

State of Wyoming
Child Major
Injury/Fatality
Review Team

Annual Report



December 2000

December, 2000

Dear Friends of Wyoming Children,

I am pleased to present the Wyoming Child Major Injury/Fatality Review Team's annual report.

We have again included a summary of actions completed in response to our last report. I commend all who contributed to these accomplishments.

Unfortunately, we have also needed to repeat recommendations not yet acted upon. We still review only those cases in which abuse or neglect was known to have occurred, and thus have no opportunity to identify patterns of injury that could help direct public health and injury prevention efforts. We also undoubtedly are missing some abusive injuries. Studies in all parts of the country have shown abuse is often unrecognized. In 1999 in Wyoming three out of four shaken babies were not correctly identified when first seen by a doctor. This is little worse than national averages, and is a real opportunity for improvement.

I again wish to thank the Department of Family Services for their support, and the team members, who generously give time and expertise to this effort. We are making a difference. I hope you will find in this report something you can act upon to make a difference in your community.

Sincerely,

Dr. Valerie Bell, Chairperson

Wyoming Child Major Injury/Fatality Review Team

INDEX

Team History	Victim Information/Risk Factors
Team Members	Recommendations:
Mission Statement	Public Awareness
Introduction	Public Policy
Accomplishments:	Law Enforcement
Public Awareness	Health Care
Public Policy	Judiciary

Law Enforcement
Health Care
Judiciary
Department of Family Services

Department of Family Services
Mental Health
Statistical Charts

ACRONYMS

CAC	Child Advocacy Center
CASA	Court Appointed Special Advocate
CBT	Computer Based Training
CPS	Child Protective Services
CPT	Child Protection Team
DFS	Department of Family Services
DUI	Driving Under the Influence
DV	Domestic Violence
LCCC	Laramie County Community College
MDT	Multidisciplinary Team
PSA	Public Service Announcement
PSD	Protective Services Division
QC	Quality Control
SBS	Shaken Baby Syndrome

The Department of Family Services is the child welfare agency serving the State of Wyoming and meets the eligibility requirements for the Child Abuse Prevention and Treatment Act (CAPTA) State Plan. The team was established by the Department of Family Services in December 1997, under the authority provided in the Child Protective

Services Act, W.S.14-3-201 through 14-3-215. The child fatality cases are submitted for review to the team by the local child fatality review team as per procedure outlined in Rules and Regulations Governing Child Protective Services, Final Rules December 1992. Definitions of abuse and neglect are found in these rules and substantiation is based upon a credible evidence standard. In August 1998, the team released the first annual report, which contained a review and evaluation of the state investigative, administrative and criminal handling of child fatalities due to child maltreatment. The annual report also included recommendations for policy and training changes needed to address statewide issues identified in this review. In March 1999, the team was expanded to include review of major injuries and policy was changed.

The **Child Major Injury/Fatality Review Team** consists of the following members:

Law Enforcement Community:	Steve Gilmore , Chief of Police, Wheatland, WY; 25 years in law enforcement, including criminal investigation of child abuse, child sexual assault and child protection issues. Currently serves on the Platte County Child Protection Team and is the Secretary/Treasurer for the Wyoming Association of Sheriffs and Chiefs, appointed to the Governor’s Domestic Violence Elimination Council.
Criminal and Civil Court Judge:	The Honorable Edward Grant , 1st Judicial District Court 17 years private general law practice, 15 years as district court judge, general jurisdiction and juvenile court.
Prosecuting Attorney:	Jon Forwood , 6 years as District Attorney, 1st Judicial District. Currently serving as a member of the Court Improvement Committee. Twenty-one years experience as a prosecutor with many child death, abuse and molestation cases including prosecution of at least 6 shaken baby deaths; leading role in the utilization of the local Child Advocacy Center.
Defense Attorney:	Ken Koski , Deputy Public Defender since 1995. Currently serving as a member of the Court Improvement Committee. General practice of law including guardian ad litem in juvenile proceedings, termination of parental rights actions, and domestic relations cases and part-time public defender in Park/Big Horn Counties 1979-1995.
Attorney:	Dan Wilde , Senior Assistant Attorney General, representing the Department of Family Services for 4 years, prior representative of children in civil rights actions for 8 years. Currently serving as a member of the Court Improvement Committee.

