2015

COMMITTEE REPORT

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

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DEDICATION

As in previous years, the New Hampshire Child Fatality Review Committee would like to dedicate this, our 14th Report, to the children of New Hampshire and to those who work to improve their health and lives.

For the last 19 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.

The Committee would like to give a very special thank you to Sandi Matheson who recently retired from the New Hampshire Child Fatality Review Committee. It was her vision, initiative, and energy that was the catalyst to the beginnings of the committee back in 1995, and which sustained our work for the 18 years she co-chaired the committee. Without her, we would not have been able to do the work of protecting New Hampshire's children.

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LETTER FROM CHAIR

New Hampshire Child Fatality Review Committee

Dear Friends of New Hampshire's Children:

The New Hampshire Child Fatality Review Committee has begun its' 19th 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.

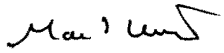
The following is the Committee's two-year report covering the work of the committee for the calendar years 2013 and 2014. Fatality data, provided by the Health Statistics and Data Management Section of the Division of Public Health Services, are presented for the calendar years 2003 to 2013. Because 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. 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 want to 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. I would also like to acknowledge those who have completed their service on the committee since our last report: Sandra Matheson and Maggie Bishop.

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

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EXECUTIVE SUMMARY

This report reflects the work of the New Hampshire Child Fatality Review Committee (hereafter referred to as "Committee") during the 2013 and 2014 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 2013 and 2014, the Committee held 10 meetings and reviewed 17 cases including: motor vehicle accidents, suicides, accidental asphyxiation, homicides, drownings, drug overdoses and cases that were ruled undetermined.

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 federal grant to participate in a web-based Sudden Death in the Young/Sudden Unexpected Infant Death Registry, an award given to a Committee member and various publications made by Committee Members.

The majority of New Hampshire resident deaths (68%) in children from birth through age eighteen were due to natural causes over the eleven year period, 2003-2013. Natural manner of death in this age group were also the most prevalent in 2013 (72%). Between 2003 and 2013, infants under age one comprised the majority of deaths due to natural causes (71%). Also during that 11 year period, adolescents 15-18, account for the majority of injury related deaths (57%). Including all manners of death (accidental, undetermined, natural, and pending), the leading causes of death in infants under age one year in 2013 were: #1 Complications During Pregnancy and Delivery; #2 Sudden Unexpected Infant Death (SUID); and #3 Congenital Anomalies. In infants age 1 month to 12 months, SUID was the leading cause of death in 2013. The SUID category includes those deaths due to SIDS, Accidental Suffocation and Strangulation in Bed, and those deemed Undetermined in unsafe sleep situations.

Recommendations, and their follow up activities, drive the work of the Committee in their quest to prevent future injuries and death. Suggestions for the adoption of practices around increasing safety, and additional education regarding the topics of water safety and firearms were the most common recommendations. The next most common were those pertaining to fire safety. Other recommendations involved encouraging reporting of suspected child abuse and/or neglect, increasing the amount of pre-natal and post-natal home visiting services for women covered by Medicaid, and clarifying the practices of Community Mental Health Centers for referrals when a consumer is pregnant. There were also a number of recommendations and activities regarding transitioning children to self-medication management as they approach adolescence and adulthood.

The follow up activities covered a variety of actions. The Committee supported enhancement of the state's child restraint law. Training and education regarding the proper use of car seats was provided in a variety of ways to various disciplines. The Division of Children, Youth, and Families (DCYF) provided informational materials in all of their District Offices regarding car seat usage, substance misuse, water safety and fire safety. A member of the Committee, Dr. Wendy Gladstone, wrote articles for the Granite State Pediatrician newsletter covering some of the Committee's recommendations.

In an effort to work together, the Domestic Violence Fatality Review Committee, in conjunction with the other Fatality Review Committees (Child, Elderly and Incapacitated, and Suicide) recommended that everyone be aware of limiting the access to lethal means, firearms in particular, when there is a risk of harm to others or a risk of self-harm. The cross-fatality review committee recommendation and an accompanying article on gun safety are shared in this report.

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.

HISTORY AND METHODOLOGY

The New Hampshire Child Fatality Review Committee was established in 1991 by an Executive Order of then Governor Judd Gregg. 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 Merrill signed an Executive Order (Appendix A) reestablishing the committee under the official auspices of the New Hampshire Department of Justice. The purpose of the Committee is to develop, as appropriate, recommendations to the Governor and relevant state and private agencies with the intent of effecting change in policies and practices, 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.

To provide support to the review process, the Department Heads of the NH Department of Justice, the NH Department of Health and Human Services, and the NH Department of Safety signed an Interagency Agreement (Appendix B) that defined the scope of information sharing and confidentiality with 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 right to confidentiality for families who lost children is respected by the work of the Committee.

The New Hampshire CFRC 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 CFRC meets the criteria for this review panel (Appendix D).

The Committee membership is comprised of representation from the medical, legal, law enforcement, judicial, 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 has hosted, beginning in November of 1998, a joint yearly one day meeting with the Child Fatality Review Committees from Vermont and Maine. The other three New England states were added to the meeting a few years later. 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. In 2012 the meeting was expanded to a two day meeting and the location was rotated between the states with Rhode Island hosting in 2012, Vermont in 2013, New Hampshire in 2014, and Maine in 2015.

In New Hampshire, cases to be reviewed by the full Committee may be selected from recommendations from 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:

1. 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.
2. The Committee discusses service delivery prior to the death, and the investigation process post death.
3. 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.
4. The Committee provides recommendations to participating agencies and encourages them to take actions consistent with their own mandates.

Each year since 1998 the Committee has published an Annual Report. Since 2009 the Report has been published biennially. This is the 14th 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. These responses are published along with the recommendations.

MISSION STATEMENT

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

OBJECTIVES

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

CHILD FATALITY REVIEW COMMITTEE MEMBERSHIP

MEMBERS WHO PARTICIPATED JANUARY 2013 TO DECEMBER 2014
Chair: Marc Clement, PhD*
Colby-Sawyer College

Thomas Andrew, MD*
Office of the Chief Medical Examiner

Honorable Susan Ashley
NH Circuit Court—Family Division

Lorraine Bartlett, MSW, Director*
NH Division for Children Youth and Families

Shanna Beckwith, Program Director
NHCADSV

Vicki Blanchard
NH Department of Safety, Bureau of EMS

Captain Mark G. Bodanza
NH Police Standards and Training Council

George Bowersox
NH Board of Pharmacy

Margaret Clifford, Chief Compliance Officer
NH Board of Pharmacy

Patricia C. Dean
NH Medicaid Services

Anne S. Diefendorf
VP Patient Safety &Quality/Assoc. Exec. Director

Diana Dorsey, MD
Pediatric Consultant

Jennie V. Duval, MD [alt.]
Deputy Chief Medical Examiner

Tracy Dumais - Cilibrasi
NH Victims' Compensation

Kim Fallon
Chief Forensic Investigator

Elizabeth Fenner-Lukaitis, Acute Care Services Coordinator*
Bureau of Behavioral Health

Det. Matthew Fleming
Bedford Police Department

Wendy Gladstone, MD
The CARE Program

Lieutenant Jill Hamel [alt.]
NH Police Standards and Training Council

Sergeant Sara Hennessey
NH State Police

Audrey Knight, MSN, RN*
NH Division of Public Health Services, MCH

Susan Meagher [alt.]
CASA of NH

Det. Richard Nanan
Manchester Police Department

Linda Parker
Bureau of Drug and Alcohol Services

Deb Pullin , CPNP
DHMC

Patricia Reed [alt]
Children's Director
Bureau of Behavioral Health

Amy Roy, MD
New Hampshire's Hospital for Children

Lynda Ruel, Director*
State Office of Victim/Witness Assistance

Debra Samaha, Program Director
Injury Prevention Center at Dartmouth

Thomas Schutzius
NH Fire Marshall's Office

Marcia Sink, Director
CASA of NH

Danielle Snook, Program Specialist*
NH Attorney General's Office

Therese J. Vaccaro, M.D.
DHMC

** denotes Executive Committee Member*

OTHER ACTIVITIES RELATED TO THE CHILD FATALITY REVIEW COMMITTEE

Sudden Death in the Young/Sudden Unexpected Infant Death Case Registries

In October, 2014, New Hampshire was one of ten states awarded a three year grant for the Sudden Death in the Young (SDY) Registry by the National Institutes of Health and the Centers for Disease Control and Prevention Services (CDC). The New Hampshire Division of Public Health Services will administer the grant, in collaboration with the New Hampshire Office of Chief Medical Examiner. The project involves participation in a registry of deaths in young people from conditions such as heart disease and epilepsy.

The program will estimate the incidence of sudden death in infants, children, and young adults up to age 24 (in New Hampshire, up to age 19), by analyzing comprehensive data on each case. Case data from death scene investigations, medical records, autopsy reports, and other pertinent data sources will be reviewed by a child death review team and experts in sudden cardiac death, sudden unexpected death in epilepsy, and pathology. Data will be entered into a centralized database managed by a data coordinating center at the Michigan Public health Institute. DNA samples from a subset of the cases, with parental consent, will be kept at a national centralized biorepository. Neither the data nor the biorepository samples will contain personally identifiable information. The resulting registry will become a resource for scientists to learn more about the causes of sudden death in the young and ultimately to develop better diagnostic and prevention approaches.

The SDY registry is an expansion of the CDC's Sudden Unexpected Infant Death Case Registry, which currently tracks unexpected deaths in infants up to age one in nine states. New Hampshire is currently one of nine states with this funding. For a summary of the New Hampshire Sudden Unexpected Infant Death Project, see page 35.

Awards

At the 2013 Attorney General's Partnering For A Future Without Violence Conference, Audrey Knight, RN, MSN, Child Health Nurse Consultant/Program Manager, and NH SIDS Program Coordinator at the New Hampshire Division of Public Health Services' Maternal and Child Health Section, and a member of the New Hampshire Child Fatality Review Committee since its inception, was awarded the Dr. Roger M. Fossum Award. The award was given for her work in leading diverse groups of health, social service, law enforcement, victim advocacy and other professionals at these Fatality Review meetings, often facilitating discussions on difficult issues of child death situations.

Publications

The June 2014 issue of Pediatrics featured an article co-authored by Dr. Thomas Andrew "Classification System of the Sudden Unexpected Infant Death Case Registry and its Application".

A copy of the article, "Bang!" is sent to the community mental health centers each December to coincide with the annual showing of the TV movie, "A Christmas Story". This article reminds individuals that "even BB guns" can pose some danger.

Other Activities

There have been some additional activities that have occurred that are not part of official recommendations, but nonetheless are aimed to reduce or prevent deaths, and increase education and supports. For instance:

- The New Hampshire Firearm Safety Coalition continues to work with gun shops and gun enthusiasts to educate about the dangers of a firearm with a person who is at risk.
- Approximately 600 "When Families Grieve" kits were disseminated throughout the state. These kits were obtained from the New Hampshire Director of Funeral Directors. Dissemination occurred with the community mental health centers, DCYF, pediatricians, hospitals state police, the Attorney General's office and hospice.

Other examples involve continuing to pursue recommendations beyond the time frame identified in the appropriate report. For instance:

- Community Mental Health Center Children's Directors are encouraged at the beginning of each school year to introduce themselves to all the school guidance counselors and school nurses in their area.
- Hospitals that have psychiatric units are reminded each November of the state's community mental health centers and are given contact information. Information about a variety of topics related to psychiatric issues is regularly shared with this group.

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 New Hampshire Department of State, Division of Vital Records Administration, 2003-2013. 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 (68%) in children from birth through age eighteen were due to natural causes over the eleven year period, 2003-2013 (Table 1). This was also the case for the year 2013 (72%, Table 2). Infants under age one comprised the majority of deaths due to natural causes (71%, Chart 1). Adolescents 15-18, on the other hand, account for the majority of injury related deaths (57%, Chart 1).

