later died due to problems that stemmed from being shaken, but the cause of death is not considered to be SBS/AHT.
- The most common perpetrator of SBS/AHT is un-related young males. Other cases have involved biological parents, child care providers, siblings and grandparents. SBS/AHT can effect children and families of any societal class, race, or family structure.

Shaken Baby Syndrome/Abusive Head Trauma (SBS/AHT) — cont...

- There is prevention work being done by Prevent Child Abuse Wyoming (PCAWY) with the distribution of Shaken Baby Syndrome Packets. These packets contain an infant bib with the message "Love me, don't shake me! My future is in your hands." These bibs are made by the Wyoming Women's Penitentiary in Lusk, WY. The packets also contain an informational booklet addressing the medical and legal ramifications of shaking an infant, as well as provide stress-relief and other prevention tips for anyone coming into contact with an infant. Radio PSA's and other promotion of Shaken Baby Syndrome prevention have also been made statewide as part of this effort.
- PCAWY partners with the Department of Family Services, Department of Health, Hospitals, Public Health Offices, Child Advocacy Centers, Child Development Centers, and numerous other prevention groups on this and various other prevention projects. The Wyoming Children's Trust Fund also provides funds for many of these strategies.

2. Safe Sleep/SIDS/Suffocation —

- Deaths related to co-sleeping, un-safe sleep environments, suffocation, and SIDS/SUID continue to show up in data from the Department of Family Services and the Department of Health.
- In 2012, the National Institute of Health (NIH) and the Eunice Kennedy Shriver Foundation identified Wyoming as being in the top twenty states for rate of SIDS and other sleep-related causes of infant death. According to the Centers for Disease Control, National Center for Health Statistics' Compressed Mortality File (1999-2009), Wyoming ranks ninth nationally for these infant deaths with a rate of 152.3 per 100,000. The NIH also released their new "Safe to Sleep" Campaign, enhanced from the nationally recognized "Back to Sleep" Campaign that was released in the 1990's. As part of their release, a "Safe to Sleep Champion" was selected from the top twenty states to receive training on the new campaign and be able to access materials about the campaign from NIH free of charge. Allison Anderson, coordinator of the WCDRPT, was selected as the champion for Wyoming and can be contacted with any questions, comments or interest there might be relating to this national campaign.

3. Drug Overdoses —

- Substance and alcohol abuse has direct links to many child injuries and fatalities in Wyoming every year. There was a link to substance and/or alcohol use by the primary guardian or perpetrator in every case file reviewed by the WCDRPT this year. It remains crucial that agencies, groups, communities, and individuals that work or interact with children and adolescents are able to recognize if substance or alcohol abuse could be occurring by the child or their parent(s)/guardian(s). It is also important that those same persons stay informed of current and emerging trends in substance or alcohol use by children and adolescents.
- There are numerous dangers with the improper medicating of children by adults in supervisory roles. It is crucial that all over-the-counter medication instruction labels are read before giving any medication to a child. If medications are prescribed to a child by a physician, instruction should be followed as labeled. Situations involving parents, or caretakers, giving children medications to control behavior without the consent of a physician have been seen statewide and are unacceptable.

4. Fetal Alcohol Spectrum Disorder —

- This disorder is a newer part of the federal Child Abuse Prevention and Treatment Act (CAPTA). It is a CAPTA requirement that states look at children with FASD in their respective areas.
- In Wyoming, there was development of a task force whose purpose is to identify infants in the state with the disorder and what services could be provided to these children. The University of Wyoming, Department of Health, and Department of Family Services all have members represented on this task force. The task force has been working with the University of Colorado to find a better way to diagnose potential cases of children with this disorder.
- It is currently very difficult to collect data on these children in Wyoming. There is some in-state information, but if Wyoming children are diagnosed out-of-state, it is not currently being tracked. Current diagnostic codes for FASD are not solidified yet either.

