

State of Wyoming

**Child Major Injury/Fatality
Review Team**

Sixth Annual Report

October 2004

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Dear Friends of Wyoming's Children,

As we present our Sixth Annual Report, it is a good time to reflect on the past accomplishments of the Wyoming Child Fatality and Major Injury Review Team. Volunteers from across the state have met to review child fatalities caused by abuse or neglect since the team was established in 1977. Team members represent many disciplines and a variety of public and private agencies whose desire and purpose is to protect children. Based on our reviews, we have made recommendations to help prevent child abuse and neglect, and have made changes within our disciplines or agencies to improve our ability to protect the children of Wyoming. This report reflects our work for the past year and the recommendations and responses since the team was established.

We believe strengthening the network of individuals and group working to prevent major injuries and death of Wyoming's children is an important component of our work. Team members have made formal and informal presentations to outside agencies and to our colleagues, and have represented the team on other committees and task forces. We continue to work toward our goal of reviewing all deaths and major injuries of Wyoming children, to better guide our State's prevention efforts.

With deep appreciation for the commitment and dedication of the members of this Team, I present the Sixth Report of the Wyoming Child Fatality and Major Injury Review Team to the Honorable Dave Freudenthal, Governor of the State of Wyoming.

On behalf of the Team,

Valarie J. Bell, MD
Chair

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.

Purpose and Responsibilities

The Child Major Injury/Fatality Review Team shall:

1. Review case files of all Wyoming child major injuries and fatalities;
2. Identify factors and predictors appearing in cases of child maltreatment that 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 that can be utilized in the modification and or the development of laws, rules and policies 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; and
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. Each member will be responsible for keeping the Team informed regarding trainings, new advances, and other pertinent information in their disciplines for inclusion in the annual report.

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History of Child Death Review

National:

In 1995, The U.S. Advisory Board on Child Abuse and Neglect concluded that child abuse and neglect fatalities and other serious and fatal injuries to children could not be significantly reduced or prevented without more complete information about why these deaths occur. It was widely acknowledged that many child abuse and neglect deaths were underreported 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 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 has not expanded its review.

Wyoming:

The Wyoming Child Major Injury/Fatality Review 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. It was originally established with the purpose of reviewing child deaths due to abuse and neglect, but was expanded to include major injuries in 1999. Child fatality and major injury 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 regularly 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 change through prevention, intervention, training, education, legislation and public policy. These recommendations are compiled and published in an annual report. This document represents the sixth annual report published by this Team.

Observed Trends in Child Fatalities/Major Injuries/Risk Factors

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

Shaken Baby Syndrome continues to be the leading cause of fatalities and major injuries in cases of abuse and neglect in Wyoming despite public awareness campaigns. The CMIFR team has made many recommendations over the years regarding this syndrome and the importance of education, not only of young men and women, but of community response providers meeting to develop innovative strategies that would prevent the 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, but this year there was a dramatic link between child abuse and methamphetamine. In addition, the Team has seen an increase in relatively young perpetrators that have abusive backgrounds, are very violent and have been in and out of the juvenile system most of their lives.