Child Advocates/CASA Representative:	Pam Emerson , Sheridan County CASA Program Director for the last 5 years; 1995-present, member of the Sheridan County Child Protection Team.
Health Professionals:	<p>Valerie Bell M.D. FAAP, 14 yrs. general pediatric practice with special interest in child abuse prevention and treatment, trains family practice residents and DFS personnel in medical aspects of child maltreatment. CMI/F Review Team Chairperson.</p> <p>Jimm Murray, Administrator, Community and Family Health Division, 32 years experience in intentional and nonintentional child deaths as a practicing official EMT, and now as an administrator for the Department of Health.</p> <p>Bill Ryan, 10 years as Laramie County Coroner.</p>
Mental Health Professionals:	Marilyn J. Tkachuk, Ph.D. , Psychologist, 15 years general practice with experience in evaluating families in conflict, troubled and abused children, and violent or neglectful parents. Lecturer at the University of Wyoming for 10 years.
Child Protective Services Agencies:	Kathy Deiss , DFS District 6 Manager, 14 years with the Department of Family Services (DFS) and 5 years with Probation & Parole, all involving child protection services.
Individuals experienced in working with children with disabilities:	Jean Phelan , Speech/Language Pathologist, Laramie County School District; board member of Prevent Child Abuse Wyoming, which represents parent groups.
Parent Group Representative:	Carol Speight , Currently serving as a member of the Court Improvement Committee. Board chairman of Wyoming Children’s Trust for 6 years; past member of the Board of Prevent Child Abuse Wyoming for 6 years.
Other Important Members:	<p>Nancy Dawson, Retired from the Division of Victim Services, past Program Manager of the State Office on Family Violence and Sexual Assault, 4 years as a director of a family violence program in Wyoming.</p> <p>James Smith, Ph.D., MSW, MPA, Assistant Professor, University of Wyoming, Division of Social Work,</p> <p>1999 – present; Lieutenant Colonel, U.S. Army Reserves, 1835th Medical Detachment (Combat Stress Component), 1993-present. Served on active duty with the U.S. Army as a</p>

	<p>Social Work Officer from 1978-1993. Extensive related experience in family advocacy and social work.</p> <p>Lee Ann Stephenson, Domestic Violence/Sexual Assault Program Manager, Division of Victim Services of the Attorney General's Office; member of Prevent Child Abuse Wyoming committee.</p>
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Although not a Team member, Honorable John G. Hanes, a Wyoming Senator, will participate as a liaison between this Team and the Judiciary Committee of the Wyoming Legislature.

Mission Statement

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

Introduction

Each year the Child Major Injury/Fatality Review Team publishes a report addressing the cases reviewed. The team's analysis of areas of need to improve child abuse and neglect response was conducted for the first time in 1997, and the team published recommendations for change in August 1998. In March 1999, new members were added to the team representing the district courts, the CASA program and law enforcement. The team also has included policy to review of major injury cases, per the recommendation from 1997. Action completed on the recommended changes from the 1998 report is as follows:

Public Awareness:

Recommendation: A statewide campaign for the prevention of Shaken Baby Syndrome (SBS) is recommended. It is also recommended the campaign target males, as review has shown males to be the perpetrators of SBS in the majority of Wyoming cases.

- In April, 2000, billboards began appearing on major traffic areas across the state and Public Service Announcements were on the radio stations noting "Real Men Don't Shake the Baby, Prevent Child Abuse Wyoming, sponsored by The Wyoming Children's Trust Fund." This campaign will continue in 2001.

Public Policy:

Recommendation: The Multidisciplinary Team statute should be consistently applied throughout the state. The statute also needs to be amended to:

- 1. Be case specific;**
 - 2. Clearly outline the lead person;**
 - 3. Define how often they meet in the life of the case.**
- The Child Major Injury/Fatality Team legislative subcommittee is developing proposed legislation that clarifies the duties of the Child Protection Teams and the Multidisciplinary Teams.

Law Enforcement:

Recommendation: Provide collaborative training in the state between law enforcement staff and DFS CPS workers.

