Wyoming Citizen Review Panel

2012 Annual Report

COMPLETING THE CIRCLE

"In helping others, we shall help ourselves, for whatever good we give out completes the circle and comes back to us" by Flora Edwards

2012 Annual Report

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June 15, 2013

Wyoming Citizen Review Panel (WYCRP) has had many changes this year which resulted in many new endeavors and one void to fill. Unfortunately Kelly Hamilton decided to move onto new adventures in January. Kelly has been with the organization for many years and leaves very large shoes to fill. We are so excited for him in his new adventures and we are so grateful that he will remain involved in the organization as a panel member. Kelly has made many great connections in Wyoming that has led to great advocacy for children and families. We wish him all the best in his new position.

We have attempted to make the transition between directors as seamless as possible. I am honored to have this new opportunity to represent this panel and advocate for children and families. I have a passion for assisting families to reach their full potential and this position provides me an opportunity to work with many great agencies to make that happen. I am excited to get started in this new adventure.

In May we hosted the Annual National Citizen Review Panel Conference in Jackson, Wyoming. It is an honor to host the conference which brings great networking opportunities for the Citizen Review Panels from around the nation. We also had the pleasure to showcase our beautiful state as well as our great relationship with the Wyoming Department of Family Services (DFS). We were honored that Director Dr. Steve Corsi provided the opening remarks for the conference which opened the door to demonstrate how collaboration efforts between state protection agencies and citizen review panels can be productive.

Another exciting project began in May. WYCRP started the Adult Protection Services SYNC reviews in Wyoming. This was a great opportunity for us to look at the adult system and how it is working in the state. The SYNC instrument was adapted to meet the needs for systems review in the protective services area. Three counties welcomed us into their communities to initiate this process in Wyoming.

I have had the pleasure of working with amazing staff and wonderful panel members these past few months. I look forward to working for Wyoming families to ensure that children remain safe in their homes and ensure strong family units are supported. I have a belief that families strive to be the best they can but sometimes need tools to facilitate that process. I will work hard to partner with Wyoming DFS and other stakeholders in our communities to provide great opportunities for children to flourish.

I look forward to working in our great communities and making connections with families, agencies, and stakeholders.

Jennifer Davis

Executive Director of Wyoming Citizen Review Panel

Introduction

The Wyoming Citizen Review Panel (WYCRP) has ventured into new territory this year creating new opportunities for the citizens of Wyoming. Under new leadership it is always difficult to ensure that systems remain in motion and that consistency remains strong for programming. WYCRP had a unique opportunity to implement many different programs under our umbrella which provided opportunities for community collaboration and forming stronger Wyoming families. The multiple programs of the WYCRP offers a complete "circle" of service for keeping Wyoming children safe and developing into productive adults in our communities. WYCRP supports a comprehensive approach to child well being by offering a variety of services that can help children and families develop strong family units and avoid entrance into the child welfare system. We also can support Wyoming Department of Family Services (DFS) in their efforts for quality services if children require assistance from the state in some capacity. The WYCRP offers recommendations for systems building that can lead to a comprehensive network of supporting children to reach their max potential as they move into adulthood. Our services range from primary prevention, early intervention, child welfare reviews and program support, and alumni support and recommendations.

The WYCRP hosted the 2013 Annual National Citizen Review Panel Conference in Jackson, Wyoming in May of this year. It must have been the beautiful location of Jackson that lured over 34 states and 100 people to the conference. The conference provides an opportunity for citizen review panels from around the United States to come together to share ideas and information about what is happening in their state. Wyoming is very fortunate to have a partnership with the Wyoming DFS which showcases how well agencies and citizen review panels can work together for system improvement and sustainability. Director Steve Corsi from the Wyoming DFS provided the opening remarks for the conference which set the stage for true collaboration efforts among agencies and review panels. The focus of this year's conference related to finding a "WAY" to move forward in child welfare by focusing on feedback from alumni. Wyoming Advocates for Youth (WAY) consists of foster care alumni who shared their stories about growing up in the Wyoming child welfare system and shared their perspective on how the system impacted their lives. The alumni have a unique perspective to share with citizens and agencies that can only be understood by those directly involved in the system. The recommendations they have to offer are powerful for systems change. This year's conference was a success and we look forward to attending next year's conference in Atlanta, Georgia.

This year's annual report will provide information about the child protection teams efforts around the state, the Child Death Review and Prevention Teams' efforts related to case file review and recommended system's improvement for prevention, the endeavors of WAY, adult protection system reviews and recommendations, as well as program updates. This report will also include information about our planned efforts for next year to assist Wyoming DFS in all aspects of child, adolescent, and adult welfare. WYCRP has had many opportunities for

program expansion which creates a circle of connections between various organizations focused on systems building in the adult and child welfare system for prevention and intervention.

2012 Wyoming Citizen Review Annual Report Information:

Child Protection Team (CPT)

At the beginning of this year WYCRP had the opportunity to visit with several of the Child Protection Teams across the state to discuss the option of forming regional groups. The purpose of creating regional child protection teams in Wyoming would be to create greater efficiency and effectiveness of the CPT's as they currently exist. Coordination between the DFS and the WYCRP on the creation and administration of these teams will also help DFS to gather greater "citizen input". The WYCRP would offer communication on a statewide level with groups and individuals working on the CPT's for children and families. These regional CPT's would be organized to align with the nine districts that DFS utilizes. Through community discussions benefits and challenges of regional CPTs were expressed.

