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I. HISTORY AND BACKGROUND

Each year an estimated 2,000 children die of abuse and neglect in the United States. These numbers have increased in recent years. Unintentional injuries are the leading cause of death for children and adolescents in New Hampshire, as well as in the rest of the country. In the United States in 1995, unintentional injuries accounted for 6,611 deaths of children under age 15. Intentional injuries (homicide and suicide) accounted for an additional 1,344 deaths in this age group. (Source: National Center for Health Statistics (NCHS), 1997)

The leading causes of injury death among children under age 15 are motor vehicle traffic injuries, fires and burns, drowning, suffocation and firearms. These cases accounted for 80% of injury deaths in this age group in 1995. (Source: NCHS, 1997)

Nationally, under-reporting, inconsistent reporting, failure to recognize abuse-related deaths, lack of interagency cooperation in information sharing, improper death investigation, and professional and community denial are all contributing factors to the increase of child fatalities. (Citation - *A Nation's Shame*, United States Advisory Board, 1997)

The first multi-agency, systematic child fatality review team was organized in Los Angeles County in 1978, in response to a number of undetected child maltreatment fatalities. As of 1995, 48 states were involved in the review of child deaths resulting from abuse, neglect and other causes.

The basic interagency child fatality review panel has, at a minimum, three components:

- membership from the criminal justice system, child protective services, and health services;

- the systematic review of child deaths chosen from coroners' records or public health records;

- team members functioning in a peer review format. (Durfee, Gellert and Tilton-Durfee, 1992)

The task of a panel in reviewing cases is to identify ways in which members of the community can work more effectively, collaborate with increased communication, compassion, mutual respect and accountability to achieve a common goal - to preserve the health, happiness and welfare of children.

In 1991, then Governor Judd Gregg signed an Executive Order creating a multidisciplinary Child Fatality Review Committee comprised of major department heads.

This Committee commissioned the University of New Hampshire Family Research Laboratory to conduct a base-line study of child deaths in New Hampshire. The specific study objectives were:

- to make recommendations for the structure and functioning of the Child Fatality Review Committee;

- to identify problems in information gathering and interagency collaboration related to review of child fatalities;

- to investigate the type and nature of preventable child fatalities; and

- to identify patterns of preventable child deaths and to make recommendations aimed at reducing childhood fatalities.

After reviewing the study findings and initiatives from other states, the Committee was restructured to accommodate the demands of an on-going review process. In 1995, in an effort to support the restructuring, then Governor Stephen Merrill signed a new Executive Order re-establishing the Committee under the official auspices of the New Hampshire Department of Justice. The Executive Order authorizes the Committee to have access to all existing records regarding child deaths, including social service reports, court documents, police records, autopsy reports, mental health records, hospital or medical data and other information that may be relevant to the review of a particular child death. To provide further support to the review process, the department heads of the New Hampshire Department of Justice, the New Hampshire Department of Health and Human Services and the New Hampshire Department of Safety signed an Interagency Agreement which defined the scope of information sharing and confidentiality within the Committee. Additionally, individual Committee members and invited participants are obligated to sign Confidentiality Agreements in order to participate in the review process.

The Committee membership is comprised of representation from the medical, law enforcement, judicial, legal, victim services, public health, mental health, child protection and education communities. Currently, the Committee has a dual structure consisting of the full Committee, which convenes bi-monthly to conduct in-depth reviews of specific cases involving child fatalities, and a Sub-Committee, which convenes on alternate months to select cases for full Committee review, collect data and help maintain the organization, structure and purpose of the Committee.

The Committee began its review process in January of 1996 by conducting a statistical analysis of all child fatalities in 1994, the last year that statistical data was available for review. In addition, the Committee conducted in-depth reviews of a number of child fatalities including deaths by motor vehicle accidents, drowning, suicide, homicide, abuse and neglect, Sudden Infant Death Syndrome and Shaken Baby Syndrome.

