THE STATE OF NEW HAMPSHIRE

THIRTEENTH REPORT OF THE

CHILD FATALITY REVIEW COMMITTEE

June 2013

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-0111NHCJA1) which is administered by the New Hampshire Department of Justice.

DEDICATION

As in previous years, the New Hampshire Child Fatality Review Committee would like to dedicate this, our Thirteenth Report, to the children of New Hampshire and to those who work to improve their health and lives. For the last 17 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.

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NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

Dear Friends of New Hampshire's Children:

The New Hampshire Child Fatality Review Committee has begun its' 17th 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 two-year report covering the work of the committee for the calendar years 2011 and 2012. Fatality data are presented for the calendar years 2003 through 2010. Because we have relatively few child fatalities in New Hampshire, a look at the data summaries should give a better indication of fatality trends, and not at a single year, which could fluctuate greatly from year to year.

As in previous years, members of the New Hampshire Child Fatality Review Committee have made presentations locally and nationally on the issues related to reducing child fatalities and on the work of our committee. We, again as in previous years, have been recognized nationally for our work in conducting successful reviews and in how we gather and respond to recommendations generated by these reviews. The six New England States have received funds to hold an annual meeting that rotates between the six states. These joint meetings help give all of us an overview of the problems and solutions the teams from these other states encounter in trying to prevent child fatalities and an opportunity to look at issues that are current in the field of child death review. New Hampshire is one of nine states currently funded by the Centers for Disease Control to participate in a national web-based registry on sudden unexpected infant deaths (SUID). A report on the NH SUID Project is included. Finally, many of our members have written articles for newsletters and other publications regarding our recommendations for helping to reduce and prevent child fatalities.

As Chair, I would like to acknowledge the hard work and dedication of the members of the committee. I again want to especially acknowledge the work of Danielle Snook, our staff assistant from the Attorney General's Office, for keeping the committee running smoothly and for all the time and energy she has spent on preparing this report. Additionally I would like to thank Debra Samaha from the Injury Prevention Center at Dartmouth who, as a relatively new member, has been a very effective team member and has contributed greatly to our work in reducing and preventing child fatalities in New Hampshire. I would also like to acknowledge those who have completed their service on the committee since our last report: Deb Coe, Dr. Hannah Galvin, Janet Houston, Jane Kendall, Suzanne Prentiss, Jill Rockey and Rosemary Shannon

In recognition of this commitment and dedication, it is with great pride that as Chair, I present this, our Thirteenth 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.

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE MEMBERS WHO SERVED

January 2011 to December 2012

Chair: Marc Clement, PhD
Colby-Sawyer College

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

Judge Susan Ashley
Family Division

*Lorraine Bartlett
Division for Children, Youth & Families
Department of Health & Human Services

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

Vicki Blanchard
Division of Emergency Medical Services
Department of Safety

Captain Mark Bodanza
Police Standards and Training

*George Bowersox
Board of Pharmacy

Bill Clark
Fire Marshall's Office

Peg Clifford
Board of Pharmacy

Deb Coe, MA
NH Coalition Against Domestic & Sexual Violence

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

*Jennie Duval, MD, Deputy Chief Medical Examiner
Office of Chief Medical Examiner

Kim Fallon, Chief Forensic Investigator
Office of Chief Medical Examiner

Elizabeth Fenner-Lukaitis, LICSW
Acute Care Services Coordinator
Bureau of Behavioral Health
Department of Health & Human Services

Detective Matt Fleming
Bedford Police Department

Hannah Galvin, MD
Emergency Department Pediatrician

Wendy Gladstone, MD
Pediatrician

*Lieutenant Jill Hamel
Police Standards and Training

Sergeant Sara Hennessey
State Police

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

Jane Hybsch, Administrator
Office of Medicaid Business and Policy
Department of Health & Human Services

Jane Kendall, RN, Medical Consultant II - Benefits Specialist, Office of Medicaid Business and Policy
Department of Health & Human Services

Audrey Knight, MSN, RN, Child Health Nurse Consultant and SIDS Program Coordinator
Division of Public Health Services, Department of Health & Human Services

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

*Susan Meagher
CASA of New Hampshire

Detective Rick Nanan
Manchester Police Department

Linda Parker, BS, CPM/Program Specialist
Division of Community Based Care Services
Bureau of Drug and Alcohol Services
Department of Health & Human Services

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

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

*Robin Raycraft-Flynn, Administrator
Bureau of Behavioral Health
Department of Health & Human Services

(Ret.) Sergeant Jill Rockey
State Police

Amy Roy, MD
Emergency Department Pediatrician
New Hampshire's Hospital for Children

Debra Samaha, Program Director
Injury Prevention Center at Dartmouth

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

Rhonda Siegel, MSEd
Injury Prevention, Adolescent Health, and Prenatal
Program, Division of Public Health Services,
Department of Health & Human Services

Marcia Sink, Executive Director
CASA of New Hampshire

*=Alternate Member

I. EXECUTIVE SUMMARY

This report reflects the work of the New Hampshire Child Fatality Review Committee (hereafter referred to as "Committee") during the 2011 and 2012 calendar years. 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. During 2011 and 2012, the Committee held 10 meetings, which included reviewing 14 cases.

The report begins with the Committee's Mission Statement and Objectives, followed by a listing of the Committee members and their affiliations. There are a few short reports from representatives on the Committee on some of the initiatives they've been involved in related to child fatality. These include a project on enlisting gun shops in suicide prevention activities; a project to decrease adolescent traffic fatalities; a radio hour on preventing teen drug use; a federal grant to participate in a web-based Sudden Unexpected Infant Death Registry, and numerous articles in professional newsletters related to the review and prevention of infant and child deaths.

A review and analysis of the 2003 – 2010 New Hampshire child fatality review data shows that the majority of deaths in New Hampshire children (0 to 18 years of age) have been due to unintentional injury. New Hampshire has been consistent with national data in ranking Sudden Infant Death Syndrome (SIDS), as one of the leading causes of infant deaths. Cancer (malignant neoplasms) continues to be the leading cause of natural death for ages one through 18. Adolescents make up the majority of injury deaths with motor vehicle traffic crashes being the major cause. Suicides in children and adolescents are primarily due to suffocation, which differs from national statistics where the primary cause is firearm deaths.

A description of the responses to the recommendations generated from the 2011-2012 case reviews demonstrate follow up actions that range from working with a radio station for public service announcements on helmet/bike/skateboard safety, to exploring if education on child abuse reporting laws could be made a requirement for obtaining or renewing a medical license for pediatricians and emergency physicians. The committee attempts to develop recommendations that are "S.A.F.E.R." (***S***pecific to the case being discussed, and ***S***ustainable; ***A***cceptable to the community and the political system; ***F***easible without too much effort; ***E***ffective and not too ***E***xpensive; and ***R***isk free, i.e. no unintended consequences).

The work of the New Hampshire Child Fatality Review Committee has received national recognition on numerous occasions for its work in not only looking at what deaths have occurred, and why, but for developing and following up on recommendations that will hopefully make a difference in preventing or reducing the risks of further such deaths from occurring.

II. STATEMENT OF ACCOUNTABILITY

The New Hampshire Child Fatality Review Committee was established in 1991 by an Executive Order of then Governor Judd Gregg. Please refer to Appendix A for a summary of the history, background, and methodology of the Committee. 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 right to confidentiality for families who lost children is respected in the work of the Committee.

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 vii) 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, which meets in the alternate months. The case review protocol can be found in (Appendix F). The purpose of the committee is 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. 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.

For thirteen years the Committee also hosted an annual Northern New England Child Fatality Review Meeting. This day-long meeting convenes the Child Fatality Review teams from Maine, Vermont, Massachusetts, Connecticut, and Rhode Island to discuss child fatalities that involved more than one New England state, share ideas and experiences to improve the functioning of the teams, and explore how information can be more effectively shared by different state agencies. In the last two years we were able to receive monies from the National Center for the Review and Prevention of Child Deaths to expand the conference to a two-day conference and rotate the location of the conference among the five New England States. Last year the conference was held in Rhode Island and in 2013 it will be held in Vermont.

This is the Thirteenth Report of the Committee, and as in previous reports, the main components of the report are the data section and the section on recommendations 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 over the previous year. These responses are published along with the recommendations. During 2011 and 2012, the Committee held 10 meetings, which involved the review of a total of 14 cases.

III. OTHER ACTIVITIES RELATED TO THE CHILD FATALITY REVIEW COMMITTEE

The following is a description of several of the activities carried out in 2011 and 2012 related to the work of the Committee.

The "Gun Shop Project"

It came to light that during one week in 2009, three individuals purchased a firearm from one shop and used that firearm to die by suicide within hours. This occurrence turned out to be a statistical "blip", but was the impetus to galvanize a unique coalition between firearm enthusiasts and suicide prevention advocates. The Firearms Safety Coalition resumed work after a hiatus of a few years. Their goals were to enlist gun shops as a means to try to prevent recently purchased firearms being used in suicides and also to educate their customers about the role they can take to prevent a suicide. One of the mantras of this group is the goal to "put time and distance between a suicidal person and a gun".

Interviews were conducted at many gun shops about methods that would be seen as useful in suicide prevention. An initial mailing to all gun shops in September 2011 included a poster, "Lifeline" cards listing the National Suicide Prevention Line for people to call, a brochure with an "11th" amendment" for storage if there were any concerns about a loved one, "Tips for Dealers" of firearms, and a DVD.

Follow up surveys showed that almost half (45%) of the stores had at least one of the above-mentioned items on display in their store. A revised packet was mailed out to the gun shops in October 2012 to include an updated poster and other materials based on feedback from the shops.

Firearms consistently account for approximately 50% of suicides of all ages. Roughly a third (12 out of 40) of all child suicides from 2003-2010 involved a firearm. 50% of the child 2010 suicides (four out of eight) involved a firearm. Studies also show that a firearm in the home increased the risk of suicide for all ages. The Firearm Safety Coalition hopes to influence these statistics.

This project has had national spotlight via articles in Combat Handgun magazine and the Harvard School of Public Health's Spring 2013 newsletter, presentations at recent American Association of Suicidology annual conferences, and presentations and/or posters at the American Public Health Association conferences.

Prescription Drug Abuse Radio Hour

On Sept 19, 2012, the head of the Drug Enforcement Agency for New Hampshire and Dr. Wendy Gladstone, pediatrician and Child Fatality Review Committee member, did a call-in radio hour with Jack Heath (107.7FM) on prescription drug abuse. Dr. Gladstone discussed how to recognize drug abuse in adolescents and how to talk to your children about drug abuse.

Teen Safe Driving Project

In Early January of 2012, the state of New Hampshire was one of 8 states chosen to receive $25,000 in funds available through The Allstate Foundation's Teen Safe Driver Grant Program.