Representative Cases

1. Young men and women in Wyoming communities must be educated about the dangers of shaking babies and ways to cope with crying infants. In 2002 and 2003, shaken baby was the leading cause of death and major injury in cases of abuse and neglect to Wyoming's children.
 - a. A father admitted to causing injuries to his 3 month old son who had prior injuries. In the final incident, the father grabbed him out of the bassinette, squeezed him, hit his head on the bassinette and tossed him on the bed. His injuries included acute and chronic subdural hematomas.
 - b. When a one month old child was taken to the emergency room, she was not breathing, had bruising to her eyes, uncontrollable retinal hemorrhaging, subdural hemorrhaging and a broken rib. She presently suffers from cortical blindness and may have cerebral palsy. The mom initially claimed that her two year child picked her up and strangled her.
2. Five of the six child fatalities in 2003 were related to methamphetamine usage.
 - a. A six month old child was found not breathing and unresponsive by his father who was alone with the child. Both he and the mother used methamphetamine. At the time of death the mother had gone to the hospital for injuries she suffered in a beating by the father.
 - b. A two and a half month old child was found dead on an electric blanket by her grandmother when she arrived at her daughter's house. The mother was asleep and had left the electric blanket on high. She tested positive for both methamphetamine and marijuana.
3. Child abuse and domestic violence often are occurring at the same time in households.
 - a. A six week old child had healing rib fractures on both sides of his chest, skull, fractures, lacerated liver and a fractured femur. His father initially claimed that he rolled off a couch and then said that the injuries occurred in an automobile accident. Neighbors reported previous domestic violence against the child's mom.
 - b. A three month old child was found to have non-accidental injuries due to abusive head trauma due to blunt force. His mom was both a victim and a perpetrator of domestic violence with the child's father and other partners.

4. Young perpetrators may have abusive backgrounds and have been involved in the juvenile system.
 - a. A sixteen year old baby-sitter banged a two year old's head against the wall and strangled him. The resulting injuries were a contusion to the brain with subdural hematoma due to blunt impact to the head. The perpetrator had an extensive record of violence, attachment disorders and placements. He was thrown out a second story window when he was a baby.
 - b. A five month old child was found not breathing and unresponsive by the father who was alone with the child. The father of this child had extensive DFS involvement and had 16 arrests including three for violence against people. When he was 12, he witnessed his father beating his mother to death.

Expansion of Child Death Review

Historically Child Death Review teams nationwide were created to examine child abuse and neglect. In recent years, however, there has been a national movement to enhance the role of Child Death Review by reviewing all preventable deaths. The majority of states today have expanded Child Death Review to include a focus on understanding and responding to the many other preventable deaths. It has been recognized that the death of a child is a sentinel event and may represent many more children injured by those same causes and put even more children at risk. Child fatality reviews can spark action and intervention that may prevent further deaths. In Wyoming, plans to expand child fatality reviews are underway. These plans include relocation of the Child Fatality Review team to the Department of Health. In Wyoming child abuse deaths represent a small percentage of total child deaths. By reviewing cases due to other causes, communities will develop a better picture of how and why their children are dying. By relocating to the Department of Health, there would be increased access to medical records and accurate, uniform data that can be used to identify risk factors and trends.

Child Maltreatment Related Deaths in Wyoming

Introduction

Child fatalities are the most tragic consequence of maltreatment. The death of a child due to abuse or neglect is a tragedy that is felt not only by those who knew and loved the child, but also by the community at large. This paper will explore the nature and scope of child maltreatment fatalities 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 from the WYCAPS system.

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 2001*, shows data for 2001. The national and state data from this report, as well as WYCAPS information, will be used in this paper.

It is important to note that efforts to collect and analyze data across states is hampered by wide variations in the way state child welfare agencies compile information. Nationally, there are no common definitions of child abuse or neglect, no common standard of proof of substantiation, and no common criteria for identifying that abuse 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 or neglect. Further constitutes a death due to abuse 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 annual data.

National Findings, 2001

- Each week, CPS agencies receive more than 50,000 referrals alleging that children have been abused or neglected.
- Nationally, an estimated 903,000 children were victims of abuse and neglect.
- Children in the age group birth to 3 years accounted for 27.7 percent of victims. Victimization percentages declined as age increased.
- Nationally, an estimated 1,300 children died of abuse or neglect at a rate of 1.81 children per 100,000 children in the population.

- Children younger than 1 year old accounted for 40.9 percent of fatalities, and 84.5 percent of fatalities were younger than 6 years of age.

