THE STATE OF NEW HAMPSHIRE

CHILD FATALITY REVIEW COMMITTEE

TENTH ANNUAL REPORT

Presented to
The Honorable John H. Lynch
Governor, State of New Hampshire
October 2007

Funding for this report and for the activities of the Child Fatality Review Committee comes from the U.S. Department of Health and Human Services Administration on Children, Youth and Families through the Children's Justice Act Grant (#G-06NHCJA1) which is administered by the New Hampshire Department of Justice.

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STATE OF NEW HAMPSHIRE

CONCORD, NEW HAMPSHIRE 03301

Executive Order Number 95-1

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 U.S. 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, Stephen Merrill, 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 29th day of September in the year of our Lord, one thousand nine hundred and ninety-five.

Governor of New Hampshire

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Governor of New Hampshire

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; and

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 that the New Hampshire Child Fatality Review Committee convenes under the official auspices of the New Hampshire Department of Justice. 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 for 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.

Kelly Ayotte — Attorney General — Date 5/6/05

John A. Stephen — Commissioner, Health and Human Services — Date 5/1/05

Richard M. Flynn — Commissioner, Department of Safety — Date 4/28/05

DEDICATION

As in previous years, the Committee would like to dedicate this, our Tenth Annual Report, to the children of New Hampshire and to those who work to improve their health and lives. For the last eleven years that the Committee has been performing child death reviews, we have been sustained in the knowledge that what we do will improve the safety of New Hampshire's children and help to reduce the number of preventable deaths of children in our state.

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

Dear Friends of New Hampshire's Children:

The New Hampshire Child Fatality Review Committee has begun its' eleventh full year of reviewing fatalities of New Hampshire's children. The work of the Committee is an effort to ensure the health and safety of the children of New Hampshire and to reduce the number of preventable child deaths.

The following is the Committee's Tenth Annual Report. This report reviews the work of the Committee for the calendar year 2006 and presents fatality data for the calendar year 2005 that has been collected and analyzed by the Bureau of Health Statistics and Data Management. We have also included, as we did in our Ninth Annual Report, a look at three years (2003 – 2005) of data. Since this is our Tenth Annual Report we have also included a summary of fatality data for the last ten years. Because we have relatively few child fatalities in New Hampshire, a look at the 3-year and 10-year data summaries should give a better indication of fatality trends than just a one-year analysis.

Included in this report is a brief description from the representative of each of the agencies represented on the committee on how that agency has been impacted over the last ten years by the work and recommendations of this child death review process. We hope that this will give the reader of our reports a better sense of the rationale for the make-up of the membership of the committee and how the work of the committee has helped agencies in their work in reducing the number of preventable child deaths in New Hampshire.

As in previous years, members of the New Hampshire Child Fatality Review Committee have made presentations in New Hampshire and nationally on the issues of child fatalities and on the work of the New Hampshire committee. We have been recognized nationally for our work and many states are interested in learning more about how we conduct our reviews and how we gather and respond to recommendations generated by these reviews. Additionally we meet annually here in New Hampshire with the other New England teams (ME/VT/MA/RI/CT). These joint meetings help give all of us an overview of the problems and solutions that the teams from other states encounter in trying to prevent child fatalities. Additionally, we published an article in the "Unified Response" newsletter about our Northern New England meeting.

As Chair, I would like to acknowledge the hard work and dedication of the members of the Committee. I especially want to acknowledge Danielle O'Gorman who, as our administrative assistant, has worked particularly hard this year to help the committee run smoothly and especially in preparing this annual report. Through the commitment of all our members, we have been able to build a collaborative network to foster teamwork and share the recommendations with the larger community.

In recognition of this commitment and dedication, it is with great pride that as Chair, I present this Tenth Annual Report to the Honorable, Governor of the State of New Hampshire.

On behalf of the Committee,

Marc A. Clement, PhD
Chair, New Hampshire Child Fatality Review Committee

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.

CHILD FATALITY REVIEW COMMITTEE MEMBERSHIP
January to December 2006

Chair: Marc Clement, PhD
Colby-Sawyer College

Thomas Andrew, MD, Chief Medical Examiner
Office of the Chief Medical Examiner

Maggie Bishop, Administrator
Division for Children, Youth & Families
NH Department of Health & Human Services

*Bernie Bluhm
Division for Children, Youth & Families
NH Department of Health & Human Services

Paul Boisseau, Executive Secretary
NH Board of Pharmacy

*George Bowesox
NH Board of Pharmacy

William Boyle, MD
Dartmouth Hitchcock Medical Center

Deb Coe
NH Coaltion Against Domestic & Sexual Violence

*Anita Coll, MEd
Prenatal and Adolescent Health Manager
Division of Public Health Services

Edward DeForrest, PhD, Former President/CEO
Spaulding Youth Center Foundation

J. William Degnan, State Fire Marshall
NH State Fire Marshall's Office
NH Department of Safety

Diana Dorsey, MD, Pediatric Consultant
NH Department of Health & Human Services

*Jennie Duval, Deputy Chief Medical Examiner
Office of the NH Chief Medical Examiner

*Jim Esdon, Program Manager
Injury Prevention Program
Dartmouth Hitchcock Medical Center

Elizabeth Fenner-Lukatis
Division of Behavioral Health

Elaine Frank, Program Director
Injury Prevention Program
Dartmouth Hitchcock Medical Center

Janet Houston, Project Coordinator
NH EMS for Children
Dartmouth Medical School

Honorable David Huot
Laconia District Court

Trooper Kathy Kimball
NH State Police
NH Department of Safety

Audrey Knight, MSN, ARNP, Child Health Nurse Consultant
and NH SIDS Program Coordinator
Bureau of Maternal & Child Health
NH Department of Health & Human Services

*Melissa Mandnell, Assistant Administrator
Children's Mental Health Services
Division of Behavioral Health Services
NH Department of Health & Human Services

Honorable Willard Martin
NH Family Court Division

Sandra Matheson, Director
Office of Victim Witness Assistance
NH Attorney General's Office

*Susan Meagher
CASA of New Hampshire

John McDermott, Manager of Field Services
Division for Juvenile Justice Services

Danielle O'Gorman, Task Force Program Specialist
NH Attorney General's Office

*Nancy Palmer, RN, CHPW, ADME
Community Health Nurse

Joe Perry, LCSW
Division of Behavioral Health

Suzanne Prentiss, Bureau Chief
Division of Emergency Medical Services
NH Department of Safety

Deborah Pullin, BSN, ARNP, Coordinator
Child Advocacy & Protection Program
Dartmouth Hitchcock Medical Center

Katherine Rannie, RN, MS
School Health Services Coordinator
NH Department of Education

Rosemary Shannon, MSW, Administrator
Div. of Alcohol & Drug Abuse Prevention & Recovery
NH Department of Health & Human Services

Marcia Sink, Executive Director
CASA of New Hampshire

Paul Spivack, MD
Hitchcock Clinic

Robert Stafford, Assistant Director
NH Police Standards and Training Council

*=Alternate

I. EXECUTIVE SUMMARY

This report reflects the work of the Committee during the 2006 calendar year. The work of the Committee and the purpose of the recommendations that are produced during the reviews are to reduce preventable child fatalities in New Hampshire.