The goal of New Hampshire's efforts were to promote and distribute educational materials about the best practices of a graduated licensing law (GDL) and to begin developing peer to peer programs designed to encourage highway safety related programs for teen drivers.

The design and printing of the GDL brochure has been completed and is in the process of being distributed throughout the state to pediatricians and other highway safety advocates committed to making the teen driving experience a safer one.

Spaulding High School in Rochester, Epping High School and the Great Bay e Charter School (GBeCS) in Exeter were chosen as the participating schools. Educational events have been held at each school and include the *Room to Live* seat belt program, a distracted driving based on the AT&T *It Can Wait* anti-texting campaign and mock crashes.

A student at GBeCS directed the creation of a seat belt video specific to teens entitled, *Somebody Loves You, Somebody Needs you*. This video is being shown by driver education and defensive driving instructors throughout the State. Spaulding High School students have formed a teen highway safety club and in November presented a peer-to-peer program called *Saving Lives one Teen At a Time*. They also testified to the house transportation committee in support of proposed GDL legislation (HB 302).

Because of the success of this effort, the New Hampshire Department of Transportation recently released an RFP asking for proposals that would promote teen highway safety by following the successful program model implemented through this Allstate Foundation grant. AT&T has provided $5,000 to further promote their anti – texting program throughout the state and The Allstate Foundation has provided an additional $10,000 to allow for the continuation of their program within the selected high schools through this academic year.

Professional Articles In Follow-up to the Recommendations

In addition to the formal recommendations, a number of committee members use the recommendations to generate articles, which are then published in the newsletters of their professional organizations. These articles are also released, when appropriate, to the public via press releases, pamphlets, or brochures.

Articles have been written by committee member, Dr. Wendy Gladstone, for the Granite State Pediatrician, which is the official newsletter of the New Hampshire Pediatric Society, the state chapter of the American Academy of Pediatrics. It is published five times a year, and mailed to the 280 pediatricians who are members of the Pediatric Society. This includes the vast majority of pediatricians practicing in the state. The newsletter is also posted on the Society's website (http://www.nhps.org/)

Articles related to the Child Fatality Review Committee appear regularly although not in every issue. During the period of this report the following articles were written:

- January 2011: "Bang Bang" (on gun safety) submitted by Dr. Wendy Gladstone
- March 2011: "Child Abuse Prevention Month" (on preventing abusive head trauma) submitted by Dr. Hannah Galvin and Debra Samaha
- May 2011: "Guns and Depression"; and "Guidelines on Reporting on Suicide" (suggestions for the media on how to report on suicide without glamorizing it in an attempt to reduce 'copy cat' suicides, written by the American Academy of Pediatrics), submitted by Dr. Wendy Gladstone
- November 2011: "New American Academy of Pediatrics Safe Sleep Guidelines"; and "What is the New Hampshire Child Fatality Review Committee?" submitted by Dr. Wendy Gladstone
- May 2012: "Longboarding"; and "Drowning", submitted by Dr. Diana Dorsey
- September 2012: "Is your Office PURPLE? (on the Period of Purple Crying, a national child abuse prevention program); and "Spread the Word" (on safe sleep for infants) submitted by Dr. Wendy Gladstone; and "Disaster Preparedness" submitted by Dr. Diana Dorsey

Grief Packets

A mailing of information and resources on grief and coping with the death of a child are sent, in collaboration with the Office of the Chief Medical Examiner, to families who have suffered the sudden and unexpected death of a child of any age in New Hampshire. Special packets are sent when the death is to an infant, or when the death is from a suicide. In 2011, seven sudden unexpected infant death bereavement packets were sent, 22 pediatric packets were sent, and seven suicide-connected packets were sent. In 2012, nine infant packets, 12 pediatric packets, and five suicide-connected packets were sent.

IV. REVIEW AND ANALYSIS OF DATA

The citation for this report is as follows: Data Source: New Hampshire Department of Health and Human Services, Injury Surveillance Program. Death Certificate Data provided by the Department of State, Division of Vital Records Data Source: Bureau of Data and Systems Management (BDSM), Office of Medicaid Business and Policy (OMBP), Office of Health Statistics and Data Management (HSDM), New Hampshire Department of Health and Human Services (NH DHHS), and New Hampshire Department of State, Division of Vital Records Administration, 2003-2010. The Centers for Disease Control and Prevention/National Center for Health Statistics protocol "*ICD-10 Cause-of-Death Lists for Tabulating Mortality Statistics*," was used in preparing this report. That protocol can be found at: http://www.cdc.gov/nchs/data/dvs/Part9InstructionManual2011.pdf

Counts of events at 10 or less per year may be due to chance alone and do not produce reliable statistics. One should use caution when interpreting small numbers and percentages derived from them.

This report presents deaths among children birth through the age of eighteen who were residents of the state of New Hampshire. The data can be broken into two major classifications of death, natural causes and injuries. Both types of death are analyzed in this report. Death by natural causes is a strictly defined term utilized when the cause of death is due *exclusively* to disease with no contribution by any injury or other exogenous factor. It encompasses, but is not limited to, diseases of the heart, malignant neoplasms (i.e.; cancer), conditions originating in the perinatal period (such as low birth weight and prematurity) and some sudden infant deaths. The other category of death is injury which refers to death from damage done to the structure or function of the body caused by an outside agent or force, which may be physical (as in a fall) or chemical (as in a burn or poisoning). Injury deaths are also classified as unintentional (such as in accidental drowning) or intentional (suicide or homicide).

The majority of deaths (67%) in children from birth through age eighteen were due to natural causes over the eight year period, 2003-2010 (Table 1). This was also the case for the year 2010 (62%, Table 2). Infants under age one comprised the majority of deaths due to natural causes in (70%, Chart 1). Adolescents (15-18), on the other hand, account for the majority of injury related deaths (60%, Chart 1).

Table 1: New Hampshire Resident Natural and Injury Deaths by Age Group, 0-18, 2003-2010

Age Group	Natural	Injury	Other/ Unknown	Total
<01	464	21	47	532
01 to 04	53	22	7	82
05 to 09	40	23	0	63
10 to 14	39	39	2	80
15 to 18	61	154	7	222
Total	**657**	**259**	**63**	**979**
Percent	**67%**	**26%**	**6%**	**100%**

Chart 1:

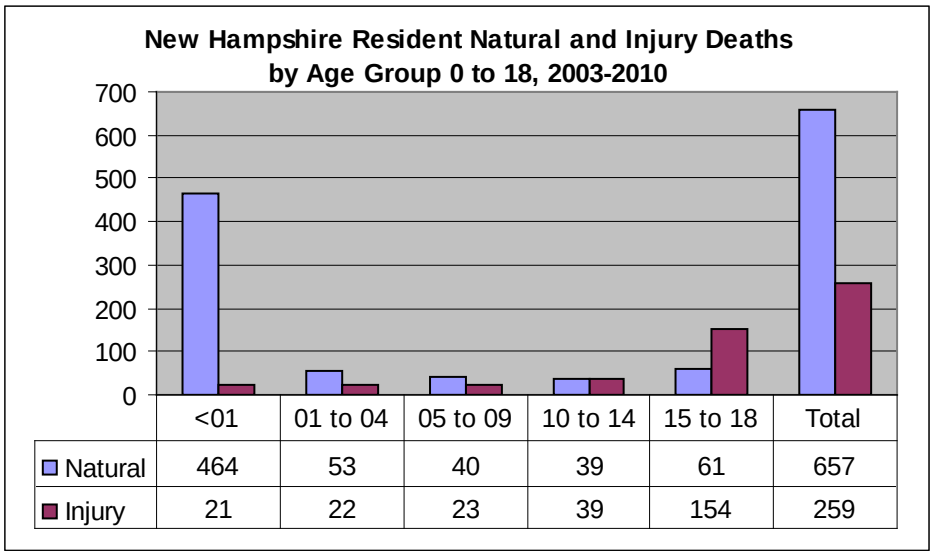


Table 2: New Hampshire Resident Natural and Injury Deaths by Age Group, 0-18, 2010

Age Group	Natural	Injury	Other/ Unknown	Total
<01	42	3	4	49
01 to 04	7	5	2	14
05 to 09	6	0	0	6
10 to 14	4	3	2	9
15 to 18	5	20	0	25
Total	**64**	**31**	**8**	**103**
Percent	**62%**	**30%**	**8%**	**100%**

As was stated previously, infants less than one year of age died primarily from natural causes. The number one causes of deaths in the aggregated eight year time period (Table 3) were due to congenital malformations, deformations, and chromosomal abnormalities. However, this category made up only 19% of natural deaths.

Table 3: New Hampshire Residents, Leading Causes of Natural Death, Infants (under age 1 year)

Natural Causes of Death	2003-2010	2010
Congenital malformations, deformations and chromosomal abnormalities	95	7
Disorders related to length of gestation and fetal growth	87	6
Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery	72	5
Respiratory and cardiovascular disorders specific to the perinatal period	58	3
Sudden infant death syndrome	50	5

Ill-defined and unknown causes of mortality	35	6
Diseases of the circulatory system	16	1
Diseases of the digestive system	12	1
Haemorrhagic and haematological disorders of fetus and newborn	11	1
Infections specific to the perinatal period	11	
Diseases of the respiratory system	10	1
Other disorders originating in the perinatal period	10	2
Certain infectious and parasitic diseases	8	2
Digestive system disorders of fetus and newborn	7	
Diseases of the nervous system	7	1
Endocrine, nutritional and metabolic diseases	6	
Neoplasms	4	
Diseases of the genitourinary system	2	
Conditions involving the integument and temperature regulation of fetus and newborn	1	
Total	**502**	**41**

In reviewing infant death data, New Hampshire has been consistent with national data in ranking Sudden Infant Death Syndrome (SIDS), as one of the leading causes of infant deaths, making up 17% of the natural deaths (Table 4). SIDS is defined as the death of an infant less than one year of age, which remains unexplained after a thorough case investigation, including a complete autopsy, death scene investigation, and a review of the infant's clinical history. With the success of the national "Back to Sleep" campaign, reminding parents and childcare providers to put infants to sleep on their backs on a firm, flat mattress, the SIDS rate has been dropping significantly since the early 1990's. However, although SIDS has declined, the rate of sudden and unexpected infant deaths, or SUID, has increased. This category includes those thought of as injury related including deaths from overlaying, suffocation, wedging, and other unsafe sleep situations.

