2015-2016 Biennial Report

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

OCTOBER 2017 *(REVISED 12/2018)*

Funding for this report and for the activities of the Child Fatality Review Committee comes from the US Department of Health and Human Services Administration for Children, Youth and Families through the Children's Justice Act Grant (#G-015NHCJA1) which is administered by the New Hampshire Department of Justice.

DEDICATION

As in previous years, the New Hampshire Child Fatality Review Committee would like to dedicate this, our 15th report, to the children of New Hampshire and to those who work to improve their health and lives.

The Committee would like to give a very special thank you to Dr. Thomas Andrew, Chief Medical Examiner for New Hampshire. Dr. Andrew has been a dedicated member of the Committee for over 17 years. Without his steady and unwavering support, the Committee would have been unable to function in an effective and supportive way to help to reduce the probability of New Hampshire children dying unnecessarily. Dr. Andrew has been a beacon of support and encouragement to all members of the Committee. His unflappable and disarming manner has helped to make our work, which is very difficult at times, a bit easier. We all wish him all the best in his new endeavors.

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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' 21st 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 biennial report covering the work of the committee for the calendar years 2015 and 2016. Fatality data are presented for the calendar years 2005 to 2015. 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. Additionally the six New England States, led by New Hampshire have been meeting yearly for the last 16 years in order to share common issues and concerns. These joint meetings help give us an opportunity to discuss problems and solutions faced by other states in trying to prevent child fatalities. We are also able to look at issues current in the field of child death review nationally. Finally, many of our members have written articles for newsletters and other publications regarding our recommendations for helping to reduce and prevent child fatalities.

As Chair, I would like to acknowledge the hard work and dedication of the members of the committee. I again want to especially acknowledge the work of Stacey MacStravic and Danielle Snook, from the Attorney General's Office, for keeping the committee running smoothly and for all the time and energy spent on preparing this report. As noted in the Dedication, we are especially indebted to Dr. Thomas Andrew, the New Hampshire Chief Medical Examiner, for his long and productive work on this committee.

In recognition of this commitment and dedication, it is with great pride that as Chair, I present this, our Fifteenth Report to the Honorable Christopher T. Sununu, Governor of the State of New Hampshire.

On behalf of the committee,

Marc Clement

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

33 Capitol Street, Concord New Hampshire (603) 271-3671

EXECUTIVE SUMMARY

This report reflects the work of the New Hampshire Child Fatality Review Committee (hereafter referred to as "Committee") during the 2015 and 2016 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 2015 and 2016, the Committee held 9 meetings and reviewed 15 cases that included: suicides, homicides, drownings, drug overdoses and cases that were ruled undetermined.

This report begins with the Committee's Purpose, History and Objectives, followed by a listing of the Committee members and their affiliations that participated on the Committee during the calendar years 2015 and 2016. Statewide data and committee recommendations and their responses follow.

The majority of deaths (68%) in children from birth through age eighteen were due to natural causes over the eleven year period, 2005-2015. This was also the case for the year 2015. Infants under age one comprised the majority of deaths (70%) due to natural causes. Adolescents 15-18, on the other hand, account for the majority of injury related deaths (56%).

Recommendations, and their follow up activities, drive the work of the Committee in their quest to prevent future injuries and death and a significant portion of this report reflects that work. During 2015-2016 , the Committee generated 25 recommendations on a range of topics including child abuse, domestic violence and substance misuse. Specific recommendations included: increasing awareness on mandated child abuse reporting requirements; increasing training for professionals on understanding the impact of trauma on children and exploring what education is provided in schools regarding substance misuse. Once again, the CFRC supported extending the length of time that DCYF could keep its records which would allow them to identify patterns of potential maltreatment which are important for protection against further abuse or neglect.

The follow up activities covered a variety of actions. Several agencies conducted initiatives aimed at increasing awareness regarding the mandated child abuse reporting requirements including conducting in-person trainings, writing articles, developing PSAs and creating an online training.

Committee members are also involved in a variety of other activities such as participation in: the Commission to Review Child Abuse Fatalities, established in 2015 by SB244; a web-based Centers for Disease Control and Prevention-funded Sudden Unexpected Infant Death/Sudden Death in the Young registry and the submission of articles on Abusive Head Trauma. In addition, Committee members engage in many activities on a regular basis that are geared towards the prevention of child injury or death.