Table 1: Number of New Hampshire Resident Natural and Injury Deaths by Age Group, 0-18, 2003-2013

Age Group	Natural	Injury	Other/ Unknown	Total
<01	631	28	65	724
01 to 04	77	31	9	117
05 to 09	52	28	0	80
10 to 14	51	53	4	108
15 to 18	76	187	11	274
Total	887	327	89	1303
Percent	68%	25%	7%	100%

Chart 1:

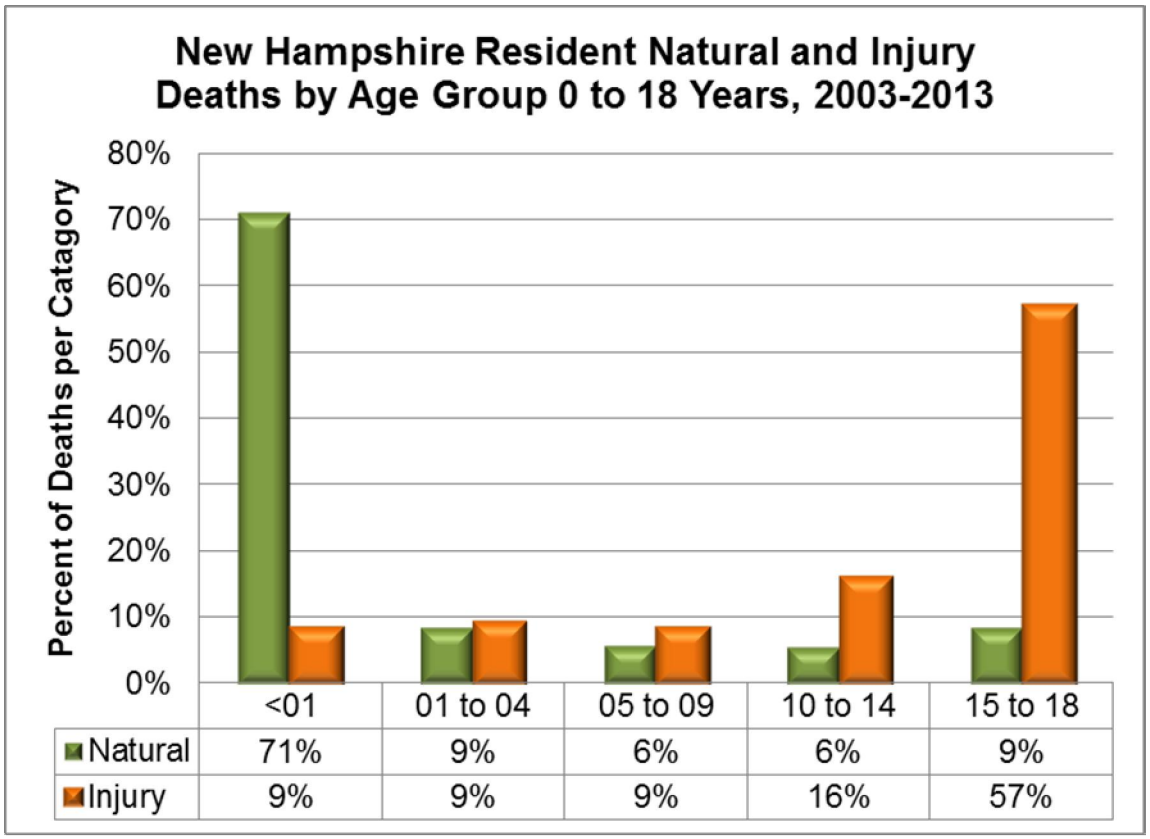


Table 2: Number of New Hampshire Resident Natural and Injury Deaths by Age Group, 0-18, 2013

Age Group	Natural	Injury	Other/ Unknown	Total
<01	58	2	8	68
01 to 04	10	2	2	14
05 to 09	3	1	0	4
10 to 14	2	3	1	6
15 to 18	10	12	2	24
Total	83	20	13	116
Percent	72%	17%	11%	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 eleven 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: Number of New Hampshire Residents,

Top Ten Leading Causes of Natural Death in 2013, Infants (under age 1 year)

Leading Causes of Natural Infant Death	2003-2013	2013
Newborn affected by maternal factors and by complications of pregnancy, labor and delivery	106	15
Respiratory and cardiovascular disorders specific to the perinatal period	88	11
Congenital malformations, deformations and chromosomal abnormalities	123	10
Disorders related to length of gestation	114	4
Haemorrhagic and haematological disorders of fetus and newborn	19	3
Diseases of the respiratory system	15	3
Digestive system disorders of fetus and newborn	12	3
Sudden Infant Death Syndrome (SIDS)	39	2
Diseases of the circulatory system	20	2
Endocrine, nutritional and metabolic diseases	8	2

New Hampshire has been consistent with national data in ranking Sudden Infant Death Syndrome (SIDS), as one of the leading causes of infant deaths. 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 child-care providers to put infants to sleep on their backs on a firm, flat mattress, the rate of SIDS cases nationally 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. In New Hampshire, SIDS rates have decreased, but there is no statistically significant difference between year groups (Table 4).

Table 4: New Hampshire Residents, Deaths from SIDS, 3-year Groups

Year Group	SIDS	BIRTHS	Rate per 10,000 Births	Lower 95% CI	Upper 95% CI
1999-2001	21	43,292	4.9	3.0	7.4
2002-2004	17	43,374	3.9	2.3	6.3
2005-2007	29	42,965	6.7	4.5	9.7
2008-2010	12	39,946	3.0	1.6	5.2
2011-2013	9	37,585	2.4	1.1	4.5

The SUID category includes those deaths due to SIDS, Accidental Suffocation and Strangulation in Bed, and those deemed Undetermined in unsafe sleep situations. According to a study in Pediatrics, 2009[1], the rate of deaths from accidental suffocation and strangulation in bed quadrupled in the past two decades.

[1] 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.

Deaths from several ICD10 codes (R95, R99 and W75) that include SIDS, "Undetermined", and deaths from accidental suffocation and strangulation in a bed setting as a cause of death cannot simply be grouped and counted in the category of "Sudden Unexpected Infant Death" (SUID) as not all R99 (Undetermined) deaths were connected to unsafe sleep.

New Hampshire is one of nine states receiving a grant from the Centers for Disease Control and Prevention (CDC) to participate in a Sudden Unexpected Infant Death Registry project to better understand the contributing factors of why babies are dying suddenly and unexpectedly. Please refer to the report section "Additional Related Activities" for more information on this grant.

Upon further investigation, in 2013, 11 of the 12 cases noted in the death certificate data met the CDC criteria for Sudden Unexpected Infant Death (SUID). Manner of death in these cases were natural for some, accidental or undetermined for others (Table 5 and 6). Compared to all natural manner of death cases, 12 possible cases of SUID would fall as the second leading cause of death (Table 7). Death due to complications of pregnancy and delivery is the leading cause of natural death and SUID is the second leading cause of infant death.

Table 5: New Hampshire Residents, Infants (under age 1 year), 2013, Manner and Cause of Death Fields from Death Certificate Data Where Underlying Cause of Death (ICD10) was code R95. R99 or W75

ICD10 Cause of Death Code	Manner of Death	Count	Cause of Death A	Cause of Death B
R95	Natural	2	SUDDEN INFANT DEATH SYNDROME	
R99	Pending	1	OTHER ILL-DEFINED AND UNSPECIFIED CAUSES OF MORTALITY	
R99	Undetermined	7	UNDETERMINED	
W75	Accidental	1	POSITIONAL ASPHYXIA	
W75	Accidental	1	ASPHYXIA	SUFFOCATION AND/OR CHEST COMPRESSION
	Total	12		

Table 6: New Hampshire Residents, Deaths with Possible SUID IDC10 Codes Compared to SUID Cases upon Review, Infants (under age 1 year), 2013

Year	ICD10 Cause of Death Code Possible SUID	SUID Cases after investigation
2011	8	7
2012	8	8
2013	12	11

Table 7: New Hampshire Residents, Causes of Death Counts,

Infants (under age 1 year), 2011 to 2013

Cause of Death	Manner of Death	2011 Count	2012 Count	2013 Count	Total Count
Newborn affected by maternal factors and by complications of pregnancy, labor and delivery	Natural	31 (53%)	35 (67%)	38 (56%)	104 (58%)
SUID (ICD 10 Code: R95, R99, W75)	Accidental	1 (2%)		2 (3%)	3 (2%)
	Undetermined	3 (5%)	3 (6%)	7 (10%)	13 (7%)
	Natural	4 (7%)	5 (10%)	2 (3%)	11 (6%)
	Pending			1 (1%)	1 (1%)
Congenital malformations, deformations and chromosomal abnormalities	Natural	10 (17%)	6 (12%)	10 (15%)	26 (15%)
Diseases of the respiratory system	Natural	1 (2%)	1 (2%)	3 (4%)	5 (3%)
Diseases of the circulatory system	Natural	2 (3%)		2 (3%)	4 (2%)
Endocrine, nutritional and metabolic diseases	Natural			2 (3%)	2 (1%)
Assault	Homicide	1 (2%)			1 (1%)
Certain infectious and parasitic diseases	Natural	1 (2%)			1 (1%)
Diseases of the digestive system	Natural		1 (2%)		1 (1%)
Diseases of the nervous system	Natural			1 (1%)	1 (1%)
Drowning	Accidental	1 (2%)			1 (1%)
Neoplasms	Natural	1 (2%)			1 (1%)
Unknown	Pending	2 (3%)			2 (1%)
	Undetermined		1 (2%)		1 (1%)
Total		58 (100%)	52 (100%)	68 (100%)	178 (100%)

Looking at natural causes of death for children and adolescents age one through 18, malignant neoplasms or cancer is the leading cause for both the aggregated time period (Table 8). This is consistent with both the national data and previous years.

Table 8: New Hampshire Residents, Leading Causes of Natural Death, Age 1 to 18

Causes of Death	2003-2013	2013
Neoplasms	87	6
Congenital malformations, deformations and chromosomal abnormalities	31	2
Diseases of the circulatory system	27	4
Diseases of the nervous system	26	3
Diseases of the respiratory system	24	4
Endocrine, nutritional and metabolic diseases	19	3
Certain infectious and parasitic diseases	8	
Diseases of the digestive system	8	1
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	6	
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	6	1
Respiratory and cardiovascular disorders specific to the perinatal period	4	
Diseases of the genitourinary system	2	
Diseases of the musculoskeletal system and connective tissue	2	
Infections specific to the perinatal period	1	
Inhalation and ingestion of other objects causing obstruction of respiratory tract	1	
Mental and behavioral disorders	1	
Not Stated	1	1
Pregnancy, childbirth and the puerperium	1	
Viral infections of the central nervous system	1	
Total	256	25

Reviewing unintentional injury deaths in children (Tables 9 and 10, Chart 2); motor vehicle traffic was the leading cause of death. This cause exceeded even those due to natural causes (Chart 1) 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 ages 15-18 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 9: New Hampshire Residents, Unintentional Injury Deaths, Ages 0-18, 2003-2013

Cause of Injury	<01	01 to 04	05 to 09	10 to 14	15 to 18	Total
Motor vehicle traffic			5	6	51	78
Other land transport accidents			4	4	43	51
Suffocation	20	6		4	2	32
Drowning	2	8	4	5	11	30
Poisoning					19	19
Smoke, fire and flames		4	3	5		12
Pedestrian		1		1	2	4
Struck by or against				2	2	4
Water transport accidents			2	1	1	4
Not stated	1				2	3
Pedal cyclist			1	1		2
Exposure to forces of nature	1					1
Falls					1	1
Firearms					1	1
Machinery			1			1
Total	24	21	24	35	139	243

Chart 2:

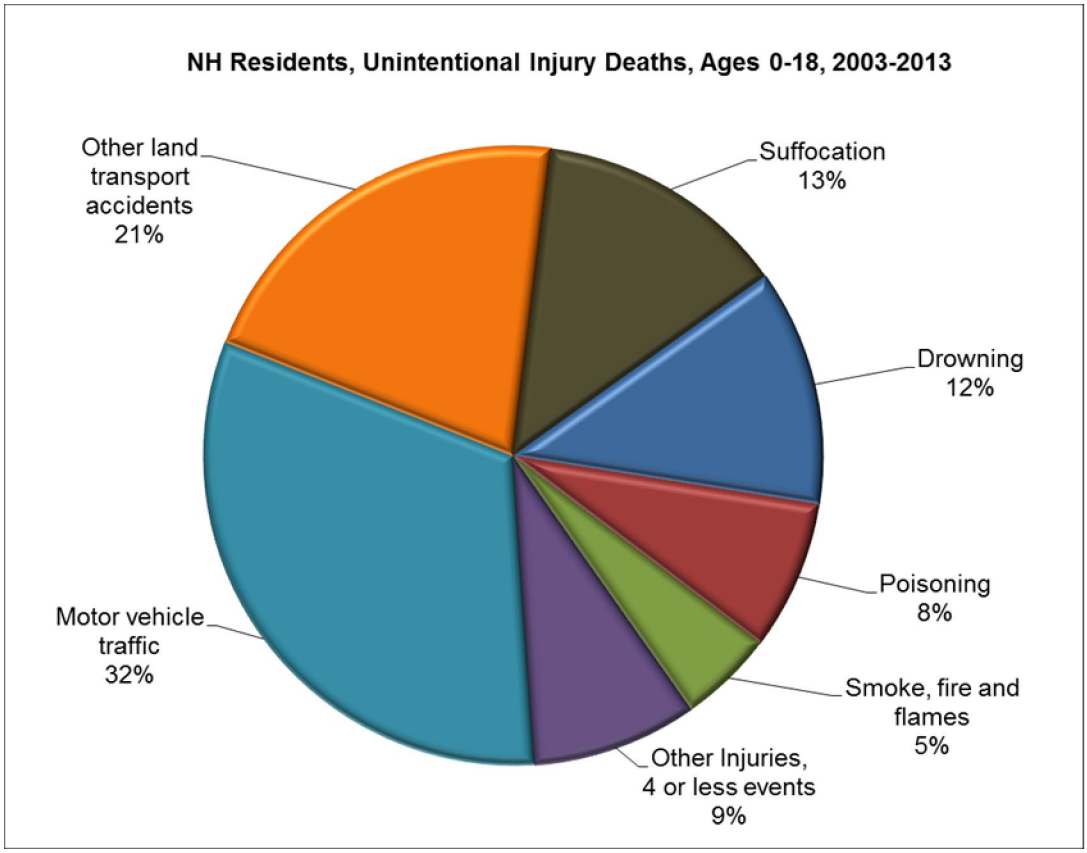


Table 10: New Hampshire Residents, Unintentional Injury Deaths, Ages 0 to 18, 2013