Benefits:

- Creation of a "new image" for those CPT's that may be struggling.
- Access to additional resources from a broader demographic.
- Less risk for duplication of services in regions due to coordination of efforts.
- Better citizen and community feedback could be gathered and delivered to the state offices. (Potential for Public Forums as one of their meetings)
- State offices and other prevention groups would have regional connections statewide.
- Potential for a decrease in expenditures to the DFS through streamlining and coordinating with CPT members and community providers.
- Better distribution of funding from year to year in areas that may be working on differing prevention measures.
- Coordination with WYCRP would allow for more direct access to statewide prevention groups, including Wyoming Advocates for Youth (foster care alumni), Prevent Child Abuse Wyoming, Wyoming Child Death Review and Prevention Team and many others.
- Creates an opportunity for the DFS to place more "attention" on the prevention end without drifting from their current legislative requirements and authority. Further support on the front end will lead to lesser need on the back end.

Challenges:

- Many of the local teams will not want to discontinue what each team is doing on a local level. We may have to look at how to transition from local teams to regional teams in order to have less disruption to current services. Or is there way to keep local teams and have regional teams?

- Teams can be territorial and it would be crucial for the regions to work collaboratively for the best chance of success.
- Member selection will be crucial. We will need to set enough of a guideline to get the appropriate members on the CPT's but will need to balance how many from each town within the regions too.
- Funding for regional travel in order to members to participate in person for meetings.

Recommendations:

- Each regional CPT will complete a yearly plan as well as a yearly report/summary and submit them electronically to DFS and WYCRP for approval. The yearly report will summarize the work and information laid out in the yearly plan they submit.
- DFS will continue to be the funding authority for the CPT's, but the WYCRP will administer the funds according to approved yearly plans submitted by the regional CPT's. (ASSUMING FUNDING IS INVOLVED)
- A guideline for mandatory membership on each team will be created to follow DFS policy requirements. Other members may sit on the team as identified by each region and approved by DFS/WYCRP. A certain number or percentage of county membership will be identified in regions containing more than one county to maintain fair input.
- Regional meetings will be held a minimum of two times per year and maximum of 4 times per year. Each region will be allowed to decide the number of meetings to be held and the locations of meetings. They will document their decisions in their yearly plans.
- Each team can establish a yearly project, either at the local or regional level to improve their community outreach and network of resources.
- One "Annual Meeting" will be held for all regional CPT's to attend to receive information and training and to provide opportunity to network with other regions. This meeting will be funded by the DFS and coordinated by DFS and WYCRP jointly.
    a. ½ day of training, ½ day of networking
    b. Potential topics: Mandatory Reporting, Definitions of Abuse and Neglect, Child Death Review.
- Input will be provided to the Wyoming Child Death Review and Prevention Team by each regional area to be included in the annual report.
- WYCRP and/or DFS could create a listserv for these teams to assist in information and document sharing.

Adult Protective Services SYNC Reviews

This year WYCRP was able to initiate the System & You Networking and Collaborating (SYNC) review process in the adult protection services area to assist with system's review and development. The SYNC instrument was designed for use in the drug court system to get feedback from clients and providers in regards to the system and the impact for the individual. The SYNC instrument is strength based assessment for systems improvement. The instrument was adapted to meet the needs of the Adult Protective System (APS) in order to look at systems of care related to adult protection in the state. The Wyoming DFS is currently in the process of updating APS policy so it is a great time to look at systems and see how new policies and old can be integrated into practices at the local offices. Through the review process it allows for opportunity to receive feedback from the field offices, clients of the adult system, and community stakeholders.

WYCRP's efforts were focused in three communities this year: Sheridan, Casper and Rock Springs. This was the first time this instrument has been utilized in the Wyoming protection system. As the instrument was utilized in these communities, there were some areas to improve so that the instrument fits the system better in order to receive more appropriate information to assist with file reviews and system's assessment.

Graphic representation has been provided about the number of intakes into the local DFS office, then broken down to the actual APS intakes. (See graphs on page 10) .

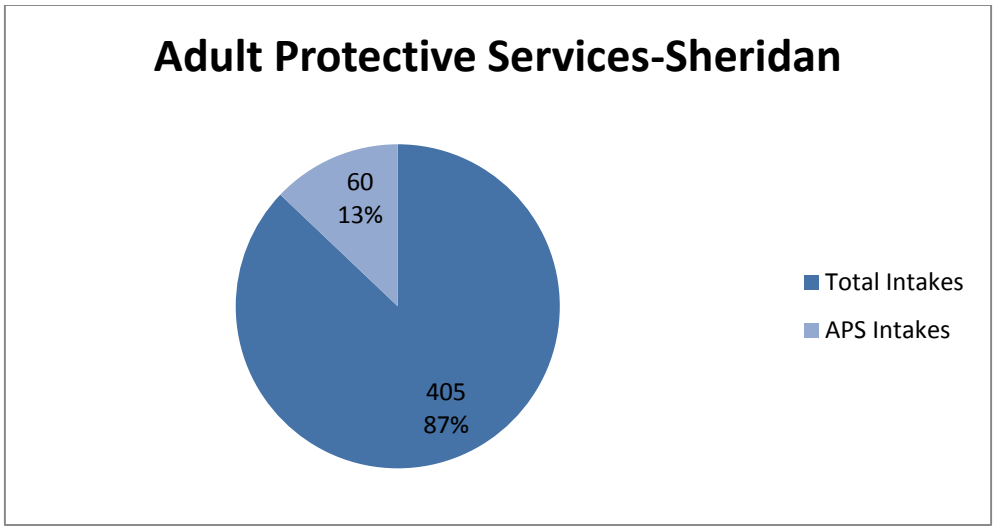
Many great things are happening with APS in the state of Wyoming. WYCRP was fortunate to receive positive responses in the communities of focus this year. Wyoming DFS is excelling in many areas around adult protection as demonstrated throughout the review process in each area. Some of the strengths of the adult protections system are as follows:

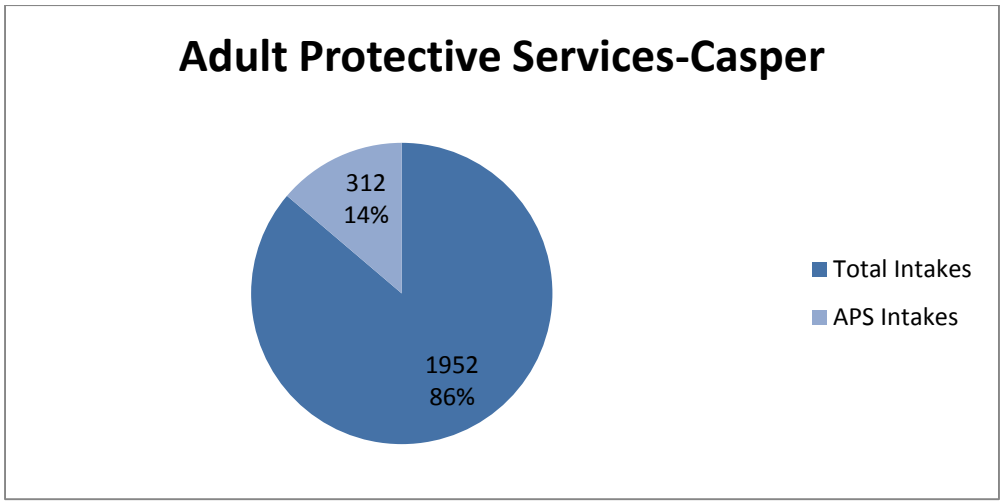
1. APS Prevention Efforts: All of the areas had a strong prevention message. Although each area handles prevention efforts differently, each area had a strong relationship with community partners to help vulnerable adults find resources in the community. Some of the areas utilized the case workers to engage in the prevention activities, while others utilized their Adult Protection Team (APT) to engage the community of resources.
2. Community Collaboration: Each area had an extensive community network set up to assist caseworkers and citizens on resources in the community. There are a multitude of resources in each area that the caseworkers were very aware of and this knowledge was shared with the individual's family for safety and permanency for vulnerable adults. It appeared through the review process that community partners were engaged at the local level to help the vulnerable adults succeed in the community. It appeared that other agencies had a reciprocal relationship with the local DFS office to assist individuals in the community by referring when necessary.

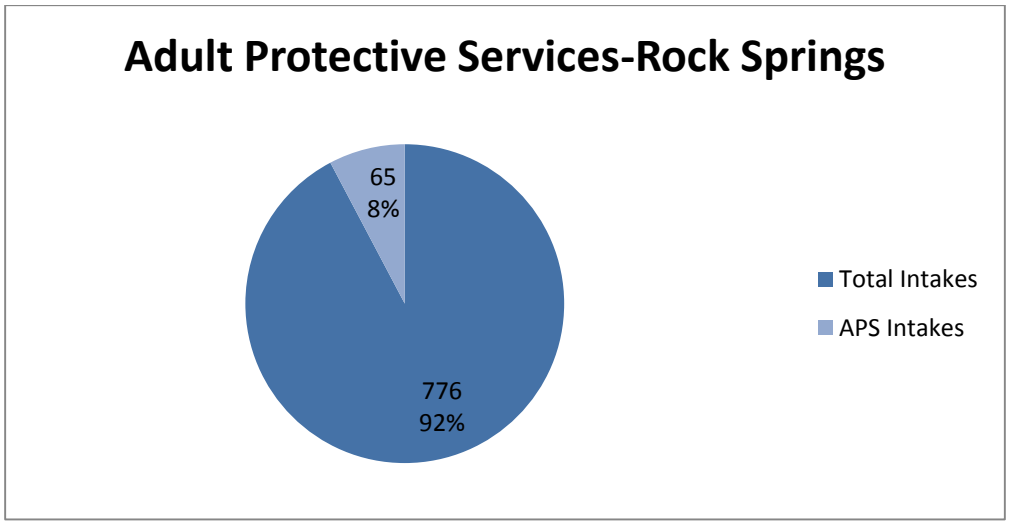
3. Commitment to Community Safety: It appeared that each area had a commitment to the adults of the community to keep them safe. It was evident that the local offices are engaged in the community and seek the advice and collaboration with other agencies to help at risk adults remains safe in the community. Law enforcement and local assisted living/skilled nursing facilities have regular communication that identifies needs in the area regarding safety concerns for the vulnerable adults. Multiple agencies come to together to help facilitate changes in the community for safety related issues such as housing and driver's safety. Often APTs offer trainings to assist with related safety concerns directly relating to the local area.