Cases brought to the Committee for review can be selected by individual members or agencies. The Committee does not review cases that have criminal and/or civil matters pending. After a case is found to be appropriate for review, the Sub-Committee begins gathering information and inviting the participation of professionals outside of the Committee who have had direct involvement with the child or family prior to the child's death.

Each child death is reviewed using the following review process:

- A clinical summary of the death is presented by the Medical Examiner's Office. Relevant medical history, social and legal information is presented by other members and invited participants who had prior involvement with the child and family.

- The Committee discusses service delivery prior to death, and the investigation process post death.

- The Committee identifies risk factors related to the death and makes recommendations aimed at improving systemic responses in an effort to prevent similar deaths in the future.

- The Committee provides recommendations to participating agencies and encourages them to take actions consistent with their own mandates.

The New Hampshire Child Fatality Review Committee is funded by the New Hampshire Department of Justice through the Children's Justice Act Grant, which is administered by the US Department of Health and Human Services. As a condition for receiving funds through the Children's Justice Act Grant, which is also the funding source for the New Hampshire Attorney General's Task Force on Child Abuse and Neglect, the State is required by statute to establish a child fatality review panel "to evaluate the extent to which the agencies are effectively discharging their child protection responsibilities." The criteria for this review process is met by the New Hampshire Child Fatality Review Committee. (See APPENDIX B)

II. CASE REVIEW PROTOCOL

1. The Committee will review data regarding all deaths of New Hampshire children up to and including 18 years old.

2. Comprehensive, multidisciplinary review of any specific cases may be initiated by the Department of Justice, the Department of Health and Human Services, the Department of Safety, or by any member of the New Hampshire Child Fatality Review Committee (CFRC).

3. The review process begins with obtaining a list of in-state child deaths from the New Hampshire Department of Health and Human Services and/or from the Office of the Chief Medical Examiner.

   A. The deaths are then sorted by manner of death: natural, homicide, traffic, suicide, accident other than traffic.

   B. Prior to clinical review, relevant records (e.g.: autopsy reports, law enforcement, Division for Children Youth and Families) are obtained.

   C. Cases may be selected for full Committee review by the Sub-Committee from a variety of resources and documents which enumerate children's deaths and their cases from 1994 on.

   D. The review focuses on such issues as:

   - Was the death investigation adequate?
   - Was there access to adequate services?
   - What recommendations for systems changes can be made?
   - Was the death preventable?*

4. After review of all confidential material, the Committee may provide a summary report of specific findings to the Governor and other relevant agencies and individuals.

5. The CFRC will develop periodic reports on child fatalities which are consistent with state and federal confidentiality requirements.

6. The CFRC will convene at times published.

7. Each CFRC member will have an alternate member from their discipline or agency and will ensure that one member will be present at every meeting.

8. Confidentiality Agreements are required of any individual participating in any CFRC meeting.

9. The CFRC Sub-Committee, comprised of members of the CFRC, assesses case information to be reviewed by the CFRC and performs other business as needed.

***WHAT IS A PREVENTABLE DEATH?**

A preventable death is one in which, by retrospective analysis, it is determined that a reasonable intervention (e.g. medical, educational, social, legal or psychological) might have prevented the death. "Reasonable" is defined as taking into consideration the conditions, circumstances, or resources available.

III. REVIEW AND ANALYSIS OF DATA

In 1994, there were **181** child fatalities in the State of New Hampshire. Child fatality causes are shown in **Tables I, II and III**. Of the total 1994 child fatalities, 79% were from natural causes, 17% unintentional injuries, 2% suicide, and 2% homicide. Of the 181 child fatalities, 157 were residents of New Hampshire and 24 were non-residents.

This report looks at child fatalities in New Hampshire in two ways. The first section represents summary analysis for all 1994 child deaths, the last year full statistics were available, in order to obtain a complete picture of child deaths in New Hampshire during a one year period. Future reports will add additional years of data to this analysis. Findings and recommendations presented in the next section, are based on thorough Committee reviews of selected child fatalities from 1994 on.