Cause of Death	<01	01 to 04	05 to 09	10 to 14	15 to 18	Total
Drowning		1				1
Motor vehicle traffic				1	3	4
Other land transport accidents					3	3
Pedestrian					1	1
Poisoning					1	1
Suffocation	2					2
Total	2	1		1	8	12

Suicide is the leading cause of intentional injury deaths for children and adolescents (Tables 11 and 12, Charts 3 and 4). The incidence of suicide amongst males is greater than females, primarily because the top 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 13 and 14).

Table 11: New Hampshire Residents, Intentional Injury, Ages 0 to 18, 2003-2013

Gender	Intentional Injury	<01	01 to 04	05 to 09	10 to 14	15 to 18	Total
Males	Homicide	3	7	1		2	13
	Suicide			1	11	32	44
	Undetermined	33	2		2	4	41
Females	Homicide	1	3	2	3	1	10
	Suicide				4	13	17
	Undetermined	25	5			3	33
Total		62	17	4	20	55	158

Chart 3:

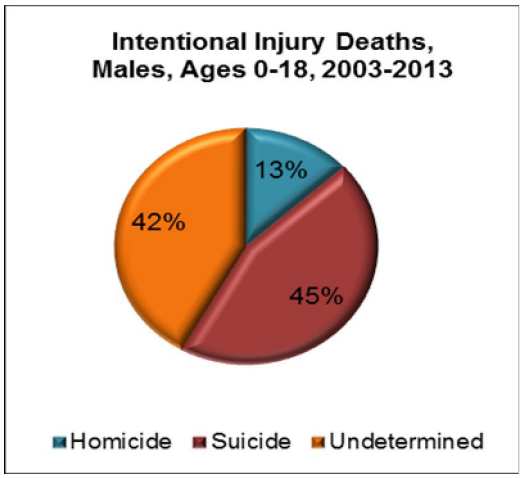


Chart 4:

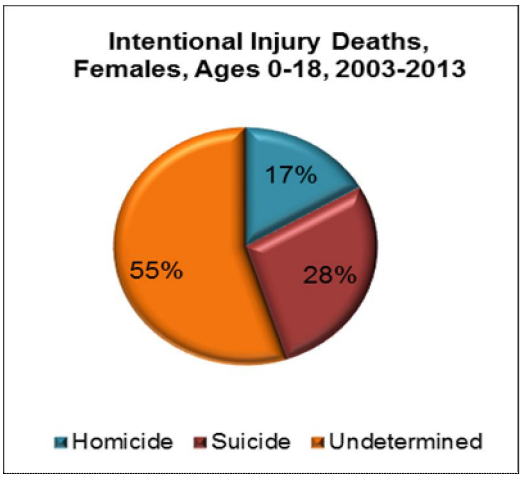


Table 12: New Hampshire Residents, Intentional Injury, Ages 0 to 18, 2013

Gender	Intentional Injury	<01	01 to 04	05 to 09	10 to 14	15 to 18	Total
Males	Homicide		1	1			2
	Suicide				1	3	4
	Undetermined	5				1	6
Females	Homicide						0
	Suicide				1	1	2
	Undetermined	2	1				3
Total		7	2	1	2	5	17

Table 13: New Hampshire Residents, Suicide Deaths, Ages 0 to 18, 2003-2013

Mechanism of Death	Total
Cut/Pierce	1
Firearm	22
Poisoning	4
Suffocation	34
Total	61

Table 14: New Hampshire Residents, Suicide Deaths, Ages 0 to 18, 2013

Mechanism of Death	Total
Firearm	3
Poisoning	1
Suffocation	2
Total	6

Looking at seasonal variations of injury deaths by mechanism (Table 15), again taking into account low numbers, there is an increased incidence of child deaths due to smoke, fire and flames (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[2]. Another seasonal difference can be seen in the increase in drowning in the summer. Most drowning deaths 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[3] (Table 15 and Chart 5). 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 spring (Table 16 and Chart 6). These would include the suicide and homicide deaths.

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

Table 15: Mechanism of Injury Deaths by Season, New Hampshire Residents, Age 0 to 18 years, 2003-2013

Cause of Injury	Dec-Jan-Feb	Mar-Apr-May	Jun-Jul-Aug	Sep-Oct-Nov	Total
Cut/Pierce	1		1	2	4
Drowning	1	4	22	3	30
Falls			1		1
Firearms	5	9	7	4	25
Machinery	1				1
Motor vehicle traffic	26	42	44	29	141
Other/ Unknown	4	1	4	3	12
Poisoning	6	10	4	4	24
Smoke, fire and flames	8	3	1		12
Struck by or against	4	3		1	8
Suffocation	13	22	16	16	67
Excessive Heat or Cold			1	1	2
Total	69	94	101	63	327

Chart 5:

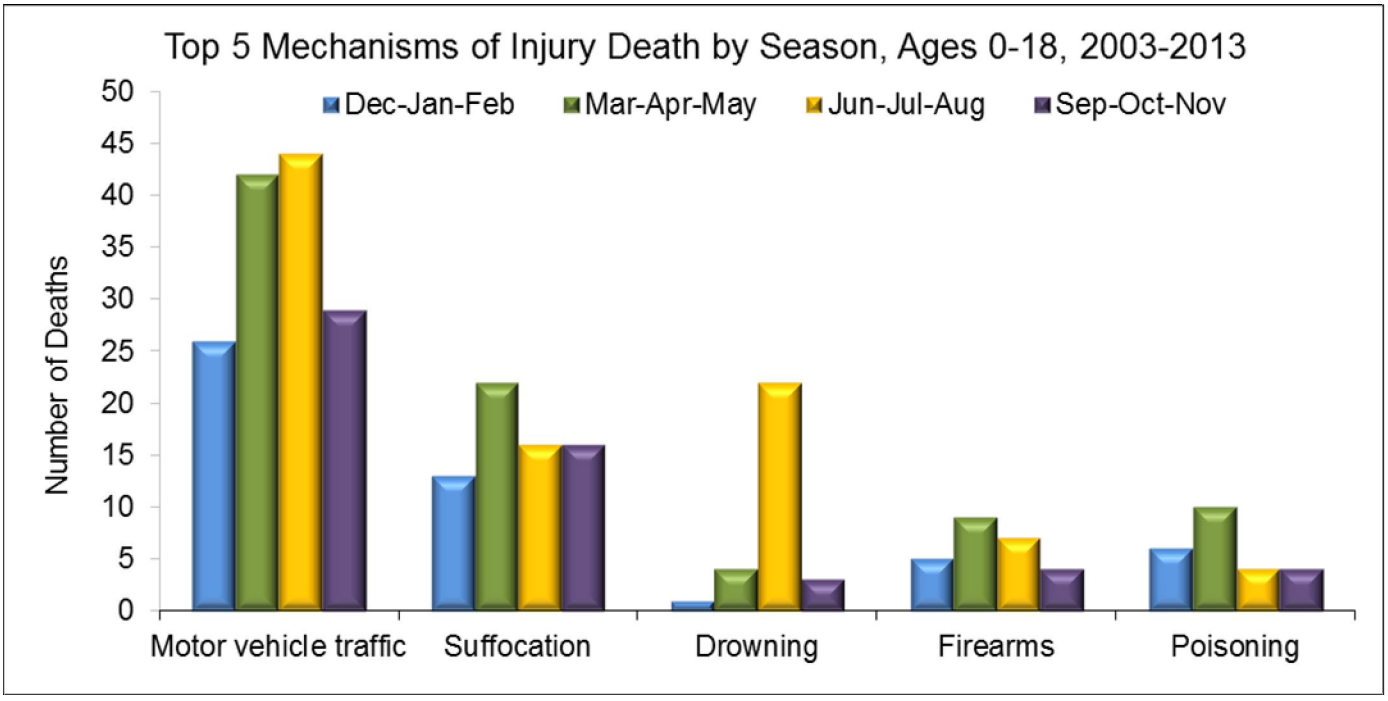
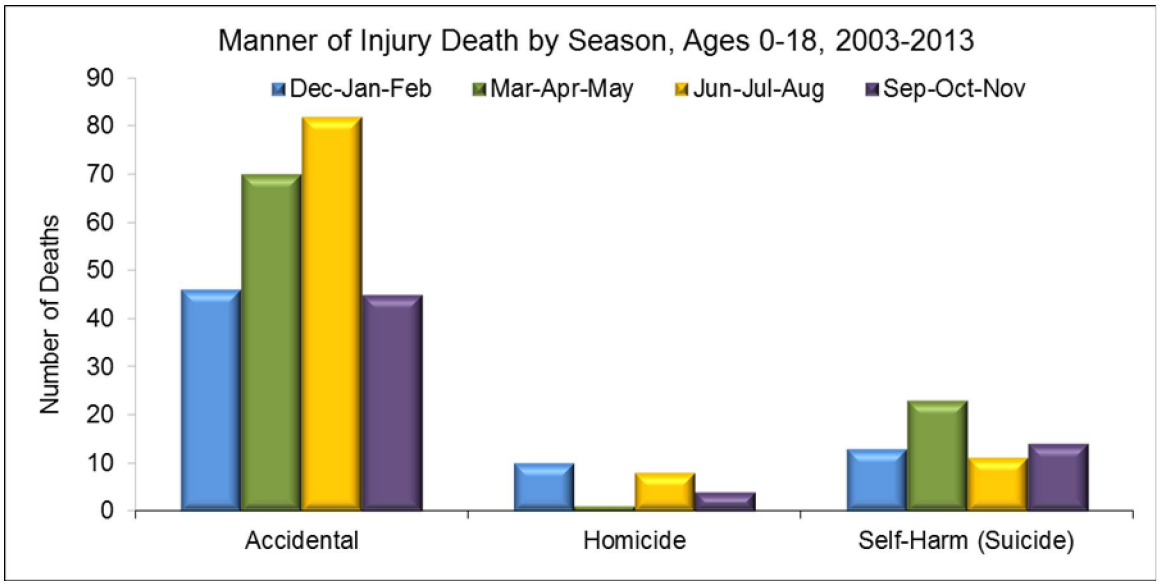


Table 16: Manner of Injury Deaths by Season, New Hampshire Residents,
Age 0 to 18 years, 2003-2013

Manner of Injury	Dec-Jan-Feb	Mar-Apr-May	Jun-Jul-Aug	Sep-Oct-Nov	Total
Accidental	46	70	82	45	243
Homicide	10	1	8	4	23
Self-Harm (Suicide)	13	23	11	14	61
Total	69	94	101	63	327

Chart 6:



CFRC RECOMMENDATIONS AND RESPONSES, 2013-2014

The purpose of recommendations made during a review is to take case specific facts and create broader recommendations for system improvement. The CFRC uses a Recommendation Development Worksheet Form (Appendix F) developed from forms used by other jurisdictions, to record it's recommendations.

For ease of organizing the recommendations, once a recommendation is made it is sorted into one of the following areas: Policy, Public Awareness, Training and Education and 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 the recommendation. It is the committee member's role to then provide the response back to the Committee. In some instances resource constraints have dampened the ability of the agency to act on the recommendation. The specific recommendations and system or institutional responses follow.

