THE STATE OF NEW HAMPSHIRE

CHILD FATALITY REVIEW COMMITTEE

THIRD ANNUAL REPORT

Presented to:
The Honorable Jeanne Shaheen
Governor, State of New Hampshire
October, 2000

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NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

October 18, 2000

Dear Friends of New Hampshire Children:

The New Hampshire Child Fatality Review Committee began actively reviewing cases in January of 1996. The difficult task of reviewing child deaths was initiated in an effort to ensure the health and safety of New Hampshire's children and to reduce the number of preventable child deaths. To this end, the Committee conducts in-depth examinations of how and why our children die and generates recommendations that challenge the public, legislature and professional community to take action in preventing future deaths.

The following is the Committee's Third Annual Report to the Governor. It describes the work of the Committee, its history, process, and case review recommendations as well as system responses to the previous year's recommendations. Currently, New Hampshire is the only state in the country that systematically tracks follow-up responses to their report recommendations. This critical piece supports the Committee's efforts to call attention to the problem of preventable child deaths and bring about statewide measures to reduce the number of preventable child deaths that occur in New Hampshire.

Much of what the Committee has accomplished in the last few years has been the direct result of multidisciplinary collaboration. Our mission calls upon us to continue building on this important work by fostering teamwork and information sharing. New Hampshire has many opportunities to strengthen its commitment to children through interagency joint efforts.

In addition to acknowledging the many volunteer hours given by the Committee members, I want to recognize the individual contributions made by retiring members Sylvia Gale of the Division for Children, Youth and Families and Ken Roos, formerly with the Bureau Health Statistics and Data Management. Sylvia's knowledge of the review process and her firm commitment to multidisciplinary work helped to get this Committee established and functioning successfully. Ken's experience in accessing, analyzing and reporting data has been an invaluable asset to the Committee in its efforts to thoroughly explore child fatalities within the state. Many thanks to Sylvia and Ken for their commitment, energy and vision in making this state a better and safer place for children.

It is with great pride that we present the Third Annual Report to the Honorable Jeanne Shaheen, Governor of the State of New Hampshire.

Sincerely,

Marc Clement, Ph.D.
Chair
New Hampshire Child Fatality Review Committee

DEDICATION

The Child Fatality Review Committee dedicates this Third Annual Report to the children of New Hampshire. What sustains us in this difficult work is the knowledge that what we do may help make the lives of New Hampshire's children safer and prevent tragic and untimely deaths.

THE NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

MISSION STATEMENT

To reduce preventable child fatalities through systematic multidisciplinary review of child fatalities in New Hampshire; through interdisciplinary training and community-based prevention education; and through data-driven recommendations for legislation and public policy.

OBJECTIVES

1. To describe trends and patterns of child death in New Hampshire.

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

3. To evaluate the service and system responses to children who are considered 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 the cause of death on death certificates.

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

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I. HISTORY, BACKGROUND AND METHODOLOGY

In 1997, there were 134 deaths in the state of New Hampshire involving children up to the age of 18 as compared to 119 deaths in 1998. The data presented here and in the Committee's first two reports shows that the great majority of the child fatalities in New Hampshire are from natural causes and that relatively few children die of preventable injury. It is the task of the Child Fatality Review Committee (CFRC) to review child deaths and determine whether certain actions could have been taken to prevent these tragedies.

The Committee's First Annual Report provided an overview of the history of child fatality review committees from their founding in Los Angeles County in 1978. In 1991, then Governor Judd Gregg signed an Executive Order creating a multidisciplinary Child Fatality Review Committee here in New Hampshire. To assist with the initial implementation of the Committee, the University of New Hampshire Family Research Laboratory was commissioned to conduct a base-line study of child deaths in New Hampshire and to provide recommendations for how the Committee should operate.

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 (see Appendix A) 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 (see Appendix A) that defined the scope of information sharing and confidentiality within the Committee. Additionally, individual Committee members and invited participants are required to sign Confidentiality Agreements (see Appendix A) in order to participate in the review process.

The New Hampshire Child Fatality Review Committee is funded by the New Hampshire Department of Justice through the Children's Justice Act (CJA) Grant, which is administered by the US Department of Health and Human Services. In order to receive funding through the CJA Grant, which also supports the 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 agencies are effectively discharging their child protection responsibilities." The New Hampshire Child Fatality Review Committee meets the criteria for this review panel (see Appendix B).