1994 NEW HAMPSHIRE CHILD FATALITIES

TABLE I
NATURAL CAUSES - 144

Certain Conditions Orig. in the Perinatal Period		47
Congenital Anomalies	32	
Symptoms, Signs, and Ill-Defined Condition		21
Neoplasms	11	
Diseases of the Nervous System and Sense Organs		8
Unknown	7	
Diseases of the Respiratory System		6
Infectious and Parasitic Diseases		4
Endocrine, Nutritional, and Metabolic Disease and Immunity Disorders		2
Mental Disorders	2	
Diseases of the Circulatory System		2
Diseases of the Blood and Blood Forming Organs		1
Diseases of the Digestive System		1
TOTAL	144	

TABLE II
INJURY - 37

Motor Vehicle Injuries	17		
Occupant		8	
Pedestrian		6	
Motorcyclist		1	
Cyclist		1	
Unspecified		1	
Suffocation	4		
Firearms	4		
Falls	3		
Drowning	3		
Fires	1		
Poisonings	1		
Other	4		
		TOTAL	37

NEW HAMPSHIRE CHILD FATALITIES, 1994

(Continued)

TABLE III

SUDDEN INFANT DEATH SYNDROME (SIDS) - 12

Position at time of Discovery:

On Stomach	5
On Side	3
On Back	1
Car Seat	1
Unknown	2
TOTAL	12

TABLE IV

AGE DISTRIBUTION

	Under Age 1	1 - 14	15 and Over	Total
Female	44 (24%)	22 (12%)	7 (4%)	73 (40%)
Male	63 (35%)	31 (17%)	14 (8%)	108 (60%)
Total	107 (59%)	53 (29%)	21 (12%)	181

TABLE V

CAUSE OF DEATH FOR INFANTS UNDER AGE 1

Certain Conditions Originating in the Prenatal Period	47	
Congenital Anomalies	28	
Symptoms, Signs and Ill-Defined Conditions	18	
Diseases of the Respiratory System	3	
Injury and Poisoning	3	
Unknown	3	
Infectious and Parasitic Diseases	2	
Diseases of the Nervous System and Sense Organs	2	
Diseases of the Blood and Blood-Forming Organs		1
TOTAL	107	

IV. FINDINGS AND RECOMMENDATIONS

The New Hampshire Child Fatality Review Committee began conducting in-depth reviews of specific child fatality cases in January 1996. Since that time, the Committee has completed 35 in-depth reviews of fatalities caused by motor vehicle crashes, drowning, suicide, homicide, abuse and neglect, Sudden Infant Death Syndrome and Shaken Baby Syndrome. Based upon these comprehensive case reviews, the Committee reports the following findings and recommendations designed to reduce child fatalities and to improve the policies, procedures and practices within and among the agencies in New Hampshire that protect and serve children.

A. PUBLIC HEALTH AND MEDICAL

Recommendations relative to the Public Health and Medical fields cover a range of policy, practice and training issues. The case reviews underscore the critical need for more discipline-specific training in the areas of identification and assessment of abuse related injury and of suspected Sudden Infant Death Syndrome (SIDS) cases. They further highlight the importance of using standardized protocols and screening tools to ensure consistency in history-taking, case flagging and to assist with multidisciplinary collaboration. Additional recommendations focus on public education campaigns and legislative action concerning product safety, firearms, motor vehicle safety and teen suicide.

- Training to first responders should include information on identifying SIDS versus child abuse.

- Training on signs of child abuse and reporting obligations should be provided to first responders, emergency room personnel, physicians, other medical staff and others who see children in a community health setting such as WIC clinics.

- The current reporting law should be amended to included reporting for certain injuries to children of certain ages (i.e. a spiral fracture of a femur in a non weight-bearing child).

- Information on SIDS and child abuse should be included in educational update efforts to the legal community.

- A revised and updated copy of *Recommended Protocols for Suspected Cases of Sudden Infant Death Syndrome (SIDS),* along with a survey evaluating the use of the current protocols, should be distributed to all New Hampshire Hospital Emergency Department and Social Services Department Directors and all deputy medical examiners.