POLICY RECOMMENDATIONS	
1. Support the enhancement of the child restraint law to make it congruent with best practices.	During the 2013 legislative session, New Hampshire's Child Occupant Protection Law, RSA 265:107-a, was updated to require all children up to age seven or 57 inches tall (whichever is reached first) to be secured in an appropriate child restraint while traveling in a motor vehicle. The upgrade was championed by Safe Kids NH and supported by several public and private organizations that are dedicated to creating safe roadways in New Hampshire, including some members of the New Hampshire Driving Toward Zero Deaths Coalition (NHDTZ). This change extends protection to all six-year-old children in New Hampshire, or approximately 15,000 children, currently. Additionally as part of this effort, awareness materials for the new law were created, again with partnerships between Safe Kids NH, State Farm Insurance and NHDTZ. The campaign included radio public service announcements, posters, flyers and information pieces that were posted on Safe Kids NH and NHDTZ web sites. Newsletter articles were also distributed and an event to highlight the passage of the bill was held at Concord Hospital Car Seat Fitting Stations with legislators, the public and State Farm Insurance. The Child Fatality Review Committee submitted a letter in support of this legislation to all sponsors of the bill.
2. Develop best and promising practice for school personnel (ex. guidance counselors, assistant principals, school nurses) for addressing firearm safety and storage issues with a family when it becomes known a student lives in a home where there is a firearm.	A presentation was conducted at a New Hampshire School Administrators Association meeting, regarding distributing information on Counseling on Access to Lethal Means (CALM) training for school staff. That information was subsequently distributed to schools via an e-mail in December 2013 and a number of schools expressed interest. Two CALM trainings were held in 2014, with a third to be held in early 2015.
3. Encourage the Firearm Safety Coalition to work with gun dealers to promote availability of firearm safety devices (Gun safes, places to lock guns for storage etc.).	This is a standard practice for all legitimate gun dealers nationally since the passage of Public Law 109–92, or the ''Protection of Lawful Commerce in Arms Act'' in 2005.

4. Explore what type of firearm assessment or screening for firearm safety and storage the Division for Children Youth and Families (DCYF) has when working with families.	DCYF actively explores the issue of firearm ownership, storage and safety when reviewing family members as possible resources for temporary placement and/or permanent placement of a child in their care. Secure storage of firearms is one of the requirements. Foster families are required to disclose on their application to become licensed if there are firearms present in the household. The licensing agency worker physically inspects the home and the storage option to ensure that the store method is both secure and inaccessible to children. Ammunition is required to be stored away from the firearm. Additionally, firearm safety is one of the topics addressed in the training for prospective foster parents.
5. Remind the Community Mental Health Centers to continue to assess for firearm safety and storage.	There are frequent communications with the Community Mental Health Centers (CMHCs) about reducing access to lethal means, including the annual mortality report written by the Bureau of Behavioral Heath, which is distributed to all the CMHCs. There are recommendations in the "Suicide Deaths" section of the report that include highlighting the need to regularly assess for firearms and other potentially lethal means for suicide. Many of the face-to-face contact sheets for CMHC Emergency Services also have a section on addressing access to lethal means. Chart reviews that occur for each suicide of a CMHC client includes looking for whether or not "access to lethal means" was explored. The data from these chart reviews is compiled into quarterly "Suicide Risk Factors" reports that are shared with the CMHCs. A report from September 2013 addressing the need for assessing for access to lethal means and safe storage highlighted this issue. A CALM Train-the-Trainer session was held in June 2013, with representatives from each of the state's ten CMHCs in attendance. Additional CALM trainings have been conducted with the CMHCs and the communities in which they serve.
6. Support legislative initiative on mandatory suicide prevention training in schools.	HB 1588, requiring suicide prevention education in schools, was introduced during the 2014 legislative session. It was voted Inexpedient to Legislate because in accordance with RSA 186:11, Duties of the State Board of Education, the Board is required to provide information about youth suicide prevention to all public and private schools to facilitate the delivery of appropriate courses and programs. Further, this statute also references suicide prevention instruction in schools. Lastly, within recently approved minimum education standards, Ed306:40, the Health and Wellness Program, includes Suicide Prevention Instruction.

7. Ensure that protocols and policies include a notification as soon as reasonably possible by law enforcement to the appropriate school superintendent and principal of any unanticipated death of a student.	This recommendation was incorporated into the Critical Incident Command training module for new law enforcement officers through Police Standards and Training Council. It was also shared with Superintendents at a School Administrators Association meeting in December 2013.
8. Explore changing current statute regarding videotaping, giving people brochure "You don't have to talk to us".	169-C:34 requires DCYF to videotape interviews done with children in public places. The Family Rights brochure is presented to parents at the time DCYF initially engages with them. 95% of the time, parents sign and engage with DCYF.
9. Explore whether professional reporting could be improved, especially after-hours.	DCYF does not have the fiscal ability to have staff available twenty-four hours a day to accept reports. DCYF is able to provide training and education to the professional reporters as to the information that should be provided when making a report. DCYF is able to provide this training to any interested medical/ or community groups.
10. Explore changing language in "Unfounded" case letter.	The language in the letter from DCYF to the reporting physician on cases deemed "Unfounded" has not been changed. DCYF policy requires staff to inform professional reporters as to the outcome of the investigation and what further involvement, if any, DCYF will have with the family.
11. Explore requiring all New Hampshire birth hospitals to provide child abuse prevention materials to families and any other caregivers prior to discharge.	The process to require this change to hospital processes would involve a review of RSA 151 followed by a review of the appropriate administrative rules. This RSA was undergoing review but was tabled by legislators. A message was sent to all birthing hospitals in New Hampshire. 100% of the hospitals responded and indicated they provided child abuse education to all new parents prior to discharge. The majority of hospitals use the Period of Purple Crying, and some indicated there is also education done in prenatal visits as well as pediatrician well child visits. Exploring hospital discharge policies on providing this information was discussed at a Perinatal Nurse Manager meeting. It was proposed to conduct a survey of New Hampshire hospitals on this issue and to also include questions on safe sleep and Abusive Head Trauma (AHT) prevention. The New Hampshire Division of Public Health Services, in collaboration with Dartmouth Hitchcock Medical Center, will be surveying hospitals in early summer 2015 on maternity unit policy and practice regarding infant safe sleep and infant crying/preventing abusive head trauma (aka "Shaken Baby Syndrome"). The survey is adapted from that which was carried out recently by the Massachusetts Health Department in collaboration with Harvard School of Public Health.

12. Support the expansion of the "Period of PURPLE Crying" program to the 7 hospitals in New Hampshire, not currently participating in the program.	A letter was drafted by the CFRC to be sent to the Risk Managers at each hospital; however, as of February 2015, eighteen of the nineteen New Hampshire birth hospitals are providing parent education on infant crying using the Period of PURPLE Crying material. This means that 95.7% of parents of babies born in New Hampshire are receiving this information, hence the letter was not sent.
13. Explore proposing legislation to change DCYF's record retention policy.	Current legislation requires that unfounded assessment records be destroyed in three years and, for open cases, the record is destroyed seven years after the case closes. Previously, the Legislature was not supportive of changing the record destruction law.
14. Explore changing assault statute for bodily injury for children under 5 with an enhanced penalty.	Legislative changes for this change in statute involve criminal charges and would need to be explored with the Department of Justice Criminal Bureau and other law enforcement entities to see if there is support for such a statutory change.
15. Contact the Commission on Medicaid to request that the Managed Care Organizations include prenatal and postnatal home visits under their covered services.	The Commission on Medicaid was contacted to request that the Medicaid Managed Care Organizations include home visits for pregnant patients and their infants to age 1. The Commission determined that this request was more appropriately directed to the state Medicaid office as it did not pertain to the transition of Medicaid services from the fee-for-service to managed care model. Informational materials documenting the advantages of implementing this change in Medicaid services was presented to representatives of Medicaid for consideration.
16. Develop a policy with law enforcement and county attorneys on preserving evidence and tracking child abuse cases that may eventually be ruled a homicide.	The Office of Victim Witness Assistance at the Attorney General's Office will continue to explore the development of a workgroup to explore how key stakeholders can better track severely injured children who may succumb to their injuries much later in life.
17. Explore with the New Hampshire Heath Information Organization (NHHIO) the possibility of flagging medical records and creating a repository for potential future criminal litigation.	The NHHIO is not a repository of records, rather it just allows for the exchange of information. Currently, there are no plans to expand to include for "storage". Other potential avenues for a potential repository are being explored. The New Hampshire Rules for Hospitals: He-P 802.20 Patient Records, currently states: Patient records shall be retained 7 years after discharge of a patient, and in the case of minors, patient records shall be retained until at least one year after reaching age 18, but in no case shall they be retained for less than 7 years after discharge.
18. Encourage the Bureau of Drug and Alcohol Services to work with the Division for Children Youth and Families (DCYF), to increase their capacity to assess the functionality of parents who are using heroin.	Newly hired Child Protective Service Worker's (CPSW's) are required to attend a six hour training offered by the Bureau of Drug and Alcohol Services titled "Initial Training on Addiction and Recovering Families and Addiction", as part of DCYF's Core Training Academy.

19. Explore the development of a policy, for pregnant and/or parenting women receiving behavioral health services, that recommends a referral for parenting support and/or additional case management.	CMHCs currently refer pregnant clients to a Primary Care Provider, Community Health Center and/or an OB/GYN for medical care if they are not already connected to a provider. Examples of other referrals include WIC (Women, Infants and Children) Head Start, Child and Family Services and Medicaid. Additional releases of information are obtained for communication about psychotropic medications as soon as the pregnancy is shared with CMHC staff. Maternal depression is screened, both during the pregnancy and after the delivery. There is on-going assessment of the parent's coping and parenting skills and the focus of treatment is the relationship between the parent and child.
20. Explore changing the current client releases of information forms signed at the beginning of client contact to include the ability to notify other health care providers (i.e. primary care, mental health, substance abuse treatment) when concerns arise.	No action has been taken yet; however, the WIC Program is in the process of evaluating all of its confidentiality and release of information policies.
21. Increase professional awareness on water safety/pool safety issues.	Home Visiting programs, funded by the Division of Public Health, Maternal and Child Health (MCH) Section and DCYF at DHHS, were explored. Currently, there is no standard checklist being used by contracted home visitors in the MCH arena. A checklist created by American Preventative Medicine has been identified and its use will be suggested as a template for home visitors to use. Currently the Healthy Homes checklist is being used but there is not pool safety verbiage. There is currently nothing about water safety on the "One Touch Healthy Homes" checklist. The checklist is used by home visitors involving 26 agencies with approximately 100 home visitors. A committee has been working to streamline the checklist, however, it is uncertain that water safety will be added to the questions. DCYF provided all staff in their district offices with information regarding water safety/pool safety for use in their work with families.
22. Explore harmonization of building codes and education of code enforcers regarding pool and water safety.	Code Enforcement officials are aware of this recommendation and are working on exploring solutions.
23. Explore obtaining information from the Center for Disease Control (CDC) and the Consumer Product Safety Council (CPSC) on drowning prevention.	The CDC sponsors a website called Pool Safety: Simple Steps Save Lives (www.poolssafety.gov) which offers a wide array of free prevention materials. These materials include free posters and PowerPoint presentations, coloring pages, tips for arranging a water safety awareness event and safety videos. Material from this site was subsequently used in a water safety campaign at Elliot Hospital/New Hampshire's Hospital for Children in June of 2014.

24. Explore providing information to parents about transitioning to self medication management in adolescents, when they are picking up prescriptions.	New Hampshire Family Voices will consider a Spring 2015 "Pass It On" article on this issue. There are a number of applications/uses of technology to support medication adherence and management. For example "Texting 4 Control" is available via the Epilepsy Foundation. A phone receives a text when medications are due. Alarms exist for youth who don't have a phone with a text plan or are amenable to alarms. Alarms exist for functions on phone, pill boxes and watches. Some alarm watches also double as pill carriers. There are also apps that assist with refills (such as Refill Buddy) and apps to assist with tracking seizures and medication side effects (seizuretracker.com, my epilepsy diary). Additionally, the Board of Pharmacy has a place on their web page to post brochures or other resources http://www.nh.gov/pharmacy/publications/index.htm.
25. Encourage insurance companies to provide case management for children, especially middle school aged, who have a chronic condition/medication.	Outreach was made to the Medicaid Medical Director about putting this topic on the agenda of a Medicaid Managed Care Quality Assurance meeting. "Triggers" may result in a referral for Case Management services; Case Management is a voluntary service that is provided with parental consent. Medication management is viewed by the Managed Care Organizations to be the responsibility of the parent and the Primary Care Provider.
26. Explore with the Board of Pharmacy if there is a mechanism for pharmacies to remind patients to renew prescriptions.	The chain pharmacies have automatic refill programs that patients can enroll in. When enrolled routine/maintenance medications are filled automatically and the patient is notified that their refill is ready to be picked up. Some of the chains also have smart phone apps that can be used to order refills and receive reminders.
27. Promote fire prevention through legislative changes that would ensure that there is a working smoke and carbon monoxide alarm during the sale or transfer of any home in New Hampshire.	Legislation regarding this issue has been proposed twice in the last several years. Both times it was voted Inexpedient to Legislate by the legislature due to concerns about the liability and financial burden it posed to sellers, especially those selling older homes. There is nothing in the current legislature calendar to address this issue.
28. Loop back to the public health coalition/network in the community involved in the cases with recommendations and/or feedback from the review.	Recommendations from the CFRC that involve the Public Health Networks (PHNs) are communicated to the administrator in the Community Health Development Section of NH Division of Public Health Services, who in turn shares them with the PHNs.