(Source: Child Maltreatment Report, 2001)

National Fatality Rates

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

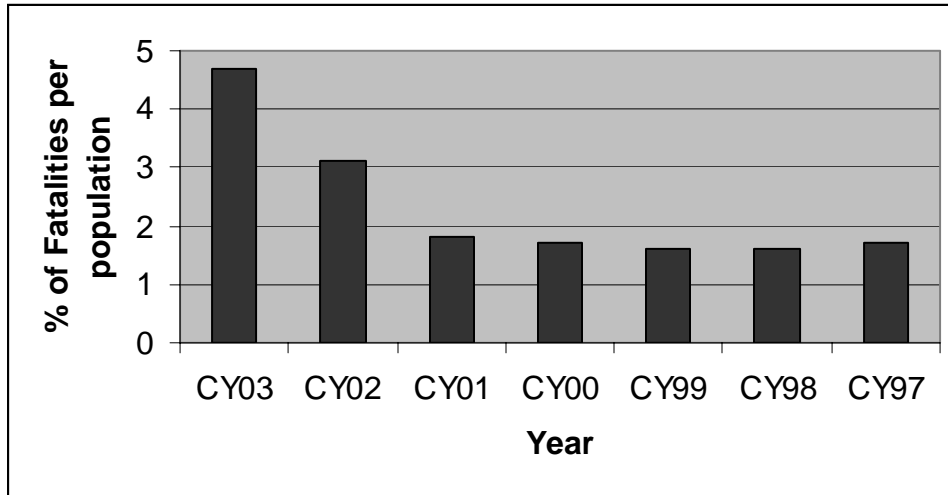
(Source: Child Maltreatment Reports 1997 through 2001)

Wyoming Fatality Rates

Year	Rate Per 100,000 children
2003	4.7
2002	3.1
2001	1.8
2000	1.7
1999	1.6
1998	1.6
1997	1.7

(Source: Child Maltreatment Reports 1997 through 2001. Data for 2002 and 2003 are estimates based on the 2001 child population. Data for 2003 is based on the number of fatalities through 8/15/03.)

Wyoming Fatality Rates per 100,000 Children



Wyoming Findings, 2002

- DFS offices around the state received 6,678 referrals alleging that children have been abused or neglected.
- 1,907 children were the subject of a report referred for investigation or assessment.
- Children in the age group birth to 3 years accounted for 26.7 percent of victims.
- 4 children died as a result of child abuse or neglect.
- Children younger than 1 year old accounted for 50 percent of fatalities due to maltreatment, and 75 percent of fatalities due to maltreatment were younger than 6 years of age.

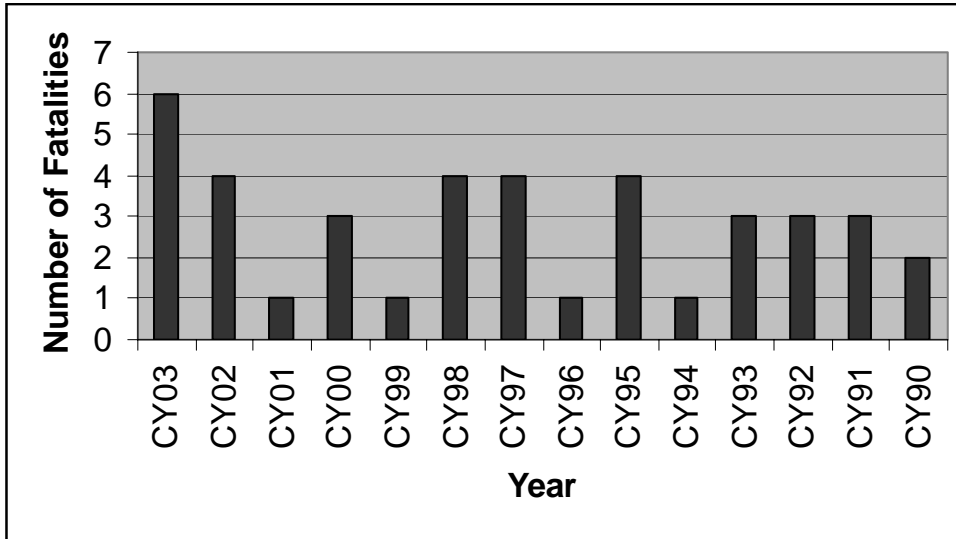
(Source: Wyoming NCANDS Report, 2002)