Last year's Ninth Annual Report summarized the work of the 2005 calendar year. Additionally in this report is a 3-year data summary for 2003 – 2005.

This report begins with the Committee's Mission Statement and Objectives, followed by a listing of the Committee members and their affiliations. There is then a short report from the representative of each of the agencies represented on the committee on how their agency has been impacted by work of the committee. Following this is a review and analysis of the 2005 New Hampshire child fatality review data and a look at the last three years of data (2003 – 2005). Additionally there is a ten-year data summary representing the 10 years that the committee has been doing its work. The recommendations and finding from the 2006 reviews are presented along with the responses to the 2005 findings and recommendations.

II. STATEMENT OF ACCOUNTABILITY

The New Hampshire Child Fatality Review Committee was established in 1991 by an Executive Order of then Governor Judd Gregg. In 1995, then Governor Merrill signed an Executive Order (Appendix B) reestablishing the Committee under the official auspices of the New Hampshire Department of Justice. To provide 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 (Appendix C) 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 (Appendix D) 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 United States 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 (Appendix E).

The Committee membership (Page ix) represents the medical, law enforcement, judicial, legal, victim services, public health, mental health, child protection, and education communities. The full Committee meets every other month to review the cases that have been selected by the Executive Committee. The case review protocol is Appendix F. The Committee also hosts an annual joint meeting with the teams from Maine and Vermont to share ideas and look at ways that information can be more effectively shared by different state agencies.

This is the Ninth Annual Report of the Committee, and as in previous reports, the main components of the report are the Data section and the section on recommendations that are

generated during the case reviews. At the end of each year, the appropriate agencies are asked to respond to the recommendations generated by the Committee in the previous year. These responses are published along with the present year's recommendations.

The Child Fatality Review Committee is scheduled to meet six times annually to consider cases selected for review and to develop, as appropriate, recommendations to the Governor and relevant state agencies with the intent of effecting change in state policy or practice, or to cause the development of new initiatives which could lead to the reduction of preventable deaths in children and youth.

During the operating year of 2005 the Committee met three times to review four cases. The process by which cases are reviewed is outlined in Appendix F: Case Review Protocol. The right to confidentiality for families who lost children is respected in the work of the Committee.

Committee recommendations for change are developed with the goal of creating a meaningful impact for children and youth at risk due to common factors present across the category of children represented in reviewed cases.

III. AGENCY VIGNETTES

The Committee is comprised of professionals from a variety of diciplines and agencies. For this report the different disciplines were asked to prepare a vignette describing the impact of participation in the committee has meant for their agency/profession.

Public Health representation's perspective:

Representation on the state's Child Fatality Review Committee (CFRC) has been instrumental in helping public health carry out its mission of promoting optimal health and well being for all the citizens of New Hampshire and protecting them from illness and injury. In accordance with the Centers for Disease Control's "Spectrum of Prevention" model, participation in the CFRC has prompted and supported public health programs in influencing policy and legislation, changing organizational practices, fostering coalitions and networks, educating providers and training people who can make a difference, promoting community education, and ultimately strengthening individual knowledge and skills.

Protocols/policies/organizational changes/improved information sharing
There have been numerous changes in protocols, guidelines, policies, and organizational practices that have occurred in the past ten years due to the influence of case reviews and subsequent recommendations such as:

- Medical protocols for unresponsive children were adopted by the Bureau of Emergency Medical Services (EMS) with input from the Department of Health and Human Services (DHHS), Dartmouth Hitchcock Medical Center, the Office of Emergency Communications, and the Office of the Chief Medical examiner.
- A training curriculum for first responders for suspected Sudden Infant Death Syndrome (SIDS) deaths was developed and presented by the DHHS' SIDS Program Coordinator and the Chief Medical Examiner. Recommended protocols for hospital staff for suspected SIDS deaths were developed, disseminated to hospital staff, and followed up with a survey on implementing use.

- DHHS and the Suicide Prevention Partnership funded a set of eight discipline-specific but interrelated procedures for responding to suicidal events among adolescents that was developed by the "Frameworks Project".
- The state WIC Nutrition Program reviewed its policies regarding suspicion of child abuse/neglect, follow up of missed appointments, and notifying a child's health care provider when high risk families exhibit signs of concern to WIC staff.
- And, in follow up to a recommendation to train staff of public agencies that do home visits (DCYF, etc.), to educate families about prevention practices such as fire safety and injury prevention, in 2004, the Home Visiting New Hampshire Program added information about checking smoke detectors to its routine checklist for home visitors.

Many of the recommendations reinforced efforts already underway to improve health care services or coordination. Examples include support of a Medical Home Initiative for children with special health care needs, or helping youth with chronic health problems transition the responsibility from parents' managing the illness to self-management, by efforts of the New Hampshire Health Care Transition Project.

In follow up to cases reviewed, recommendations were made to 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. The Home Visiting New Hampshire Program began in May 2001 with contracts with thirteen community agencies and, as of July 2007, has expanded to eighteen agencies.

In follow up to a recommendation to coordinate existing efforts of agencies, the Frameworks Suicide Prevention Project, facilitated by the National Alliance on Mental Illness, New Hampshire (NAMI NH) and funded by a federal Garrett Lee Smith grant, provided universal "Gatekeeper" training on how to respond to disclosures of significant risk, such as child abuse/neglect, behavioral health issues, fire setting, and substance abuse. And in 2005, the Commissioner of DHHS created the NH Suicide Prevention Council, a public-private partnership bridging various state programs together with community partners.

Supporting legislation

In 2002, the New Hampshire legislature amended sections of RSA 263 that pertain to youth operators of motor vehicles with support of recommendations by the CFRC in follow up to cases reviewed. The time during which no more than one non-family member under age 25 is allowed in the vehicle was increased from three to six months. The holder of a youth operator license is now also required to remain conviction–free for twelve months before being allowed to apply for any form of license.

Training professionals

In addition to education provided as a result of new protocols or guidelines, as described previously, numerous trainings have been provided to a variety of health professionals as a result of recommendations following case reviews. These include first responders, hospital staff, health care providers, and community health clinic staff. Training topics were selected in response to specific cases and included identifying child abuse, Shaken Baby Syndrome, and SIDS. A May 2000 conference for representatives of the media addressed responsible reporting of youth suicide.

In follow up to a recommendation to educate hospital and first responder staff about the use of the Poison Control Center, a brochure was developed to outline best practices, and was distributed to all hospital emergency department staff and first responders.

Community education

Numerous educational outreach projects were launched in follow up to CFRC recommendations. In collaboration with the above-mentioned changes in the youth motor vehicle operator law, a public education campaign was implemented in October 2002 to educate teens and parents about the new law. In follow up to a recommendation to educate the public about discouraging people from disabling smoke detectors, the "NH SAFE KIDS" Program did a pilot project in Pittsfield, in 2002, going into homes of low income families to determine if smoke detectors were present and functioning, replace batteries and install detectors where needed.