According to a study in Pediatrics, 2009 Shapiro-Mendoza, C.K., Kimball, M., Tomashek, K.M., Anderson, R.N., and Blanding, S. (2009) US Infant Mortality Trends Attributable to Accidental Suffocation and Strangulation in Bed From 1984 Through 2004: Are Rates Increasing?*Pediatrics*, 123, 533–539., the number of deaths from accidental suffocation and strangulation in bed quadrupled in the past two decades. Deaths from several codes that include SIDS, "Undetermined", and deaths from accidental suffocation and strangulation in a bed setting (R95, R99 and W75) as a cause of death can now be grouped in the category of "Sudden Unexpected Infant Death" (SUID). With such clustering, deaths from SUID total count for 2010 is 11 cases (including natural, accidental, and undertermined cause of death). This brings SUID to the rank of number one for the cause of infant deaths in the state in 2010.

Table 4: New Hampshire Residents, Five Leading Causes of Natural Death, Infants (under age 1 year), 2010

Five Leading Causes of Death	Total
Congenital malformations, deformations and chromosomal abnormalities	7
Disorders related to length of gestation and fetal growth	6
Ill-defined and unknown causes of mortality	6
Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery	5
Sudden infant death syndrome	5
Total	**29**

This change in cause of infant deaths indicates a need to increase educational outreach to new and expectant parents, and to all infant care providers, on the importance of a safe sleep environment. The NH Division of Public Health Services has launched a NH Safe Sleep campaign to get the message out about the American Academy of Pediatrics' latest recommendations on reducing the risk of SIDS and deaths from an unsafe sleep environment. The campaign is one of the strategies of the state's Sudden Unexpected Infant Death (SUID) Project. For more information, please refer to the "Summary Report: The New Hampshire Sudden Unexpected Infant Death (SUID) Project" elsewhere in this report.

Looking at natural causes of death for children and adolescents one through 18, malignant neoplasms, or cancer, is the leading cause for both the aggregated time period (Table 5). This is consistent with both the national data and previous years.

Table 5: New Hampshire Residents, Leading Causes of Natural Death, Age 1 to 18

Leading Causes of Death	2003-2010	2010
Neoplasms	70	4
Congenital malformations, deformations and chromosomal abnormalities	29	4
Diseases of the nervous system	20	1
Diseases of the circulatory system	18	4
Endocrine, nutritional and metabolic diseases	15	1
Diseases of the respiratory system	14	3
Certain infectious and parasitic diseases	7	1
Diseases of the digestive system	7	
Ill-defined and unknown causes of mortality	6	3
General symptoms and signs	3	1
Respiratory and cardiovascular disorders specific to the perinatal period	3	
Diseases of the genitourinary system	2	1
Diseases of the musculoskeletal system and connective tissue	2	1
Mental and behavioural disorders	2	
Infections specific to the perinatal period	1	
Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium	1	
Total	**200**	**24**

Reviewing unintentional injury deaths in children (Tables 6 and 7, Chart 2), motor vehicle traffic was the leading cause of death. This cause exceeded even those due to natural causes (Tables 1 and 2) to show that for adolescents, motor vehicle crashes are the leading cause of death. More adolescents died due to motor vehicle crashes than all other unintentional injuries combined. Drowning, poisonings, and suffocation are also top causes of death. Unintentional injury deaths in adolescents for these causes are greater than for any other age group.

The poisoning deaths of adolescents 15-19 have unfortunately been climbing. This is primarily due to the increase in deaths coded X42, which is accidental poisoning by and exposure to narcotic and psychodysleptics (hallucinogens), not elsewhere classified.

Table 6: New Hampshire Residents, Unintentional Injury Deaths, Ages 0-18, 2003-2010

Cause of Death	<01	01 to 04	05 to 09	10 to 14	15 to 18	Total
Drowning	1	5	4	4	9	23
Fire or hot object/substance		2	3	5		10
Firearm					1	1
Machinery			1			1
Motor vehicle traffic		3	10	11	83	107
Natural/environmental	1					1
Other land transport			1	2	4	7
Other transport			2	1	1	4
Pedal cyclist - other			1	1		2
Pedestrian - other		1		1	1	3
Poisoning					16	16
Struck by or against				1	2	3
Suffocation	13	3		2		18
Total	**15**	**14**	**22**	**28**	**117**	**196**

Chart 2:

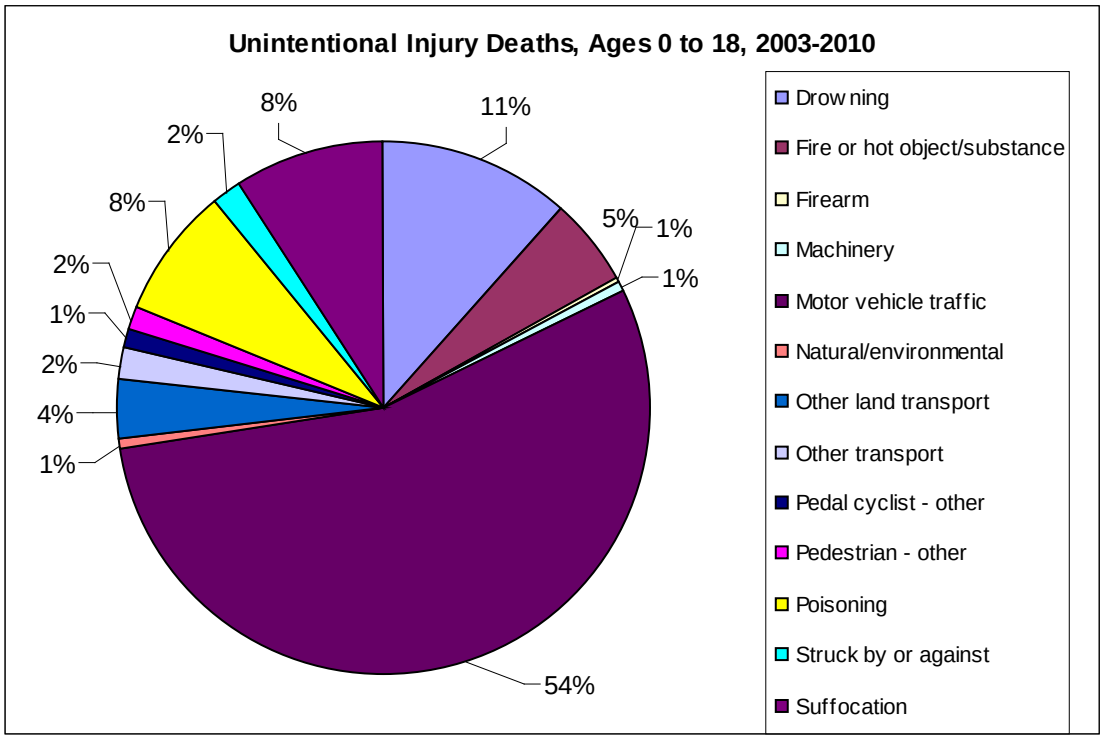


Table 7: New Hampshire Residents, Unintentional Injury Deaths, Ages 0 to 18, 2010

Cause of Death	<01	01 to 04	05 to 09	10 to 14	15 to 18	Total
Drowning		1				1
Motor vehicle traffic				1	10	11
Poisoning					1	1
Struck by or against					1	1
Suffocation	1			1		2
Total	**1**	**1**	**0**	**2**	**12**	**16**

Suicide is the leading cause of intentional injury deaths for children and adolescents (Tables 8 and 9, Charts 3 and 4). The incidence of suicide amongst males is greater than females, primarily because their choice of method is more lethal (e.g. firearm versus poisoning). Hanging/Asphyxiation was the leading mechanism of suicide death in both males and females, while nationally it is firearms (Tables 10 and 11).

Table 8: New Hampshire Residents, Intentional Injury, Ages 0 to 18, 2003-2010

	<01	01 to 04	05 to 09	10 to 14	15 to 18	Total
Males						
Homicide	2	5			1	**8**
Suicide				7	23	**30**
Undetermined	27	2		2	3	**34**
Females						
Homicide		3	2	2	1	**8**
Suicide				1	9	**10**
Undetermined	20	5			4	**29**
Total	**49**	**15**	**2**	**12**	**41**	**119**

Chart 3:

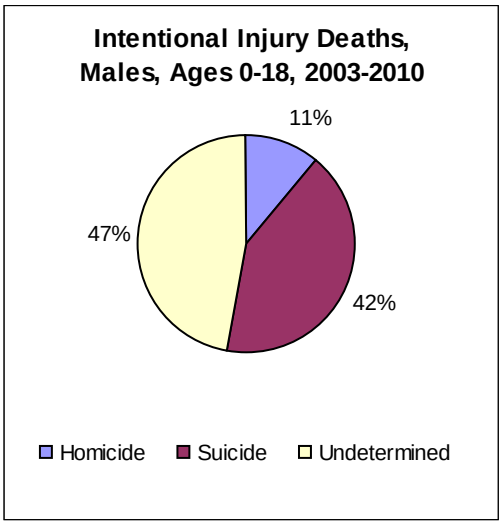


Chart 4:

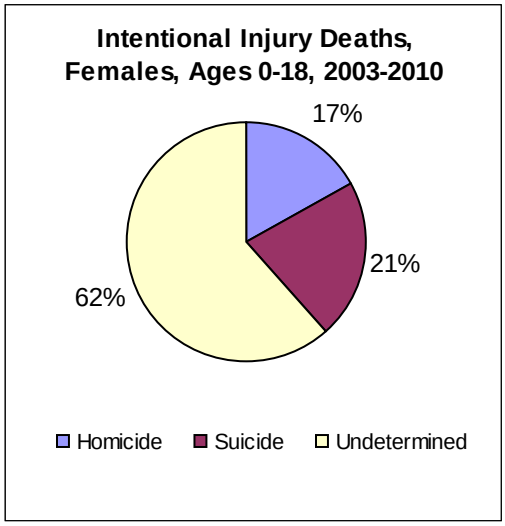


Table 9: New Hampshire Residents, Intentional Injury, Ages 0 to 18, 2010

	<01	01 to 04	05 to 09	10 to 14	15 to 18	Total
Males						
Homicide	2					**2**
Suicide				1	7	**8**
Undetermined	3	1		2		**6**
Females						
Homicide	1					**1**
Suicide						**0**
Undetermined	1	1				**2**
Total	**7**	**2**	**0**	**3**	**7**	**19**

Table 10: New Hampshire Residents, Suicide Deaths, Ages 0 to 18, 2003-2010

Mechanism of Death	Total
Cut/pierce	**1**
Firearm	**12**
Poisoning	**2**
Suffocation	**25**
Total	**40**