- Physicians and other key medical staff should be trained regarding appropriate opportunities for organ donation and how to make arrangements for such donations, keeping family members informed.
- A comprehensive screening tool which includes psycho-social assessment should be administered to all who enter the health care system.

- Upon suspecting abuse, medical providers should follow the current *Child Abuse and Neglect Protocols for the Identification, Reporting, Investigation, Prosecution and Treatment* published by the New Hampshire Attorney General's Task Force on Child Abuse and Neglect or refer to a member of the New Hampshire C.A.R.E. (Child Abuse Reporting and Evaluation) Network for assistance.

- Because motor vehicle crashes are the leading cause of death to New Hampshire teenagers, and many of these deaths result from a combination of inexperience and factors relating to youthful age, future legislation strengthening "graduated licensing" and seat belt laws should be supported.

- Education targeted to parents of teenagers on what they can do to keep teen drivers safe should be encouraged as a measure to reduce the injury rate among this group.

- Since many motor vehicle child fatalities result from children improperly or not restrained in a safety seat and/or seat belt, public education and enforcement efforts in this area and training in the use of child restraints should be continued.

- Because suicide is the second leading cause of death among New Hampshire teenagers age 15-19 and most of these deaths are caused by firearms, measures should be taken to reduce youth access to guns. These measures should include education of parents on the importance of keeping guns away from their children and high risk teens and support for safe storage legislation.

- Hazardous products such as certain types of bunk beds, playpens and window blinds are still being used and have caused child deaths long after they have been recalled. In order to help prevent these deaths a system of notification should be instituted whereby New Hampshire hospitals notify the Department of Health and Human Services when a serious product-related injury occurs. This and other information on hazardous products should be widely disseminated to the public, professionals working with children and families and the media.

- To ensure proper follow-up of suspicious cases seen in the hospital emergency department, a method of flagging and cross-referencing records should be developed. This negates the need to "re-invent the wheel" with each new contact, and facilitates follow-up evaluations as to whether proper, perhaps court ordered, protocols are being observed. Hospital Social Service Departments are uniquely situated to arrange or coordinate case management to insure that a family has access to needed support and assistance.

B. MENTAL HEALTH

Recommendations regarding mental health interventions in cases involving a child fatality, either while in service or after discharge from a facility, are focused on the need for more comprehensive evaluation at intake, more sensitive intervention and follow-up after identification of the potential problem, and better tracking of the continued need for services even when the identified patient is terminated from treatment.

- More comprehensive screening for child maltreatment issues, better tracking of these issues as they emerge and evolve throughout case management, and more training regarding the impact of abuse and neglect on child development is needed.

- When a mental health provider reports a suspected case of child maltreatment, it is recommended that there be better coordination between the provider and the Division for Children, Youth and Families (DCYF) to support further evaluation and specific assessment to determine the nature of the abuse or neglect and needed treatment.

- Community education regarding the "Wraparound Team" system is recommended. Information on the goals, purpose, and policies as well as how to access the Team's services, need to be disseminated to community agencies in counties that have Teams established.

- The mental health system needs to develop and implement primary prevention strategies specific to children who are at risk of preventable child fatalities.

- Providers should be made aware of local resources for families experiencing child maltreatment and exercise the widest margin of flexibility within the social service network to advocate for their clients.

C. EDUCATION SYSTEM

The New Hampshire State Department of Education (NHSDE) administers the Youth Risk Behavior Survey every other year to monitor priority health-risk behaviors that contribute to the leading causes of mortality, morbidity, and social problems among youth in New Hampshire. These behaviors fall into six categories:

- Tobacco use;
- Alcohol and other drug use;
- Sexual behaviors that result in HIV infection, other sexually-transmitted infections, and unintended pregnancies;
- Dietary behaviors;
- Physical activities.

The NHSDE will monitor the current status of school health education at the middle/junior and senior high school levels. These findings will be used to develop and strengthen policies and school-based programs.

Information regarding child fatality trends and patterns in New Hampshire will be shared with the members of the New Hampshire Department of Education's Safe Schools Committee and will be disseminated to health and educational leaders and to local schools and communities.