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 bimonthly to conduct in-depth reviews of specific cases involving child fatalities, and a Sub-Committee, which convenes on alternate months to select cases for review, collect data and provide organizational support to the Committee.

The Committee began reviewing cases of child fatalities in January of 1996. In addition to the regular meeting schedule, the Committee hosted a joint meeting in November of 1998 with Child Fatality Review Teams from Vermont, Maine and Massachusetts. This meeting provided a forum for participants to come together and learn about some of the issues that other teams encounter in their efforts to review child deaths. It also offered an opportunity for members to establish contacts with their counterparts in other states. Participants from Maine, New Hampshire and Vermont continue to meet annually to further explore areas of common interest and to examine in more detail how each state conducts case reviews.

In New Hampshire, cases to be reviewed by the full Committee 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 to gather information and invite participants from outside 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 (see Case Review Protocol, page three):

- The Medical Examiner's Office presents a clinical summary of the death. Other participants who had prior involvement with the child and family then present relevant medical, social and legal information.

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

- The Committee identifies risk factors related to the death and makes recommendations aimed at improving systematic 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.

At the end of each year, the appropriate agencies are asked to respond to the recommendations generated from the prior year's reviews. These responses are published in the subsequent year's annual report. Responses to the recommendations published in The Second Annual Report to the Governor begin on page eleven of this report.

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

The Third Annual Report examines the data on child fatalities from 1997 and 1998. In 1997, there were 134 child fatalities in the State of New Hampshire. Of this total, 74% were from natural causes, 16% from unintentional injuries, 5% suicide, 4% homicide and 1% other. In 1998, there were 119 child fatalities. Of this total, 71% were from natural causes, 20% unintentional injuries, 8% suicide, and 1% homicide. This data was provided by the New Hampshire Department of Health and Human Services' Bureau of Health Statistics and Data Management.

NATURAL DEATHS

Cause of Death Group	1997			1998		
	Age		**Total**	Age		**Total**
	0 - 1	1 - 18		0 - 1	1 -18	
Certain Conditions Originating in the Perinatal Period	30	0	**30**	33	1	**34**
Congenital Anomalies	17	3	**20**	15	3	**18**
Neoplasms	0	16	**16**	0	10	**10**
Symptoms, Signs, and Ill -Defined Conditions	9	5	**14**	8	1	**9**
All Other Causes	6	13	**19**	5	8	**13**
TOTAL	62	37	**99**	61	23	**84**

NATURAL DEATHS: AGE 0-18

	AGES 0 - 1	AGES 1 – 18	**TOTAL**
1997	62	37	**99**
1998	61	23	**84**

INJURY DEATHS: AGES 0-18: 1997/1998

	1997	**1998**	**TOTAL**
Unintentional	22	24	**46**
Homicide	5	1	**6**
Suicide	7	10	**17**
Other	1	0	**1**
TOTAL	**35**	**35**	**70**

INJURY DEATHS: 0-18 YEARS

	AGES IN YEARS					
1997	0	1-4	5-9	10-14	15-18	**Total**
Unintentional	**1**	**4**	**3**	**3**	**11**	**22**
Suffocation	0	1	0	0	0	**1**
MV Crashes, Occupant (includes driver Or passenger)	0	0	1	1	9	**11**
MV Crashes, Pedestrian	0	1	1	1	0	**3**
Drowning	0	0	0	1	0	**1**
Fire/Burn	0	0	0	0	1	**1**
Fall	0	1	1	0	0	**2**
Other	1	1	0	0	1	**3**
Homicide	**0**	**0**	**1**	**0**	**4**	**5**
Firearm	0	0	0	0	1	**1**
Cut/Pierce	0	0	0	0	2	**2**
Other	0	0	1	0	1	**2**
Suicide	**0**	**0**	**0**	**5**	**2**	**7**
Hanging	0	0	0	4	2	**6**
Firearm	0	0	0	1	0	**1**
Other	**0**	**0**	**0**	**0**	**1**	**1**
TOTAL	**1**	**4**	**4**	**8**	**18**	**35**