Regional Child Fatalities, 2001

State	Total Child Fatalities	Rate per 100,000 children
Wyoming	1	.78
Colorado	20	1.77
Idaho	4	1.07
Montana	4	1.74
Nebraska	9	2.00
South Dakota	2	.99
Utah	11	1.51
*National data	1,300	1.81

(Source: Child Maltreatment Report, 2001)

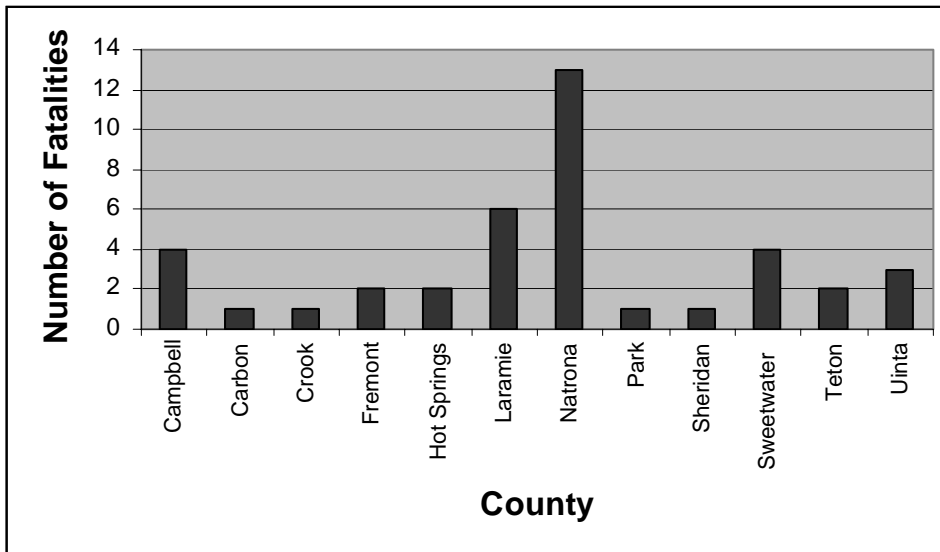
Wyoming Child Fatalities by Year



(Source: Wyoming WYCAPS data. Fatalities for 2003 are through 8/15/03)

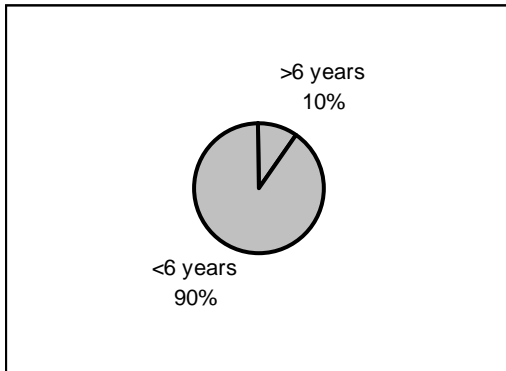
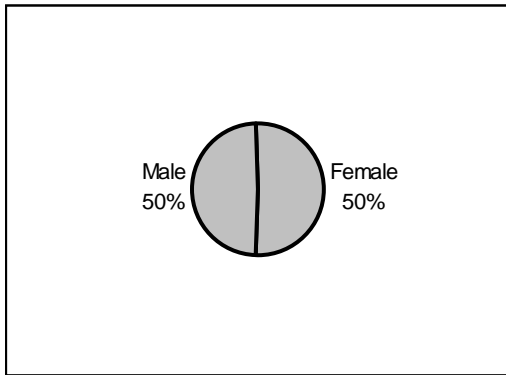
Demographics of Wyoming Fatalities