Table 11: New Hampshire Residents, Suicide Deaths, Ages 0 to 18, 2010

Mechanism of Death	Total
Firearm	**4**
Suffocation	**4**
Total	**8**

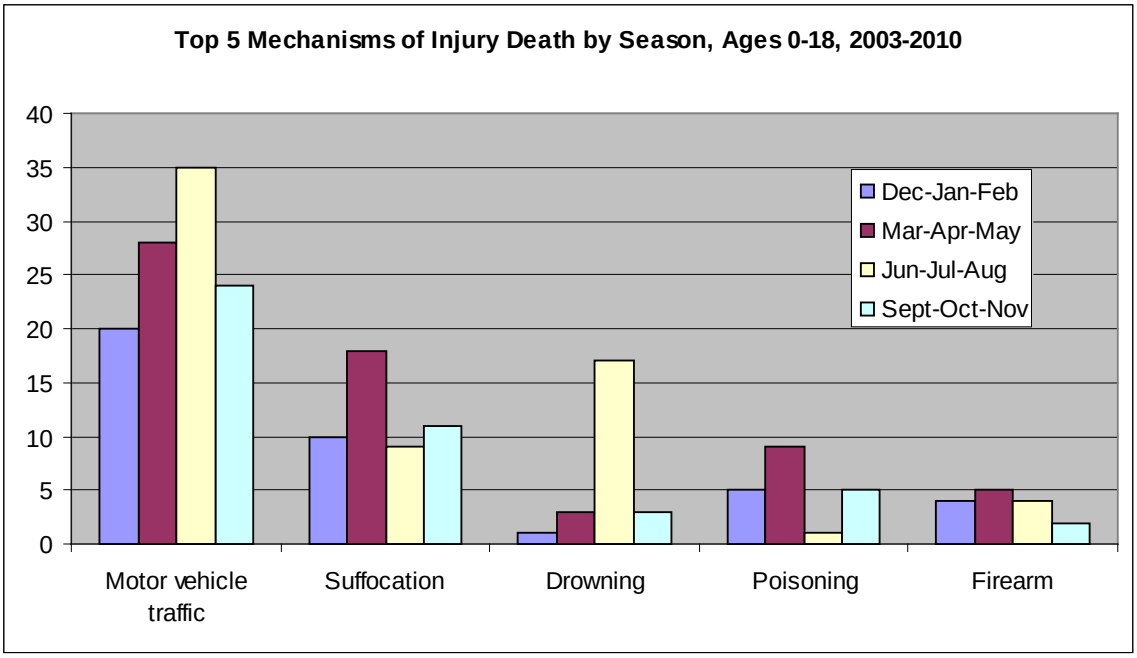
Looking at seasonal variations of injury deaths by mechanism (Table 12), again taking into account low numbers, there is an increased incidence of child deaths due to fire or hot object/substance (i.e. burns) in the winter. This is consistent with national data and is due primarily to smoking, followed by fires ignited by alternate heating mechanisms, often misused, such as a space heater.[1] Another seasonal difference can be seen in the increase in drowning in the summer. Most drownings in the state occur in natural bodies of water, such as rivers and lakes, where summer is the high season for exposure. Motor vehicle crashes were slightly higher in the summer, similar to national data, probably due to the larger number of vehicle miles traveled[2] (Table 12). It is interesting to note that among the intentional (all of the firearm, majority of suffocation, and some of the poisoning) injury deaths, many occur in the March-April-May period (Chart 5). These would include the suicide and homicide deaths.

Table 12: Mechanism of Injury Deaths by Season, New Hampshire Residents, Age 0 to 18 years, 2003-2008

Cause of Injury Death	Dec-Jan-Feb	Mar-Apr-May	Jun-Jul-Aug	Sept-Oct-Nov	Total
Cut/pierce			1	2	**3**
Drowning	1	3	17	3	**24**
Fire or hot object/substance	6	3	1		**10**
Firearm	4	5	4	2	**15**
Machinery	1				**1**
Motor vehicle traffic	20	28	35	24	**107**
Natural/environmental			1		**1**
Other land transport	3	2	2		**7**
Other transport		2	2		**4**
Pedal cyclist - other		2			**2**
Pedestrian - other		1	2		**3**
Poisoning	5	9	1	5	**20**
Struck by or against	1	2			**3**
Suffocation	10	18	9	11	**48**
Other	6	1	2	1	**10**
Total	**57**	**76**	**77**	**48**	**258**

[1] http://www.nfpa.org/assets/files/pdf/homesfactsheet.pdf
[2] www-nrd.nhtsa.dot.gov/Pubs/811124.PDF

Chart 5:


Top 5 Mechanisms of Injury Death by Season, Ages 0-18, 2003-2010
40
35
30
25
20
15
10
5
0
Dec-Jan-Feb
Mar-Apr-May
Jun-Jul-Aug
Sept-Oct-Nov
Motor vehicle traffic
Suffocation
Drowning
Poisoning
Firearm

V. RESPONSES TO RECOMMENDATIONS FROM CHILD FATALITY COMMITTEE (CFRC) REVIEWS CONDUCTED IN 2011 AND 2012

The CFRC uses a ***Recommendation Development Worksheet Form*** (Appendix G) developed from forms used by other states, to record recommendations resulting from the case reviews conducted by the Committee. Once a recommendation is made, it is sorted into one of the following categories:

- Public Awareness
- Training and Education
- Policy
- Professional Collaboration

Each recommendation is then assigned to the appropriate committee member responsible for taking the recommendation back to the agency that is capable of responding to and/or implementing that recommendation.

A summary of the responses and follow up to these recommendations follows. Cases reviewed included deaths from motor vehicle crashes, suicides, drowning, fire and off-road vehicles which had occurred within the past five years.

PUBLIC AWARENESS RECOMMENDATIONS AND RESPONSES

1. Explore conducting public awareness activities/campaign geared towards children and/or parents on the importance of wearing helmets.

RESPONSE:

- *Using personal stories helps create empathy and changes knowledge, but doesn't always affect behavior change. Using stories and peer support along with actual no-cost or low cost safety equipment, such as helmets can increase the likelihood of positive behavior change. The following websites were found as a source of information on effectiveness of public awareness campaigns, including the use of peers and personal stories:*

http://www.cdc.gov/healthcommunication/cdcynergy/cdcynergylite.html

http://www.cdc.gov/healthcommunication/healthbasics/index.html

http://www.thecommunityguide.org/news/2012/HealthCommunicationCampaigns.html

http://www.cdc.gov/healthcommunication/sciencedigest/index.html

http://www.agoodmanonline.com/about/index.html

- *Efforts were made to explore the possibility of working with Kevin Pierce, the local Olympic snowboarder who suffered a serious traumatic brain injury while training. Although he has been promoting helmet safety since his injury, and has a You Tube video on the subject (http://www.youtube.com/watch?v=ptD87--iY3s) it appeared that working with New Hampshire Injury Prevention Program staff for further efforts would not be feasible.*

- *WMUR promoted Safe Kids 500 event as a bike safety. Radio Public Service Announcements and an interview were conducted by Jim Esdon from Safe Kids NH.*

- *Dr. Jose Montero, Director of the NH Department of Health and Human Services' Division of Public Health Services, does monthly pieces on health with WMUR and incorporates injury prevention such as wearing helmets, as appropriate and as time allows.*

2. Continue educational efforts through school nurses, pediatricians and other healthcare providers, to parents on biking and skateboarding safety, including the bike safety laws, and the use of helmets and pedestrian safety. Include information about consideration of a child's developmental stages.

RESPONSE:

- *Safe Kids NH sends out packets electronically through the New Hampshire School Nurse List Serv on bike/wheeled/pedestrian safety and low cost helmet packet every spring. This includes information on children's developmental stages.*

- *Safe Kids NH will include a Child Health Month flyer that is on the topic of the New Hampshire helmet law in future packets distributed to the School Nurse List serv.*

- *Safe Kids NH will continue to promote "Walk This Way" pedestrian safety events in New Hampshire as was held in Franklin in the fall of 2012. "Safe Routes to School" grantees are encouraged to promote pedestrian/bike safety in projects via http://www.nh.gov/dot/org/projectdevelopment/planning/srts/ web site.*

- *Dartmouth Hitchcock clinics have expanded its "Helmet Rx" program to its Manchester clinic site over the past two years. This program distributed over 640 helmets through the Dartmouth Hitchcock system involving Lebanon and Manchester sites.*

3. Increase both children and parents' awareness of the dynamics of natural bodies of water by including it in existing community education initiatives.

RESPONSE:

- *A SafeKids fact sheet on the dangers of drowning was distributed through the school nurse Listserv to be passed on to parents.*

4. Continue discussion between Injury Prevention and Fish and Game about placing "*Kids Don't Float*" signs in risky areas.

RESPONSE:

- *Fish and Game contact was not available to Safe Kids NH until this past summer due to changes in staffing. When approaching communities about Kids Don't Float signage, there is the issue of running into liability concerns from communities, which has resulted in no new signage being installed.*

- *Safe Kids NH invited and welcomed the participation of the Army Corps of Engineers to this past season's Safe Kids 500 event in Loudon to highlight a drowning/water safety display. Safe Kids NH staff has been a resource to communities who inquire about drowning information.*

5. Issue water safety warnings as part of the Department of Health and Human Services (DHHS) websites and possibly in their weather advisories.

RESPONSE:

- *A water safety press release is done by the Department of Health and Human Services (DHHS) at least annually to coordinate with national awareness events (e.g. www.dhhs.nh.gov/media/pr/2012/05212012water.htm).*

- *Water safety fact sheets are on the DHHS website through the Child Safety Month factsheet library (e.g. http://www.dhhs.nh.gov/dphs/documents/water-safety.pdf).*

- *The DHHS Injury Prevention Program will work with the DHHS Public Information Office to put a "slider" on the DHHS website's opening page that reminds the general public about swimming in unsafe situations to cool off in the hot summer months.*

6. Explore current outreach efforts on educating about the dangers of over the counter (OTC) and prescription drugs.

RESPONSE:

- *Staff of NAMI NH were contacted about looking for alternative Facebook pages in suicide deaths. They were unaware of recent postings in relation to a local adolescent suicide but will be alert for future events.*

a. *Regional networks for prevention that are funded by the Bureau of Drug and Alcohol Services often address OTC drug abuse within their regions. This is done by bringing community stakeholders together to address the environmental risks and to raise awareness in an attempt to prevent abuse or*

suicide from OTC drugs. The Bureau of Behavioral Health Services Administrator met with the Community Mental Health Center Children's Directors to discuss this topic. Although they did not have any recommendations, they are committed to keeping it on their radar.

b. *Laurie Warnock is the New Hampshire Educator for the Northern New England Poison Center (NNEPC). She has been focusing on several projects, including one specifically targeted to adolescents in Coos County. Based on a design from students at the Seacoast School of Technology, Ms. Warnock created a static cling sticker with a QR code embedded in it. If used with a smart phone, the QR code links to poison prevention video and the NNEPC's website. Stickers were put up across Coos County, particularly in places where adolescents congregate. The NNEPC is tracking web hits to determine use of the sticker.*

   In January of 2012, "Call to Action: Responding to New Hampshire's Prescription Drug Epidemic" was released by the Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment. This document outlines efforts that are being and could be conducted to help reduce the prescription drug abuse problem in the state amongst all ages, including adolescents. It also serves as a work plan for organizations and agencies working on this issue.