Public health is a key player in the New Hampshire Child Health Month Coalition which annually develops a packet of handouts on a variety of health and safety topics for parents and care providers that gets distributed to all school nurses, health care providers, child care providers, social service providers, parenting programs, foster parents, state funded health centers, WIC clinics, domestic violence shelters and DCYF District Offices. In follow up to cases reviewed, handouts have been developed in the past ten years on a variety of topics related to causes of death. Examples include a 2002 handout on the dangers of possible death from games ("The Choking Game") resulting in accidental suffocation; a 2001 handout on "club drugs", on the dangers of drugs associated with RAVES; a 2002 handout on the change regarding motor vehicle use among children; and a handout in 2005 to educate parents about co-sleeping.

Public health representation in the state's CFRC has been important in allowing programs such as those in the Maternal and Child Health Section to integrate the Child Fatality Review Committee processes into public health activities by using data and findings to help shape and act on recommendations; clarify roles and engage members in prevention activities; use data to help define problems that MCH and other public health programs can address through its activities; identify risk and protective factors, develop solutions, propose strategies, policies, and interventions to prevent further deaths from occurring; and promote accountability through evaluation of impact/outcomes.

Law Enforcement

Several different agencies within the field of law enforcement currently participate on the Child Fatality Review Committee. These agencies include the State Fire Marshal's Office, the State Police, the Juvenile Justice Services Division of Health & Human Services and the New Hampshire Police Standards & Training Council.

Our current representation from these various agencies brings many years of experience to the table on both the local and state levels. The majority of our dealings with children is when they are found to be in abusive situations which may have led to their death. In other cases, children have been victims of accidents, some of which were preventable. Through participation on the committee, each of our agencies agrees that it allows for structured discussion and thoughtful attempts at risk prevention in realistic ways.

For example, committee participation has assisted those in fire service when conducting investigations of fatal fires involving children. Looking at the total picture within the home structure helps in determining how human behavior in a fire situation may be altered to increase survivability. The discussions have also identified ways of preventing the incident in the first place. There may be involvement of other agencies to remove children from a family at risk and also other intervention such as addressing juvenile fire setting behaviors before they involve the setting of a fire that may kill the child or others. With the committee's broad spectrum of membership, it allows "thinking outside the box" when looking for ways to reduce the risk to others, no matter what the cause of death was.

When considering the juvenile justice system, participation on the committee re-enforces the initiative to collaborate among the various disciplines and systems to achieve the best outcomes for youth and families. It also provides valuable contacts for informal problem solving.

Each agency within law enforcement would agree that participation has assisted us with targeting specific areas for improved field training. Participation on the committee has been a valuable experience.

Education

As a member of the CFRC for over a decade, I value participation in these meetings as it gives me an opportunity to ponder deaths that are most often "tip of the iceberg" occurrences, leaving so much room for thoughtful consideration of prevention efforts beyond just the deaths, and beyond the education jurisdiction. As we deliberate the causes and circumstances surrounding a death it often becomes clear that so many systems issues may need to be addressed to keep children in similar circumstances safe and healthy. That can be quite enlightening. Networking opportunities on that committee often extend beyond the meeting and produce collaborative interdisciplinary efforts that are always worthwhile.

IV. REVIEW AND ANALYSIS OF DATA

A. CHILD FATALITIES IN NEW HAMPSHIRE – 2005

This report contains information on deaths of New Hampshire residents, ages 0-18 for the calendar year 2005. There were 129 child deaths reported during this time period. Of this number, 72% were due to natural causes and 28% were due to injuries. Of the injury deaths, 78% were unintentional injuries (i.e. motor vehicle traffic crashes, drownings, fires, etc.) 14% were deaths by suicide, 6% were homicide and 2% were unspecified.

The Department of State, Division of Vital Records Administration (DVRA) completed the data analysis in this report based on the vital statistics death data collected by the Division. The New Hampshire DVRA is the state resource for obtaining records and information regarding vital events that occur in our state.

This report presents deaths among children who are residents of New Hampshire. The data can be broken into two major classifications of death, natural causes and injuries. Both types of deaths are analyzed in this report.

During 2005, 72% of all child deaths were due to natural causes. Infants (<1 year) represented 78% of all natural deaths among children through age 18 (See Table 1). Adolescents account for the majority of injury-related deaths, with deaths from unintentional injuries more frequent than those from intentional (i.e. homicide and suicide) injuries.

Table 1

New Hampshire Resident Natural and Injury Deaths by Age Groups 0-18, 2005

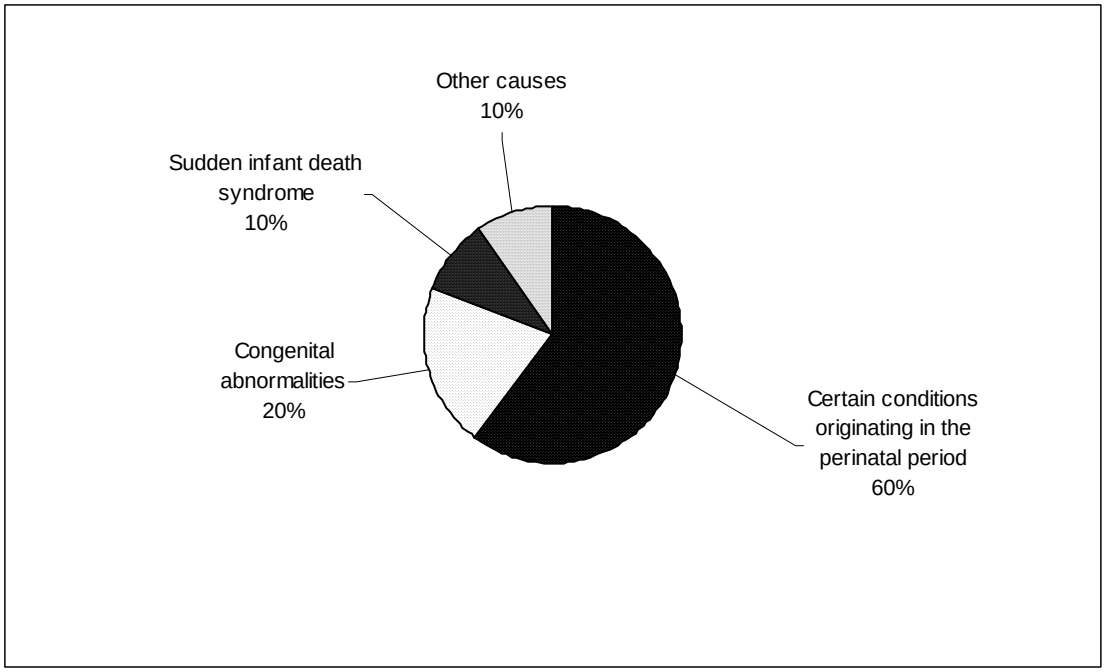
Age Group	Natural	Injury	Total
<1	73	2	75 (58%)
1 - 4	1	0	1 (1%)
5 - 9	3	5	8 (6%)
10 - 14	5	6	11 (9%)
15 - 18	11	23	34 (26%)
Total	**93 (72%)**	**36 (28%)**	**129**

Infants are more likely to die from natural causes than older children. The major cause of death for infants is "Certain Conditions Originating in the Perinatal Period" which makes up 47% of all natural infant deaths. "Congenital Abnormalities" and "Sudden Infant Death Syndrome (SIDS)" are the next two leading causes of natural death for infants (See Table 2 and Figure 1).