- DFS and Wyoming Investigators Association co-sponsored advanced training on investigation techniques, intervention, and internet sexual exploitation issues (January 2000) in Casper.
- Dr. Valerie Bell trained Cheyenne police officers in recognition and investigation of child abuse.
- Child Advocacy Centers opened in Casper, Cheyenne, and Rock Spring where law enforcement staff, DFS CPS workers, and the District Attorney's office staff work together in investigations.
- The first Wyoming conference on Child Pornography on the Internet was held in Casper in October, 2000, a joint conference by Prevent Child Abuse Wyoming, Parent Education Network, Wyoming Childrens Action Alliance, Wyoming U.S. Attorney' Office, and Wyoming Division of Criminal Investigation. The Wyoming-based child pornography cases also involved child sexual abuse.
- A Forensic Interviewing in Child Sexual Abuse Cases workshop was held in Rock Springs on December 13-14, 1999, at Western Wyoming Community College. The speaker was Roe Bubar, J.D. This was sponsored by the Sweetwater County Child Advocacy Team. Forty-four people representing law enforcement, mental health, medical, social services, victim advocates and education agencies as well as the county attorney and community members attended the first day of the workshop.
- A central registry for domestic violence protection orders was implemented in July 2000 and includes a child protection component.

Health Care:

Recommendation: Implement training to increase awareness and enhance recognition of child abuse/neglect by medical care providers. Such education should be part of continuing education programs for first responders, EMTs, nurses, physicians, and other health care providers.

- Dr. Valerie Bell made a presentation on sexual abuse for physicians at United Medical Center in Cheyenne.

Judiciary:

Recommendation: Educate and train in the role of protecting children, addressing safety, well-being, and permanency.

- A discussion was held with district and county attorneys at the annual prosecutors meeting on Nov. 16-17, 2000, in their role of ensuring the safety of children who are passengers in vehicles when DUI is charged.
- The National Council of Juvenile and Family Court Judges held the first National Summit on Sept. 24-27, 2000 at the Jackson Lake Lodge in Wyoming. Exploring Effective Interventions in Domestic Violence and Child Maltreatment." Four Wyoming Circuit Court judges attended as well as several Wyoming domestic violence advocates who provided services to children of homes with violence. The recently published 'Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice' was promoted as best practice for CPS and domestic violence agencies.
- The Wyoming Supreme Court is participating in a Court Improvement Project regarding abuse/neglect of children.

Department of Family Services:

Categories specific to domestic violence and formal psychological evaluation should be added to formal risk assessment procedures.

- The use of psychological evaluations for screening of foster parents is being piloted in Gillette, Sheridan, Douglas, Wheatland, Sundance, Buffalo and Newcastle.

The leadership and structure of the Child Protection Team should be reviewed to help strengthen the disposition of child maltreatment cases.

- The Department implemented training as part of its CORE curriculum to encourage new workers to use Child Protection Teams in assisting in diagnosis and treatment.

Means of strengthening links between public assistance and preventive programs should be explored and implemented.

- The Home Visiting Program through the Department of Health will be funded by approximately \$3,521,500 TANF funds.
- Day care certification staff and providers have been trained on recognition and reporting of child abuse and neglect. Approximately three hundred day care providers were trained on September 30, 2000, in Casper.

DFS should investigate for abuse/neglect or child endangerment whenever DUI is charged and children are in the vehicle, recommending prosecution when serious child safety concerns are found.

- DFS initiated training regarding imminent danger/DUI for all new workers as part of the CORE training. Discussion and a training letter were provided to the field staff.

Increase frequency of risk assessment by more clearly defining its use in CPS policy.

- The Department has established an online CPS risk assessment.

All CPS case plans must include a safety plan for the child.

- Advanced training for all social work staff was provided on case planning and safety planning for two consecutive years. New workers are provided training on case and safety plans as part of their CORE training.

Child safety issues need to supersede family reunification in out-of-home CPS placements.

- Statewide training was conducted in June, July and August, 2000, for all Department Social Service staff on the Adoption and Safe Families Act.

CPS workers should receive training in the dynamics of domestic abuse and how it affects safety.

- Some CPS workers attended a training on domestic violence held in Sheridan August 4-6, 1999.
- On August 14, 2000, domestic violence cross training for child support workers and social workers throughout the state at junior colleges and outreach centers was well attended. The presenter was Dona Playton, Attorney/Education Coordinator, Wyoming Coalition against Domestic Violence and Sexual Assault. The compressed video conference at LCCC was attended by 30-40 social workers, benefit specialists and child support workers.
- Dare to Dream, the Second Annual Victims Services Conference, was held in Jackson May 15-17, 2000, with some Wyoming DFS workers in attendance.

Recommendation: Case plans should require services which are clearly appropriate for the determined needs and abilities of the individuals involved.

- Termination of Parental Rights grid training was conducted in February and March 1999 and included a section on case planning. Training addressed writing case plans which are time limited, task oriented with measurable outcomes and with responsibilities clearly outlined. One hundred and forty (140) staff were trained.