- Local school districts should take an active preventive role in interagency coordination and systems interaction regarding responding to cases of suspected child abuse and neglect.

- Training should be provided for local school districts to ensure that proper procedures exist for reporting suspected cases of child abuse and neglect.

D. CHILD PROTECTION SERVICES

Of the 35 child fatality cases reviewed in depth by the Committee, 25% - 35% had past or current involvement (at time of death) with the Division for Children, Youth and Families (DCYF). The Division's ability to "track" reports on identified children and their families, to compile information relevant to those individuals, and to maintain information on families who may move from district to district, has already been vastly improved by the implementation of the BRIDGES system. Given the relative newness of this on-line case management system, data and case information retrieval is still somewhat difficult, but is expected to improve as enhancements to the system are developed.

A number of recommendations for system change were offered by the Committee, many of which are currently being addressed by the Division in some manner.

- Most notably, a recommendation which was repeatedly offered, is that both founded and unfounded reports should be retained longer than the current seven (7) and three (3) years respectively. While it is understood that this would require a legislative change, the Committee strongly feels that a longer retention period for these case files is necessary to assure greater protection for children in families where abuse or neglect have been alleged or has occurred.

- Reports made to DCYF by law enforcement or medical professionals regarding suspected abuse or neglect of a child in his or her own home should be prioritized and automatically screened in after referral for assessment by a child protection service worker.

- A change in the DCYF assessment policy and practice should be made in cases of multiple referrals on the same child/family to require that a different worker be assigned after the third (unfounded) report and that after five (5) unfounded reports the case be referred for a multidisciplinary review.

- There should be increased training for reporters of suspected abuse or neglect to DCYF, such as school, medical, and other community professionals, on their reporting obligation and the reporting process. It is also recommended that a standardized reporting form be developed to maximize the quality of the reports being received for assessment.

- The Division's assessment practices should reinforce the necessity of interviewing **all** household members and, where possible, former household members of any child found to have been abused or neglected. Further, it is advised that the assessment worker always

establish contact with the reporter at or near the beginning of any assessment, whenever possible.

- DCYF staff should receive expanded training regarding drug and alcohol use and misuse and the assessment of the effects upon children and their families. Further, increased communication between DCYF staff and substance abuse treatment providers is seen as necessary to provide enhanced safety for children under assessment or in the care of DCYF.

With cases involving teen-aged or other young parents who may have received services from DCYF, it is recommended that a specialized protocol be developed to guide caseworkers through a comprehensive review of all juvenile records and any case information reference to either parent's family of origin, including any prenatal services received by the mother and the child's medical records. A thorough assessment should be conducted of the parenting skills and abilities, and the resources and support systems available and being utilized by the parents to assure they are adequately providing for the health and safety of the child(ren).

E. DISTRICT COURT AND LAW ENFORCEMENT

The majority of the recommendations made by the Committee relative to the District Courts, revolve around the issue of family violence and the prevalence of violence in the families of many of the child fatalities in New Hampshire.

- The continuation of the New Hampshire AmeriCorps Victim Assistance Program, which provides victim advocates within the District Courts to offer much needed support and services to battered women and their children, was recommended All courts should be provided with domestic violence resources and materials which should be displayed in public areas and rest rooms.

- The importance of a judge knowing whether children were present in the home during a domestic violence incident and the necessity to ask the right questions to make this determination, was discussed. The Domestic Violence Protocol should be changed to include appropriate questions which should be asked, and should provide guidelines for the reporting of the presence of children to the Division for Children, Youth and Families in cases of serious abuse.

- The Courts should question the petitioner on the presence and use of firearms by the defendant to threaten or intimate the plaintiff and should order the defendant's relinquishment of all firearms, ammunition and other deadly weapons. Victim advocates should be trained to ask victims about the defendant's use of firearms and any history of substance abuse, criminal history, and to ensure that this information is made available to law enforcement to assist in serving protective orders and securing firearms and deadly weapons.