TRAINING/EDUCATION RECOMMENDATIONS	
1. Promote Child Passenger Safety Certification (CPS) technician training to healthcare providers, law enforcement, first responders, fire departments and other professionals.	The CPS training information is posted on www.safekidsnh.org web site, the New Hampshire Driving to Zero web site, sent out via CPS email list, promoted in Safe Kids New Hampshire newsletter, and added to the Spark Portal. The Spark Portal is part of SPARK NH- of the New Hampshire Early Childhood Advisory Council. The Portal is a free resource open to all individuals working, or interested in working, in the early childhood field in New Hampshire. It allows early childhood (children birth through grade three) professionals to post employment and professional development opportunities in early education, family support and health, and allows anyone who is interested to view each of these opportunities. The Portal has three main pages that enable users to easily search through employment postings and professional development opportunities, and provides links to various early childhood resources. Pediatric practice managers within the Dartmouth Hitchcock system were also contacted to offer support by the Injury Prevention Center at Dartmouth for training and information regarding Child Passenger Safety Certification. A functional training for law enforcement has been created and will be offered as an in-service training in 2015 through the New Hampshire Police Standards and Training Council. Also, an informational piece about correct car seat use, misuse and New Hampshire law is under development for distribution to law enforcement. DCYF has provided training to their staff in the Manchester District Office on car seat safety in December 2014. There is a Foster Care Specialist who will be the contact person. An identified DCYF staff person in each District Office will become a certified child passenger safety technician. Written information on child passenger safety, safe sleep and infant crying has been shared with DCYF Adolescent Program Managers to include in the Trails Curriculum for foster teens. This curriculum is currently being revised by Granite State College.
2. Raise awareness for law enforcement to inquire about firearm safety and storage when interacting with members of the public.	This is already incorporated into the firearms program curriculum in both the Full and Part-Time Officer Academies at Police Standards and Training Council. An article on this issue will be published in a 2015 issue of "*Articulatable Suspicion*" that is shared with law enforcement statewide.

3. Submit article to Granite State Pediatrician about availability of gun locks.	A notice was printed in the May 2013 issue of the American Academy of Pediatrics, New Hampshire Chapter newsletter, the "*Granite State Pediatrician*" regarding the availability of free gun locks for families. Additionally, information was distributed to nurses that free gun locks are available at local police stations.
4. Continue to promote training on suicide prevention, postvention and related trauma to law enforcement personnel through Police Standards and Training Council.	Pre and postvention classes are offered in both the Full and Part-Time Officer Academies. An additional in-service class on this issue, presented by the National Alliance for Mental Illness (NAMI-NH) was conducted in 2014 and will be offered again in 2015.
5. Increase professional awareness on water safety/pool safety issues.	An article on this issue was published in 2013 and another is slated to be issued in a 2015 issue of "*Articulatible Suspicion"* that is shared with law enforcement statewide. Water safety information was included in the Safe Kids NH newsletter. Water safety "Water Watcher" cards and brochures were received and distributed to members of CFRC, Safe Kids NH members and pediatric venues while quantities lasted, information on how to order more from www.poolsafely.gov was provided.
6. Remind medical providers to discuss with parents transitioning to self medication management in adolescents with chronic illness.	An article will appear in a 2015 issue of the *"Granite State Pediatrician"* and the New Hampshire Medical Society Newsletter and will be distributed through the Family Practice email listserv. Avenues for distributing the article to Physician Assistants and Nurse Practitioners are being explored.
7. Promote fire prevention information in conjunction with October as Fire Safety Awareness Month.	An article was printed in September 2013 in the American Academy of Pediatrics New Hampshire Chapter newsletter, the "*Granite State Pediatrician*", regarding Fire Safety in the Kitchen. The 2013 National Fire Prevention motto was "Prevent Kitchen Fires". Posters on Fire Safety from the Fire Marshall's Office were disseminated to the state-funded community health centers and home visiting programs in the fall to be posted in community sites.
8. Explore pool safety campaign with pool supply retail companies.	The contact person for pool and pool supply companies had been out on sick leave and this was not able to be accomplished. It will be something that will be explored in 2015.

9. Remind health care providers to include all past concerns when making a report to DCYF – regardless if those concerns are related to the issue being reported presently. The more information they can provide in their report, the more helpful it is.	An article on this issue was sent out to the Family Practice email listserv and is scheduled to be printed in the newsletter of the New Hampshire Medical Society. This issue was discussed at a meeting at Dartmouth Hitchcock Medical Center in August 2014 with a number of pediatric clinicians, social workers, nurses, and others and several administrators from central and local DCYF offices. Information regarding reporting and the details of information to report, including any and all previous concerns, was shared. A presentation on the importance of notifying both DCYF and law enforcement of all unanticipated deaths and serious bodily injuries in suspicious circumstances in children was made at a meeting of the emergency medicine physicians, physician assistants and nurse practitioners at Elliot Hospital/New Hampshire's Hospital for Children in June of 2014. The Elliot Hospital followed up on this presentation by rewriting their child abuse policy, emphasizing the need to involve the police in instances of unanticipated death or serious bodily injury in children. They have also emphasized that all hospital staff are mandated reporters and clarified the reporting procedure for after business hours. Other hospitals are encouraged to follow their lead. Additional hospital-wide presentations on reporting child abuse will be given twice a year. These presentations will involve medical personnel, social workers, DCYF, and law enforcement. The first one will is scheduled for March 2015. Finally, the Elliot Hospital will be hosting their first biannual multidisciplinary abuse and neglect reporting seminar in May 2015. DCYF will work with Risk Managers if invited to do so. An article on reporting to DCYF was written by a committee member and appeared in the January 2014 issue of the "*Granite State Pediatrician":* http://www.nhps.org/images/gsp0114.pdf There have been discussions about the possibility of creating a PSA, but nothing definite has occurred so far.

PUBLIC AWARENESS RECOMMENDATIONS	
1. Encourage partnerships between police and communities, to do outreach activities about firearm safety and storage.	This has been integrated into the Part-Time Officer Academy at the Police Standards and Training Council and it is being explored on expanding it to the Full-Time Officer Academy.
2. Educate the public about their responsibility and importance of reporting suspected child abuse.	An article on preventing child abuse was published in the April 2014 issue of "*Parenting New Hampshire*" magazine.
3. Promote fire prevention information in conjunction with October as Fire Safety Awareness Month.	The New Hampshire Division of Public Health Services has routinely shared the education information in the "Safety Educator" provided by colleagues in the Fire Marshal's Office (http://www.nh.gov/safety/divisions/firesafety/special-operations/pub_ed/documents/NovDec2014SafetyEducator.pdf). The "Safety Educator" has been sent out to health care providers.
4. Increase public awareness that most fire departments will inspect residential wood stoves for free.	The Division of Public Health Services has routinely shared the education information in the "Safety Educator" provided by colleagues in the Fire Marshal's Office (http://www.nh.gov/safety/divisions/firesafety/special-operations/pub_ed/documents/NovDec2014SafetyEducator.pdf). The "Safety Educator" has been sent out to health care providers
5. Increase public awareness about pool safety/water safety issues.	Water safety information was included in the Safe Kids NH newsletter. Water safety "Water Watcher" cards and brochures were distributed to members of the CFRC and Safe Kids NH and pediatric venues while quantities lasted, information on how to order more from www.poolsafely.gov was provided. Water Safety Information was disseminated at Discover WILD NH. This is the Fish and Game Open House every Spring where vendors and educators give out information regarding outdoor activities. An article on this issues appeared in the May 2014 issue of the "*Granite State Pediatrician*" http://www.nhps.org/images/gsp0514.pdf A press release on pool drowning deaths in New Hampshire is scheduled to be distributed in 2015. There have been discussions about the possibility of creating a PSA, but nothing definite has occurred so far.

PROFESSIONAL COLLABORATION RECOMMENDATIONS	
1. Encourage use of home safety risk assessment tool that includes fire safety for home visiting programs.	The Healthy Homes Checklist was not open for revision at the time of this recommendation. In 2015 the opportunity exists to review and revise the checklist. Home Visiting programs funded by the Division of Public Health Services' Maternal and Child Health Section and the DCYF were contacted and it was determined that there was no consistent tool used. Recommendations are currently under review.
2. Support use of the injury prevention curriculum being proposed for use with home visitors and public health program staff - such as WIC.	The training curriculum was updated to include pictures and 57 home visitors received training to date. The training was expanded to include WIC staff and some did attend. The curriculum is now in its second revision. Since the training is not a mandated for home visiting staff, it has been a challenge to get trainings scheduled. It has been suggested that it be added to list of mandated trainings for home visiting staff.
3. Continue to work with the media on Media Guidelines involving reporting all suicides.	The Media/Communications subcommittee of the Suicide Prevention Council regularly monitors coverage of suicides in local media. A letter is sent to the media outlet, either congratulating them for a job well done (when the Media Guidelines have been followed), or a "Could have done better" letter with suggestions about coverage that would fall under the Media Guidelines.
4. Reissue/re-circulate article submitted to the "Granite State Pediatrician" on what "founded" means by DCYF.	The editor of the "*Granite State Pediatrician*" declined to publish this article a second time. The information was sent out to the New Hampshire Family Practice listserv.
5. Increase professional awareness on water safety/ pool safety issues.	Members of the CFRC and staff from DCYF received these materials. Information on ordering more materials was also provided.
6. Reach out to school nurses about educating parents and sending information home about youth transitioning to taking over their own medication management and readiness.	New Hampshire Family Voices will include materials regarding youth self management of medications and youth assessments in school nurse trainings conducted by the Special Medical Services (SMS) Title V Maternal and Child Health Epilepsy Grant. The SMS school nurse liaison has agreed to share materials regarding youth self management of medications and youth readiness assessments via school nurse list serv.

CFRC INTERNAL RECOMMENDATIONS	
1. Educate the committee on various drugs that are used by both parents and youth	There were presentations made to the CFRC on Methadone and Suboxone treatment. A Drug Recognition Expert (DRE) from the NH State Police presented to the CFRC as well as to the Regional Child Fatality Review meeting in May 2014. Information from other Child Death Review teams in states that have recently passed laws legalizing marijuana was requested. These states will share their data regarding deaths involving marijuana with New Hampshire when that data is available. It is expected that there will be a few years lag before good data is available. Additionally, articles focusing on child marijuana use were shared with the Committee
2. Increase awareness about fire prevention.	CFRC members were provided with information to sign up for the Fire Marshall's monthly newsletter.

POLICY STATEMENTS

The following recommendations were also generated from case reviews conducted during the reporting period of this report. Some were immediately tabled due to lack of resources and the inability to implement. Others are policy statements the Committee wanted to issue.

- Support the New Hampshire Teen Driving Project.
- Support inclusion of including Parents Nights in driver's education.
- Support primary seatbelt law in New Hampshire.
- Support the full implementation of the drug prescription monitoring program by medical providers.
- Encourage superior court judges to attend annual Attorney General's "Partnering For a Future Without Violence Conference" to improve understanding of child abuse issues.

CROSS FATALITY RECOMMENDATION

The Domestic Violence Fatality Review Committee proposed a "Cross-Fatality Recommendation" regarding "access to lethal means" be created and shared with the other Fatality Review Committees.

Firearms are the most commonly used method in completed suicides. The 2013 Annual Suicide report noted that firearms are used 46% of the time. The 2013 Domestic Violence Fatality Review Committee annual report noted that firearms were used 42% of the time for fatalities related to domestic violence. Reducing access to lethal means may reduce suicide deaths and deaths from other circumstances.

Firearm safety is important to stress, given the aforementioned statistics and the fact that roughly one-third of residences in New Hampshire have one or more firearms at any given time. The following statement was part of the Domestic Violence Annual Report for 2014 and is included in this report with their permission and support.