	AGES IN YEARS					
1998	0	1-4	5-9	10-14	15-18	**Total**
Unintentional	**1**	**2**	**4**	**4**	**13**	**24**
Suffocation	0	1	1	0	0	**2**
MV Crashes, Occupant (includes driver or passenger)	1	0	0	1	7	**9**
MV Crashes, Pedestrian	0	0	0	1	1	**2**
MV Crashes, Pedal Bicyclist	0	0	0	1	1	**2**
MV Crashes, Unspecified Person	0	0	1	0	3	**4**
Other Transport	0	1	0	0	0	**1**
Drowning	0	0	0	0	1	**1**
Fall	0	0	1	1	0	**2**
Other	0	0	1	0	0	**1**
Homicide	**0**	**0**	**0**	**1**	**0**	**1**
Cut/Pierce	0	0	0	1	0	**1**
Suicide	**0**	**0**	**0**	**1**	**9**	**10**
Hanging	0	0	0	1	1	**2**
Firearm	0	0	0	0	7	**7**
Other	0	0	0	0	1	**1**
TOTAL	**1**	**2**	**4**	**6**	**22**	**35**

AGE DISTRIBUTION OF INJURY DEATHS BY GENDER: 0-18: 1997/1998

	1997						1998					
	Male	**Pct.**	**Female**	**Pct.**	**Total**	**Pct.**	**Male**	**Pct.**	**Female**	**Pct.**	**Total**	**Pct.**
Under Age 1	0	0%	1	3%	1	3%	1	3%	0	0%	1	3%
1 - 14	7	20%	9	26%	16	46%	8	23%	4	11%	12	34%
15 - 18	14	40%	4	11%	18	51%	17	49%	5	14%	22	63%
TOTAL	21	60%	14	40%	35	100%	26	74%	9	26%	35	100%

CAUSES OF DEATH FOR INFANTS: 1997/1998

	1997	**1998**
Certain Gastrointestinal	1	0
Pneumonia & Influenza	0	0
Congenital Anomalies	17	15
Certain Perinatal Conditions	30	33
Unintentional Injuries and Adverse Effects	1	1
Homicide	0	0
Ill-Defined Conditions (e.g. SIDS)	9	8
Other Causes	5	5
TOTAL	**63**	**62**

SUDDEN INFANT DEATH SYNDROME (SIDS): 1997/1998

Position at time of Discovery	**1997**	**1998**
On Stomach	2	3
On Side	2	3
On Back	3	1
Unknown	0	1
TOTAL	**7***	**8***

***1997** Of the seven cases, two are most likely SIDS, but final autopsy reports are not available. Of the seven, one infant was in an adult bed.

***1998** Of the eight cases, three infants were in adult beds, two infants were bed sharing with parents.

IV. 1999 FINDINGS AND RECOMMENDATIONS

Throughout 1999, the Committee reviewed cases that involved suicide, homicide, drowning and substance abuse. The case reviews continue to indicate the need for interagency collaboration, policy revision and increased professional development. The Committee's findings pinpoint some opportunities for improvement in these areas. The following findings and recommendations are intended to encourage public policy development and systems improvements within and among the agencies that serve children and families.

A. PUBLIC HEALTH AND MEDICAL

- Encourage hospitals and other medical facilities to develop and implement protocols for dealing with non-patient unattended death.

- Promote school-based health clinics to include basic health education, reproductive health education and a mental health care component that provides risk assessment and referral services for identified high-risk students.

- Encourage hospital staff and others involved in the care of newborns to make referrals to the infant's primary care/community health provider when discharging newborns with identifiable risk factors.

- Support efforts for continued and expanded funding for home visiting resources for newborns and families to provide a comprehensive safety net for at-risk families.

- Organize a training conference to be made available to media on reporting of suicide and other issues that may affect youth behavior.

- Support the development of guidelines for responsible reporting of youth risk behaviors, fatalities and suicide.

- Revise current policy to require Child Protective Service Workers (CPSW) and medical personnel to pursue signed releases when there is multi-system involvement with a child and share this information with appropriate care providers.

- Encourage primary care and mental health providers to communicate more closely when working with shared clients who are identified as at-risk.

- Conduct autopsies for all child fatalities under age 18, excluding motor vehicle crashes. (This is the second year this recommendation has been made.)

- Review the Women, Infant and Children Program (WIC) policies to determine if WIC can serve as a point of screening and referral for at-risk families.

B. MENTAL HEALTH

- Establish a substance abuse screening protocol for mental health providers to use when patients present with depression and/or anxiety.

- Improve access and quality of substance abuse and psychiatric services for youth and adolescents, which includes in-patient, outpatient and follow-up services.

- Improve interagency communication among community-based service providers working with children and families involved with the Division for Children, Youth and Families (DCYF).