Table 2
New Hampshire Resident Deaths by Natural Causes
<1 year of age, 2005

Natural Cause of Death	<1 Yr
Certain conditions originating in the perinatal period	44
Congenital abnormalities	15
Sudden infant death syndrome	7
Not classified	7
Total	**73**

Figure 1

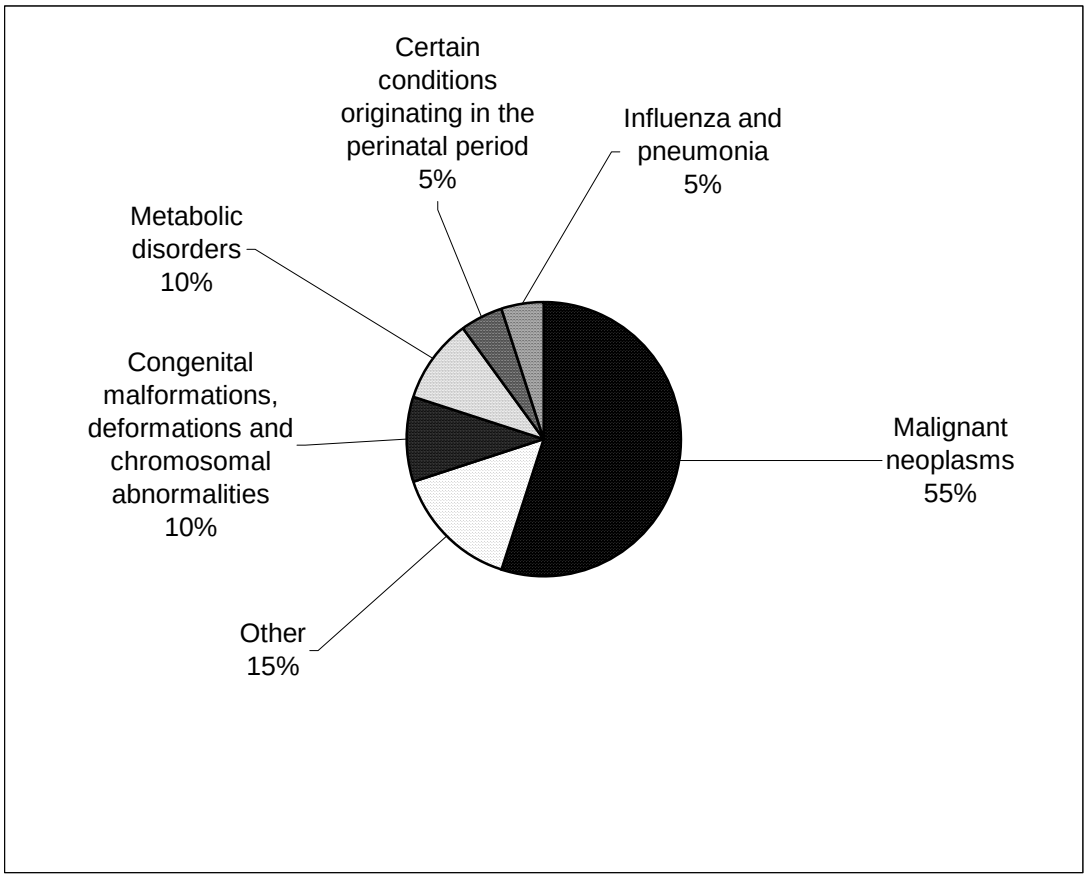


"Certain Conditions Originating in the Perinatal Period" was the third leading cause of natural death for children ages 1-18. Most of the other natural causes of death for this age group are spread out among a few other different causes. (Table 3 and Figure 2)

Table 3
New Hampshire Resident Deaths by Natural Causes, ages 1-18 years, 2005

Natural Cause of Death	1-18 yrs
Malignant neoplasms	11
Other	3
Metabolic disorders	2
Congenital malformations, deformations and chromosomal abnormalities	2
Certain conditions originating in the perinatal period	1
Influenza and pneumonia	1
Total	**20**

Figure 2



As in previous years, the majority of deaths of older children are due to injury. Motor vehicle traffic crashes are the leading cause of death for children and adolescents in both New Hampshire and the United States. Over 35% of all unintentional injury deaths of New Hampshire residents ages 1-18 in 2005 were due to motor vehicle crashes. Of that number 90% were ages 15-18.

During 2005, the number of suicides accounted for 17% of adolescent deaths. The mechanisms of suicide deaths include poisoning and suffocation (hanging). See Table 4.

Table 10

New Hampshire Resident Injury Deaths by Intent, Mechanism, and Age Group, 2005

Unintentional Injuries

Cause of Death	<1	1 – 4	5 - 9	10 - 14	15 - 18	Total
Drowning	-	-	2	-	2	4
Fire/hot object or substance- fire/flame	-	-	-	2	-	2
Motor vehicle traffic	-	-	-	-	9	9
Other land transport	-	-	1	1	2	4
Suffocation	1	-	-	-	-	1
Other causes	1	-	-	-	-	1
Pedestrian, other	-	-	-	1	1	2
Poisoning	-	-	-	-	3	3
Other classifiable	-	-	-	1	1	2
Total - Unintentional Injuries	**2**	**0**	**4**	**4**	**18**	**28 (78%)**

Suicide

Cause of Death	<1	1 – 4	5 - 9	10 - 14	15 - 18	Total
Poisoning	-	-	-	-	1	1
Suffocation	-	-	-	1	3	4
Total - Suicide	**0**	**0**	**0**	**1**	**4**	**5 (14%)**

Homicide

Cause of Death	<1	1 – 4	5 - 9	10 - 14	15 - 18	Total
Firearm	-	-	-	1	-	1
Drowning	-	-	1	-	-	1
Total - Homicide	**0**	**0**	**1**	**1**	**0**	**2 (5%)**

Undetermined Manner

Cause of Death	<1	1 – 4	5 - 9	10 - 14	15 - 18	Total
Unspecified	-	-	-	-	1	1
Total - Undetermined	**0**	**0**	**0**	**0**	**1**	**1 (3%)**

Looking at table 5, male children are more likely to die than female children from injury. In 2005 about 56% more males died from unintentional injuries than females.

Table 5

New Hampshire Resident Injury Deaths by Intent, Gender, and Age Group, Ages 0-18, 2005

Unintentional Injury Deaths

Age Group	Male	Female	Total
<1	2	-	2
1 - 4	-	-	0
5 - 9	4	-	4
10 - 14	3	1	4
15 - 18	13	5	18
Total	**22**	**6**	**28**

Suicide

Age Group	Male	Female	Total
10 - 14	1	-	1
15 - 18	3	1	4
Total	**4**	**1**	**5**

Homicide

Age Group	Male	Female	Total
5 – 9	-	1	1
10 – 14	-	1	1
Total	**0**	**2**	**2**

Undetermined

Age Group	Male	Female	Total
15 – 18	-	1	1
Total	**0**	**1**	**1**

All Injury Deaths (All Intents)

Age Group	Male	Female	Total
Total	**26 (72%)**	**10 (28%)**	**36**

Table 6 gives specific information on the causes of death for infants (less than age 1). “Respiratory Distress of the Newborn” and “Congenital Malformations, Deformations and Chromosomal Abnormalities” are each responsible for 21% of all infant deaths.