The expression, "Reducing Access to Lethal Means", is commonly associated with suicide prevention activities. Research has demonstrated that restricting access to lethal means (or method) decreases the incidence of suicide death. (Mann JJ, Apter A, Bertolote J, et al. (2005). Suicide prevention strategies: A systematic review. JAMA, 294, 2064-2074)

Limiting access to lethal means is a recommendation of the National Strategy for Suicide Prevention (Goal 6) and the New Hampshire Suicide Prevention Plan. As a result, it is being recommended for all of the State of New Hampshire's Fatality Boards. The goal of this recommendation is not only to reduce the incidence of suicide deaths, but also to reduce suicide/homicide, homicide and unintentional deaths and injuries.

Limiting access to lethal means involves efforts to securely store items that can be used for self harm and/or harm to others. Firearms are the primary focus as they are the most lethal method. Access to medications should also be included as the most frequently used method for suicide attempts. Knives, pesticides, and other potential items for harm should also be addressed when, and where, applicable.

Secure storage means the item(s) is/are consistently locked up and out of sight of the person at risk, the combination or the key is known to only those for whom there is no concern, and/or the item(s) are stored out of the residence. These efforts would include any residence the person of concern frequents.

THE IMPORTANCE OF GUN SAFETY

New Hampshire, along with the rest of the nation, is engaged in dialogue about gun laws in the wake of the school shooting at Sandy Hook Elementary school in Newtown, Connecticut in December 2012. This article is not about any stance towards more, or less, restrictions on gun ownership. Research is mixed and inconclusive as to whether or not stricter gun laws on ownership result in less violence. New and/or existing gun laws apply only to guns legally obtained, not all guns. Instead, this article is about safety of guns in the home. The Domestic Violence Fatality Review Committee is concerned with gun safety and how best to achieve that goal.

The importance of gun safety should be obvious. Sadly, many times the expression "access to lethal means" comes into play for the cases reviewed.

Research [1] has found that guns are involved in more than 31,000 deaths, and an estimated 74,000 nonfatal injuries, among US residents each year. Increased gun safety by all who have guns, wherever they have guns, has the potential to affect over 100,000 individuals each year.

The risks (meaning deaths and injuries) involving guns are more often risks related to suicide and suicide attempts, as opposed to homicides and accidental shooting injuries and deaths. Statistics show that more people

die by suicide with a gun each year than are murdered by someone using a gun. In 2010 in the U.S., 19,392 people died by gun suicide compared with 11,078 who were killed by others.

Guns can be lethal, and guns that are not "in use" may be accessible.

Gun owners and their families are much more likely to kill themselves than are non-gun-owners. A 2008 study by Matthew Miller and David Hemenway, both from the Harvard Injury Control Research Center, found that rates of gun suicides in states with the highest rates of gun ownership are 3.7 times higher for men and 7.9 times higher for women, compared with states with the lowest gun ownership— though the rates of non-gun suicides are about the same. For individuals in gun-owning households, compared to individuals in households without guns, there was no difference in rates of mental illness or in terms of serious consideration of suicide.[2] this study suggests that the single factor of a gun is responsible for the difference.

One third of the households in the United States have at least one gun; be it for self- defense, hunting, target shooting, collections, re-enactments, their jobs, etc. The varied purposes and benefits of gun ownership are important to the individuals and their lifestyles. This article is about gun safety for the guns in these households.

Research supports gun safety, regardless of the purpose of the gun(s). Restricting access to lethal means (or method) decreases the incidence of suicide death. [3] Suicide, as previously mentioned, is by far the most common occurrence in deaths involving guns. Gun safety, however, is important to prevent deaths and injuries from all events: suicide, murder-suicide, homicide, and unintentional shootings. Gun safety can occur by following the suggestions below for all guns in the residence:

- Individuals should seek proper instruction before using a gun. This can be done by attending a reputable gun safety handling course or by seeking private instruction before attempting to use a gun. Individuals are encouraged to learn how it operates before handling a new gun. The safety device can never replace safe gun handling. Knowing how to use each gun properly decreases accidental shootings.

- Individuals need to be sure of their target—and what's beyond. One must be absolutely sure the target has been identified without any doubt. It is also equally important to be aware of the area beyond the target.

- It is not advisable to mix alcohol or drugs with shooting.

- Individuals should store guns safely and securely when not in use. "Secure storage" means the gun(s) is/are consistently locked up. It is suggested that if there is a concern about suicide and an individual, that the gun(s) also be kept out of sight of that individual. Lock all guns unloaded in a safe designed for guns or in a tamper-proof, locked storage place. Lock the ammunition separately. The combination, or the location of key to the lock, should be known only by those for whom there is no concern, and/or the gun(s) is/are stored away from the residence. "Secure storage" would need to occur for any residence a person of concern frequents. Hiding unlocked guns is not advised; children often know their parent's hiding places.

- Individuals who own guns for self-defense own guns that are always "in use". The responsible gun owner needs to make prudent decisions as to how to balance easy access to the gun for self defense use if, and when, needed with sensible precautions against access to the gun by persons and/or situations that are of concern.

- Other individuals who come into contact with someone for whom there is concern (e.g. family members, First Responders called for any reason, neighbors and/or co-workers) are encouraged to explore access to firearms and, if necessary, make arrangements for temporary storage away from the individual. Efforts are currently underway to address this issue for First Responders.

References:

1.Centers for disease control and Prevention. Web-based injury statistics query and reporting systems: fatal injury reports. Available at http:/www.cdc.gov/injury/wisquers/fatal-injury-reports.html. Accessed January 9, 2013.

2.Drexler M. Guns and Suicide: the Hidden Toll, *Harvard School of Public Health* newsletter, Spring 2013, 24-35.

3.Mann JJ, Apter A, Bertolote J, et al. (2005). Suicide prevention strategies: A systematic review. *JAMA*, 294, 2064-2074)

NEW HAMPSHIRE SUDDEN UNEXPECTED INFANT DEATH (SUID) PROJECT

Background

Sudden Unexpected Infant Death (SUID) is the death of an infant less than one year of age that occurs suddenly and unexpectedly and whose cause of death is not immediately obvious before investigation. In 2013, 3,434 infants in the United States died suddenly and unexpectedly. Most SUIDs are reported as one of three types: Accidental Suffocation and Strangulation in Bed, Unknown Cause, or Sudden Infant Death Syndrome (SIDS). SIDS is the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, which includes an autopsy, a death scene examination, and a review of the infant's clinical history.

The "Back to Sleep" Campaign, originally launched in 1994 by several national health organizations including the American Academy of Pediatrics and the Maternal and Child Health Bureau of the Health Resources and Services Administration, helped reduce the SIDS rate in the United States by almost 50% in twenty years. The key message was to put infants to sleep, every time, on their back, on a firm, flat mattress in a safety-approved crib without any loose bedding or soft objects; avoid overheating and tobacco smoke exposure; and get early and consistent prenatal care and breast feed. In 2013, the campaign message was changed to "Safe to Sleep" to add prevention of infant death from an unsafe sleep environment. Messages such as avoiding bed-sharing and sleeping close but separate from parents were added to prevent deaths from accidental suffocation or roll over by another child or adult.

Improvement in the investigation and reporting of SUIDs has been supported by funding from the Centers for Disease Control and Prevention. This has helped classify, collect and monitor infant death data to observe trends and target prevention strategies to decrease the rate of SUIDs including SIDS.

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 NH 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 to enable Medical Examiners to make more accurate and consistent diagnoses;
- monitoring the incidence of different types of SUID;
- 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). New Hampshire will be applying to continue the grant for the upcoming three year cycle.

Case Registry

The State began entering data into the registry on resident infants whose New Hampshire death occurred suddenly and unexpectedly as of January 1, 2011. 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. Cases of homicide are not included in this surveillance registry.

Between January 1, 2011 and December 31, 2014, 37 sudden and unexpected infant deaths in sleep settings occurred among New Hampshire residents. Of these, ten were classified as SIDS, 25 as "Undetermined", and two from Asphyxia. 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 is used to track and monitor trends over time, and to develop targeted strategies to prevent further deaths. The data below reflects the 37 SUID cases from 2011 through 2014. Because the incidence of sudden and unexpected infant deaths is less than 20 per year, the data from 2011-2014 has been aggregated. Any differences among the years is not statistically significant.

2011-2014 Case Registry Data: Infant Demographics

- 59% were male
- 86% were white
- 11% were Hispanic
- 22% had low birth weight

Age Groups of infants at death:

- 16% less than one month
- 38% one to two months
- 27% three to four months
- 19% five to twelve months

2011-2014 Case Registry Data: Caregiver Facts

Caregiver Demographics Table

Demographics	Caregiver 1	Caregiver 2
Biological Parent	97%	86%
Female	94%	11%
Male	6%	89%
Employed	43%	79%
Low Income	74%	68%
High School Graduate Only	69%	50%
College Graduate	14%	11%
Age 17-20 Years	9%	0%
Age 21-25	34%	15%
Age 26-30	29%	42%
Age 31 and up	29%	42%

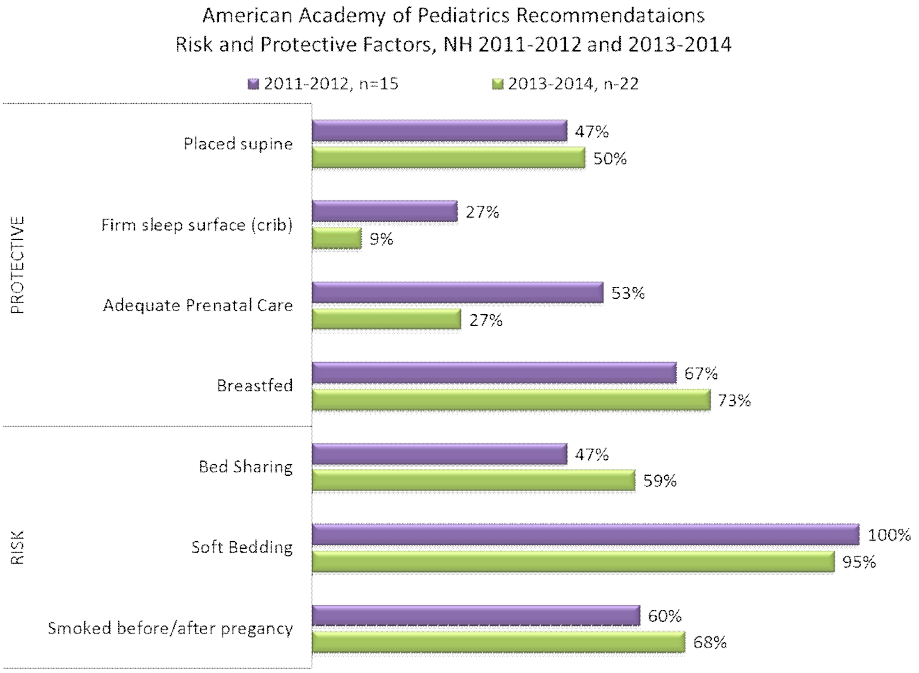
Of the 37 infants, 65% of the mothers were Medicaid recipients. In 16% (six) of the cases, the Division of Children, Youth, and Families had an open case with the child at the time of the death.

Recommendations from the American Academy of Pediatrics - SUID Risk and Protective Factors

In 2011, the American Academy of Pediatrics (AAP) released its "SIDS and Other Sleep Related Infant Deaths: Expansion of Recommendations for Safe Infant Sleeping Environment". Evidence-based recommendations are listed below, with related data from the 2013 and 2014 New Hampshire SUID registry cases. The data is used to inform strategies to decrease risk factors contributing to infant mortality from SIDS and an unsafe sleep environment and increase

Recommendations from the American Academy of Pediatrics to decrease risk factors and increase protective factors (*):	New Hampshire Data (2013-2014)
Recommendation 1: Back to sleep for every sleep, including naps.	• 50% (11) of SUID infants not placed on their back to sleep at time of incident.
Recommendation 2: Use a firm flat sleep surface in a safety approved crib.	• 91% (21) of SUID infants not placed to sleep on firm surface, such as mattress on a safety-approved crib or bassinet with a fitted sheet. • 50% (11) of SUID infants sleeping on an adult bed. • For infants who were not in crib or bassinet at time of death, 68 % (15) had crib or bassinet in home/place infant was found.
Recommendation 3: Room-sharing without bed-sharing is recommended. No co-sleeping on a bed, couch, chair, etc.	• 59% (13) of SUID infants were sharing same sleep surface with an adult at the time of incident. • Only 9% (2) of SUID infants were room-sharing without bed-sharing at time of incident. (Neither in a safe sleep setting.)
Recommendation 4: Keep soft objects, toys, and loose bedding out of the crib including pillows and bumper pads.	• 95% (21) of SUID infants had soft objects or loose bedding in their sleep environment.
Recommendation 5: Pregnant women should receive regular prenatal care.*	• 27% (6) of mothers received adequate prenatal care.
Recommendation 6: Avoid tobacco smoke exposure during pregnancy and after birth.	• 68% (15) of mothers smoked during pregnancy and/or after.
Recommendation 7: Avoid alcohol and illicit drug use during pregnancy and after birth.	• 32% (12) of mothers had history of substance abuse (drug and/or alcohol). • 14% (5) of mothers' partners had history of substance abuse (drug and/or alcohol).
Recommendation 8: Breastfeeding is recommended.*	• 73% (16) of SUID infants were breastfed.
Recommendation 9: Offer a pacifier at nap and bedtime.*	• 14% (3) of SUID infants were not placed to sleep with pacifier at time of incident.
Recommendation 10: Avoid overheating.	• 86% (19) reported environment was not overheated at time of incident.