- There should be protective custody for surviving siblings, after the death of a child secondary to abuse and neglect and continued services for the family. Reality-based counseling for the victim's mother should be encouraged.

V. CONCLUSION

Although the Child Fatality Review Committee has accomplished a lot over the past two years, there is much work that remains to be done. The Committee calls upon community members, from policy makers to front-line workers, to carefully consider the contents of this Report and take appropriate actions to help shape a safe and healthy future for New Hampshire's children. The Committee will make every effort to monitor the Report's recommendations and review their implementation in the 1999 report.

The Committee is confident that this Annual Report, our subsequent work and continued multidisciplinary collaborations will move us closer to our goal of reducing preventable child fatalities and helping children in New Hampshire lead full lives.

Appendix A

STATE OF NEW HAMPSHIRE

CONCORD, NEW HAMPSHIRE 03301

an order establishing a New Hampshire
Child Fatality Review Committee

WHEREAS, as Governor, I have expressed special interest in improving services to children who are victims of abuse and neglect; and

WHEREAS, the US Advisory Board on Child Abuse and Neglect has recommended that efforts be made to address the issue of child fatalities; and

WHEREAS, the formation of a standing committee composed of representatives of state agencies and relevant professional fields of practice will establish a useful repository of knowledge regarding child deaths; and

WHEREAS, in order to assure that New Hampshire can provide a continuing response to child fatality cases, the New Hampshire Child Fatality Review Committee must receive access to all existing records on each questionable or unexplained child death. This would include social service reports, court documents, police records, autopsy reports, mental health records, hospital or medical related data and any other information that may have a bearing on the involved child and family; and

WHEREAS, the comprehensive review of such child fatality cases by a New Hampshire Child Fatality Review Committee will result in the identification of preventable deaths and recommendations for intervention strategies; and

WHEREAS, the New Hampshire Child Fatality Review Committee represents an additional aspect of our effort to provide comprehensive services for children throughout the State of New Hampshire;

NOW, THEREFORE, I, _____, Governor of the State of New Hampshire, do hereby establish a multi-disciplinary child fatality review committee. The objectives of this committee shall be:

1. To enable all interested parties to more effectively facilitate the prevention, investigation and prosecution of child fatalities.

2. To identify and investigate the prevalence of a number of risks and potential risk factors in the population of deceased children.

3. To evaluate the service system responses to children and families who are considered to be high risk, and to offer recommendations for any improvements in those responses.

4. To identify high risk groups for further consideration by executive, legislative or judicial branch programs.

5. To improve the sources of data collection by developing protocols for autopsies, death investigations and complete recording of cause of death on the death certificates.

6. To describe trends and patterns of child deaths in New Hampshire.

Given under my hand and seal at the Executive Chambers in Concord, this ____ day of _____ in the year of our Lord, one thousand nine hundred and ninety-____.

_____
Governor of New Hampshire

Appendix A

INTERAGENCY AGREEMENT TO ESTABLISH THE NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

This cooperative agreement is made this ___ day of _____, ____ between the New Hampshire Department of Justice, the New Hampshire Department of Health and Human Services and the New Hampshire Department of Safety.

WHEREAS, the parties hereto as vested with the authority to promote and protect the public health and to provide services which improve the well-being of children and families.

WHEREAS, under RSA 125:9 II, the Department of Health and Human Services - Division for Public Health has the statutory authority to: "Make investigations and inquiries concerning the causes of epidemics and other diseases; the sources of morbidity and mortality; and the effects of localities, employment, conditions, circumstances, and the environment on the public health."

WHEREAS, under RSA 169-C, the Department of Health and Human Services - Division for Children, Youth and Families has the responsibility to protect the well-being of children and their families.