Throughout all of the areas there are several areas of concern that were shared. These included:

1. Reporting Medicaid Fraud: There seemed to be confusion as to when it was appropriate to refer cases to the state Medicaid Fraud unit. Caseworkers and state Medicaid staff have had difficulties differentiating who should be leading the case. The procedure for when it is appropriate to report adult cases to the Medicaid Fraud department
2. Intake Process: There appears an unclear definition of what constitutes a "vulnerable" adult or how it is determined if an adult has "capacity" for decision making. At times it seems as though cases may have been overlooked simply by lack of understanding due to clear definitions.
3. File inconsistency: It is difficult to review paper files as there is not a standardized file used in APS. This is also difficult as the reviewers did not have access to the WYCAPS data base which may eliminate some of the issues with missing information.
4. Designated workers at the local office for APS: Workers report that it is difficult to constantly transition from APS to CPS cases since there is so much variability between the two. This makes it difficult to have consistency with case management, both personally with the case workers and within the entire system.
5. Form redundancy: Workers feel that the forms are redundant and do not always reflect the appropriate information related to the file.
6. Funding for salary to designate APS workers at the local offices: Due to the recent budget cuts it is difficult to have adequate staff for operations, especially designated case workers for APS.
7. Quality of Referrals: Many of the referral sources in the community are unaware of DFS's limitations regarding APS file which leads to extra work for the intake workers.
8. Availability of Emergency Funds: In the reviews at the local level it was expressed that emergency funds were difficult to access and not received in a timely manner. Due to difficulty with timely delivery of funds, often times the crisis is resolved or further escalated before the funds are available making it difficult to assist the individual.


Adult Protective Services-Sheridan
60
13%
405
87%
Total Intakes
APS Intakes


Adult Protective Services-Casper
312
14%
1952
86%
Total Intakes
APS Intakes


Adult Protective Services-Rock Springs
65
8%
776
92%
Total Intakes
APS Intakes

The following ***recommendations*** could potentially improve the adult protective services local and state areas:

1. Form Utilization Review: The current APS forms are being reviewed at the state office to ensure quality of information that is being collected through the reporting process. Recommend that the local office have an opportunity to provide input into this review process.
2. Continued training related to APS: It is difficult at the field office to have consistency with APS files as they are the minority of the cases worked in each office. Since many of the office do not have a designated APS caseworker, several of the offices felt it would be beneficial to have regular ongoing trainings related to APS in the yearly mandatory training hours.
3. Core training: Several of the offices felt it would be beneficial to have a more in-depth explanation of the APS system since it is less familiar to the caseworkers.
4. Standardization of APS file: It is recommended that a standardized file system be established for all local offices in order to provide some consistency in the area of APS. Often times many of the forms are not utilized if the file is not opened for investigation but a standardized form to account for any and all forms necessary to work a case file would be helpful. It was recommended that a type of checklist with the necessary forms and timeframes would be helpful.
5. Funding: Due to the growing aging population, several of the offices felt it might be beneficial to start discussions at the state level and with the state legislature regarding funding more services related to APS. It was suggested that the earlier this conversation began the more beneficial it would be for program sustainability and expansion.
6. Community trainings: One of the issues that were heard in all of the offices was that there is a misunderstanding of the Wyoming DFS role in adult protection at the community level. Many agencies and citizens believe that DFS can remove adults from their homes due to variety of situations. The local offices felt it would be helpful to have some trainings offered in the local communities to explain the differences between child protective services and adult protective services. The local offices felt that the support of these trainings coming from the state office would be beneficial in order to maintain their relationships in the community.
7. Emergency Funds: It was suggested that each local office receive a portion of the emergency funds for the year so that they can access them quickly when in need. This would also allow for each office to have more individualized control over the needs of the local community.

Wyoming Advocates for Youth (WAY)

Wyoming Advocates for Youth (WAY) has had a busy year which included leading focus groups, participating in permanency roundtable discussions, and hosting the National Citizen Review Panel meeting in Jackson. Currently WAY has foster care alumni groups in Casper, Cheyenne and Laramie. WAY also works with the young women preparing to transition out of the Sheridan Girl's School.

The alumni groups have identified several areas of concern for youth transitioning out of foster care which includes lack of transitional housing opportunities and transportation limitations upon exiting the foster care system. It is a concern that many of the youth end up homeless and unable to afford or find adequate housing after leaving the foster care system. Another issue that the alumni have identified is the difficulty that youth in care experience obtaining a driver's license including basic car ownership responsibilities. The alumni groups have found that many youth do not have the opportunity to take the driver's test because they often do not have a vehicle available to them for the exam. Often the trouble arises because it is difficult to determine who is to assume liability for the foster youth. Another important aspect related to driving is that fact that many youth do not have adequate skills related to car ownership when they leave foster care. This year there were several classes offered to youth by the alumni, in partnership with Wyoming Kinship Advocacy to train youth on the importance of car ownership, some basic financial information, and hands on car maintenance class. These were very successful as demonstrated by the pre and post test improvements. There are several issues that impact this issue and we will be taking a more in depth look at this issue over the next year to determine what is happening around the state.

WAY also has been working on the Foster Care Bill of Rights. A draft bill was examined by Senator Leslie Nutting from Laramie County. Senator Nutting has asked for some revisions to the bill and more inclusive information regarding foster parent rights. Senator Nutting has offered to assist the alumni with revisions and then possibly sponsoring the bill once it has been revised. WAY alumni will be focusing their efforts on this issue before the next legislative session.