- The 1999 Wyoming Social Services Conference included presenters from the National Resource Center on Child Maltreatment who provided training on the importance of using a model of assessment for risk linked to the case plan and services assuring child safety.

Recommendation: Assure child safety is the priority over family reunification. Family reunification should be attempted only when safety can be reasonably assured. Incidents of multiple and severe injury to a child must be viewed as a deeply entrenched dynamic in the family system. These families must demonstrate their ability to safely care for a child prior to attempts at reunification. Reunification should depend heavily upon satisfactory completion of identified goals.

- Addition of safety wording to state law surrounding permanency hearings occurred this legislative session and with an effective date of July 1, 1999. Addition of a safety plan will be proposed in the rewrite of CPS rules.
- DFS is upgrading QC efforts to include peer and formal review of cases to address safety issues.

Recommendation: Establish major injury review teams at the state and county levels functioning independently from the multidisciplinary teams assigned to a case.

- Policy establishing child major injury/fatality review teams became effective March 1, 1999.

Nine Cases of Major Injury to Wyoming Children were Reviewed in the Calendar Year of 1999

While major injuries continued to decline in 1999, there were a number of continuing disturbing trends. The majority of victims are under one year of age. Shaken Baby Syndrome (SBS) continues to be a major source of serious injuries. Substance abuse and domestic violence were risk factors in more than half of these cases. (Major injuries do not include sexual abuse.)

Cases continue to first be reviewed by a local team; then that report, along with the police report, coroner's report, medical report, any additional pertinent report, and the DFS investigative report is sent to the state team. Cases are reviewed for system issues such as multi-agency training needs, communication improvements across agencies, needed statute changes, improved prosecution outcomes, and reduction of further trauma to the victim's family. Meetings are held the third Thursday of each month in Cheyenne, with the majority of the team members attending all meetings. Members present a case, and frank discussion occurs followed by recommendations for change, training or other preventive activities. Training in the areas of Multidisciplinary Teams, Child Protection

Teams, the Department of Health's Home Visiting Program, and Concurrent Case Plans was provided to the team.

Victim Information:

- Seven of these children were 6 months of age or younger
- Six were male and three were female
- Four children suffered injuries related to shaken baby syndrome
- One child was badly burned
- Seven of the children had broken bones
- Two children suffered skull fractures

Risk Factors:

- Five cases involved caregivers with substance abuse problems
- Four cases involved domestic violence
- Three cases involved teenage parents

RECOMMENDATIONS

Based on the victim information and risk factors of the cases reviewed, the Team recommends continued emphasis in following areas:

Public Awareness:

- A statewide campaign explaining the dangers of driving under the influence (DUI) of alcohol or drugs when children are in the vehicle is still recommended and should be pursued.
- Promotion and support is needed for legislation to expand the scope of state child fatality review to include all child deaths by other than natural means.
- All professionals who have regular contact with families and children, including teachers and child care workers, health and mental health care providers, law enforcement officers, public assistance workers and court personnel should receive initial and ongoing training related to domestic violence and its impact on children.
- Awareness of home visitation programs currently available in Wyoming should be promoted.

Public Policy:

- Training which reinforces the role of a multidisciplinary response to child maltreatment should be continued and expanded.
- Incidents of alleged child abuse/neglect or child sexual assault should be investigated fully according to state statutes and DFS rules.

- Major injury review teams should be established in each county independent of the functioning of the multidisciplinary team specific to each case.
- The Multidisciplinary Team statute should be consistently applied throughout the state. The statute also needs to be amended to:
 1. Be case specific;
 2. Clearly outline the lead person;
 3. Define how often they meet in the life of the case.
- All professionals who have regular contact with families and children, including teachers and child care workers, health and mental health care providers, law enforcement officers, public assistance workers and court personnel should receive initial and ongoing training related to confidentiality.
- Legislation should be developed to promote coordination of domestic violence agencies and Child Protective Services to protect children living in households where violence occurs.

Law Enforcement:

- Training to improve communication and cooperation between law enforcement agencies and the Department of Family Services should be continued.
- Collaborative training should be held on a regular basis, which promotes effective cooperation and understanding of the policies and procedures of each community agency involved with child protective cases.
- Training promoting awareness that operating a motor vehicle under the influence of drugs or alcohol places children at risk should be established. A referral to the Department of Family Services for assessment of child safety shall be made.
- Law enforcement staff should coordinate with domestic violence agencies to provide awareness of domestic violence issues.
- DFS should be notified when there is child endangerment due to exposure to methamphetamine labs.