5. Infant Burns/Scalding —

- Anyone interacting with infants and/or small children needs to understand the safety guidelines of electric blankets and space heaters if they choose to use them on or around children. This is especially true when they are in higher use during winter months. Overheating can cause numerous medical problems and even death.
- Many pre-natal and "welcome home" parent education programs include the importance of testing the water temperature before bathing an infant or young child. Cases still exist, however, where parents do not know or forget to make this quick check which can lead to scalding injuries. More promotion of bath safety with infants and young children could help.

6. Suicide —

- According to the Centers for Disease Control (CDC)-WISQARS data from 1999-2010, suicide remains the second leading cause of death among Wyoming children ages 10-17. It falls behind the broader "unintentional injury" category.
- Governor Matt Mead developed a task force of sorts to address the issues of bullying and suicide by each of the Wyoming human service agencies. The WCDRPT strongly agrees with the purpose of this group and the services they could provide for prevention.
- A number of local, state, and national groups and individuals associated with bullying and suicide prevention have conducted presentations and trainings to schools and communities statewide. This has to be an ongoing effort, however.
- This is not a problem for just children and adolescents. Suicide affects parents, teachers, communities, and really all citizens by the impacts it can create both short and long term. Taking responsibility for creating positive and supportive environments for children and adolescents in communities, and in the state as a whole, is crucial.

Data and Statistics:

Submitted by the Vital Statistics Services:

In 2012, there were 60 deaths to Wyoming residents under the age of 18. Out of those 60, 30 deaths were Wyoming residents under the age of 1.

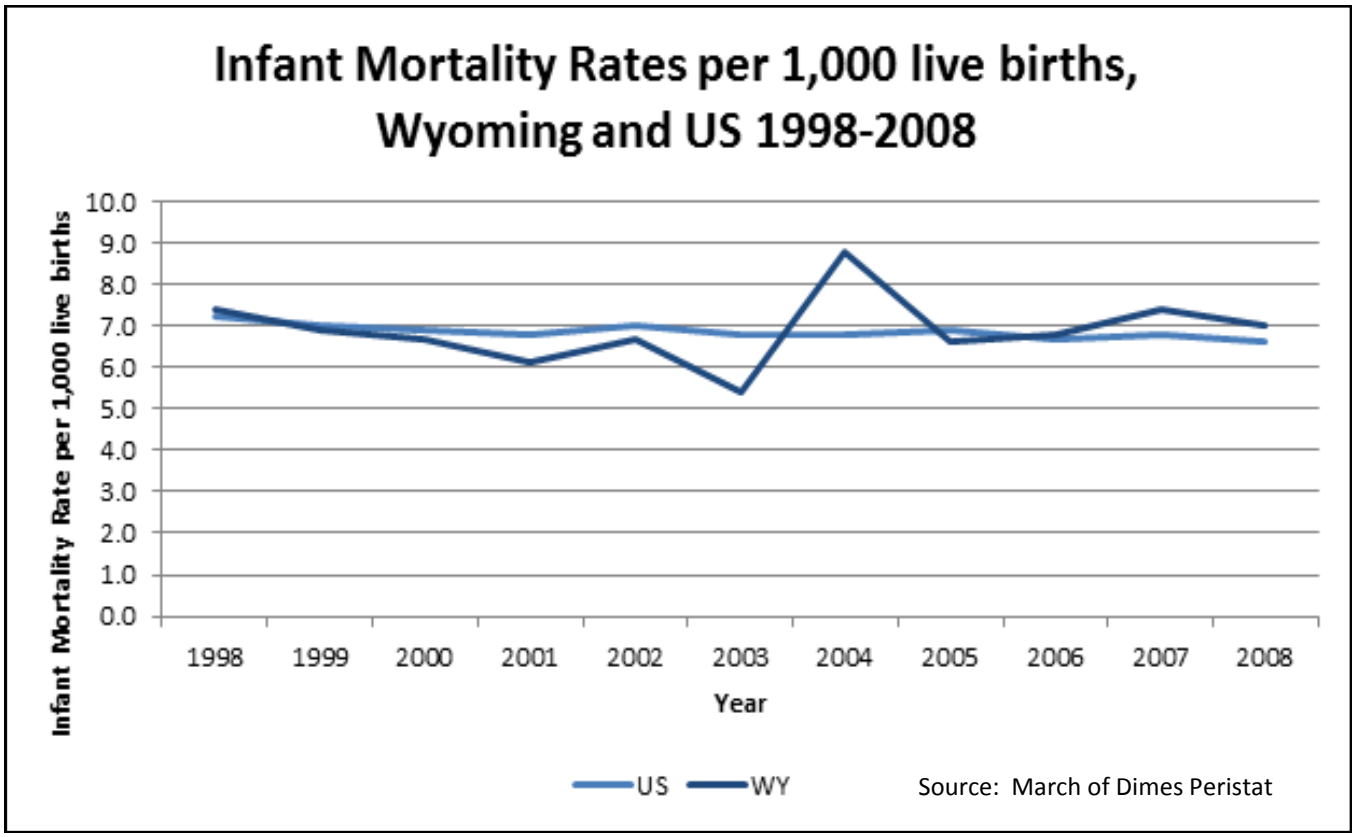
Data is preliminary and will not be finalized until late spring [2013].