Table 6
New Hampshire Resident Deaths by Cause of Death for Infants <1 year of age, 2005

Natural Cause of Death	Total
Respiratory distress of newborn	15
Congenital malformations, deformations and chromosomal abnormalities	15
Disorders related to short gestation and low birth weight, NEC	13
Other Causes	7
Sudden infant death syndrome	7
Newborn affected by maternal complications of pregnancy	5
Infection Specific to perinatal period	4
Newborn affected by complications of placenta, cord and membranes	2
Necrotizing entercolitis of newborn	1
Haemorrhagic and haematological disorders	1
Total	**73**

B. CHILD DEATHS IN NEW HAMPSHIRE, 1996-2005

This section of the report contains information spanning the past decade of child fatalities. Similar to the data for 2004 and 2005, total deaths during this decade, 1996-2005, show that most deaths from natural causes occur among infants of < 1 year (71%). In addition, unintentional injuries account for most injury-related deaths.

Table 13
New Hampshire Resident Natural and Injury Deaths by Age Groups 0-18
1996-2005

Age Group	Natural	Injury	Total
<1	647	27	674 (52%)
1 - 4	77	37	114 (9%)
5 - 9	48	36	84 (6%)
10 - 14	62	71	133 (10%)
15 - 18	74	224	298 (23%)
Total	**908 (70%)**	**395 (30%)**	**1303**

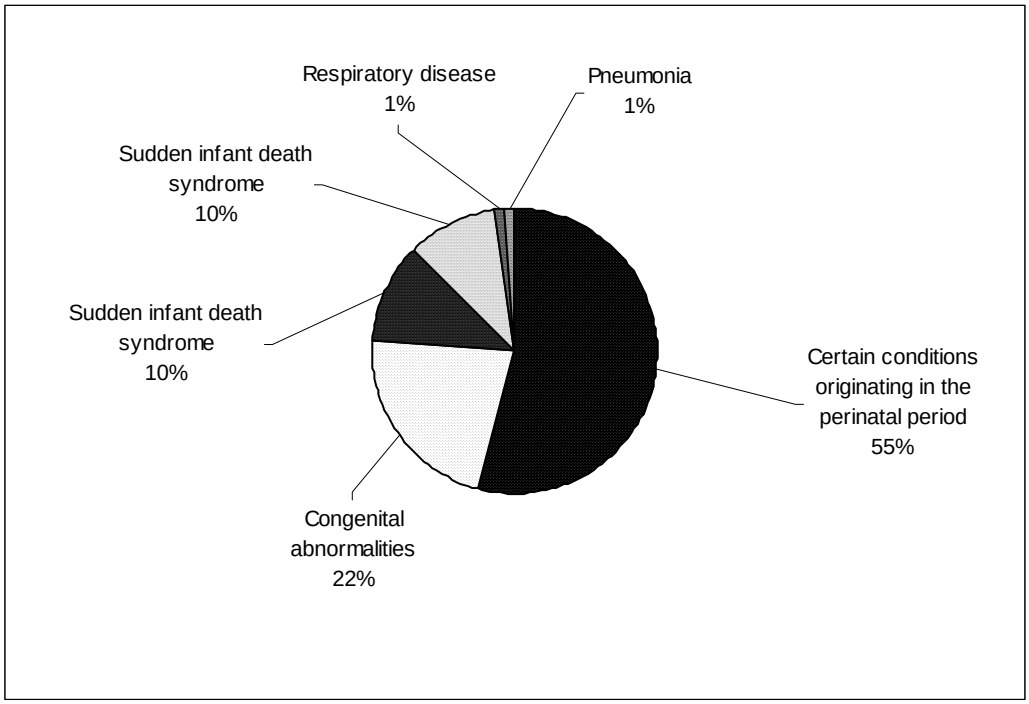
Table 14 and Figure 4 give specific information on the causes of death for infants (less than age 1). The major cause of death for infants is "Certain Conditions Originating in the Perinatal Period" which makes up 54% of all natural infant deaths. "Congenital Abnormalities" (22%) and "Sudden Infant Death Syndrome" (10%) make up the next two leading causes of all natural infant deaths.

Table 14

New Hampshire Resident Deaths by Natural Causes
<1 year of age, 1996-2005

Natural Cause of Death	<1 Yr
Certain conditions originating in the perinatal period	350
Congenital abnormalities	143
All other diseases (Residual)	73
Sudden infant death syndrome	67
Respiratory disease	7
Pneumonia	7
Total	**647**

Figure 4

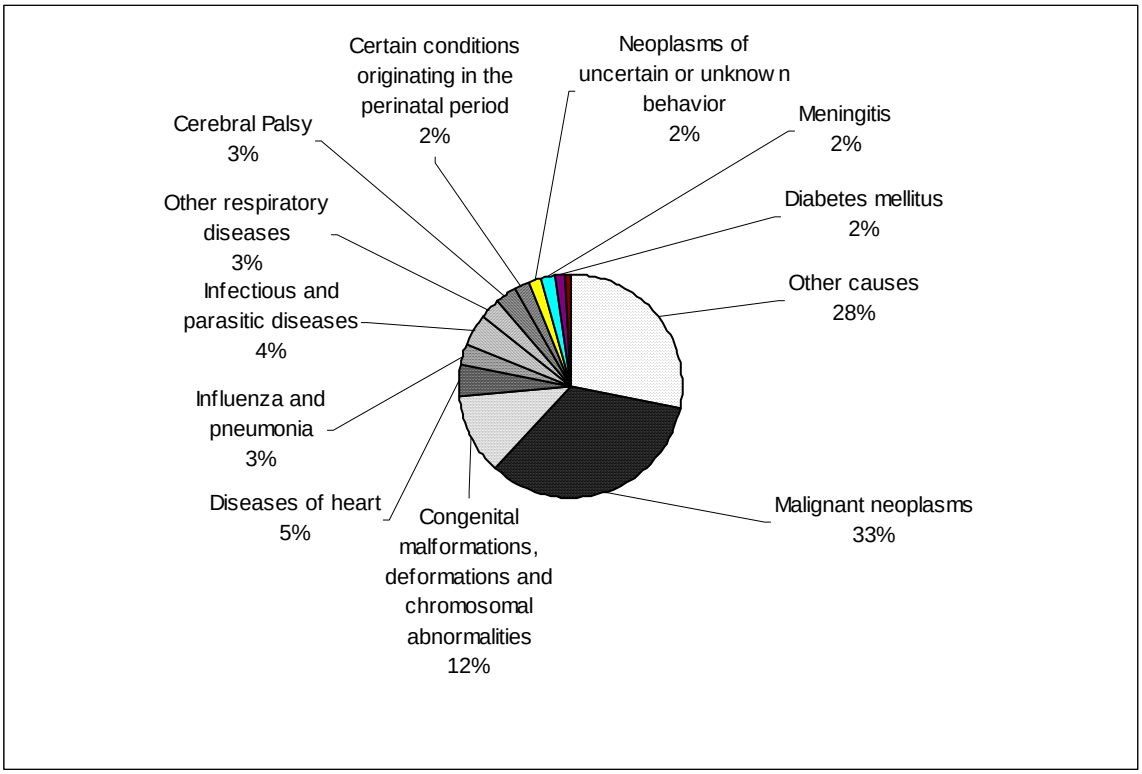


Malignant neoplasms (tumors) are the leading cause of natural death for children ages 1-18, responsible for 33% of the natural deaths. (Table 15 and Figure 5)