WHEREAS, the objectives of the New Hampshire Child Fatality Review committee are agreed to be:

1) To describe trends and patterns of child deaths in New Hampshire.
2) To identify and investigate the prevalence of a number of risks and potential risk factors in the population of deceased children.
3) To evaluate the service and system responses to children and families who are considered to be high risk, and to offer recommendations for improvement in those responses.
4) to characterize high risk groups in terms that are compatible with the development of public policy.
5) To improve the sources of data collection by developing protocols for autopsies, death investigations and complete recording of cause of death on the death certificates.
6) To enable the parties to more effectively facilitate the prevention, investigation and prosecution of child fatalities.

WHEREAS, all parties agree that the membership of the New Hampshire Child Fatality Review Committee needs to be comprised of the following disciplines: law enforcement, judiciary, medical, mental health, public health, child protection services, with specific membership from designated agencies to include, but not to be limited to: the Office of the Chief Medical Examiner, the New Hampshire Pediatric Society and the New Hampshire SIDS Program.

WHEREAS, the parties agree that meetings of the New Hampshire Child Fatality Review committee will be held no fewer than six (6) times per year to conduct reviews of child fatalities.

NOW THEREFORE, it is hereby agreed to establish the New Hampshire Child Fatality Review committee under the official auspices of the New Hampshire Department of Justice, subject to renewal of this Interagency Agreement on a trial basis. All members of the New Hampshire Child Fatality Review Committee will sign a confidentiality statement that prohibits any unauthorized dissemination of information beyond the purpose of the review process. The New Hampshire Child Fatality Review Committee shall not create new files with specific case identifying information. Non-identified, aggregate data will be collected by the Committee. Case identification will only be utilized in the review process in order to enlist interagency cooperation. No material may be used for reasons other than that which it was intended. It is further understood that there may be individual cases reviewed by the Committee which will require that a particular agency be asked to take the lead in addressing a systemic or quality of care issue based on that agency's clear connection with the issue at hand.

_____	_____
Attorney General	Date
_____	_____
Commissioner, Health and Human Services	Date
_____	_____
Commissioner, Department of Safety	Date

Appendix A

CONFIDENTIALITY AGREEMENT FOR THE NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

The purpose of the New Hampshire Child Fatality Review Committee is to conduct a full examination of unresolved or preventable child death incidents. In order to assure a coordinated response that fully addresses all systemic concerns surrounding child fatality cases, the New Hampshire Child Fatality Review Committee must have access to all existing records on each child death. This includes social service reports, court documents, police records, autopsy records, mental health records, hospital or medical related data and any other information that may have a bearing on the involved child and family.

With this purpose in mind, I the undersigned, as a representative of:

_____

agree that all information secured in this review will remain confidential and not be used for reasons other than that which was intended. No material will be taken from the meeting with case identifying information.

_____
Print Name

_____
Authorized Signature

_____
Witness

_____
Date

Appendix A

NEW HAMPSHIRE CHILD FATALITY REVIEW TEAM **CFR CASE _____**

DATA COLLECTION FORM
To be completed for all child deaths under 18 years of age

A. Identification of the Decedent

Name	SSN	Sex
Date of Birth	Date of Death	Race
Residence (county)	Injury/event (county)	Death recorded (county)
Mother's name	Mother's Date of Birth	
Mother's SSN	Mother's educational level*	

*Educational level: a. HS b. Some HS c. HS Grad d. Some college

Medical Examiner - record # _____
Autopsy? ____ Yes _____ No ____ Other Jurisdiction

Social Information
1. Mark all that apply. For all persons living in the residence of the decedent, indicate their relationship, their age and if they have legal custody of the child. (Use<1 if younger than 1 year)

Relationship to Decedent			Age	Custody	Relationship to Decedent			Age	Custody
a		Biological mother			h		Foster father		
b		Biological father			i		Other relative		
c		Adoptive mother			j		Parent's female paramour		
d		Adoptive father			k		Parent's male paramour		
e		Step mother			l		Another child		
f		Step father			m		Another child		
g		Foster mother			n		Other		

2. Current marital status of person(s) having legal custody of decedent? (Circle one)
a. Married c. Divorced e. Unknown
b. Widowed d. Never married f. Not applicable

3. Complete the following for everyone residing with the child at the time of the child's death.
a. Prior restraining order issued ____ Yes ____ No ____ Unknown

1. Date of most recent _____ Defendant's relationship to child _____
2. Date of most recent _____ Defendant's relationship to child _____

b. Prior arrest for crimes against persons. ____ Yes ____ No ____ Unknown

1. Date of most recent _____ Defendant's relationship to child _____
2. Date of most recent _____ Defendant's relationship to child _____

E. Witnesses

1. Was injury/event witnessed by at least one person who was in charge of watching the child?
____ Yes ____ No ____ Unknown
2. Who was in charge of watching the child at the time of injury/event? Give age (in years).