Fatalities by County 1990-August 15, 2003



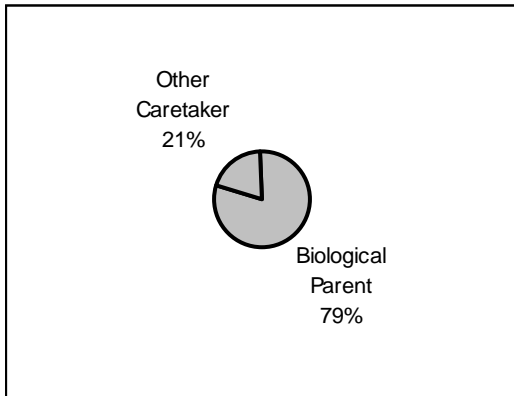
(Source: WYCAPS data)

Characteristics of Victims 1990-August 15, 2003



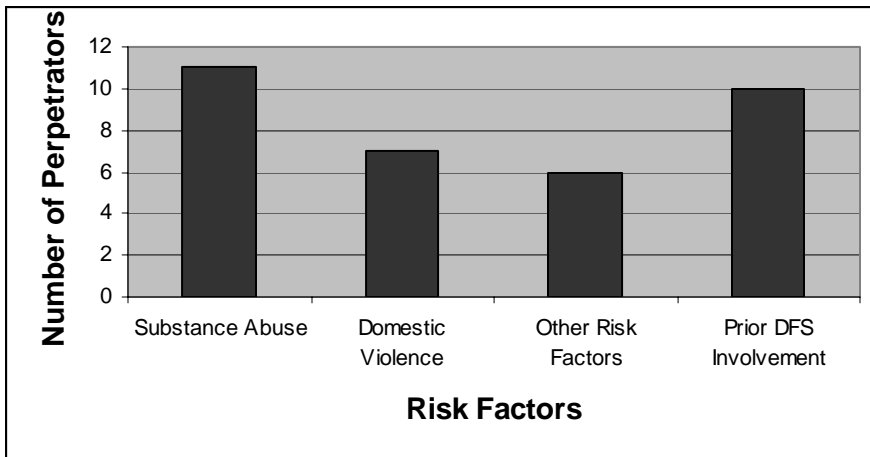
(Source: WYCAPS data.)

Characteristics of Perpetrators 1998-August 15, 2003



(Source: WYCAPS data.)

Characteristics of Perpetrators 1998-August 15, 2003 Cont.



(Source: WYCAPS data.)

2002/2003 Recommendations

Since January 2003, the CMIFR Team completed the reviews of eleven 2002 cases. Seven of them were major injuries and four were fatalities. The Team also completed reviews of eighteen 2003 cases. Twelve of them were major injuries and six of them 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 Awareness

A statewide campaign explaining the dangers of driving under the influence (DUI) of alcohol or drugs when children are in the vehicle, including motorized vehicles such as snowmobiles and boats is still recommended and should be pursued.

Community human service agencies should be trained in recognizing behavioral problems and signs of abuse in order to make referrals and report abuse to appropriate authorities.

Information regarding Shaken Baby Syndrome (SBS) should be distributed to schools, PTOs, baby sitting clinics, DAD 101 courses, worker's compensation, unemployment offices, probation officers and Temporary Assistance to Needy Families (TANF) funded agencies.

Educators should have training in recognizing and reporting child abuse.

Public Policy

Training which reinforces the role of multidisciplinary response to child maltreatment should be continued and expanded. 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 clarification of confidentiality in relationship to multidisciplinary responses to child maltreatment.

The Multidisciplinary Team (MDT) statute should be consistently applied throughout the state:

1. Be case specific.
2. Clearly outlining the lead person; and
3. Define the frequency of meetings in the life of the case.

Legislation should be developed regarding children operating ATV's.

Child Death Review policies should be revised to include reviews of all child deaths instead of just those related to child abuse and neglect.