WAY hosted the National Citizen Review Panel by engaging panel members from across the United States in some discussions about their personal experiences in the foster care system and their suggestions for system's improvement. The alumni participated in an open forum roundtable discussions at the conference which facilitated conversation around foster care placement.

Recommendations:

1. WYCRP with assistance of the Wyoming DFS will compose a survey of foster parents and foster youth in regards to obtaining a driver's license and transitional planning regarding housing.

2. It is also recommended that DFS assist with the draft legislation for the Foster Care Bill of Rights to move forward after revisions that best meet the needs of all parties.

Wyoming Child Death Review and Prevention Team (WCDRPT)

The Wyoming Child Death Review and Prevention Team (WCDRPT) strive to minimize child major injuries and fatalities in Wyoming through comprehensive, multi-disciplinary case reviews. The team actively advocates for child victims by making recommendations for change through prevention, intervention, training, education, legislation, and public policy. Between June 1, 2012 and June 30, 2013 the WCDRPT reviewed 9 case files classified as major injuries or fatalities by the DFS. Below is a summary of each case, as well as the strengths, concerns and recommendations formulated by the members of the WCDRPT.

Case #2012-001:

Summary:
This was a child fatality case involving a four year old male who drowned. Alcohol was involved in the incident but testing occurred several hours after incident so accurate level was unknown. The boy was wearing a life jacket, but in an adult size.

Strengths:

- DFS, Law Enforcement, and all other parties involved of this case handled it appropriately and efficiently. The case file was comprehensive and included a death certificate.
- Charges were filed against the biological parent.

Concerns:

- Alcohol was involved in the incident, but the biological father was not tested until four hours after the incident, at that time he did not test above the legal limit.
- All three children in the case were wearing inadequate life preservers which were adult sized.

Recommendations:

1. Education about water safety in regards to children and families should be easily accessible and the rules and regulations relating to such should be posted at all public water recreation areas if not already being done.
2. In order to ensure best practice during case reviews, it would be beneficial for DFS to provide training to the members on a regular basis regarding how the investigation process works and case files are compiled.

Case #2012-002:

Summary:

This was a major injury case involving a three year old female who was taken to the emergency room and found to have multiple bruises in various stages of healing as well as a spiral fracture of the right humerus and fractured left wrist.

There were also prior situations where the child had made visits to the emergency room with "accidental injuries". The child was removed from her home due to the incident. Perpetrator was the biological mother's boyfriend.

Strengths:

- All appropriate action was taken by Law Enforcement and Medical personnel in this case.

Concerns:

- There did not appear to be any examination of any of the other children removed from the home. Details of the services offered to the bio-mother or foster care placements were limited. It would be beneficial to determine the level of outreach that was offered.
- It was mentioned as a general statement, that some counties in Wyoming would have considered reunification with a perpetrator parent in a case such as this. Further clarification on this statement would be helpful to determine consistency around the state. This was a great concern for the team. It was questioned what kind of recommendation could be made to ensure greater consistency across the state.
- This case follows the very common trend of "mom's boyfriend" being a perpetrator of abuse and/or neglect.

Recommendations:

1. Specific services provided by DFS to either family prior to the incident and/or after the incident should be clearly listed in the case files.
2. There should be consist policies between all DFS offices and courts statewide to deal with handling reunifications, understanding that counties may have different cultures and the circumstances of each case may differ.

Case #2012-003:

Summary:

This was a major injury case involving a two year old female who was brought to the emergency room with a broken leg. The type of break that occurred did not match the parents explanation. Law enforcement took custody of the child. Domestic violence was very prevalent in the home at the time of the injury.

Strengths:

- The DFS investigation was completed timely and appropriately. Services provided for the children and family were appropriate, which included appropriate foster placement.
- Law Enforcement took appropriate and timely action in this case.

Concerns:

- There was concern that the emergency room/hospital had seen this child multiple times without a referral to DFS. There were multiple visits that should have been recognized as potential abuse concerns by emergency room personnel, but there was never a report made to law enforcement or DFS.
- There was concern for legal action taken against the perpetrator who had a very disturbing criminal history and was only given probation for this incident.
- There was general concern, again, that this followed the trend of mom's boyfriend being the perpetrator. There was also a history of domestic violence with the adults in the home.

Recommendations:

1. Education and awareness about the signs and symptoms of abuse and neglect, as well as the mandated reporting regulations for Wyoming, needs to be addressed with the medical community statewide to decrease incidents involving repeat visits. This includes hospitals, physicians' offices, pre-natal clinics, public health offices, EMS services and other related groups.
2. Continued investigation by DFS and Law Enforcement to the connection of domestic violence in the homes where incidents of child major injuries and fatalities occur is beneficial to ensuring the best services are being provided to these families. This could occur by providing domestic violence trainings.

Case #2012-004:

Summary:

This was a major injury case involving a 10-week old male who's supposed biological father called authorities when the child was unresponsive at home. Authorities were not allowed in the home and so the responders were not able to provide assistance to the child upon their arrival.. The child was found to have head trauma in multiple stages of healing as well as broken ribs. The child was discharged into DFS custody and went into a foster care placement. Perpetrator was biological mother's boyfriend (assumed biological dad at time of incident).