Relationship to Decedent			Age	Relationship to Decent			Age
a		Biological mother		i		Other relative	
b		Biological father		j		Parent's female paramour	
c		Adoptive mother		k		Parent's male paramour	
d		Adoptive father		l		Another child	
e		Step mother		m		Baby-sitter/child care worker	
f		Step father		n		Other	
g		Foster mother		o		No one in charge of watching	
h		Foster Father					

3. Was there documentation that, at the time of the injury/event, any of the persons indicated in #2 above appeared to be _____ Intoxicated ____ under the influence of drugs ____ mentally ill ____ retarded
____ otherwise impaired
_____ asleep (If checked, circle on the following)
a. all persons asleep b. some asleep c. none asleep d. unknown

5. If the injury/event was not witnessed by at least one person in charge of watching the child, was the child unsupervised?
____ Yes ____ No

Cause and Circumstances of the death (complete sections appropriate to the death)

Natural Disease

Sudden Infant Death Syndrome (SIDS)

1. Position of infant at discovery?
____ On stomach, face down
____ On stomach, face to side
____ On back
____ On side
____ Unknown
____ Other _____

Illness or other natural cause

1. Apparent illness or other condition
____ Known condition
____ Prematurity
____ Unknown

Prenatal Smoking ____ Yes ____ No ____ Unknown

Injury
1. Was the injury intentionally inflicted? ____ Yes ____ No

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE STATUTORY AUTHORITY

As a condition for receiving funds from the New Hampshire Department of Justice through the Children's Justice Act Grant, administered by United States Department of Health and Human Services, the State of New Hampshire is required to establish a citizen/professional review panel to "evaluate the extent to which the agencies are effectively discharging their child protection responsibilities." The criteria for this review process is met by the New Hampshire Child Fatality Review Committee. 42 U.S.C. S1Oba(c)(A). (CAPTA, Child Abuse Prevention & Treatment Act).

The membership is composed of "volunteer members who are broadly representative of the community in which such panel is established, including members who have expertise in the prevention and treatment of child abuse or neglect." 42 U.S.C. 5106a(c)(A)(B).

The 1996 CAPTA amendments require:

The amendments continue the requirement that, to receive funding, a state must have in effect methods to preserve confidentiality of records "in order to protect the rights of the child and of the child's parents or guardians." The persons and entities to whom reports and records can be released include:

> (II) Federal, State, or local government entities, or any agent of such entities, having a need for such information in order to carry out its responsibilities under law to protect children from abuse and neglect;
>
> (III) child abuse citizen review panels;
>
> (IV) child fatality review panels;
>
> (VI) other entities or classes of individuals statutorially authorized by the State to receive such information pursuant to a legitimate State purpose. (42 USC 5106a(b)(2(A)(v))

Confidentiality provisions prohibit the panel's disclosure "to any person or government official any identifying information about any specific child protection case with respect to which the panel is provided information" or making any other information public unless authorized by state statutes. The amendments further provide that the state shall establish civil penalties for violation of the confidentiality provisions. 42 USC 5106a(c)(4)(B)

VI. APPENDICES

APPENDIX A. CHILD FATALITY REVIEW COMMITTEE OFFICIAL DOCUMENTATION

- **Executive Order**
- **Interagency Agreement**
- **Confidentiality Form**
- **Data Collection Form**

APPENDIX B. CHILD FATALITY REVIEW COMMITTEE STATUTORY AUTHORITY