Law Enforcement

Training in child abuse prevention and investigation should be ongoing and could be accomplished by utilizing the Wyoming Association of Sheriff's and Chief's, the Wyoming Investigators Association, or multidisciplinary trainings in communities. This training should include the importance of emergency response teams when a child fatality or major injury occurs as well as the importance of local child fatality and major injury review teams review of these cases when they are completed.

Partnerships should be developed with childbirth instructors in Wyoming to have police officers talk to their classes about ways to keep children safe.

School Resource Officers should have training regarding child abuse and intervention strategies.

Those incarcerated in adult or juvenile correctional facilities should receive training on the consequences of possessing firearms by felons, domestic violence, shaken baby syndrome, child abuse, drug use and other topics common to major injury or fatality to children.

Model policies should be developed regarding child fatality review/major injury investigations.

Information should be gathered each year regarding the number of training hours Wyoming peace officers receive each year in child abuse issues. Post certification should include training regarding child abuse/neglect and domestic violence.

Health Care

Physicians should be made aware that night/weekend monitoring for high risk infants and children can be arranged through home health if public health nurses are not available.

Home visitation programs are crucial for young parents, particularly those caring for a special needs child. Extended care in high risk cases should continue until the child is school age.

Public health nurses should continue to receive orientation in recognition of child abuse/neglect.

A stronger referral system should be in place. At time of birth Medicaid eligible recipients would be referred to the public health agency.

First time mothers should be referred to community nursing agencies.

Judiciary

Improve functioning of Multidisciplinary Teams (MDT) by:

1. Creating a MDT coordinator position in all districts.
2. Provide training to MDT coordinators and team members on the role of protecting children, addressing safety, well-being and permanency.

Use a coordinated team approach to investigation and prosecution of child maltreatment.

Provide educational opportunities to those teams regarding advances in detection, substantiation and prosecution of child maltreatment.

Implement an automated court tracking system to allow judges full access to case information and status of each family under court jurisdiction.

Create safeguards before allowing non-custodial parents unsupervised visitation. This could include:

1. A checklist of red flags for both Circuit Court Judges (to use in DV cases) and for District Court Judges (to use in both juvenile and civil cases) when considering visitation with non-custodial parents.
2. A court initiated or DFS policy that would require a background and safety check similar to current relative home studies on non-custodial parents prior to unsupervised visitation.

Provide specialized training for prosecutors as well as a special support unit within the Attorney General's Office for improving the prosecution of:

1. Shaken baby and blunt force head trauma
2. The effects of domestic violence on children
3. Sexual abuse of children

Department of Family Services

An EMT should be included on local child fatality teams, if pertinent.

A policy requiring a coroner on a local team and the state team should be implemented.

When pertinent and a protection order exists, a copy of that order should be obtained for State Team Review.

Education on child support and visitation should be publicized as two separate issues.

A process should be in place to offer a mother, in a major injury/fatality investigation, information regarding her rights/concerns.

Training should be provided to Early Childhood Center's staff in recognizing behavioral problems and signs of abuse to make referrals and report abuse to appropriate authorities.

Available screening instruments should be evaluated.

An education report is needed in the case file.

Early childhood centers should have training in recognition of abuse and in reporting abuse to appropriate authorities.

DFS should follow the status of the perpetrator regarding the potential release date and conditions of parole.

There should be a better referral system between DFS and the Nurse Family Partnership in communities.

Emergency response teams need to be created to deal with child fatalities or major injuries.

Wyoming Child Protection Teams should develop strategies regarding prevention of shaken baby syndrome in their communities.

Child Protection Teams across Wyoming should share protocols regarding referrals to community agencies.

DFS should develop a clear protocol for handling cases when Native American children come into care. Training on that protocol should be given to the DFS offices handling the largest number of Native American Children as well as district and county attorney's and the courts.

DFS case closure should be based on assessment and safety planning priorities. Incorporating a family centered approach would improve case planning.