Health Care:

- Public Health nurses should arrange for night/weekend monitoring for easier access for high risk infants and children.
- Training to increase awareness and enhance recognition of child abuse/neglect by medical care providers should be continued. Such education should be part of continuing education programs for first responders, EMT, nurses, physicians, and other health care providers.
- The State Medical Society should implement training to enhance cooperation and communication between medical care providers and the Department of Family Services.

- Departments of Health and Family Services should collaborate training on a regular basis to medical professionals to increase accurate reporting and encourage cooperative and effective sharing of information and resources for intervention and prosecution when necessary.
- Specific training in recognition of head trauma and Shaken Baby Syndrome (SBS) should be provided to all Emergency Room staff.

Judiciary:

- Additional clarification for all Wyoming judges in their role of ensuring the safety of children who are passengers in vehicles when Driving Under the Influence (DUI) is charged in their court and who are victims of child maltreatment should be provided.
- Multidisciplinary Teams should be educated and trained in the role of protecting children, addressing safety, well-being, and permanency.
- Judges Association, Bar Association, and DFS should provide educational opportunities regarding advances in detection, substantiation and prosecution of child maltreatment, pursuing a team approach, including law enforcement staff, to see how each part of the system relates to and depends on the others for a successful resolution.

Department of Family Services:

- Categories specific to domestic violence and formal psychological evaluation should be added to formal risk assessment procedures.
- Work should continue regarding legislation to clarify membership and duties of Child Protection Teams.
- Efforts to investigate for abuse/neglect or child endangerment whenever DUI is charged and children are in the vehicle, recommending prosecution when serious child safety concerns are found should continue.
- Changes in CPS guidelines for assessing the safety of children who are passengers in a vehicle and the driver/caretaker is found guilty of DUI should be completed.
- Frequency of risk assessment should be increased by clearly defining its use in CPS policy.
- All CPS case plans should include a safety plan for the child.
- Child safety issues should supersede family reunification in out-of-home CPS placements.
- CPS workers should receive initial and ongoing training in the dynamics of domestic abuse and how it effects child safety, including line supervisors.
- DFS should have a representative participating on the Governor's Domestic Violence Elimination Council (DoVE Council).
- Clear protocols for intervening with families in which both domestic violence and child maltreatment are present should be developed.
- A safety/investigation file should be created for cases with multiple file volumes.
- A full file review should be required as part of the Intake/Investigative process.

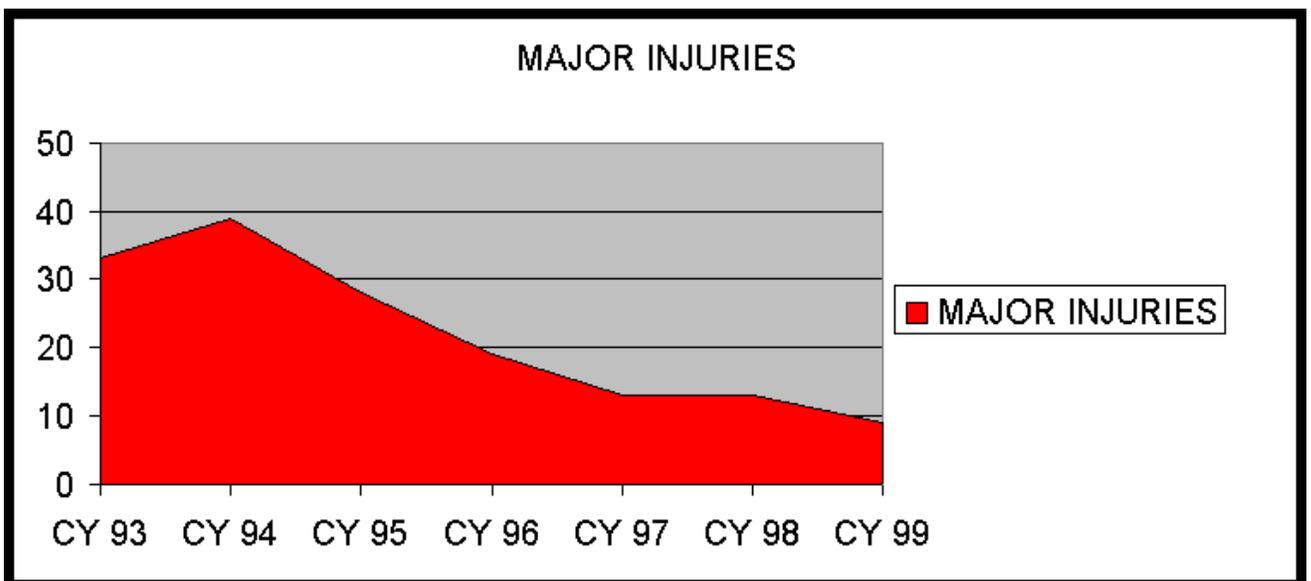
- Intake workers' pay should be increased to help create stability and quality of the work force.
- Effectiveness of communication between specialized units should be evaluated.
- Case-management procedures for children in legal custody should be developed, providing similar assurances for children in out-of-home care.