The graph below compares information on the presence of risk and protective factors from the 2013/2014 deaths with that from the 2011/2012 deaths.



protective factors. N = 22

New Hampshire SUID Review Group

As required by the CDC Cooperative Agreement, New Hampshire reviews all resident sudden and unexpected infant sleep-related deaths during the grant cycle. Since 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. (See attached List of NH SUID Review Group Members during 2013-2014.) For each case review, invited guests include: infant's primary care provider, a representative from the maternity unit of the infant's birth hospital, a representative from the infant's home visiting program (if enrolled), and the law enforcement officer, first responder, and Assistant Deputy Medical Examiner involved in the death.

Meetings are 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 not routinely be available to the investigation. This increased scope of information is of value to both for data analysis and for better classifying the cause and manner of death. By having a more comprehensive overview of the case, the Office of Chief Medical Examiner is better able to make a more accurate diagnosis, consistent with the current guidelines of the National Association of Medical Examiners. In calendar years 2013 – 2014, there were 12 review meetings held, and a total of 27 different cases were reviewed, some requiring discussion at more than one meeting.

SUID Review Group Recommendations

The NH SUID Review Group generates 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 or increase protective factors. Following discussion of each case, draft recommendations are proposed which are refined through follow up 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 attached "New Hampshire Sudden Unexpected Infant Death (SUID) Review Group Recommendations and Follow up on 2013 – 2014 Reviews of Infant Deaths".

Other NH SUID Project Activities

The members of the NH SUID Review Group have been involved in a variety of activities sharing information on understanding and reducing the risks of SIDS and other causes of SUID, promoting safe sleep, and improving death scene investigations. Below is a summary of many, but not all, of their activities.

2013 Activities

- 18 presentations at New Hampshire meetings/conferences/workshops. Attendees included the following: WIC agency directors, nutritionists and breastfeeding coordinators; physicians, nurses, midwives and other medical staff; Dartmouth Hitchcock Medical Center residents; child care directors and staff; lactation consultants; home visitors; DCYF supervisors; and Department of Health and Human Services' Special Medical Services' staff.
- Regional presentation at the Northern New England Child Fatality Review Committee meeting, Burlington, Vermont, on NH SUID investigations and the NH SUID Project.
- Panel presentation with CDC and two other state SUID grantees at American Public Health Association annual conference November 2013 on using data to make changes.
- Nine guest lecturer appearances at local college and university classes of nursing, public health, criminal psychology, Physician's Assistants students and to one high school class.
- SUID risk reduction/safe sleep material displayed at 11 conferences or large group meetings including NH Pediatric Society conference, NH Immunization Program annual conference, Loudon Speedway Bicycle Night, Perinatal Substance Abuse conference, school nurse annual conference, NH Breastfeeding Task Force annual conference, WIC/MCH Program "Moving Moms to Behavior Change" conference, NH Association for Infant Mental Health conference, Healthy Homes conference, Northern New England Perinatal Quality Improvement Network conference, and the DCYF Foster Parent conference.
- Article published in the WIC agency staff electronic newsletter on safe sleep.
- Safe sleep information included in 250 "Give Away" bags at WIC Diaper Derby (baby crawling contest) at the Rockingham Mall, and 1,200 bags at Moms Night Out event at four Simon malls.
- Newly developed handout on breast care for breastfeeding women with an infant loss disseminated to NH Breastfeeding Task Force, WIC agency staff, perinatal nurse managers, and lactation consultants, and posted on various websites as resource.
- Dr. Jose Montero, former Director of the NH Division of Public Health Services, spoke on SIDS on WMUR radio show for October, SIDS Awareness Month.
- Division of Public Health Services' website's slider for the month of October, on National SIDS/SUID Awareness Month, generated 572 hits during that month.
- NH SUID Project was recognized at the fall 2013 CDC grantees' meeting for surpassing the other grantees in infrastructure and programmatic measures assessed.

2014 Activities

- 24 Presentations at New Hampshire meetings/conferences/workshops. Attendees included the following: nurses, physicians, child care providers, homeless shelter representatives, foster parents, Assistant Deputy Medical Examiners, DCYF Leadership Team, NH Division of Public Health Services' Data Users Group, NH Safe Kids members, lab workers, NH Department of Health and Human Services' Special Medical Services' staff, home visiting program staff, perinatal nurse managers, lactation consultants, WIC staff and NH Breast Feeding Task Force members.
- Podium/oral presentation at the National Association of Medical Examiners, Portland, Oregon.
- Five guest lecturer appearances at local college and university classes of nursing, public health, forensic psychology, and surgical technology students.
- SUID risk reduction/safe sleep material displayed at 17 conferences or large group meetings. These included Community Health Educators, Northern New England Perinatal Quality Improvement Network (NNPQIN), Strengthen-

ing Families Summit, DCYF conference, Safe Kids 500 at NH Motor Speedway, Baby Behavior training, Healthy Homes annual conference, NH ARCH, Early Learning NH conference, Dartmouth Hitchcock Medical Center Pediatric Grand Rounds, Tuberculosis/Sexually Transmitted Diseases/HIV conference, School Nurses conference, Foster Parents conference and the Caring for Our Children child care conference.

- Articles were published in paper and electronic newsletters including Granite State Pediatrician, Aging Issues, and the WIC Program agency newsletter.
- June 2014 Pediatrics journal contained the article "Classification System of the Sudden Unexpected Infant Death Case Registry and its Application" co-authored by Dr. Thomas Andrew, NH Chief Medical Examiner and SUID Review Group member.
- Representatives from the NH SUID Review Group, and the NH Division of Public Health Services joined other Region I states at a two-day federally sponsored Infant Mortality CoIIN (Collaborative Improvement and Innovation Network) meeting in July, in Virginia to learn about resources and develop strategies one of which is to reduce SIDS/ SUID deaths.
- Emails disseminated to broad range of recipients on a variety of SUID/safe sleep-related topics including a January warning about overbundling, suggestions for getting the safe sleep message out for October as SIDS/SUID Awareness Month, and the three newly developed infographics from the National Institute of Health.
- Social media efforts on safe sleep for October National SIDS/SUID Awareness Month included NH Division of Public Health Services tweets and a slider on the NH Department of Health and Human Services' webpage which generated 772 hits.
- Letters and emails from several SUID Review Group members were sent to Pottery Barn and TJMaxx complaining about the display of unsafe sleep environment in their paper and on-line catalogues and television advertisements.
- NH SUID Project staff from the NH Office of Chief Medical Examiner visited the Colorado SUID Project to share the successes of the NH team and learn strategies for improvement from the Colorado team.
- Curriculum development was initiated for training on Infant Crying and Safe Sleep for DCYF, Foster Parents, and Home Visitors, chaired by Injury Prevention Center at Children's Hospital at Dartmouth in collaboration with Division of Public Health Services staff.
- The board book, Sleep Baby, Safe and Snug, was distributed to home visiting programs supported by the NH Division of Public Health Services' Maternal and Child Health Section, for the new mothers enrolled in their programs. Several birth hospitals are also now distributing this book to mothers who deliver at their facilities.
- The NH SUID Project was recognized at the fall 2014 CDC grantees' meeting for its successful internal and external political environment that supports the program, for its organizational capacity, for the enthusiastic attendance of its Review Group members and the variety of activities they carry out both independently, and in follow up to case recommendations.

Sudden Death in the Young Case Registry Project

In September 2014, the NH Division of Public Health Services was awarded one of ten Cooperative Agreements from the CDC for the Sudden Death in the Young (SDY) Case Registry project, which will expand the current CDC- funded SUID Infant Death Registry grant activities. As with the SUID Project, this project will be administered and coordinated by the Division of Public Health Section's Maternal and Child Health Section in collaboration with the NH Office of Chief Medical Examiner. As part of the Cooperative Agreement, New Hampshire has expanded the SUID Project to also include deaths in youth up to age nineteen, starting January 1, 2015, who die suddenly and unexpectedly who may have conditions such as heart disease and epilepsy. The multidisciplinary death review group will be supplemented by a state panel of clinical experts to discuss the cases and determine which meet national project criteria for submission

SUID REVIEW GROUP MEMBERSHIP

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2013 and 2014 Members
(*Child Fatality Review Committee Member)

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SUID RECOMMENDATIONS AND RESPONSES, 2013-2014

POLICY RECOMMENDATIONS	
1. Add incidence, if any, and duration of breastfeeding to Death Scene Investigation Form.	These items are being added to the Death Scene Investigation form.
2. Add a notation if there was a crib present to Death Scene Investigation Form, and take photograph, even if infant was not found in a crib.	These items have been added to the form.
3. Obtain make/model when a consumer product is involved in a death (i.e. Bouncy Seat).	This is being discussed at the annual Assistant Deputy Medical Examiner (ADME) in-service.
4. Report cases involving an item such as a bouncy seat/pack'n play death to Consumer Product Safety Commission.	This is routinely done by one of the ADMEs who reviews cases for possible consumer product involvement.
5. Contact Consumer Product Safety Commission to recommend that labels be added to Pack'n Plays regarding proper use of product.	This will be followed up by the ADME who reviews cases for possible consumer product involvement.
6. Assess/change (if needed) current policy that both reporting physician and child's current physician are both notified when DCYF closes an open neglect/abuse case.	The DCYF Policy Analyst was invited to a subsequent SUID Review meeting to discuss policy updates and current practice. The DCYF reporting policy was reviewed. DCYF must inform the professional reporter of case closure and note feedback in its information system.
7. Alter DCYF policy to have home visitor do safe sleep check, and add box to DCYF form to indicate when environment check is completed.	DCYF plans to add language in the home visiting contracts to assure compliance with safe sleep protocols when the contracts are next amended. The safe sleep environmental check was added to the DCYF enhanced assessment policy which is currently being piloted.
8. Encourage health care and social service agencies and providers to review their policy about what to do when a parent is impaired.	All members of the SUID Review Group were asked to go back to their respective disciplines to discuss this recommendation and how it could be implemented in their respective settings and with their contract agencies, etc.
9. Encourage hospitals to have policy about making referrals for home visiting services for infants born to high-risk mothers, such as those with prenatal drug history.	This topic was included in the November 20, 2014 conference "Optimizing Our Interactions with Families with Substance Use Disorders" attended by over 120 perinatal nurses, prenatal care providers, and home visitors.

10. Encourage a policy such that health care providers can get a release signed by the mother at the prenatal visit so providers can to talk with one another, including methadone treatment facilities.	This topic was included in the November 20, 2014 conference "Optimizing Our Interactions with Families with Substance Use Disorders" attended by over 120 perinatal nurses, prenatal care providers, and home visitors.
11. Propose at Child Care Licensing rule revision meetings that current child care rule requiring 1:20 ratio of staff trained in CPR to number of children supervised be changed with 2016 Rules Revisions to requiring that all staff be CPR trained.	Current NH Child Care Licensing rules are in the process of being revised for a 2016 release. The Child Care and Development Block Grant law require all teaching staff and license exempt providers who receive block grant funds to be certified in CPR and first aid by Federal Fiscal Year 2016.
12. Propose at Child Care Licensing rule revision meetings that revisions include the provision of safe sleep training to providers who care for infants.	Current rules are in the process of being revised for a 2016 release. The Child Care and Development Block Grant law will be requiring all teaching staff and licensed exempt providers who receive funds to take a required pre-service health and safety training titled: Prevention of Shaken Baby Syndrome and Abusive Head Trauma and Prevention of Sudden Infant Death Syndrome.