Mental Health

Increased training that will enhance mental health professionals' recognition of child abuse/neglect, understanding of DFS policies, procedures, and reporting requirements should be provided.

Collaborative training should be held with various mental health groups, especially those licensed or certified to treat substance abuse, that increases understanding of the roles of domestic violence and substance abuse in child abuse/neglect and improves assessment and treatment of these problems.

Training should be explored regarding new and innovative intervention strategies for treatment of substance abuse.

In cases of extreme violence, a neuropsychological assessment should be completed.

Appropriate counseling/treatment which addresses specific mental health needs of a child, as well as for parents who victimize their children should be provided.

Medical

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 responder, EMT's, nurses, physicians, and other health care providers.

The State Medical Society should implement training to enhance cooperation and communication between medical care provider and DFS.

Departments of Health and Family Services should collaborate training on a regular basis to medical professional 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 and child health care providers.

Responses to 2002 Recommendations

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

Department of Health

1. Recommendation: A stronger referral system should be in place—at the time of birth, Medicaid eligible recipients would be referred to the public health agency.

PHN has been interested in this area for several years, even before the home visiting legislation was passed in 2000. It is important that both the prenatal and post-partum referral system be strengthened. A referral process needs to be formalized and institutionalized so that it is regular and dependable and inclusive of all areas of the state. PHN offices are now being provided with access to the lists of women that have most recently been found to be eligible for Medicaid. This allows PHN to make sure that women have contact information as early as possible in pregnancy, and they can then be referred to appropriate community resources as well as be provided with education and support related to healthy birth outcomes.

2. Recommendation: Previously funded by TANF, a proposal for home visitation funding should be presented to legislators.

The legislature has already funded a home visitation program. However, program funding has not kept pace with the increase in caseload and is under funded to meet the legislative mandates (To visit 95% of TANF eligible pregnant/post-partum) The TANF funding was originally projected to cost \$2,784,000 per year. The current budget is \$1,760,750 per year of TANF funding. Maternal and Child Health also contributes to home visiting, but that funding is also not increased and may go down. The program is at the same funding as the year 2000.

3. Recommendation: First time mothers should be referred to community nursing agencies.

Some resources could be directed towards marketing home visiting and the Welcome Home visit as a normal, expected part of having a baby. In some communities the perception exists that Welcome Home or PHN visits are mostly for people who are poor or who do not know how to care for their babies. Communities should embrace Welcome Home visits for everyone who takes a new baby home. People should not be expected to go home and become a new parent without information and support.

4. Recommendation: 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's, nurses, physicians and other health care providers.

EMS providers in the state are provided the Pediatric Education for Pre-hospital Professionals which includes entire sections on Child Maltreatment and Head Trauma. The Emergency Nurses

Association has the Emergency Nurses Pediatric Course, which also includes entire sections on these topics. The physicians go through the Advanced Trauma Life Support Course, which includes head trauma and goes into Pediatric Trauma, including abuse.

These courses plus many others occur on a regular basis around Wyoming and are well attended. Child maltreatment, head trauma and shaken baby syndrome have been extensively taught through these courses.

PHN could benefit by an orientation level DVD or CD computer desktop interactive training that would be short and easily accessed. A training tool needs to be created that every ER and PHN office could have for orientation, staff meetings, and periodic review. DFS offices could loan a disc to new physicians and other groups. The Kempe Center in Denver is also a good resource for speakers and training.

5. Recommendation: The State Medical Society should implement training to enhance cooperation and communication between medical care providers and DFS.

Rather than reinventing another course of training, the existing educational structure should be supported and enhanced. Many of the recommendations made by the CMIFR team pertain to communication. It may behoove us to provide the arena for people from diverse background to convene to develop an effective communication structure for all. State agencies could provide the place and opportunity for those in the trenches across the state to convene. Other steps that would be helpful are as follows:

Analysis and reporting of available child trauma data (Change monitoring activity into surveillance);

Develop or adopt proven effective prevention/intervention strategies for the specific types of traumas that we measure;

Implement prevention strategies;

Modify data collection to address new questions generated in steps 1-3.