7. Educate parents that they have the right to take away their child's driver's license. Review what was previously done for Child Health Month Coalition material regarding teen driver; update if necessary, and disseminate.

   RESPONSE:

   - *The Child Health Month Coalition handout was reviewed and updated in 2011 and is currently available on DHHS website. It has not been mass disseminated lately.*

   - *The School Nurse List Serv was contacted and information about the new website for the Child Health Month Coalition handouts (www.parenthelpnh.org) was promoted. (This new location for over 100 Child Health Month Coalition fact sheets has a new web address that goes directly to the Department of Health and Human Services site: http://www.dhhs.nh.gov/dphs/fhsfactsheets.htm)*

8. Increase awareness of proper use of seatbelts (i.e. air bags won't help if not wearing seatbelt) and seat positioning. Research what materials are available and distribute to the Child Fatality Review Committee (CFRC) members. Explore if car dealers provide assistance or information about installing car seats.

   RESPONSE:

   - *Appropriate materials were researched and collected and will be distributed to CFRC members for dissemination at a future meeting.*

- *A small sampling of New Hampshire car dealers were informally surveyed. It was found that car dealers do not provide any assistance to parents who want to install child car seats. The concern is for liability in case the seat is installed improperly. Most car dealers surveyed say they recommend that parents go to the local police station for help in installing child car seats.*

9. Support the proclamation of National Abusive Head Trauma (formerly called Shaken Baby Syndrome) Awareness Week.

RESPONSE:

- *Several members of the CFRC are members of the NH Abusive Head Trauma Coalition. The coalition was successful in working with the Governor's Office to issue a proclamation designating April as Child Abuse Awareness Month.*

TRAINING/EDUCATION RECOMMENDATIONS AND RESPONSES

10. Distribute the new 2011 American Academy of Pediatrics' recommendations to reduce deaths from Sudden Infant Deaths (SIDS) and unsafe sleep environments to obstetricians and pediatricians with a cover letter from the Child Fatality Review Committee (CFRC) and from the Division of Public Health Services in time for October SIDS Awareness Month

RESPONSE:

- *Although a targeted mailing from the CFRC to physicians was not done for 2011, information about the new recommendations was shared by email, in newsletters, by handouts displayed at conferences and meetings, and by presentations on reducing the risks of SIDS and promoting Safe Sleep to a broad variety of health and social service professionals who work with infants and new or expectant parents. These communications were carried out by several of the multi-disciplinary members of the CFRC, in 2011 and 2012. Those receiving the information included childcare providers, state-funded home visiting programs, community health centers, community mental health centers, Early Supports and Services programs, pediatricians, early childhood education students, nurses, Assistant Deputy Medical Examiners, and police.*

- *In October 2012, in recognition of October as SIDS Awareness Month, the NH Department of Health and Human Services had a Governor's Proclamation signed; sent a "Tweet" out on the new Safe to Sleep national campaign; and displayed information on the opening DHHS website page "slider" for the month on SIDS, the updated national Safe to Sleep campaign, and the American Academy of Pediatrics' recommendations, with links to key websites, documents, and handout.*

11. Form a Sudden Unexpected Infant Death Public/Professional Awareness Workgroup

***RESPONSE**:*

- *The NH Division of Public Health Services initiated a NH Safe Sleep Campaign workgroup in December 2012 to increase professional and public awareness about reducing the risks of SIDS and deaths from an unsafe sleep environment. Initial target audiences for 2013 activities are primary care providers of infants, and all who work with new or expectant parents.*

12. Submit an article in New Hampshire Police Standards and Training newsletter, "Articulatable Suspicion", reminding officers of ordinances pertaining to skateboarding, as well as bicycle helmets.

RESPONSE:

- *An article was written and submitted to "Articulatable Suspicion".*

13. Submit an article to *Granite State Pediatrician*, the newsletter of the NH Pediatric Society, on bike and skateboarding safety. Include information on asking parents to take into consideration their child's development.

RESPONSE:

- *An article was written and submitted to the Granite State Pediatrician.*

14. Increase awareness of law enforcement regarding increased patrolling of natural bodies of water swimming areas especially on hot summer days. Include information regarding the propensity for autistic children to be drawn to water, which can be helpful in cases where autistic children have gone missing.

RESPONSE:

- *An article was written and submitted to "Articulatable Suspicion", the New Hampshire Police Standards and Training newsletter.*

15. Remind physicians to discuss safe storage of drugs to protect children of all ages, including adolescents.

RESPONSE:

- *An article on "Teen Proofing" was written and submitted to the Granite State Pediatrician, the newsletter of the NH Pediatric Society.*

16. Promote Child Passenger Safety Certification (CPS) technician training to healthcare providers, law enforcement, first responders, and fire departments.

RESPONSE:

- *Information on upcoming CPS trainings was subsequently shared via email to the members of the CFRC to be disseminated to their various contacts.*

- *A preliminary discussion was held to discuss the possibility of developing an in-service training for law enforcement on car seat safety, partnering with Police Standards and Training. NH Highway Safety Agency will need to be included in this discussion moving forward.*

- *A child passenger safety educational session on car seat safety for DCYF Child Protection Workers and foster parents was scheduled for December 2012.*

17. Educate new pediatricians, emergency room doctors and other medical staff regarding responsibility of reporting suspected child abuse and neglect and HIPPA violations. Explore connecting a requirement on this topic to obtaining or renewing a NH medical license.

RESPONSE:

- *There is no requirement for competence in any specific educational topic in order to obtain or renew a license (only a requirement for 100 hours of category 1 credits every 2 years).*

- *An article was submitted to the NH Medical Society, the NH Board of Medicine, the NH Pediatric Society and the NH Board of Nursing to go into their newsletters on the importance of reporting suspected child abuse and neglect and HIPPA violations.*

- *The link to child abuse and neglect reporting requirements was added to the NH Pediatric website and will be added to the NH Medical Society website. The NH Board of Medicine and NH Board of Nursing were contacted about adding it to their websites as well.*

POLICY RECOMMENDATIONS AND RESPONSES

18. Encourage Emergency Department providers to take and document an infant's rectal temperature in all infant deaths. Reach out to emergency room nurses to see what the current policy/practice is and if it is included on their flow chart.

RESPONSE:

- *Emergency Department nurses were contacted via the NH Emergency Nurses Association. It was identified that this practice is in need of development. There is no standard flow sheet used statewide.*

19. Encourage all Assistant Deputy Medical Examiners (ADME) to include both the infant's rectal temperature, and notation of the approximate temperature of the room where the infant died, in reports of sudden unexpected infant deaths.

- *The Office of Chief Medical Examiner staff will instruct ADMEs to take the rectal temperature, and make note of the approximate room temperature at an infant death scene.*

- *The Office of Chief Medical Examiner will follow-up with hospitals if infant rectal temperature is not documented in the ADME's report.*

- *The Office of Chief Medical Examiner staff will add rectal temperature and approximate room temperature to the Infant Death Scene Investigation form.*

20. Explore policy change regarding implementation of regulations on mandatory use of helmets for skateboarding.

RESPONSE:

- *Information on different state statutes regarding helmet laws for skateboarding (including inline skating) was collected and shared with the Child Fatality Review Committee from sources such as SafeKids Worldwide.*

- *Data on the effectiveness of helmet laws were reviewed. The data generally show that there are higher proportions of helmet use following legislation, particularly when the law is targeted to a specific age group that were low pre-law helmet wearing (e.g. young children; however, over the long term, bicycle helmet legislation varies by income area. Ongoing strategies such as free helmet fittings and give-aways may be necessary in conjunction with the law, particularly in mid and low income areas. There is some evidence that interventions offered in healthcare settings can increase self-reported helmet wearing.*

21. Explore adding questions about child's ability to swim as part of the anticipatory guidance questions in well child visits. If changing an electronic medical record (EMR) template is not possible, encourage health care providers to discuss swimming ability as part of age-appropriate water safety anticipatory guidance.

RESPONSE:

- *The American Academy of Pediatrics' "Bright Futures – Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd edition, adhered to by many providers, recommends age appropriate water safety anticipatory guidance, including sample questions, for well child visits at ages 12 month, 30 months, 5-6 years, 7-8 years, and 9-10 years. It recommends asking about swimming skills at 5-6 years, 7-8 years, and 9-10 years. The prompt on most EMR's for this topic is for a "water safety" discussion. It is the responsibility of each private health care organization to request desired additions, such as specifically adding swimming ability, to their electronic medical record template, which is often a difficult process.*

- *An article on the importance of discussing water safety, including swimming ability, with parents at well child visits was written and submitted to the Granite State Pediatrician, newsletter of the NH Pediatric Society.*

22. Follow up with the NH Division of Children, Youth, and Families to review standards for interviewing collateral contacts.

RESPONSE:

- *No follow up noted for this recommendation at this time.*

23. Support the medical prescription monitoring legislation and stay updated on its progress. If possible, submit a letter of endorsement by the Child Fatality Review Committee or by one of the member's organizations.

RESPONSE:

- *Senate Bill 286, relative to a controlled drug prescription health and safety program, went into effect June 12, 2012 (with section 4 of statute going into effect 9/1/15). A letter of endorsement from the Committee had not been sent prior to the bill passage.*
- *The Injury Prevention Advisory Council is having training on 3/26/13 which will include a panel discussion on the prescription drug monitoring program.*
- *Information on the task force charged with implementing the legislation was shared with the CFRC. The CFRC representative from the Board of Pharmacy will provide the committee with periodic updates upon request.*

24. Encourage support and information sharing by the CFRC on the New Hampshire Pediatric Society Allstate grant funds for the Teen Safe Driving Project.

RESPONSE:

- *Information on the Allstate Insurance Company/American Academy of Pediatrics grant for the Teen Safe Driving Project grant activities was sent to CFRC members to disseminate.*

25. Support legislative efforts to strengthen graduated drivers licensing, seatbelt use for all, and enhancement of the child restraint law to make it congruent with best practices.

RESPONSE:

- *The CFRC Committee submitted a letter in support of House Bill 242, relative to child passenger restraint requirements to the House Transportation Committee and all of the bill's sponsors.*

26. Encourage dissemination of the Bureau of Drug and Alcohol Services' material by the CFRC.

RESPONSE:

- *The Bureau of Drug and Alcohol Services has information on trauma, substance abuse, pregnancy, recovery, etc. for many different audiences available in DVD's, Video's, Curriculum and Pamphlets/Brochures. A resource listing of the material available will be shared with the CFRC at a future meeting.*

27. Improve accessibility to complete medical records from criminal investigations, and access to doctors, nurses and other professionals/staff for trial preparation and testimony by drafting sample language, and approaching the NH Medical Society for its support.