Strengths:

- The DFS timeline in this case was very thorough. There was also good communication and coordination with law enforcement and the county attorney's office. The narratives were well written.
- Procedures were followed and the case file documents were complete. The foster care placement of this child has been extremely successful and the true bio-dad has been actively involved.

Concerns:

- The biggest concern in this case was related to the report of evidence of previous head injuries of the child by medical personnel. This child had been taken for medical treatment previously, but the personnel in that case had not reported any possible abuse to the authorities.
- This case appeared to slip through the cracks from the local Public Health office perspective. The child was born he was in a NICU in Rapid City, SD and should have been referred and followed up by the local public health nurse (PHN) in Converse County. The Public Health office in Converse County was supposed to do a visit with this family, but it somehow got missed and was never followed up on. It was discussed that these Public Health offices do go on visits to tertiary locations such as out-of-state hospitals. There could have been lack of communication from either side in this instance, but it just was mentioned that open and clear communication and collaboration with these tertiary facilities is important.

Recommendations:

1. Clear and concise communication between the local Public Health offices statewide with birthing hospitals both in Wyoming and in the surrounding states to ensure that infants, especially those who would be identified "high-risk," do not slip through the cracks.

2. Detailed descriptions of interviews and behaviors of all persons during visitations are recommended to assist the team in understanding all the details of a case. Broad statements make interpretation difficult and could potentially lead to confusion during legal proceedings
3. Training for medical professionals on mandated reporting and referrals.

Case #2013-001:

Summary:

This was a major injury case involving a 2 year old male. The child was a passenger in a motor vehicle accident involving drunk driving by the child's parent. The child sustained a broken right scapula, a fracture right arm, road rash and lacerations that required sutures. The parent also received a number of injuries, including broken bones and was charged with DUI, Reckless Endangerment and Violation of Child Safety Restraint System. Petition for neglect was filed, protective custody was not taken, and child was released to father. The mother did have a similar previous CPS involvement when the child was two months old. She was sentenced to 15 days in jail and one year probation for this incident.

Strengths:

- DFS provided appropriate services for this family in a prior case as well as in this case. Even with poor cooperation from the child's father, family counseling was completed.
- Law enforcement and medical professionals took appropriate action in this case.
- The mother received rehabilitation services for her alcohol dependency immediately following the incident and was appropriately charged for DUI, Reckless Endangerment, and Improper Use of Child Safety Equipment. (15 days in jail, 1 year probation).

Concerns:

- There was some concern by team members that a similar incident had occurred about two years prior and law enforcement immediately released the child into the custody of the father. Some members felt there was a 'failure to protect' aspect by the father that should have been considered. Because the father stated he was unaware that the mother was intoxicated on the date of the incident, there would be no reason for him not to receive custody.
- Due to the rural nature of Wyoming there was discussion about family issues being overlooked due to the small community atmosphere. This is a concern in many Wyoming communities, because of population size, that families may receive different treatment in the handling of cases because of their status in the community. It was not felt

that this case was handled inappropriately, but should be considered when handling cases in small communities.

Recommendations:

1. Continued prevention and education services around child safety equipment in vehicles and the proper use of this equipment.
2. All cases taken by DFS, in any community, need to be handled using the same general policy and procedures. Personal relationship or standings may exist in the given community but professional handling of the case is essential to ensure the most effective and appropriate results.

Case #2013-002:

Summary:

This was a major injury case involving a 16 month old male with an unexplained broken leg (spiral fracture). Neglect charges were filed and substantiated, but the exact perpetrator and cause of injury were unknown. A number of services were provided to the family in this case, including parenting classes, counseling and food stamps.

Strengths:

- All efforts by law enforcement and medical professionals were handled appropriately.
- There were numerous face-to-face contacts made by the DFS caseworker with efforts to help the mother.
- The DFS did a great job at providing services. There were supervised visits with the biological mother and her boyfriend, weekly counseling sessions, parenting classes, food stamps/WIC provided and a substance abuse evaluation was performed and came out clear. The mother was very cooperative, and has since regained custody. Currently she is taking classes, is on an anti-depressant, and is receiving help with housing.

Concerns:

- Overall, there were few concerns with the outcomes of this case. There were some conflicting reports of the age of the injured child and the date the injury occurred related to the police reports and DFS reports. This was likely due to the unknown nature and actual time of the injury, however.
- There were few documents in the case file regarding allegations, conclusions, or court proceedings.

Recommendations:

1. All major injury and fatality case files should include documentation of court proceedings and substantiations.

Case #2013-003:

Summary:

This was a child fatality involving a two month old infant male. There was no history of abuse or neglect. The biological mother fell asleep with the infant in the same bed as her. The mother's blood alcohol content was still fairly high at time of testing. Mother pled no contest to criminal misdemeanor neglect and was substantiated on for neglect by the Department of Family Services. She received two years' probation.

Strengths:

- The DFS documentation was well done. DFS and Law Enforcement worked together collaboratively.
- The investigation was handled appropriately and there was a conviction in this case on the mother (2 years probation).