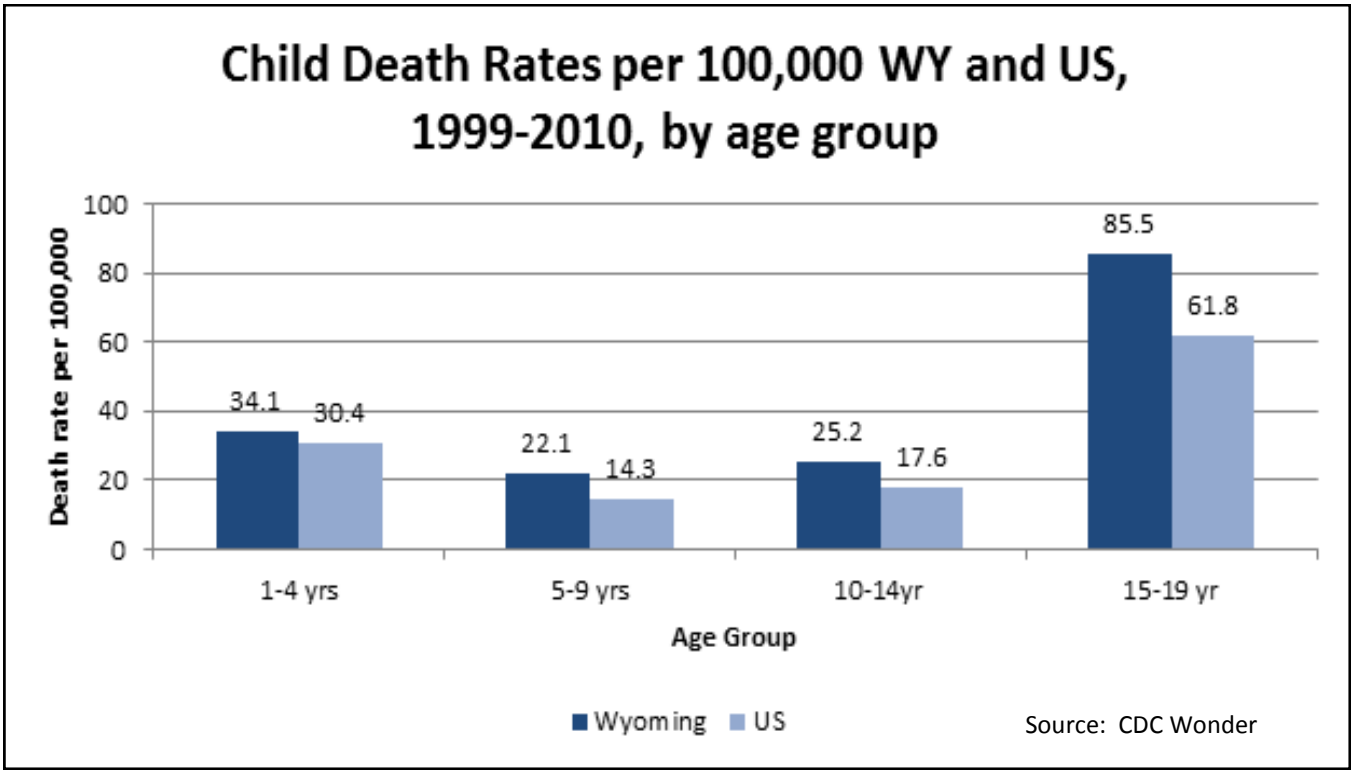
Submitted by the Wyoming Highway Patrol:

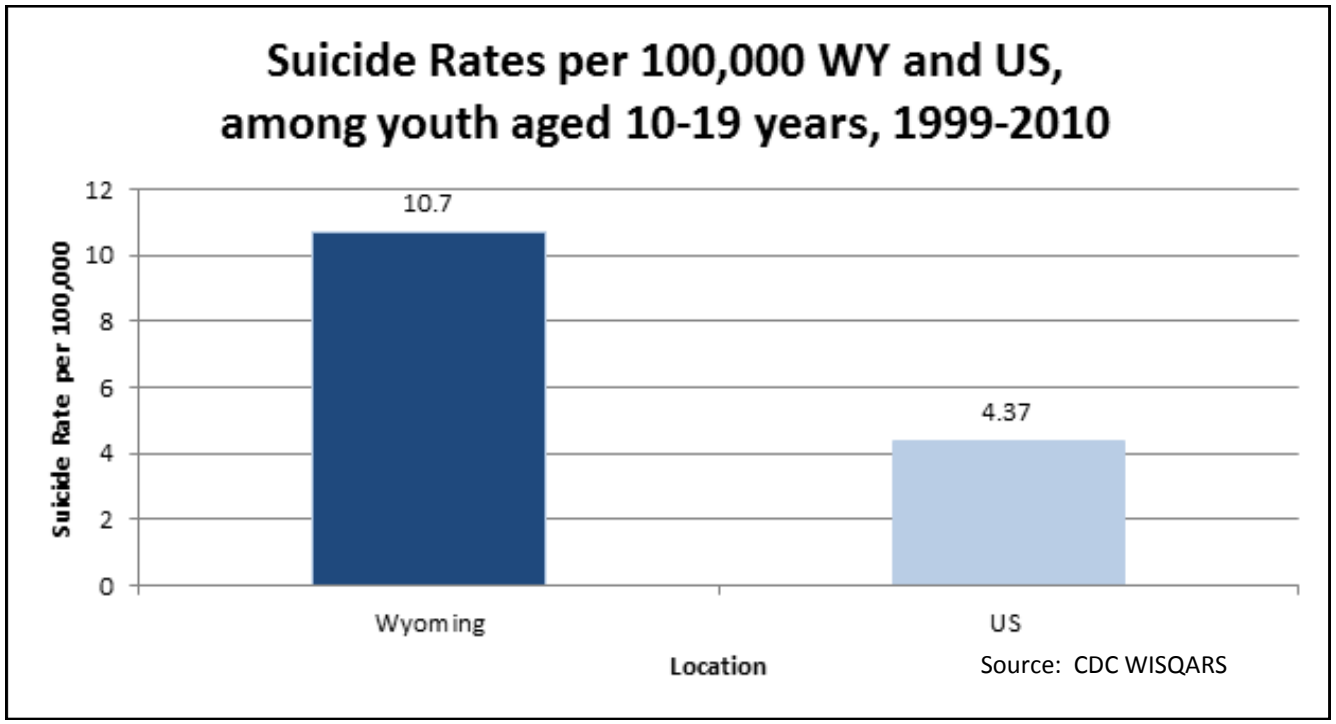
The chart below shows the most updated information as of November 2012:

Number Persons With an Incapacitating Injury in a Traffic Crash Between The Ages of 0-17 With Safety Equipment / Year						
	2008	**2009**	**2010**	**2011**	**2012**	**Total**
Booster Seat	2	0	6	1	2	11
Child Restraint – Type U	0	0	1	1	1	3
Forward Facing Child	1	3	2	0	4	10
Helmet Used	3	4	1	2	1	11
Lap Belt Only	1	2	1	0	0	4
None Used	40	34	21	14	28	137
Not Available	0	0	0	1	2	3
Other	0	0	0	1	0	1
Rear Facing Child Restraint	0	0	1	0	0	1
Shoulder and Lap Belt	28	24	20	8	11	91
Shoulder Belt Only	1	0	0	0	0	1
Unknown	4	1	2	0	1	8
Pedestrians	6	7	10	9	5	37
Total	86	75	65	37	55	318

Data submitted by the Wyoming Department of Health:







Submitted by the Wyoming Department of Family Services:

All Data is from 2009-2011 and includes Major Injury and Fatality cases.

Cause:	**# of Cases:**
Shaken Baby Syndrome:	9
Head Injuries:	8
Other Fractures:	7
Suffocation:	4
Burns:	3
Drowning:	2

2012 Recommendations:

The following are the recommendations of the Wyoming Child Death Review and Prevention Team based on the expertise of its members, data collected and/or evaluated and prevention measures known by the team:

- The Coroner Offices in each county, Department of Family Services, and the Department of Health, including Vital Statistics Services, should work to develop consistent coding and definitions of all fatalities (including children), as well as explore a possible data system or process that could lead to more accuracy between all related groups. Enhanced communication and collaboration among these entities would lead to more accurate data and the evaluation of trends by all groups. Wyoming would also better compare with regional and national data and statistics.

- Any agency, group, or individual utilizing data relating to child fatalities should use the terminology of "intentional/unintentional" as opposed to "accidental/non-accidental" when discussing classifications. This will create greater consistency among reports and other documentation.

- Continued collaboration between the Department of Family Services (DFS) and the Wyoming Child Death Review and Prevention Team (WCDRPT) on amending the current SS-51 form used by DFS. The suggested amendments would expedite the WCDRPT case file review process, as required by state statute, and allow greater efficiency for the input of case files to the database of the National Center for the Review and Prevention of Child Deaths. It would also allow for greater consistency of information shared between DFS and the WCDRPT.

- Efforts continue to be made statewide targeting children, parents, schools, and communities around suicide prevention, as well as bullying prevention.

2012 Recommendations, continued:

- While the overall number of incapacitating injuries of a child in motor vehicle accidents has decreased over the last three years, the lack of safety equipment used in many of these injuries is still a predominant issue. Further efforts should be made statewide to provide child safety seats to families that are struggling financially.

- A number of the cases reviewed by this team revealed multiple doctor or emergency room visits before a report of abuse was made for a child. Increased efforts need to be made in hospital emergency rooms and urgent care facilities regarding mandatory reporting education and recognizing the physical and behavioral signs of abuse.

- Continued efforts should be made by the Public Health offices in each county, as well as any other home visitation programs, to communicate and collaborate with tertiary facilities as needed (i.e. out-of-state hospitals). Having a solid collaboration with these facilities will ensure the best services are offered to all Wyoming families, including at-risk families.

Resources:

American Academy of Pediatrics:

www.healthychildren.org

National Center for the Review and Prevention of Child Deaths:

www.childdeathreview.org

National Institute of Health:

www.nih.gov

Centers for Disease Control, National Center for Health Statistics:

www.cdc.gov/nchs

Wyoming Department of Health (DOH):

www.health.wyo.gov

Wyoming Department of Family Services (DFS):

dfsweb.wyo.gov

Wyoming Citizen Review Panel:

www.wycrp.org

For More Information on the Wyoming Child Death Review and Prevention Team:

Contact:

Allison Anderson, Coordinator
PO Box 1504
Cheyenne, WY 82003
307-632-0032
aanderson@wycrp.org

Lauri Lamm, WY Dept. of Family Services
2300 Capitol Ave.
Hathaway Bldg., 3rd Floor
Cheyenne, WY 82002
307-777-5536
lauri.lamm@wyo.gov

The WCDRPT is coordinated by the Wyoming Citizen Review Panel, Inc.
More information can be found at
www.wycrp.org.