- Increase communication between physicians and mental health providers.

- Require all mental health reports on court involved families to be forwarded to the courts, in addition to the Juvenile Service Officers (JSO).

- Develop policies regarding mental health services to surviving siblings and to children living in homes where domestic violence is present.

- Support continued outreach efforts surrounding mental health and mental illness awareness.

C. EDUCATION SYSTEM

- Encourage schools to develop and adopt crisis plans that are designed to help school staff manage information sharing with the press during highly stressful situations.

- Promote school health services protocols to include medical and mental health guidelines designed to assist school staff in responding pro-actively to teen pregnancy.

- Encourage development of protocols that address issues of disclosure of certain information for medical purposes including, but not limited to teen pregnancy cases.

- Promote a school-based and/or school-linked health clinic approach to include health education, reproductive health education and a mental health care component that provides risk assessment and referral services for identified high-risk students.

- Develop model policies for risk assessment for harmful behavior of at-risk youth facing suspension and expulsion, and encourage alternatives to minimize risk.

- Promote increased access to mental health counseling through Medicaid funding in schools and increase communications where DCYF is involved. Develop policy and procedures to help move toward a mental health triage system.

- Encourage parents to attend a certain number of parent education seminars when child abuse and neglect, Children in Need of Services (CHINS) and/or juvenile petitions or school suspensions are involved.

D. CHILD PROTECTIVE SERVICES

- Develop policies regarding mental health services to surviving siblings and to children living in homes where domestic violence is present.

- Require parents to attend a certain number of parent education seminars when child abuse and neglect, CHINS, and/or juvenile petitions or school suspensions are involved.

- Implement best practice standards to be applied to on-going monitoring of cases beyond court ordered reunification.

- Improve inter-state communication and information sharing regarding DCYF-involved children.

- Increase training and staff resources to support adequate and coordinated assessments and appropriate follow-up of all cases.

- Develop a policy to support opening a case after multiple attempts to contact parent(s) are unsuccessful. Re-examine the statute regarding Motion to Enter.

- Improve overall case management by developing clearly defined policies and procedures which address case re-assignment and continuity when JSO and caseworker staff turnover occur.

- Improve all aspects of the wrap-around process including educating the professional community about a team's purpose/function and how to access it.

- Examine the impact of the Parental Reimbursement requirement.

- Support efforts to increase funding to provide DCYF and related providers with the resources needed to effectively protect children and youth.

E. DISTRICT COURT AND LAW ENFORCEMENT

- Require all mental health reports on court involved families to be forwarded to the courts, in addition to the Juvenile Services Officer (JSO).

- Require parents to attend a certain number of parent education seminars when child abuse and neglect, CHINS, and/or juvenile petitions or school suspensions are involved.

- Provide education/awareness to law enforcement and campus security regarding RSA:318-B:26IX of the Controlled Drug Act. This statute addresses the liability of any person who manufactures, sells or dispenses a controlled drug in which a death results from the injection, inhalation or ingestion of that substance.

The following five recommendations do not apply to the information protected under RSA 173:C - Confidential Communications Between Victims and Counselors:

- Develop a mechanism for compiling and providing to all parties to a court-involved child/family, information on any and all prior hearings including, DCYF cases, family, civil and criminal court proceedings and the records of the same from other states.

- Improve case information management by having one court oversee the records relating to multi-system involved families, i.e. juvenile, abuse and neglect and CHINS

- Increase multidisciplinary access to records, including court findings (probate, family, and district), and ensure that courts are filing reports to DCYF when abuse or suspicion of abuse is indicated on domestic violence petitions, regardless of the current status of a case.

- Establish a policy requiring that all service provider records be sent directly to the court.

- Establish a policy for comprehensive case management which requires that all previous medical, mental health, residential and/or other provider records be accessed and reviewed by those in decision-making roles, i.e. the courts, DCYF, CASA.

F. LEGISLATION

- Support efforts to increase funding to provide DCYF and other providers with the resources needed to effectively protect children and youth.

- Support legislation to reduce youth access to firearms.

- Support statewide expansion of the Family Court Division concept.

V. RESPONSES TO 1998 RECOMMENDATIONS

The Second Annual Report to the Governor, published in October of 1999, listed recommendations, which were generated from specific case reviews conducted in 1998. As with the previous report, the appropriate agencies and/or disciplines were given a chance to address the recommendations and have provided the following responses. For a complete list of the 1998 recommendations, please review the above referenced report.