Table 15
New Hampshire Resident Deaths by Natural Causes, ages 1-18 years, 1996-2005

Natural Cause of Death	1-18 yrs
Malignant neoplasms	87
Other causes	74
Congenital malformations, deformations and chromosomal abnormalities	31
Diseases of heart	12
Infectious and parasitic diseases	11
Influenza and pneumonia	8
Other respiratory diseases	8
Cerebral Palsy	8
Certain conditions originating in the perinatal period	6
Neoplasms of uncertain or unknown behavior	5
Meningitis	5
Diabetes mellitus	4
Cerebrovascular Diseases	2
Total	**261**

Figure 5



The majority of the deaths to older children are due to injury. Motor vehicle traffic crashes are the leading cause of death for children and adolescents in both New Hampshire and the United States. In New Hampshire, suicides account for a large number of adolescent deaths. The most common mechanisms of suicide are firearms, suffocation (hanging), and poisoning (See Table 16).

Table 16
New Hampshire Resident Injury Deaths by Intent, Mechanism, and Age Group
1996-2005

Unintentional Injuries

Cause of Death	<1	1 - 4	5 - 9	10 - 14	15 - 18	Total
Drowning	1	12	6	6	7	32
Fire/hot object or substance-fire/flame	1	4	3	6	3	17
Firearm	-	-	-	-	1	1
Motor vehicle traffic	-	1	11	14	110	136
Motorcycle	-	-	1	3	7	11
Pedal Cyclists	-	-	-	3	1	4
Other land transport	-	1	3	2	6	12
Other transport	-	-	2	1	1	4
Pedestrian, other	-	4	3	5	4	16
Poisoning	-	1	-	-	8	9
Natural/environmental	1	1	-	-	-	2

Struck by or against	-	-	1	2	-	3
Suffocation	11	4	1	8	2	26
Fall	-	1	1	3	2	7
Other causes	5	2	-	-	5	12
Total - Unintentional Injuries	**19**	**31**	**32**	**53**	**157**	**292 (74%)**

Suicide

Cause of Death	**<1**	**1 - 4**	**5 - 9**	**10 - 14**	**15 - 18**	**Total**
Firearm	-	-	-	3	24	27
Poisoning	-	-	-	-	7	7
Suffocation	-	-	-	12	23	35
Other causes	-	-	-	-	2	2
Total - Suicide	**0**	**0**	**0**	**15**	**56**	**71 (18)**

Homicide

Cause of Death	**<1**	**1 - 4**	**5 - 9**	**10 - 14**	**15 - 18**	**Total**
Cut/pierce	-	2	1	1	3	7
Other causes	3	2	-	-	-	5
Firearm	1	-	-	2	2	5
Suffocation	3	1	1	-	-	5
Struck by or against	1	-	-	-	1	2
Drowning	-	-	1	-	-	1
Fire/hot object or substance-fire/flame	-	-	1	-	-	1
Total - Homicide	**8**	**5**	**4**	**3**	**6**	**26 (7%)**

Undetermined Manner

Cause of Death	**<1**	**1 - 4**	**5 - 9**	**10 - 14**	**15 - 18**	**Total**
Other causes	-	1	-	-	3	4
Poisoning	-	-	-	-	2	2
Total - Undetermined	**0**	**1**	**0**	**0**	**5**	**6 (1%)**

Looking at Table 17, male children are more likely than female children to die from injury. In 1996-2005, more than twice the deaths from unintentional injuries were males and more than 75% of completed suicides were also males.

Table 17

New Hampshire Resident Injury Deaths by Intent, Gender, and Age Group, Ages 0-18, 1996-2005

Unintentional Injury Deaths

Age Group	Male	Female	Total
<1	8	11	19
1 - 4	20	11	31
5 - 9	22	10	32
10 -14	37	16	53
15 - 18	112	45	157
Total	**199**	**93**	**292**

Suicide

Age Group	Male	Female	Total
10 - 14	11	4	15
15 -18	45	11	56
Total	**56**	**15**	**71**

Homicide

Age Group	Male	Female	Total
<1	5	3	8
1 - 4	3	2	5
5 - 9	2	2	4
10 -14	2	1	3
15 -18	4	2	6
Total	**16**	**10**	**26**

Undetermined

Age Group	Male	Female	Total
1 - 4	0	1	1
15 - 18	2	3	5
Total	**2**	**4**	**6**

All Injury Deaths (All Intents)

Age Group	Male	Female	Total
Total	**273 (69%)**	**122 (31%)**	**395**

Looking at the injury deaths by season, there is some fluctuation in the total number of deaths among the different seasons and there are some differences in the mechanism/cause of injury for the different seasons (See Table 18). For example, most of the drownings occurred in the summer and most of the burns occurred in the winter. Motor vehicle traffic crash deaths

were slightly higher in the fall and summer, with only slightly fewer occurring in the spring and winter.

Table 18

Mechanisms of Injury Deaths by Season (Ages 0-18), 1996-2005

Mechanism/Cause of Death	Fall	Spring	Summer	Winter
Cut/pierce	5	1	1	-
Drowning	3	9	19	2
Fire/hot object or substance- fire/flame	3	-	2	13
Firearm	6	9	8	10
Motor vehicle	44	27	42	23
Motorcycle	1	4	5	1
Pedal cyclist	1	1	2	-
Other land transport	4	1	2	5
Other transport	-	2	2	0
Pedestrian, other	4	4	5	3
Poisoning	5	6	4	3
Natural/environmental	-	2	-	-
Struck by or against	1	1	2	1
Suffocation	18	21	13	14
Fall	2	-	5	-
Other causes and unspecified	2	7	4	10
Total	**99**	**95**	**116**	**85**

Winter = December - February
Spring = March - May
Summer = June - August
Fall = September - November

V. 2006 FINDINGS AND RECOMMENDATIONS

In the calendar year 2006, the Committee reports the following findings and recommendations, which are intended to help reduce child fatalities through enhanced policy development and service delivery within and among the agencies that serve children and families. Recommendations are grouped by social system.

A. PUBLIC HEALTH AND HEALTHCARE

- Endorse the Optimal Graduated Driver Licensing Program Provisions as outlined in the Advocates for Highway and Auto Safety 2006 State Highway Law Report.
- Endorse the recommendation "Support the electronic maintenance and linking of data sets between multiple sources of data relevant to motor vehicle crashes" and "Encourage law enforcement and the courts to enforce current youth operator restrictions".
- Encourage the media to include information on whether or not seatbelts were worn when reporting on motor vehicles crashes.
- Support an electronic drug monitoring program.

B. EMERGENCY MEDICAL SERVICES

There were no recommendaitosn for Emergency Medical Services this year.