RESPONSE:

- *No follow up noted for this recommendation at this time.*

PROFESSIONAL COLLABORATION RECOMMENDATIONS AND RESPONSES

28. Encourage primary care and prenatal providers to refer families at risk to a home visiting program by increasing the outreach efforts of home visiting programs funded by the Division of Public Health Services' Maternal and Child Health Section (MCH).

RESPONSE:

- *Due to state budget deficits, the future of several MCH-contracted home visiting programs was tenuous in 2011, thus outreach to local providers by the contract agencies was limited. For State Fiscal Year 2013, nine community agencies received competitive grants for a home visiting program that is a combination of what previously had been two different MCH-funded programs. Ten community agencies also were awarded competitive grants for a new federally-funded Healthy Families America - model home visiting program. Local agencies carrying out these programs are currently doing outreach to their local providers to get referrals for pregnant women and families needing services and meeting program criteria.*

29. Invite out of state providers to CFRC meetings.

RESPONSE:

- *As is appropriate to the specific case being reviewed, the CFRC will invite out of state providers to the review meeting.*

30. Encourage the NH Hospital Association to strengthen collaboration with mental health centers in discharging patients.

RESPONSE:

An email was sent to all the hospitals by the Acute Care Services Coordinator of the NH Bureau of Behavioral Health with referral information about the Community Mental Health Centers.

VII. THE NEW HAMPSHIRE SUDDEN UNEXPECTED INFANT DEATH (SUID) PROJECT

BACKGROUND

In August, 2010, the New Hampshire Department of Health and Human Services, Division of Public Health Services, Maternal and Child Health Section, was awarded one of seven competitively bid grants from the Centers for Disease Control (CDC) to pilot a web-based data system of Sudden Unexpected Infant Deaths (SUID). The grant, often referred to as the New Hampshire SUID Project, is a collaborative effort with the Department of Justice, Office of the Attorney General, Office of Chief Medical Examiner, which has the legal authority to investigate such deaths, including requesting case information.

Registry objectives included:

- having a state-level web-based surveillance system that builds on national child death review activities;
- categorizing SUID using standard definitions, for Medical Examiners to make better and more consistent diagnoses;
- monitoring the incidence of different types of sudden unexpected infant death;
- describing the demographic and environmental factors for each type of SUID; and
- informing prevention activities to potentially save lives.

The grant had initially been awarded to five states for three years (2009 – 2012), with New Hampshire not being one of the five. When additional funding became available, New Hampshire and Minnesota were selected to join the five for years two and three of the grant cycle (September 2010 – August 2012). In September 2012, New Hampshire was awarded one of the nine CDC SUID Case Registry grants, allowing the state to continue the NH SUID Project for an additional three years (September 2012 – August 2015).

Case Registry

New Hampshire began entering data into the registry on infants whose New Hampshire death occurred suddenly and unexpectedly as of January 1, 2011, excluding cases of homicide. CDC is interested primarily in the sudden and unexpected deaths of infants residing in the state who die in a sleep setting. These include deaths from Sudden Infant Death Syndrome (SIDS), deaths from accidental asphyxiation or suffocation in a sleep setting, and those deaths classified as "Undetermined". This last diagnosis is used to describe deaths for which it was not possible to definitely conclude what the cause of death may be, i.e. SIDS versus accidental suffocation by loose bedding.

There were seven infant deaths that occurred in New Hampshire, suddenly and unexpectedly, in a sleep setting in 2011. Six were New Hampshire residents, one an infant visiting from out of state. Of the six resident deaths, two were classified as SIDS, four as Undetermined.

Data from the 2011 deaths are the first complete year of New Hampshire registry data. De-identified data is extracted from the registry by the CDC and analyzed along with data from other states using the registry, to better understand why infants are dying suddenly and

unexpectedly. The data will be used by both CDC and the state of New Hampshire to track and monitor trends over time, and to develop targeted strategies to prevent further deaths. For details about these six deaths, please see "New Hampshire Public Health Issue Brief: 2011 Sleep Related Infant Deaths". (Appendix H)

New Hampshire SUID Review Group

States receiving funding are required to do a review of all the sudden and unexpected infant sleep-related deaths during the grant cycle. As New Hampshire already had an active state-level Child Fatality Review Committee, this group was used as the core of the SUID Review Group. Supplemental members with expertise in areas related to perinatal care or services impacting infants, such as an obstetrics, neonatology, midwifery, breast feeding, home visiting, WIC services, etc. were invited to join the SUID Review Group. Please see attached List of New Hampshire Sudden Unexpected Infant Death Review Group Members". (Appendix I)

The first SUID Review Group meeting was held June 2011. Meetings are currently held every other month, alternating with the meetings of the Child Fatality Review Committee. One of the purposes of the meetings is to obtain a more comprehensive collection of information from the multi-disciplinary members, about the case, than might routinely be available to the investigation. This increased scope of information is of value to both the registry's data analysis and to the Office of Chief Medical Examiner staff classifying the cause and manner of death. By having a more comprehensive overview of the case, the medical examiners are better able to make a more accurate diagnosis, especially one consistent with the current guidelines of the National Association of Medical Examiners.

SUID Review Group Recommendations

An additional purpose of the review meetings is to generate recommendations that may decrease sudden unexpected infant deaths in a sleep setting with strategies such as improving services, developing or altering policies, educating target groups, etc. that may ultimately decrease risk factors. Following discussion of each case, draft recommendations are proposed which get refined in subsequent meetings and communications. It is the responsibility of the SUID Review Group members to take action on the recommendations, although for a variety of reasons, not all recommendations may be feasible or achievable. Please see section "New Hampshire Sudden Unexpected Infant Death (SUID) Review Group Recommendations and Follow up on Reviews of Calendar Year 2011 Infant Deaths".

Other NH SUID Project Activities

In addition to the Review Group, the NH SUID Project has launched a NH Safe Sleep Campaign, whose workgroup includes many of the SUID Review Group members, and several external participants. Activities include:

- Development and use of a Safe Sleep display board with safe sleep and SIDS risk reduction handouts used by NH SUID Review Group members at a broad variety of conferences and meetings throughout the state.

- Selecting three handouts from the Safe to Sleep national campaign and the Consumer Product Safety Commission, with NH Safe Sleep Campaign contact information added, and mass copied for wide distribution.
- Providing safe sleep information in free give away bags to new or expectant moms at events such as the Diaper Derby at the Rockingham Mall, or the annual Moms Night Out event at four Simon Malls in collaboration with the state WIC Program.
- Planning a Safe Sleep Symposium with state and national level authorities on SUID as speakers, in Concord, New Hampshire, for October 29, 2013, with the target audience home visitors to expectant and new parents, and health and social service providers who have direct contact with expectant or new parents.
- Conducting a targeted electronic and paper mailing to obstetricians, pediatricians and family practice physicians during summer 2013 to promote awareness of the American Academy of Pediatrics' safe sleep recommendations, and use of the new Safe to Sleep national campaign handouts with patients.
- Planning a survey to the state's birthing hospitals on current policies and practices related to the American Academy of Pediatrics recommendations to reduce SIDS and promote a safer sleep environment.

NEW HAMPSHIRE SUDDEN UNEXPECTED INFANT DEATH (SUID) REVIEW GROUP RECOMMENDATIONS AND FOLLOW UP ON REVIEWS OF CALENDAR YEAR 2011 INFANT DEATHS

For Chief Medical Examiner's Office

1. Add pacifier use to Infant Death Scene Investigation Form. Notify Assistant Deputy Medical Examiners (ADME) of change in form and rationale behind the change.

   RESPONSE:
   - *Pacifier use will be added to the form. A recommendation to include it was communicated by the Chief Forensic Investigator to the ADMEs via their Listserv. This will be reinforced at the next routine ADME update/training.*

2. Explore use of special growth charts for premature infants when charting growth measurements of a deceased premature infant.

   RESPONSE:
   - *The New Hampshire Office of Chief Medical Examiner has obtained growth charts for premature infants and will use them going forward for the appropriate cases.*

3. Reinforce education to ADMEs to do doll re-enactments on all SUIDs.

   RESPONSE:
   - *Use of/the importance of doll-re-enactments was included in the 2011 ADME update/training by the Chief Forensic Investigator, and will be reinforced at a subsequent session.*

4. Add space for details of mattress found in SUID cases to Infant Death Scene Investigation Form.

RESPONSE:

- *Infant Death Scene Investigation Form will be altered to include more space to detail firmness of infant's sleep surface. A recommendation to include it was communicated by the Chief Forensic Investigator to the ADMEs via their Listserv. This will be reinforced at the next routine ADME update/training.*

For Birth Hospitals

5. Educate hospital nursery staff about revised American Academy of Pediatrics (AAP) recommendations, including no blankets, no side propping. Encourage modeling by hospital staff of not using a blanket and no side propping. Increase safe sleep guidance to new moms before discharge especially those breastfeeding.

RESPONSE:

- *The Chief Forensic Investigator, and the New Hampshire Division of Public Health's SIDS Program Coordinator presented information about the revised AAP recommendations, SUID deaths in New Hampshire and the New Hampshire SUID Project at the fall 2011 Perinatal Nurse Managers' Meeting. The importance of role modeling, stressing the practice of no bed sharing and no blanket, and the importance of educating moms, especially those who are breastfeeding, on the recommendations, prior to discharge, was emphasized. The Chief Forensic Investigator spoke at the 2012 conference of the New England Perinatal Quality Initiative Network on infant death scenes. This conference is attended by many hospital nursery staff.*

6. Encourage perinatal nurses to review protocols to include more frequent monitoring of premature infants being breastfed.

RESPONSE:

- *The increased risk of premature infants and small for gestational age infants dying from accidental suffocation while bed sharing for nursing was discussed at the fall 2011 Perinatal Nurse Managers' Meeting. A survey to state birthing hospitals to assess SIDS/Safe Sleep risk reduction current practice and policy, and the need for training, in New Hampshire and in Colorado is planned for summer 2013 by the New Hampshire and the Colorado SUID Projects.*

7. Encourage hospitals to check that bereavement protocols for staff are in place.

RESPONSE:

- *No formal statewide follow up done. Topic may be discussed at a future Perinatal Nurse Managers' Meeting.*

8. Assess need to refer for mental health services any woman who gives birth having had no prenatal care which may indicate existing high risk factors.