Medical and Public Health

- ***Establish a flagging system to be used by emergency room physicians to assist in tracking cases where child abuse is suspected.***

A case flagging system of this nature is unlikely in the short term. While, in theory, it would be advantageous for the emergency room physician evaluating a given child for a traumatic injury to be alerted to previous suspicious injuries, the legal implications for such case flagging are unknown. There appears to be a reticence among health care providers to attempt to track individual cases as this is perceived to be the role of DCYF. How such DCYF information filters down to the immediately relevant level of the emergency room physician examining an injured child remains unspecified. There also exists a concern over litigation by individuals who may consider themselves accused of unproven abuse by the medical system without due process.

- ***Issue the death certificate only after all information has been reviewed.***

This recommendation is, in a sense, a two-edged sword. Child deaths outside the Medical Examiner's jurisdiction should all be natural and relatively straightforward certifications, based on the child's underlying, terminal disease. In cases handled by Office of the Chief Medical Examiner (OCME), if, after the gross autopsy, the cause of death remains obscure, a death certificate is filed with the cause of death listed as "Pending further studies". Only after the microscopical, toxicological and other indicated studies are completed will OCME issue an "Amended Death Certificate" indicating the determined cause and manner of death. Preliminary opinions or reports are not issued by OCME.

While this is essentially in compliance with the above recommendation, ultimate determination and certification of cause and manner may take 6-8 weeks or even longer in complex cases requiring special studies. This being the case, OCME makes every effort to stay in touch with interested parties in a given case to keep them abreast of the status of outstanding test results, thus, hopefully, addressing the concerns inherent in the recommendation.

- ***Identify the cause/manner of death to determine risk to other siblings, e.g. child abuse and neglect.***

When all is said and done, the basic mission of any medico-legal authority is to determine, as accurately as possible, the cause and manner of death in cases falling under their jurisdiction. Since September 1997, OCME has certified the cause and manner of death of a person under 18 as "Undetermined" on only one occasion. This was after an extensive investigation of the circumstances of death and an exhaustive toxicological analysis. Fortunately, there were no siblings and no other children in the household in question.

The timeliness of the ultimate cause/manner determination in complex cases may be such that, unless there is open and forthright communication among OCME, law enforcement, DCYF and the family, children could conceivably remain at risk. While cause and manner can reasonably be expected to be determined at some point, risk to other children in the home is best minimized by interdisciplinary cooperation while the case remains pending.

- ***Autopsy all deaths under 18 years.***

This is undoubtedly a worthy and admirable goal, however, it is not likely attainable. In the matter of anticipated deaths of children due to natural diseases, such cases do not fall under the jurisdiction of the medical examiner and will only undergo a postmortem examination should the attending physician obtain informed consent from the family of the deceased. In the matter of child deaths which, in accordance with New Hampshire RSA 611:3 II, **are** reportable to the Medical Examiner (and are of presumably of keener interest to the CFRC), the aim of OCME is, indeed, to perform autopsies on all.

Occasionally, the legal next of kin of the deceased will voice objection to the autopsy. OCME will first endeavor to stress to the family the importance and potential value of such an examination, however, in a finite percentage of cases objections may be firmly held. Only in the cases of possible criminal acts or compelling public heath concerns would a family's wishes in this regard not be honored. With the Committee's recommendation, OCME shall renew its efforts to conduct complete autopsies on all reportable deaths under 18 years of age.

Mental Health

- ***Increase mental health agencies' involvement in the Child Fatality Review process.***

The Division of Behavioral Health introduced legislation (House Bill 1463) which was enacted that allows Community Mental Health Center case-specific information relevant to reviews of the CFRC to be shared with the committee.

- ***Increase funding and resources for treatment and follow-up services for substance involved children, adolescents and teens.***

The passage of House Bill 1606 established the Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment Services. This multidisciplinary committee will:

1. Develop and revise, as necessary, a statewide plan for the effective prevention of alcohol and drug abuse, particularly among youth, and a comprehensive system of intervention and treatment for individuals and families affected by alcohol and drug abuse.
2. Promote collaboration between and among state agencies and communities to foster the development of effective community-based alcohol and drug abuse prevention programs.
3. Promote the development of treatment services to meet the needs of citizens addicted to alcohol and other drugs.
4. Identify unmet needs and the resources required to reduce the incidents of alcohol and drug abuse in New Hampshire and to make recommendations to the governor regarding legislation and funding to address such needs.