Department of Family Services

1. Recommendation: An EMT should be included on local child fatality teams, if pertinent.

This recommendation was included in Department policy effective June 1, 2004.

A policy requiring a coroner on a local team and the state team should be implemented.

This recommendation was included in Department policy effective June 1, 2004.

2. Recommendation: When Pertinent and a protection order exists, a copy of that order should be obtained for State Team Review.

Appropriate language will be added to Department policy.

3. Recommendation: A process should be in place to offer a mother, in a major injury/fatality investigation, information regarding her rights/concerns.

The Rules and Regulations Governing Child Protective Services require that during the initial in-person interview with the child's custodial parent, legal guardian or legal custodian, the Department shall inform them in writing that a complaint has been received and the duty to investigate, and that the investigation may involve law enforcement or the court if needed to protect the child. If the mother is the alleged perpetrator, she is informed in writing that a complaint has been received against her and of the Department's duty to investigate, and that the investigation may involve law enforcement of the court if needed to protect the child.

The Rules and Regulations Governing Child Protective Services also require that in a substantiated case of child maltreatment, the non-custodial parent is informed of the findings. The perpetrator is informed that their name has been placed on the Central Registry, they may respond in writing to the finding and that they may request an administrative hearing to review the findings.

4. Recommendation: Available screening instruments should be evaluated.

This will be accomplished through the implementation of the Department's Program Improvement Plan and partnership with the National Resource Center on Child Maltreatment.

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

This will be accomplished through the implementation of the Department's Program Improvement Plan.

6. Recommendation: Emergency response teams need to be created to deal with child fatalities or major injuries.

In June 2004, training was provided in Sweetwater County. The training has been made available to other communities.

7. Recommendation: DFS should develop a clear protocol for handling cases when Native American children come into care. Training on that protocol should be given to the DFS offices handling the largest number of Native American Children as well as district and county attorney's and the courts.

The Department's Authority for Placement Policy, Section II(G) addresses the mandates of the federal Indian Child Welfare Act (ICWA) of 1978, P.L. 95-608. ICWA is also addressed in new worker training and an ICWA specialist has been identified in the State Office and the Attorney General's office to provide consultation to the field offices.

8. Recommendation; DFS case closure should be based on assessment and safety planning priorities. Incorporating a family centered approach would improve case planning.

This will be accomplished through the implementation of the Department's Program Improvement Plan.

Division of Victims Services

Recommendation: Child protection workers, including line supervisors should receive initial and ongoing training in the dynamics of domestic abuse and how it affects child safety:

Training occurred at 6 training sites across the state between May and August 2003 for the Department of Family Service's child protection and local domestic violence program staff. The training, taught jointly by both a local and national level trainers, addressed specific roles of the agencies in addressing child maltreatment where domestic violence is also occurring. Other topics covered were: specific agency roles, community based coordinated response, safety planning, confidentiality, and the dynamics of family violence when family violence is also occurring. This training was paid for by a Rural Domestic Violence and Child Victimization Enforcement grant from the Department of Justice.

The Division of Victim Services has worked with the Department of Family Services in the development of training competencies for child protection workers, covering the areas particularly of assessment of safety of children when domestic violence is also occurring. With the DFS development of DV resource teams across the state, the Division of Victim Services has continued to participate in outlining training competencies for these team members and has continued to provide training opportunities and funds to achieve these competencies.

The Division of Victim Service's Director is participating in the Quality Practice Initiative; a committee formed by the Director of DFS and includes several state agencies involved with families who have the challenges of child abuse, domestic violence, substance abuse, mental health concerns, and legal services involvement. The committee's aim is to improve the overall response by governmental agencies to families facing these multiple challenges, improving the safety and outcomes for Wyoming children and families.