Concerns:

- Circumstances surrounding the incident from the time the mother discovered the child unresponsive were concerning. Why did a Deputy intercept the vehicle on its way to town instead of EMS responders? Why did the Deputy attempt to perform CPR in the bed of the pickup as opposed to just getting the child to the hospital faster? Was 40 minutes really how long it would take to get from the home to hospital?
- There was concern that the family had no connection to Public Health or Home Visitation Services. There was no record of any well-baby visits.
- There was concern that there was no documentation of DFS offering services to the family after the incident. Follow up on this point showed that the attorney for the family advised against accepting of any DFS services, so a case plan was created but not followed. The mother did complete alcohol counseling as terms of her probation.
- Although there was death certificate/coroner report data in this case, there was lack of a toxicology report from the coroner. Follow up with the County Coroner showed that the infant had low-level anti-depressants, likely from nursing, and no trace of alcohol at the time of death.
- There was no documentation addressing if the family/mother had received pre-natal education or education from the location of her delivery. This also includes a lack of connection with the local public health for possible home visitation services.

Recommendations:

1. DFS, Emergency Medical Services (EMS) and Law Enforcement should provide dispatch reports, as well as the general law enforcement reports in order to assure better communication between agencies in order to remove questions of why responders may have acted against normal standard operating procedures.
2. Coroner reports, death certificates, toxicology reports and any other related forms should be incorporated into all fatality case files. Counties need to identify the challenges of this getting accomplished in their communities and create better communication and collaboration to ensure these documents are being shared.
3. Pre-natal education, education from the hospital or other birthing location and connection to the local Public Health office are all excellent opportunities for prevention, particularly of safe sleep practices. Continued work on this education is encouraged and all related facilities should review their practices with reaching the pregnant and new mothers in their communities to offer the best services.

Case #2013-004:

Summary:

This case involves the near fatality of an 11 month old male. The child was put into a bath tub by their biological mother who left the child in the bath with the water running and went to lie down in her bedroom. She later found the infant floating face down and unresponsive in the water and the tub was overflowing. The child survived and did not suffer any permanent physical damage from this incident. The mother was sentenced to 4 years' probation via plea agreement and chose to sever her parental rights. The biological father was in prison at the time of the incident. DFS was seeking to sever his parental rights as well.

Strengths:

- Law Enforcement appropriately took protective custody of the child the night of the incident. The children were placed in relative foster care. The mother did have visitation but then relinquished rights and DFS was appropriately working on termination of parental rights for the biological father who was in prison at the time.
- Law enforcement and medical professionals did take appropriate action in this case. Law enforcement did save the infant's life in this case and did receive a commendation for their response.
- There was a conviction and substantiation in this case.

Concerns:

- There was some concern by team members that DFS in Carbon County was unaware of this family since there were open charges and a DFS substantiation of child endangerment from an incident with their oldest child from Natrona County. It was likely that this family was receiving services (Medicaid, Food Stamps, etc.), so how was that connection not made?
- It was unclear what may have happened with the previous charges from Natrona County and if there was ever a sentence attached to them. Follow up to this shows a clear gap in this case when it comes to communication between DFS offices and the tracking of families that relocate. DFS stated that in Wyoming it is generally easy to track families, especially if they are receiving benefits. They also made the comment, however, that benefits' workers may not see a child protective services notice. The team showed concern for how easy it seemed for a family with a recent substantiation and pending criminal charges to fall off the grid and still receive services.
- There were comments made about the horrendous abuse the biological mother had received as a child and a number of domestic violence incidents that surrounded her and many of her family members. It was also mentioned that the mother does have some cognitive delays. It is important to acknowledge what generational behaviors may exist in these cases.
- The team mentioned performing central registry checks for families receiving benefits. Why was there not a child protection alert in this case? There seems to be a clear lack of effort from Natrona County DFS in following this family and alerting whatever local DFS may be able to provide further assistance to this family from a preventative stand point. If this family had been tracked to Carbon County, DFS or even public health services could have helped this family in Carbon County. This mom had the second child while in Carbon County and there was no record of prenatal, hospital, or home visitation services to give this family helpful prevention and educational information.
- There was concern about the access the biological father would have to the children after his release from prison, since the children are with the paternal aunt. There was a recommendation that DFS or Public Health offer services to best support these children moving forward.
- There was a concern that the family may not have been utilizing child care assistance which she may have qualified for to help while she worked nights.

Recommendations:

1. Investigate a tracking system of families linked with CPS, who move around Wyoming or in and out of the state, is crucial..
2. DFS should investigate adopting a policy for recognizing efforts and individuals in the community who are instrumental in saving lives of children and families.

3. There should be a system for families to utilize to easily identify safe and licensed child care options, both from location and financial support perspectives.

Case #2013-005:

Summary:

This was a child fatality case involving an 11 month old female. This child was at the home of her babysitter when she reportedly fell down a flight of stairs that did not have a baby gate on it. The child was taken to the hospital, but died during neurosurgery. The babysitter was charged with negligent homicide, but right before the trial pled guilty to a lesser charge of child endangerment and received a sentence of one year probation. There was also DFS substantiation in this case.

Strengths:

- DFS and Law Enforcement had adequate documentation in this case related to the victim. The inclusion of the SUIDI Reporting Form by Law Enforcement had some wonderful case and investigation information.
- Medical professionals did take appropriate action in this case and made proper contact with the DFS and Law Enforcement when the child arrived at the hospital.
- There was a conviction through a plea agreement of the babysitter in this case.

Concerns:

- There was some concern by team members surrounding the behavior of the babysitter and her description of events seemed very 'odd' and 'staged'. There was no direct examination of Shaken Baby Syndrome, but there were thoughts that this could have been a factor in the death as well.
- There was great concern about the lack of documentation showing any interviews of the other children that were being supervised by the babysitter at the time of the incident. It was later updated that only the 2 year old son of the babysitter was home at the time of the incident, and he was not interviewed. The older children that had been dropped off at school were not interviewed either, in relation to anything that may have occurred prior to that incident.
- The sentence of 1 year of probation given in this case seemed light, but it was thought that the infant's family may have asked for leniency. It was later updated that 1 year probation is standard in this county for charges of Child Endangerment.