The passage of Senate Bill 153 requires that a percentage of profits derived by the Liquor Commission be placed into and continually appropriated to a special fund for alcohol education and abuse prevention and treatment programs. Fifty percent of the amount by which each year's gross profits exceed fiscal year 2001 actual gross profit, but not more than 5 percent of the current year gross profits derived by the Liquor Commission from the sale of liquor and other revenues, shall be deposited into the Alcohol Abuse Prevention and Treatment Fund established by RSA 176-A:1.

Education

- ***Review the Department of Education's protocol on reporting suspected child abuse and neglect.***

The New Hampshire State Department of Education (SDE) endorses DCYF's child abuse prevention protocols. A School Health Resource Manual released in April 2000 includes the protocols and provides a series of questions and answers about the state's requirements.

- ***Develop driver education guidelines that offer advice to parents on how to monitor and improve the driving skills of the student.***

The SDE has supported driver education instructors by providing them with parental involvement materials and consultation on this topic. Additionally, the Department supported the implementation of recent legislation requiring practice driving for adolescents with parental supervision.

- ***Develop public education to inform parents of their ability to defer their teenager from driving if he/she is not mature enough***.

A pamphlet "Its Your Choice Too" has been produced by the Governor's Highway Safety Agency and its use has been promoted by the Department of Education. The pamphlet pertains to roles and responsibilities of parents in relation to their teenage drivers.

- ***Develop guidelines that address the unique considerations of teens with special education issues who are preparing to become licensed drivers.***

No written guidelines have been produced but guidance has been offered via multiple professional development opportunities sponsored by the Department of Education. Special education teachers and professionals from the driver rehabilitation community have provided these trainings geared for driver education instructors.

- ***Develop a protocol for information sharing which allows the public schools to provide private driver's education companies with a listing of all students who did not pass the driver's education course offered through the schools.***

The SDE does not endorse sharing the names of students who have not passed driver education courses with private companies due to privacy concerns. This recommendation has thereby not been addressed.

Child Protective Services

- ***Increase funding and resources to the Division for Children, Youth and Families in order to hire more front-line staff to decrease child protection worker's caseloads.***
  AWAITING RESPONSE

District Court and Law Enforcement

- ***Provide three months for Predisposition Investigation (PDI) to ensure thoroughness.***
  AWAITING RESPONSE

- ***Develop guidelines for judges and Juvenile Service Officers relating to making referrals to the Division of Alcohol and Drug Abuse Prevention (DADAPR) or other Licensed Alcohol and Drug (LADC) counselors for early identification and intervention in cases where substance use and/or abuse is suspected.***
  AWAITING RESPONSE

- ***Develop guidelines for case review by judge/JSO to assess whether the treatment program is meeting the child's/adolescent's needs.***
  AWAITING RESPONSE

Legislation

- ***Review existing legislation and consider drafting a sample which would permit the Child Fatality Review Committee to proceed as outlined in our documentation.***

The recent passage of House Bill 1463, that allows Community Mental Health Centers to share case-specific information relative to reviews with the CFRC Committee, will assist the Committee in future reviews that involve the mental health system. Currently, the Committee is experiencing success with information sharing among the disciplines involved in the review process and as a result, the Committee will not pursue drafting legislation at this time.

- ***Change RSA ### to increase the time that child protections records are held.*** **AWAITING RESPONSE**

- ***Increase funding and resources to the Division for Children, Youth and Families in order to hire more front-line staff to decrease child protection workers' caseloads.*** **AWAITING RESPONSE**

VI. CONCLUSION

The Committee has made significant progress over the last four years in developing and refining the difficult work of reviewing child fatalities. We continue to challenge the professional community and state legislature to act expeditiously in evaluating the policies, procedures, services and laws that impact their work with children and families. Steadfast in our mission, the Committee will continue to vigorously review cases and treat each as a critical step that brings us closer to our goal of reducing child deaths and helping children lead safe and healthy lives.

APPENDIX A. EXECUTIVE ORDER

APPENDIX B. INTERAGENCY AGREEMENT

APPENDIX C. CONFIDENTIALITY AGREEMENT

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE CONFIDENTIALITY AGREEMENT

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 reports, 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 D. STATUTORY AGREEMENT

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 New Hampshire Child Fatality Review Committee meets the criteria for this review process. 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 which 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;
>
> (V) 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).