1. Minimum monthly contacts
2. Three month periodic reviews for the court
3. Twelve month disposition hearings

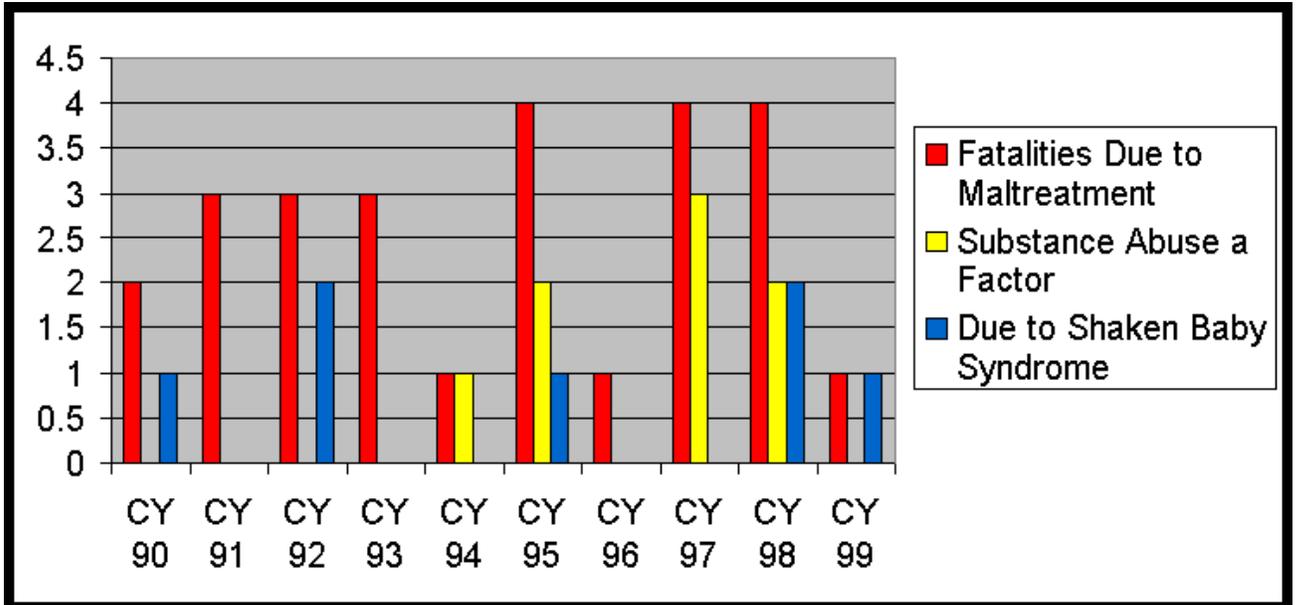
- In closed cases where major injuries occurred or which were assessed to be high risk, require a minimum of one follow-up face-to-face contact by the worker with the victim and the perpetrator.
- Sexual abuse cases should be defined as major injuries and reviewed by the Child Major Injury/Fatality Team.

Mental Health:

- Training to increase awareness and enhance mental health professionals' recognition of child abuse/neglect, understanding of DFS policies/procedures, and report requirements should be promoted.
- Collaborative training held with various mental health groups, especially those licensed or certified to treat substance abuse, to increase understanding of the roles of domestic violence and substance abuse in child abuse/neglect, and to improve assessment and treatment of these problems should be developed.
- Training should be developed on Shaken Baby Syndrome for prisons, jails, and residential treatment facilities (adult, juvenile and drug treatment facilities).



NOTE: This is a very positive trend and reflects a real reduction in major injuries from abuse and neglect. We believe the reduction is most likely due to the effectiveness of prevention programs.



Source: Jan Stiles and the Wyoming Major Injury and Fatality Review Team