RESPONSE:

- *No formal statewide follow up done. Topic may be discussed at a future Perinatal Nurse Managers' Meeting.*

9. *Conduct pulse oximetry on all newborns to detect Critical Congenital Heart Defects (CCHD).*

RESPONSE:

- *In 2012, New Hampshire passed legislation mandating screening newborns for CCHD. All birth hospitals are now conducting pulse oximetry on their newborns.*

For Hospital Emergency Departments

10. Encourage hospital staff to take a temperature when infant death emergency "code" is over.

RESPONSE:

- *Hospital staff should take and document a rectal temperature on all infants who are resuscitated in the Emergency Department, even if the resuscitation is unsuccessful. It is a potentially important piece of information for care in a code situation. If the resuscitation is unsuccessful, it is vital information for the Medical Examiner's Office to have when determining the final cause of death. This information was discussed and reviewed at the New Hampshire Chapter of the Emergency Nurse's Association Meeting February 2013.*

For Law Enforcement

11. Remind law enforcement that they can request final autopsy reports of their cases.

RESPONSE:

- *A reminder that law enforcement can request final autopsy reports of their cases was included in a recent law enforcement newsletter. That item was also added to the information given to Police Recruits in their Crime Scene/Death Scene Instruction.*

12. Discuss need for development of/review of police department checklist of items to consider when investigating a Sudden Unexpected Infant Death (SUID).

RESPONSE:

- *At 2011 and 2012 SUID Review Group Meetings, which included representatives from law enforcement, the list of the top 25 key death scene investigation pieces of information recommended by the Centers for Disease Control was shared. The Death Scene Investigation Form currently used by the Manchester Police Department was shared at a meeting with the SUID Review Group by staff from the Manchester Police Department for review and feedback for improvement.*

13. Share scene photos, etc. as appropriate at SUID review meetings.

RESPONSE:

- *When the New Hampshire SUID Project Staff invite the local law enforcement agency involved in the case being reviewed at an upcoming SUID Review Group meeting, they now suggest that law enforcement bring photos of the scene to the review and share with the group to have a better understanding of the case.*

For Public Health

14. Check Text4Baby message for content about not smoking, and not bed sharing. Continue state Text4Baby campaign outreach efforts.

RESPONSE:

- *The Text4Baby messages include information about the importance of not smoking, not bed sharing, and other safe sleep and SIDS risk reduction-related recommendations. New Hampshire health and social service providers continue to do an excellent job educating newly pregnant women about Text4Baby. The state continues to be one of the leaders in the nation for percent of pregnant women enrolled in the Text4Baby campaign.*

15. Educate new /prospective parents about how to calm a fussy infant and the dangers of taking a baby into bed to calm by using scenarios on TV and radio PSAs.

RESPONSE:

- *Scenarios on TV and radio PSAs have not been carried out to educate parents about calming a fussy baby; however, numerous state and local organizations and numerous birthing hospitals throughout the state are now supporting or carrying out the Period of Purple Crying child abuse prevention program. The New Hampshire Injury Prevention Program, in collaboration with the New Hampshire Children's Trust and the New Hampshire Abusive Head Trauma Coalition, is the lead agency for this initiative. An article on the Period of Purple Crying, written by SUID Review Group member Dr.Wendy Gladstone, who represents the New Hampshire Pediatric Society, was published in a recent edition of the Granite State Pediatrician, the New Hampshire Pediatric Society newsletter.*

16. Educate home visiting programs on the AAP recommendations, their role in educating care providers, and the importance of viewing an infant's sleep setting during a visit.

RESPONSE:

- *Information on the AAP Recommendations, including the role of home visitors in educating parents and in viewing where an infant sleeps, was shared with Division of Public Health Maternal and Child Health - funded home visiting program staff by the New Hampshire Division of Public Health SIDS Program Coordinator, in 2011 and 2012. A Safe Sleep Symposium is planned for October 2013, which will include staff*

from home visiting programs as a target audience. Training specifically for Child Protection Service home visiting staff is also planned for the future.

For Child Protection Services

17. Explore if the Department for Children, Youth, and Families (DCYF) can re-open an unfounded case based on new family information from SUID review meeting.

RESPONSE:

- *DCYF can either re-open an unfounded case, or add information to an existing case if warranted. Based on the new information received, it could also trigger a whole new assessment.*

18. Educate home visiting programs funded by DCYF on the importance of viewing infant sleep setting and including safe sleep education during home visits.

RESPONSE:

- *Information on the AAP Recommendations, including the role of home visitors in educating parents and viewing where an infant sleeps, was shared with Division of Public Health Maternal and Child Health - funded home visiting program staff by the New Hampshire SIDS Program Coordinator, in 2011 and 2012. Many of the staff that attended these meetings provides services through DCFY-funded home visiting programs at their agencies, as well. A Safe Sleep Symposium is planned for October 2013, which will include staff from DCYF-funded home visiting programs and foster/adoptive parents as part of the target audience. Training specifically for Child Protection Service home visiting staff is also planned for the future.*

19. Arrange a back-up system for obtaining Child Protection Service case information for SUID review meetings if the DCYF representative is unable to attend meeting.

RESPONSE:

- *DCYF will provide information at every meeting and will have a designate present in the event that the representative is unable to attend.*

For SUID Project Staff

20. Share case recommendations from the CDR with baby's primary care provider.

RESPONSE:

- *SUID Review Group member Dr. Wendy Gladstone, the representative from the New Hampshire Pediatric Society, follows up with the baby's primary care provider following the case review to report on any discussion or information shared that might be of significance to the provider regarding the case.*

21. Increase support and access to home visiting services by sending biennial SUID Review Group report to policy makers.

RESPONSE:

- *The SUID Review Group report will be included in the 2011-2012 Child Fatality Review Committee Report, to be presented to the Governor in June, 2013, and subsequently disseminated to key stakeholders and policy makers.*

22. Form workgroup to discuss getting new AAP recommendations out to parents, providers, social service providers, etc.

RESPONSE:

- *A New Hampshire Safe Sleep Campaign workgroup was formed in December 2012 to promote the AAP Recommendations to the general public, health and social service professionals, and all who care for infants, or have contact with those who care for infants.*

23. Target Obstetricians for educating about the AAP recommendations and their role in discussing with prospective parents where baby is going to sleep.

RESPONSE:

- *The Chief Forensic Investigator spoke at the 2012 conference of the New England Perinatal Quality Initiative Network on infant death scenes. This conference was attended by many obstetricians. Information on the new AAP recommendations and the role of prenatal care providers in educating pregnant women on the recommendations, was included in the conference material of the January and March 2013 conferences of the New England Perinatal Quality Initiative Network. These conferences were attended by numerous obstetric and perinatal care staff. Prenatal care providers will be a target audience for the October 2013 Safe Sleep Symposium, being planned by the New Hampshire Safe Sleep Coalition.*

24. Notify SUID Review Group members of towns where both parents of case victim live if different so that members can check files to bring relevant information on both parents to case review, as appropriate.

RESPONSE:

- *SUID Project staff now includes both the names of the infant's parents and their towns (if different) in the SUID Review Group agenda information sent prior to the case review.*

25. Arrange a back-up system for obtaining Child Protective Service case information for SUID review meetings if the DCYF representative is unable to attend meeting.

RESPONSE:

- *A request will be added to the SUID Review Group meeting agenda that if a member is unable to attend the meeting, s/he should find a substitute to attend the meeting, or share key case information with either another member, or one of the SUID Review Group Co-Chairs prior to the meeting.*

For SUID Review Group Members to Impact Health Care Providers Especially Prenatal, Pediatric, and Family Practice Providers

26. Educate new /prospective parents about how to calm a fussy infant and the dangers of taking a baby into bed to calm by using scenarios on TV and radio PSAs.
RESPONSE:

- *Scenarios on TV and radio PSAs have not been carried out to educate parents about calming a fussy baby; however, numerous state and local organizations and numerous birthing hospitals throughout the state are now supporting or carrying out the Period of Purple Crying child abuse prevention program. The New Hampshire Injury Prevention Program, in collaboration with the New Hampshire Children's Trust and the New Hampshire Abusive Head Trauma Coalition, is the lead agency for this initiative. An article on the Period of Purple Crying, written by SUID Review Group member Dr.Wendy Gladstone, who represents the New Hampshire Pediatric Society, was published in a recent edition of the Granite State Pediatrician, the New Hampshire Pediatric Society newsletter.*

27. Encourage prenatal, pediatric, and family practice providers, and all health and social service providers with direct contact with new and prospective parents, to educate on the AAP recommendations, including the risk of infant deaths due to smoking, increased risk due to smoking plus bed sharing, and asking where the baby will/does sleep.

RESPONSE:

- *Information on the AAP Recommendations was presented by SUID Review Group Member, Dr. Robert Darnall, in 2012, at a Dartmouth Hitchcock Medical Center Pediatric Grand Rounds. An article on the AAP Recommendations and the SUID Review Group by group member Dr. Wendy Gladstone was published in a recent edition of the Granite State Pediatrician, the New Hampshire Pediatric Society newsletter. Dr. Gladstone, additionally, has done several presentations to pediatricians and groups of health care providers on reducing the risks of SIDS and promoting a safe sleep environment. In 2011, 2012, and 2013, information on the AAP recommendations and the need to educate new and prospective parents was shared with all the state-funded Community Mental Health Center staff, the WIC agencies, and the state-funded Community Health Centers, state-funded home visiting programs, child care providers, Perinatal Nurse Managers, and Emergency Department nurses through a variety of meetings, large and small presentations, poster displays at state conferences, newsletters, and email blitzes. The October 2013 Safe Sleep Symposium will reach over 150 staff who have direct or indirect*

contact with new and expectant parent. Additional activities are being planned by the New Hampshire Safe Sleep Coalition to continue to get the message out.

28. Follow-up with the national American College of Obstetricians and Gynecologists, and the American College of Nurse-Midwives, about their effort to spread the AAP recommendations nationally to members.

RESPONSE:

- *No specific details are available about efforts being done on the national level.*

Additional activities by SUID Review Group Members, not previously mentioned, to share information on reducing the risk of SIDS and deaths from unsafe sleep environments with others from the disciplines, which they represent:

- Office of Chief Medical Examiner staff:

Numerous presentations to students, physicians, law enforcement, and other groups, on the state and national level, are made throughout the year by the Chief Medical Examiner and the Chief Forensic Investigator, which include information on Sudden Unexpected Infant Deaths, and forensic investigations including those for infants who die suddenly and unexpectedly.

- Law Enforcement:

In 2012, Safe Sleep information, including the 2-sided flyer from the national Safe To Sleep campaign which could be downloaded and posted, was disseminated through the Police Standards and Training electronic bulletin board which reaches hundreds of Law Enforcement officers each month.

- NH Division of Public Health Services:

Activities for October 2012, SIDS Awareness month included a "slider" on the NH Department of Health and Human Services' website contained information on the reducing the risks of SIDS and promoting safe sleep for infants, including links to the updated Safe to Sleep national campaign and other sources of related information. A "Tweet" was sent from the New Hampshire Division of Public Health on the "Bare is Best" safe sleep message. The Governor signed a proclamation designating October as SIDS Awareness Month in New Hampshire. These activities are in addition to the numerous presentations done throughout the year to child care providers, hospitals, and other community-agency based health and social service providers such as WIC Nutritionists, on reducing the risk of SIDS and promoting safe sleep practices, by the New Hampshire SIDS Program Coordinator. In 2011, 2012, and 2013, the AAP Recommendations and information on the revised Safe to Sleep national campaign was also disseminated among state-funded health and social service programs through email.