C. BEHAVIORAL HEALTH

- Support the community based coalitions' efforts.
- Increase the outreach to coalitions to increase referrals to prevention and treatment services.
- Educate medical providers on the available referral resources.
- Support the coordination of AOD and mental health services.
- Cross train providers on assessing for mental health, substance abuse and violence exposure problems.
- Support an increase in the funding for the Governor's Commission on Alcohol and Drug Abuse.

D. EDUCATION SYSTEM

. *There were no recommendations for the Education System this year.*

E. CHILD PROTECTIVE SERVICES

- In determining custody, DJJS/DCYF should investigate any past history of violence against children and/or intimate partners committed by the person being considered as a placement for a child and that history taken into consideration when determining what is in the best interest of the child.

F. DISTRICT COURT AND LAW ENFORCEMENT

- The State toxicology laboratory should increase its scope of drug screening in motor vehicle fatalities.
- If evidence at the scene of a motor vehicle accident indicates that a particular drug might be involved, that information needs to be communicated to the State toxicology laboratory for particular testing along with the blood sample.
- The Division of Motor Vehicles and the Courts should collaborate to collect information and statistics on common moving motor vehicle violations that could result in a motor vehicle crash/fatality for different age groups of drivers.
- Each new driver should be issued a brochure or pamphlet that outlines the laws, rules and regulations that are pertinent to new drivers.
- Parents who sign the consent form for their children to obtain a drivers license, should be given a brochure or information packet on the laws, rules and restrictions pertinent to new/teen drivers.
- The Division of Motor Vehicles and the Courts should collaborate to collect information and statistics on common moving motor vehicle violations that could result in a motor vehicle crash/fatality for different age groups of drivers

G. LEGISLATION

. *There were no recommendations for the Legislation this year.*

H. CHILD FATALITY REVIEW COMMITTEE

- Support the community based coalitions' efforts.
- Increase the outreach to coalitions to increase referrals to prevention and treatment services.
- Educate medical providers on the available referral resources.
- Support the coordination of AOD and mental health services.
- Cross train providers on assessing for mental health, substance abuse and violence exposure problems.
- Support an increase in the funding for the Governor's Commission on Alcohol and Drug Abuse.

VI. RESPONSES TO 2005 RECOMMENDATIONS

The Ninth Annual Report to the Governor, published in October 2006, listed recommendations generated from specific case reviews conducted in 2005. As with the previous reports, the appropriate agencies and/or disciplines were given a chance to address the recommendations and have provided the following responses.

A. PUBLIC HEALTH AND HEALTHCARE

There were no recommendations made for Public Health and Healthcare this past year.

B. EMERGENCY MEDICAL SERVICES

There were no recommendations made for Emergency Medical Services this past year.

C. MENTAL HEALTH

- Improve mental health provider services for at-risk clients including outreach in home and other community settings.
- Upon completion of the pilot project of Frameworks Project support should be given to Community Mental Health Center involvement in statewide implementation.

D. EDUCATION SYSTEM

- ***The Department of Education will continue to support the development of school emergency response plans and suicide response plans that address incidents at school as well as away from school.***

  The Department of Education (DOE) has worked very closely with the Deparment of Safety over the years to assist schools to develop emergency response plans. In the most recent legislative session, a bill was signed into law that requires all public and non-public schools to have emergency response plans that comply with national standards within two years. Ongoing collaborations between departments will assist schools to successfully meet those requirements. The DOE also has a close working relationship with the State Fire Marshal and has conducted joint visits to schools with serious fire code violations that have resulted in restricted use of the buildings until corrections have been made. In addition, the DOE has been a key player for many years in assisting to develop state level youth suicide prevention plans, especially school-focused interventions.

- ***The Department of Education will recommend that school districts consider changing school start times to better accommodate adolescent sleep needs and patterns thereby promoting academic success and reducing high risk activities that often take part as a result of sleep depravation as well as specifically occurring in unsupervised afternoon hours.***

  Last March, the DOE School Health Services Consultant spoke at a state superintendents' meeting and made this recommendation, providing resources for consideration. A lively discussion ensued and at least two districts indicated they were changing start times accordingly for the 2007/2008 school year. The same recommendation and a similar discussion took place over the school nurse list serve (approximately 600 members). More schools seem to be considering this recommendation and the DOE plans to continue sharing resources and encouraging districts to alter start times.

- ***The Department of Education will include the teen institute web site on its list of internet resources for school nurses as well as disseminate any program offerings to appropriate school personnel***.

  The Teen Institute web site is listed as a resource theDOE website. When appropriate, schools are referred to this site for information related to adolescent issues

.

E. CHILD PROTECTIVE SERVICES

- ***Align the destruction policy on DCYF founded cases to be consistent with the statute of limitations.***
- ***While the information in Central Registry at DCYF isn't readily available, there should be a system in place that would allow a search of the information without compromising the privacy of the individual.***

F. DISTRICT COURT AND LAW ENFORCEMENT

There were no recommendations made for District Court and Law Enforcement this past year.

G. LEGISLATION

There were no recommendations made for Legislation this past year.

H. CHILD FATALITY REVIEW COMMITTEE

- ***The Committee should develop television ads for reporting child abuse and neglect and should partner with a bank or company to provide financial support in order to air the public service announcements***.

VII. CONCLUSION

It is the hope of the Committee that this report has highlighted the work of the New Hampshire Child Fatality Review Committee. We hope also that it will help to strengthen your resolve to work, as an individual or a member of a public or private agency, to reduce the incidence of preventable deaths of children in New Hampshire.

APPENDIX A. HISTORY, BACKGROUND AND METHODOLOGY

(As printed in the Fourth Annual Report)

In 1999, there were 143 deaths in the state of New Hampshire involving children up to the age of 18. This compares with 134 deaths in 1997 and 119 deaths in 1998. The data presented here and in the Committee's first three annual 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. These are the children that are of concern to the Committee and it is the task of the Committee to 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 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 (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 (Appendix B) 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 (Appendix C) 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 (Appendix D).

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 the Executive 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 may 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 Executive 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.

APPENDIX B: EXECUTIVE ORDER

STATE OF NEW HAMPSHIRE

CONCORD, NEW HAMPSHIRE 03301

Executive Order Number 95-1

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 U.S. 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, Stephen Merrill, 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 29th day of September in the year of our Lord, one thousand nine hundred and ninety-five.

Stephen Merrill

Governor of New Hampshire

APPENDIX C: INTERAGENCY AGREEMENT

ATTORNEY GENERAL
DEPARTMENT OF JUSTICE
33 CAPITOL STREET
CONCORD, NEW HAMPSHIRE 03301-6397

KELLY A. AYOTTE
ATTORNEY GENERAL

MICHAEL A. DELANEY
DEPUTY ATTORNEY GENERAL

INTERAGENCY AGREEMENT

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

This cooperative agreement is made 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 are vested with the authority to promote and protect the public health and to provide services which improve the well-being of children and families; and

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 source of morbidity and mortality; and the effects of localities, employment, conditions, circumstances, and the environment on the public health;" and

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; and

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 populations 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.