TRAINING AND EDUCATION	
1. Reinforce importance of scene re-enactment to Assistant Deputy Medical Examiners (ADME) at trainings/updates.	This is being discussed at the April 2015 bi-annual ADME in-service.
2. request that ADMEs obtain both medium and long range photos of doll reenactment.	This is being discussed at the April 2015 bi-annual ADME in-services.
3. Educate parents and foster parents regarding safe sleep information, including not using car seats for sleep.	This information was built into foster parent initial training.
4. Encourage health care providers, home visitors, and DCYF to check with parent about where baby sleeps, including when not at home (i.e. when at boyfriend's apartment) and educate about importance of providing safe sleep environment.	All members of the SUID Review Group were asked to go back to their respective disciplines to incorporate this additional point in their safe sleep education or presentations. A workgroup met in early 2015 to begin work on a one page handout for parents or those caring for a young infant on what to do when an infant must be put to sleep in an unexpected situation away from home.
5. Educate non-licensed child care providers about providing a safe sleep every time, and not just for young infants. Do paper mailing or email through Resource and Referral centers to non-licensed or license exempt providers regarding safe sleep information with Safe Sleep Campaign material.	This information is integrated into all safe sleep presentations to child care providers made by the NH SIDS/SUID Program Coordinator. A mailing is planned for not only non-licensed and license exempt providers, but all licensed providers for late fall 2015 when the updated American Academy of Pediatrics' Safe Sleep recommendations are due to be released. The Child Care and Development Block Grant law will be requiring all teaching staff and licensed exempt providers who receive block grants funds to take required pre-service health and safety trainings titled: Prevention of Shaken Baby Syndrome and Abusive Head Trauma and Prevention of Sudden Infant Death Syndrome.
6. Encourage health care and social service agencies and providers to review their policy about what to do when a parent is impaired (i.e. due to sleepiness from methadone dose), and staff are concerned about parent's ability to care for child, such as calling DCYF.	This information was shared with representatives from MCH-funded home visiting programs and community health centers at a subsequent meeting.
7. Encourage health care providers to ask parents where child is getting out of home care, if licensed, if parent has asked/seen where child sleeps, and if parent is aware of childcare quality indicators.	All members of the SUID Review Group were asked to go back to their respective disciplines to discuss this recommendation and how it could be implemented in their respective settings and with their contract agencies, etc. Information on childcare quality indicators was emailed as follow up to the group by the Child Care Licensing representative of the SUID Review Group.
8. Educate maternity nurses, lactation consultants, and providers (Obstetricians, nurse midwives, pediatricians) on importance of proper alignment when breastfeeding to reduce SUID deaths via presentations and information in newsletters.	The Lactation Consultant member of the SUID Review Group presented on the importance of proper alignment at the October 2013 NH Safe Sleep Campaign's Infant Safe Sleep Symposium, the fall 2014 Perinatal Nurse Managers' Meeting and at a 2015 NH Breast Feeding Task Force meeting. She continues to integrate this information into all of her training opportunities.

9. Educate parents to call 911 instead of driving to Emergency Department or urgent care site. (Include at newborn discharge teaching or at well child visits.)	All members of the SUID Review Group were asked to go back to their respective disciplines to discuss this recommendation and how it could be implemented in their respective settings and with their contract agencies, etc.
10. Educate breast feeding moms about safe sleep and risk of accidental overlay.	This topic was presented at the NH Safe Sleep Campaign's October 29, 2013 Infant Safe Sleep Symposium, at the November 10, 2014 Perinatal Nurse Manager's meeting, and at the February 17, 2015 NH Breastfeeding Task Force meeting. It has also been presented in smaller group meetings and presentations to agency staff from state-funded prenatal programs, home visiting programs, community health centers, and WIC agencies.
11. Encourage assessment for referral to a substance abuse program before mom/baby is discharged from birth hospital.	This topic was included in the November 20, 2014 conference "Optimizing Our Interactions with Families with Substance Use Disorders" attended by over 120 perinatal nurses, prenatal care providers, and home visitors.
12. Check out current law enforcement training on handling infant death/sensitivity issues and need for updates.	A workshop on law enforcement investigations of infant deaths was included at the 2015 "Partnering for a Future Without Violence" 2015 conference sponsored by the Attorney General's Task Force on Child Abuse and Neglect. Sensitivity issues were included. Additionally, some police departments, such as the city of Manchester, periodically address the handling of these types of cases and scenes with newer officers and as a refresher for seasoned officers, approximately twice a year. Typically, if they do respond to a case and some type of issue arises, it is usually addressed right away.
13. Educate community members that emergency mental health support is available through DBHRT (Disaster Behavioral Health Response Team).	Information about DBHRT was sent by the Behavioral Health representative on the SUID Review Group to all SUID Review Group members in February 2014 to disseminate to all of their constituents.
14. Educate birth hospitals about SUID death at their facility and review findings by sending letter from SUID Review Group to Quality Assurance/Information Department.	The Association of Women's Health, Obstetrical and Neonatal Nursing (AWHONN) representative on the SUID Review Group personally contacts the birth hospital to invite the nurse manager to attend the case discussion. This has been very successful in both notifying the birth hospital as well as having the review group gain a better understanding about the case, or about what role the hospital plays in educating on safe sleep.

15. Include in education to parents and foster parents regarding not using car seats for sleep, and to have baby sleeping in same room.	Including education about room sharing but not bed sharing, and not using a car seat for sleeping are standard components of safe sleep as is recommended by the American Academy of Pediatrics. A new training curriculum for foster parents specifically mentions these points.
16. Educate grandparents on safe sleep through American Association of Retired Persons, the NH Department of Adult and Elderly Services, and distribution of "Safe Sleep for Grandparents" brochure	The national Safe to Sleep campaign brochure "Safe Sleep for Grandparents" is routinely included in any conference or workshop handout material carried out by the NH Division of Public Health Services, or at any conference display table hosted by the Division. An article on safe sleep written by one of the members of the SUID Review Group appeared in the November 2014 issue of "Aging Issues", the free monthly newsletter of the Department of Adult and Elderly Services. A tweet about the role of grandparents in safe sleep was also sent out by the NH Division of Public Health Services and by the Division's Bureau of Population and Community Health's twitter feed in October 2014 as part of observation of National SIDS/SUID Awareness Month.
17. Improve child care providers' knowledge of safe sleep practice by reminding about current licensing rule of infants placed supine to sleep unless note signed by medical provider, through information update emails and training.	All Child Care Licensing Coordinators address the issue of safe sleep with any provider when they observe an infant who has not been placed supine to sleep such as sleeping in a bouncy seat or car seat. They also ensure that cribs meet the current CPSC standards, as well as remove items from a crib which are not appropriate based on the child's age. Safe sleep handouts will be disseminated to all licensed providers this year. Every presentation or workshop to child care providers by the NH SIDS/SUID Program Coordinator includes a reminder about the current licensing rule on supine placement.
18. Remind child care providers that DBHRT (statewide network of local community emergency behavioral health team services) is available for agencies including child care centers if needed:	Information on DBHRT will be sent via email list serve from Child Care Licensing and Resource and Referral centers to all licensed child care providers and license-exempt providers in the summer of 2015.
19. Educate parents/general public about quality child care indicators, including what to ask/look for in child care safe sleep environment.	The SPARK NH Quality of Early Childhood Programs and Services Committee has released handouts for both parents and providers with questions to ask in regard to quality early childhood programs and the markers of quality. This information and information on how to find local quality child care providers (i.e. through Child Care Resource and Referral agencies) was shared via email in June 2014 by the Child Care Licensing Unit representative on the SUID Review Group for the group's broad dissemination.

PUBLIC AWARENESS	
1. Explore finding or developing public service announcements (PSAs) or videos using parents whose baby died in unsafe sleep environment to share their story to educate others.	This recommendation will be pursued in the future.
2. Use New Hampshire SUID data in PSAs and media outreach.	New Hampshire data has been inserted in various articles and presentations, and will continue to be used in the future.
3. Explore use of public and social media to get the Safe Sleep message out, especially for October via PSAs, tweets, face book, possible bus poster in Manchester, billboards, highway signs, etc.)	In both 2013 and 2014, tweets were sent from the NH Division of Public Health Services, and the Division's Bureau of Population and Community Health's twitter feed. An October slider on the NH Department of Health and Human Services' web page for October SIDS/SUID Awareness month resulted in 572 hits in 2013, and 771 in 2014. Collaboration on several safe sleep educational outreach projects between the NH Division of Public Health Services and the NH Safe Kids will result in posters displayed inside buses in several Manchester routes, and, with funding from the Kohl's department store, on the outside of buses in several parts of the state in fall 2015.

PROFESSIONAL COLLABORATION	
1. Improve communication between DCYF and pediatricians (via possible NH Pediatric Society newsletter article, meetings, trainings, etc.)	A discussion was held with local pediatricians about suggestions for better interfacing with DCYF, especially around drug-exposed newborns. A pediatrician member of the SUID Review Group wrote an article on this topic for a 2014 issue of the "*Granite State Pediatrician*", electronic newsletter of the NH Chapter of the American Academy of Pediatrics.
2. Explore if Office of Chief Medical Examiner death scene photos could be used for home visiting injury prevention curriculum.	This is being explored to assess confidentiality issues.
3. Educate providers on the importance of communicating when patient has drug history and/or is under drug treatment	This topic was included in the November 20, 2014 conference "Optimizing Our Interactions with Families with Substance Use Disorders" attended by over 120 perinatal nurses, prenatal care providers, and home visitors.
4. Encourage prenatal providers to be sure to give clients with substance use history safe sleep education	This topic was included in the November 20, 2014 conference "Optimizing Our Interactions with Families with Substance Use Disorders" attended by over 120 perinatal nurses, prenatal care providers, and home visitors.

5. Combine opportunities to educate about safe sleep/no bed sharing with "Period of PURPLE Crying" child abuse prevention activities (decrease fussiness so parents won't bed share to calm).	The NH Division of Public Health Services and the Injury Prevention Center at Children's Hospital at Dartmouth staff are frequently pairing the two topics in presentations and conference display table material. New training curriculum developed for home visiting staff is also now blending the two topics.
6. Do outreach to doulas and home birth providers through mailing of Safe Sleep information and display table at provider conferences.	A mailing is planned to doulas and home birth providers for late fall 2015 when the updated American Academy of Pediatrics' Safe Sleep recommendations are due to be released. The SUID Review Group has a new home birth provider representative in 2015, who will attend the review meetings and share information with her peers.
7. Contact/request Child Care Resource and Referral agencies to do outreach to their local prenatal care providers and hospitals about child care resources available.	No action at this time, but planned for the year ahead.

SUID INTERNAL/REVIEW GROUP	
1. Request methadone treatment charts as part of SUID information collection for SUID reviews.	This was deemed not possible due to confidentiality rules.
2. Check "Bright Futures", the American Academy of Pediatrics' Guidelines for Health Supervision of Infants, Children, and Adults, for currently recommended periodicity of safe sleep discussion at well child visits.	Bright Futures recommends that safe sleep be discussed at the following visits: prenatal, one week, one month, 2 month, four month, and six months. This information will be shared at an upcoming SUID Review meeting.
3. Send follow up letter to infant's primary care provider and birth hospital after SUID reviews.	One of the pediatrician members of the SUID Review Committee routinely follows up with the infant's primary care provider after the case review to share recommendations. Frequently, the birth hospital sends its perinatal nurse manager to participate in the case review. Letters to those birth hospitals that didn't send a representative have not routinely been sent a follow up letter.
4. Improve availability of Medicaid information at review meetings.	Communication with the Medicaid program has resulted in a backup system being developed to give Medicaid information on any cases being reviewed to another SUID Review Group member to assure that the information is available at the meeting. The new system has proven successful.

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: EXECUTIVE ORDER

STATE OF NEW HAMPSHIRE

CONCORD, NEW HAMPSHIRE 03301

Executive Order Number 95-1

an order establishing a New Hampshire
child fatality review committee

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

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

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

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

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

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

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

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

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

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

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

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

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

Given under my hand and seal at the Executive Chambers in Concord, this 29th day of September in the year of our Lord, one thousand nine hundred and ninety-five.

Stephen Merrill

Governor of New Hampshire

APPENDIX B: 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:

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

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

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.

To characterize high risk groups in terms that are compatible with the development of public policy.

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.

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 C: CONFIDENTIALITY AGREEMENT

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE
CONFIDENTIALITY AGREEMENT

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

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

_____

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

_____

Print Name

_____

Authorized Signature

_____

Witness

_____

Date

APPENDIX D: STATUTORY AUTHORITY

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:

> 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;
>
> child abuse citizen review panels;
>
> child fatality review panels;
>
> 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 E: 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 F: 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)							