Recommendations:

1. Parents should have easily accessible educational information on how to select appropriate child care. This education should include how to ensure safe environments, knowing the practices and techniques used by the caretaker(s), and how to obtain a background check on the caretaker they choose, if desired. Further promotion to parents for the use of licensed child care facilities is also recommended.
2. All law enforcement offices should be required to use the SUIDI Reporting Form in their investigation of applicable infant deaths. Copies of this form and any re-creation documentation should be sent to the appropriate DFS office for inclusion in the case files.
3. Law Enforcement and DFS should be interviewing any capable child as a possible witness surrounding an incident.

Prevent Child Abuse Wyoming (PCAWY)

Prevent Child Abuse Wyoming entered its second year of operation and had some wonderful opportunities to expand a number of their initial projects and campaigns. All of these efforts were in continuation of PCAWY's mission to coordinate prevention efforts in Wyoming to reduce incidents of child neglect, physical, emotional and sexual abuse. Some of the major highlights from the June 2012-June 2013 time frame include:

1. Distribution of almost 1000 Halo Infant Sleep Sacks to all Public Health Offices in Wyoming. Every office received at least a six month supply according to newborn numbers they submitted via survey. Follow up was done with all offices and WY Department of Health – Maternal and Child Health Division will purchase an additional 2000 Sleep Sacks for the next year to restock the offices, as well as for distribute to PRAMS data survey participants.
2. Continued distribution of over 1500 Shaken Baby Syndrome Infant Bib Packets. This distribution included state and national conferences, state and local meetings, local community events around the state and the distribution by the DFS of 1000 Packets by their Benefit Specialists to clients who could utilize them.
3. Primary prevention and mandated reporting training at Wyoming Medical Center in Casper, WY. This training was given to approximately 35 hospital and EMS staff, including ER nurses and physicians, pediatric nurses and physicians. This was a pilot training for what will become a series of trainings statewide to other hospitals and medical facilities to promote the continued education, awareness, and importance of the signs and symptoms of abuse and neglect, as well as the mandatory reporting responsibilities of those being trained.
4. Continued development of collaboration and awareness efforts statewide. This includes collaboration with local groups such as Women's Civic League, state agencies such as the Wyoming DFS and Department of Health (DOH), prevention and intervention services such as Safe Harbor, Children's Justice Center and the Y.E.S. House, and even medical facilities such as the Wyoming Medical Center. PCAWY continues to have a presence and working relationship with the Laramie County Injury Prevention Council, Wyoming Sexual Violence Prevention Council, State Advisory Council on Juvenile Justice and the Wyoming Child Death Review and Prevention Team. There are already additional prospects in place for collaboration over the next year, and PCAWY will continue seeking as many collaboration and awareness opportunities as possible under current staffing and fiscal provisions.

Wyoming Home Visitation Collaboration (Maternal Infant Early Childhood Home Visitation-MIECHV grant)

This is one of Wyoming Citizen Review Panel's new programs. In April of 2013, the WYCRP in conjunction with Parents as Teachers was awarded the Maternal Infant Early Childhood Home Visitation Grant (MIECHV) for the state of Wyoming. Parents as Teachers National Office was the grantee with WYCRP as the primary contractor for the state of Wyoming for implementation and systems building around early childhood home visitation under this funding stream. WYCRP will implement the Parents as Teachers model in four target counties. We will hire a program manager and administrative assistant to be housed out of our Cheyenne office. The grant will be implemented in four at-risk counties which were identified in the Wyoming State Needs Assessment completed by the Wyoming Department of Health. We will initiate the Parents as Teachers home visitation model in Fremont, Albany, Sweetwater, and Natrona counties. Each county will have a parent educator to implement the Parents as Teachers home visitation model to at-risk families as determined by the federal benchmarks. There will also be two supervisors hired, one will supervise the parent educators in Sweetwater and Fremont counties and the other will supervise parent educators in Albany and Natrona counties. There will be a focus on systems building in Carbon County to help coordinate home visitation services in that area. This funding allows for the opportunity to add additional home visitation to those families that currently do not qualify for the current home visitation services. Another important component to this funding stream is to help build capacity and collaboration in the state around early childhood home visitation. This is an exciting new adventure and we are just beginning to get it off the ground.

Conclusion:

There have been many exciting opportunities as the Wyoming Citizen Review Panel this year. The programs that are being implemented have made strides to improve the wellbeing of children and families of the state of Wyoming. In the next year WYCRP plans to expand services to include home visitation for at-risk families and provide an expanded resource for children prenatal to three. WYCRP will continue to work hard to expand the foster care alumni groups around the state so that youth and alumni can have a voice to integrate systems change for the citizens of Wyoming. There are many things on the horizon for Prevent Child Abuse Wyoming which will lead to better awareness and wellbeing for Wyoming's children. It is the hope of WYCRP that services continue to improve by engaging citizens, families and organizations to all have a united voice in Wyoming.

"Our task must be to free ourselves…by widening our circle of compassion to embrace all living creatures and the whole of nature and its beauty" By Albert Einstein