Telephone 603-271-3658 • FAX 603-271-2110 • TDD Access: Relay NH 1-800-735-2964

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; and

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 that the New Hampshire Child Fatality Review Committee convenes under the official auspices of the New Hampshire Department of Justice. 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 for 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.

Kelly Ayotte — Attorney General — Date 5/6/05

John A. Stephen — Commissioner, Health and Human Services — Date 5/1/05

Richard M. Flynn — Commissioner, Department of Safety — Date 4/28/05

APPENDIX D: 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 E: 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 statutorily 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).

APPENDIX F: 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, and 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 Executive 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 Executive 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.

APPENDIX G: LIST OF ICD-10 CODES USED FOR ANALYSIS

Accidental discharge of firearms	W32 - W34
Accidental drowning and submersion	W65 - W74
Accidental exposure to smoke, fire and flames	X00 - X09
Accidental poisoning and exposure to noxious substances	X40 - X49
Acute and rapidly progressive nephritic and nephrotic syndrome	N00 - N01 , N04
Acute and subacute endocarditis	I33
Acute bronchitis and bronchiolitis	J20 - J21
Acute myocardial infarction	I21 - I22
Acute poliomyelitis	A80
Acute rheumatic fever and chronic rheumatic heart diseases	I00 - I09
Alcoholic liver disease	K70
All other and unspecified malignant neoplasms	C17 , C23 - C24 , C26 - C31 , C37 - C41 , C44
All other diseases (Residual)	D65 - E07 , E15 - E34 , E65 - F99 , G04 - G12
All other forms of chronic ischemic heart disease	I20 , I25.1 - I25.9
All other forms of heart disease	I26 - I28 , I34 - I38 , I42 - I49 , I51
Alzheimer's disease	G30
Anemias	D50 - D64
Aortic aneurysm and dissection	I71
Arthropod-borne viral encephalitis	A83 - A84 , A85.2
Assault (homicide) by discharge of firearms	X93 - X95
Assault (homicide) by other and unspecified means and their sequela	U01-U02 , X85 - X92 , X96 - Y09 , Y87.1
Asthma	J45 - J46
Atherosclerosis	I70
Atherosclerotic cardiovascular disease, so described	I25.0
Bronchitis, chronic and unspecified	J40 - J42
Cerebrovascular diseases	I60 - I69
Certain conditions originating in the perinatal period	P00 - P96
Certain other intestinal infections	A04 , A07 - A09
Cholelithiasis and other disorders of gallbladder	K80 - K82
Chronic glomerulonephritis, nephritis and nephritis not specified as acute or chronic, and renal sclerosis unspecified	N02 - N03 , N05 - N07 , N26
Complications of medical and surgical care	Y40 - Y84 , Y88
Congenital malformations, deformations and chromosomal abnormalities	Q00 - Q99
Diabetes mellitus	E10 - E14
Discharge of firearms, undetermined intent	Y22 - Y24
Diseases of appendix	K35 - K38
Diseases of pericardium and acute myocarditis	I30 - I31 , I40
Emphysema	J43
Essential (primary) hypertension and hypertensive renal disease	I10 , I12
Falls	W00 - W19
Heart failure	I50
Hernia	K40 - K46
Hodgkin's disease	C81

Human immunodeficiency virus (HIV) disease	B20 - B24
Hyperplasia of prostate	N40
Hypertensive heart and renal disease	I13
Hypertensive heart disease	I11
In situ neoplasms, benign neoplasms and neoplasms of uncertain or unknown behavior	D00 - D48
Infections of kidney	N10 - N12 , N13.6 , N15.1
Inflammatory diseases of female pelvic organs	N70 - N76
Influenza	J10 - J11
Intentional self-harm (suicide) by discharge of firearms	X72 - X74
Intentional self-harm (suicide) by other and unspecified means and their sequelae	U03 , X60 - X71 , X75 - X84 , Y87.0
Legal intervention	Y35 , Y89.0
Leukemia	C91 - C95
Malaria	B50 - B54
Malignant melanoma of skin	C43
Malignant neoplasm of bladder	C67
Malignant neoplasm of breast	C50
Malignant neoplasm of cervix uteri	C53
Malignant neoplasm of esophagus	C15
Malignant neoplasm of larynx	C32
Malignant neoplasm of ovary	C56
Malignant neoplasm of pancreas	C25
Malignant neoplasm of prostate	C61
Malignant neoplasm of stomach	C16
Malignant neoplasms of colon, rectum and anus	C18 - C21
Malignant neoplasms of corpus uteri and uterus, part unspecified	C54 - C55
Malignant neoplasms of kidney and renal pelvis	C64 - C65
Malignant neoplasms of lip, oral cavity and pharynx	C00 - C14
Malignant neoplasms of liver and intrahepatic bile ducts	C22
Malignant neoplasms of meninges, brain and other parts of central nervous system	C70 - C72
Malignant neoplasms of trachea, bronchus and lung	C33 - C34
Malnutrition	E40 - E46
Measles	B05
Meningitis	G00 , G03
Meningococcal infection	A39
Motor vehicle accidents	V02 - V04 , V09.0 , V09.2 , V12 - V14 , V19.0 -
Multiple myeloma and immunoproliferative neoplasms	C88 , C90
Non-Hodgkin’s lymphoma	C82 - C85
Operations of war and their sequelae	Y36 , Y89.1
Other acute ischemic heart diseases	I24
Other and unspecified events of undetermined intent and their sequelae	Y10 - Y21 , Y25 - Y34 , Y87.2 , Y89.9
Other and unspecified infectious and parasitic diseases and their sequelae	A00 , A05 , A20 - A36 , A42 - A44 , A48 - A
Other and unspecified malignant neoplasms of lymphoid, hematopoietic, and related tissue	C96
Other and unspecified nontransport accidents and their sequelae	W20 - W31 , W35 - W64 , W75 - W99 , X10 - X

Other chronic liver disease and cirrhosis	K73 - K74
Other chronic lower respiratory diseases	J44 , J47
Other complications of pregnancy, childbirth and the puerperium	O10 - O99
Other diseases of arteries, arterioles and capillaries	I72 - I78
Other diseases of respiratory system	J00 - J06 , J30 - J39 , J67 , J70 - J98
Other disorders of circulatory system	I80 - I99
Other disorders of kidney	N25 , N27
Other land transport accidents	V01 , V05 - V06 , V09.1 , V09.3 - V09.9 , V10 -
Other nutritional deficiencies	E50 - E64
Other tuberculosis	A17 - A19
Parkinson’s disease	G20 - G21
Peptic ulcer	K25 - K28
Pneumoconioses and chemical effects	J60 - J66 , J68
Pneumonia	J12 - J18
Pneumonitis due to solids and liquids	J69
Pregnancy with abortive outcome	O00 - O07
Renal failure	N17 - N19
Respiratory tuberculosis	A16
Salmonella infections	A01 - A02
Scarlet fever and erysipelas	A38 , A46
Septicemia	A40 - A41
Shigellosis and amebiasis	A03 , A06
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	R00 - R99
Syphilis	A50 - A53
Unspecified acute lower respiratory infection	J22
Viral hepatitis	B15 - B19
Water, air and space, and other and unspecified transport accidents and their sequelae	V90 - V99 , Y85
Whooping cough	A37