- Safe Kids NH:

Articles on the AAP Recommendations and information on the revised Safe to Sleep national campaign have been published in 2011 and 2012 in the Safe Kids NH newsletter. Information and links to related resources will also be posted soon on the Children's Hospital at Dartmouth, Injury Prevention Center website.

VIII. CONCLUSION

This report highlights the important work of the New Hampshire Child Fatality Review Committee. We hope 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 27th day of September in the year of our Lord, one thousand nine hundred and ninety-five.

Governor of New Hampshire

APPENDIX C: 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, the New Hampshire Department of Education 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.
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, education, with specific membership 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.

_____ _____

Attorney General Date

_____ _____

Commissioner, Health and Human Services Date

_____ _____

Commissioner, Department of Safety Date

_____ _____

Commissioner, Department of Education Date

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 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: RECOMMENDATION DEVELOPMENT WORKSHEET

MEETING DATE: _____

TYPE OF DEATH(S)/PROBLEM(S) REVIEWED:

RECOMMENDATION(S) AND IMPLEMENTATION PLAN

	Recommendation:	**Steps to implement:**	**Person responsible for implementing steps:**	**Timeline:**	**Additional Follow-Up:**	**Response/ Current Status**	**Category *Public Awareness *Training/ Education *Policy *Professional Collaboration**
1)							
2)							
3)							
4)							
5)							
6)							

APPENDIX H: ISSUE BRIEF

NEW HAMPSHIRE PUBLIC HEALTH ISSUE BRIEF: 2011 SLEEP-RELATED INFANT DEATHS

INTRODUCTION

In 2011, there were six sleep-related infant deaths in New Hampshire to State residents, all with one or more risk factors which increased the chance of death. Two of these six deaths were due to Sudden Infant Death Syndrome (SIDS). Four were classified as "Undetermined", i.e., it was not possible to determine if the death was from SIDS, or from another cause, such as accidental suffocation in the sleep environment. *Caution is recommended in generalizing these results as they are from a single year and the numbers are small.*

ABOUT THE BABIES

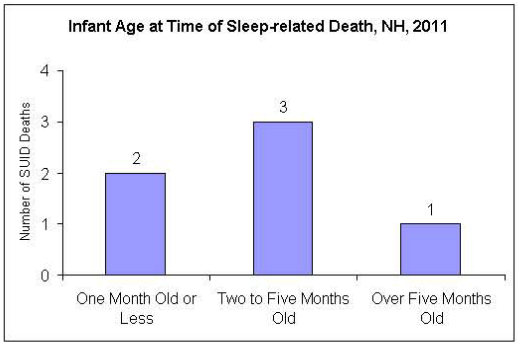
- Five of the six infants who died were males.
- Three were between two and five months of age.
- All six infants who died were white, and only one was of Hispanic ethnicity.
- Three of the six infants were from Hillsborough County.
- Infants born at term (37 or more completed weeks of gestation) represent only one of the six.
- Infants with low birth weight represent three of the six.

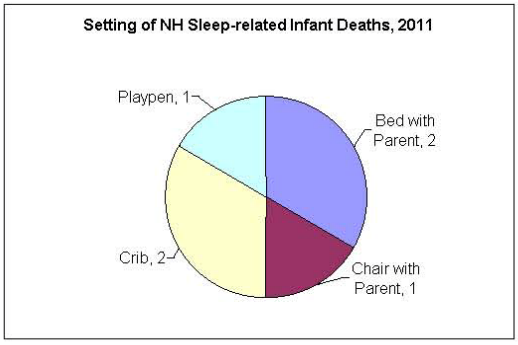
ABOUT THE BABIES' CAREGIVERS

- None of the infants' mothers smoked during or after pregnancy.
- Three of the six infants' mothers had some college education.
- Three of the six infants' mothers were between 20 and 30 years old.
- Five of the six infants' mothers were in a low-income bracket.
- Four of the six births of infants who died were paid by Medicaid.
- Two of the six infants' mothers had late or no prenatal care.
- Four of the six infants were breastfed, with one of the four deaths involving the mother falling asleep with her child while breastfeeding.

ABOUT THE SLEEP ENVIRONMENTS

- Three of the six infants shared a sleep surface with their mother.
- One of the six infants was found to be overheated.
- Only two of the six infants had been placed to sleep on their backs.
- In four of the six deaths, the infants were found sleeping in a place other than a crib.
- Five of the six infants had soft objects or loose bedding in their sleep area.





PREVENTING SLEEP-RELATED DEATHS

The American Academy of Pediatrics, supported by strong and consistent scientific evidence, recommends that infants are safest room-sharing without bed-sharing. **Infants should sleep ALONE, on their BACKS, in a safety-approved CRIB, bassinette, or portable play area**. Put baby on a firm flat mattress without any soft objects or loose bedding, and avoid overheating. Best practices for mothers include avoiding smoke exposure during pregnancy and after birth, getting early and routine prenatal care, and breastfeeding. The New Hampshire Department of Health and Human Services, Division of Public Health Services promotes these recommendations to parents, caregivers, and health care professionals.

New Hampshire Department of Health and Human Services
Division of Public Health Services
Maternal and Child Health Section
29 Hazen Drive, Concord, NH 03301
Phone: 603-271-4517
http://www.dhhs.nh.gov/dphs/bchs/mch

Released May 2013

APPENDIX I: SUID GROUP MEMBERSHIP

THE NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE'S SUDDEN UNEXPECTED INFANT DEATH (SUID) REVIEW GROUP MEMBERS

January 2011 - December 2012

Co-Chair: Marc Clement, PhD
Colby-Sawyer College

Co-Chair: Audrey Knight, MSN, RN
Department of Health and Human Services
Division Of Public Health Services

Members of the New Hampshire Child Fatality Review Committee:

*=Alternate Member

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

Judge Susan Ashley
Family Division

*Lorraine Bartlett
Division for Children, Youth & Families
Department of Health & Human Services

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

Vicki Blanchard
Division of Emergency Medical Services
Department of Safety

Captain Mark Bodanza
Police Standards and Training

*George Bowersox
Board of Pharmacy

Bill Clark
Fire Marshall's Office

Peg Clifford
Board of Pharmacy

Deb Coe, MA
NH Coalition Against Domestic & Sexual Violence

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

Kim Fallon, Chief Forensic Investigator
Office of Chief Medical Examiner

Elizabeth Fenner-Lukaitis, LICSW
Acute Care Services Coordinator
Bureau of Behavioral Health
Department of Health & Human Services

Detective Matt Fleming
Bedford Police Department

Hannah Galvin, MD
Emergency Department Pediatrician

Wendy Gladstone, MD
Pediatrician

*Lieutenant Jill Hamel
Police Standards and Training

Sergeant Sara Hennessey
State Police

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

Jane Hybsch, Administrator
Office of Medicaid Business and Policy
Department of Health & Human Services

Jane Kendall, RN, Medical Consultant II - Benefits Specialist, Office of Medicaid Business and Policy
Department of Health & Human Services

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

*Susan Meagher
CASA of New Hampshire

Detective Rick Nanan
Manchester Police Department

Linda Parker, BS, CPM/Program Specialist
Division of Community Based Care Services
Bureau of Drug and Alcohol Services
Department of Health & Human Services

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

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

*Robin Raycraft-Flynn, Administrator
Bureau of Behavioral Health
Department of Health & Human Services

Sergeant Jill Rockey
State Police

Amy Roy, MD
Emergency Department Pediatrician
New Hampshire's Hospital for Children

Debra Samaha, Program Director
Injury Prevention Center at Dartmouth

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

Rhonda Siegel, MSEd
Injury Prevention, Adolescent Health, and Prenatal Program, Division of Public Health Services, Department of Health & Human Services

Marcia Sink, Executive Director
CASA of New Hampshire

Additional Members of the New Hampshire Sudden Unexpected Infant Death Review Group:

Deborah Bell-Polson MSN, RNC-OB
Clinical Nurse Manage,r Maternity Services
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Sharon Breidt, RN
Elliot Hospital Emergency Department

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Harbour Women's Health

Dr. Robert Darnall, MD
Professor of Pediatrics & Neonatologist
ChaD/DHMC

Nicholle Desmarais, NH SUID Project Data Clerk
Office of Chief Medical Examiner

Cynthia DeSteuben, CNM, MSN
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State Police

Victoria Flanagan, RN, MS
Dartmouth Hitchcock Medical Center

Jonelle Gaffney
CASA of NH

Karen Jameson, RN, Home Visiting Program/Prenatal Program Coordinator
Good Beginnings of Sullivan County

Claremont

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Elliot Hospital

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Division of Public Health Services, Department of Health & Human Services

Paula Wellde, MSN, RNC-OB, C-EFM
Perinatal Patient Safety Coordinator
Portsmouth Regional Hospital

Mike Witt, MD
Elliot Hospital Emergency Department


PROGRESS IN SAFETY
Unintentional gun deaths have dropped by over 50% in New Hampshire over the last three decades!
ABOUT THE COALITION
GUN SAFETY RULES
The Newsletter of the New Hampshire Chapter of the American Academy of Pediatrics!
The Granite State Pediatrician
September, 2012
Volume 24, Number 5
Is Your Office PURPLE?
Is Your Patient Depressed? Is There a Gun Within Reach?
SAVE THE DATE:
November, 2012
DON'T BE AN OSTRICH
The Granite State Pediatrician - page 3
Safe to Sleep Campaign
CONCERNED ABOUT A FAMILY MEMBER OR FRIEND?
ARE THEY SUICIDAL?
SUICIDES IN NH for outnumber homicides
FIREARMS ARE THE LEADING METHOD
ATTEMPTS WITH A GUN ARE MORE DEADLY than attempts with other methods
HOLD ON TO THEIR GUNS
—Putting time and distance between a suicidal person and a gun may save a life.
Message of the Quarter
NH Suicide Prevention Project Focuses on Gun Shops
By THE ASSOCIATED PRESS
Published: April 20, 2013 at 11:26 AM ET
SAFETY AND KIDS
TEACHING
SMALL CHILDREN
SCHOOL-AGE CHIL
Suggestions for KEEPING GUNS SAFELY
HELP KEEP OU YOUNG PEOPLE
What Pediatricians need to know about Longboarding
Bang, Bang: You're Dead
How many of your patients got guns as presents recently?
Please Take Notice!
WNING & HANDLING A GUN
SPREAD THE WORD
- Wendy Gladstone MD
Diana Dorsey MD- Submitted for the NH Child Fatality Review Committee.