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.

PURPOSE

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

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.

We recognize that the responsibility for responding to and preventing child fatalities lies with the community, not with any single agency or entity. The Child Fatality Review Committee (CFRC) reviews child deaths to decrease the risks for children and provide solutions in the form of recommendations to key stakeholders with the intention of reducing future fatalities. The CFRC is not an investigative body and is not a mechanism to assign fault to an agency or individual. It is a forum for sharing information essential to the improvement of a community's response to a child fatality.

HISTORY

The New Hampshire Child Fatality Review Committee (CFRC) was established in 1991 by an Executive Order of then Governor Judd Gregg. After reviewing the study findings and initiatives from other states, the Review Committee was restructured to accommodate the demands of an on-going review process. In 1995, in an effort to support the restructuring, then Governor Steven Merrill signed an Executive Order reestablishing the Review Committee under the official auspices of the New Hampshire Department of Justice.

An Interagency Agreement was established to provide support to the review process. The Department Heads of the New Hampshire Department of Justice, the New Hampshire Department of Health and Human Services, and the New Hampshire Department of Safety signed an Interagency Agreement that defined the scope of information sharing and confidentiality within the Review Committee. This has been renewed as needed.

Additionally, individual Review Committee members and invited participants are required to sign Confidentiality Agreements in order to participate in the review process. The right to confidentiality for families who lost children is respected by the work of the Review 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.

The Review Committee began reviewing cases of child fatalities in January of 1996 and provided its first Committee report in 1998. In addition to the regular meeting schedule, the Review Committee began hosting, beginning in November of 1998, a yearly one day joint 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 among the states with Rhode Island hosting in 2012, Vermont in 2013, New Hampshire in 2014, Maine in 2015, Connecticut in 2016 and New Hampshire again in 2017.

OBJECTIVES

The objectives of the Review Committee as outlined in the Executive Order shall be:

- To enable all interested parties to more effectively facilitate the prevention, investigation and prosecution of child fatalities.
- To identify and investigate the prevalence of a number of risks and potential risk factors in the population of deceased children.
- 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.
- To identify high risk groups for further consideration by executive, legislative or judicial branch programs.
- 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 describe trends and patterns of child deaths in New Hampshire.

The Review Committee achieves these objectives by:

- Developing recommendations for improved services and system responses to benefit children who may be at risk for harm.
- Informing systems to more effectively facilitate the prevention and investigation of child fatalities.
- Identifying trends and patterns of child death in New Hampshire.

CHILD FATALITY REVIEW COMMITTEE MEMBERSHIP

MEMBERS WHO PARTICIPATED JANUARY 2015 TO DECEMBER 2016

Chair: Marc Clement, PhD*
Colby-Sawyer College

Thomas Andrew, MD*
Office of the Chief Medical Examiner

Honorable Susan Ashley
NH Circuit Court—Family Division

Joy Barrett
Granite State Children's Alliance

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

Shanna Beckwith
NH Coalition Against Domestic and Sexual Violence

Vicki Blanchard
Bureau of Emergency Medical Services

Captain Mark G. Bodanza
NH Police Standards and Training Council

Karl Boisvert, LCMHC [alt.]
Bureau of Mental Health Services

Margaret Clifford
NH Board of Pharmacy

Anne S. Diefendorf
Foundation for Healthy Communities

Diana Dorsey, MD
NH Special Medical Services

Jennie V. Duval, MD [alt.]
Office of the Chief Medical Examiner

Tracy Dumais - Cilibrasi
NH Victims' Compensation Program

Kim Fallon
Office of the Chief Medical Examiner

Adam Fanjoy
NH Fire Marshall's Office

Elizabeth Fenner-Lukaitis, LICSW
Bureau of Mental Health Services

Detective Steven Flynn
Manchester Police Department

Wendy Gladstone, MD
NH Pediatric Society

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

Sergeant Sara Hennessey
NH State Police

Molly Hill [alt.]
CASA of NH

Audrey Knight, MSN, RN*
Bureau of Population Health and Community Services

Lisa Lamphere
NH Victims' Compensation Program

Marie Linebaugh
NH Coalition Against Domestic and Sexual Violence

Susan Meagher [alt.]
CASA of NH

JoAnne Miles
Bureau of Population Health and Community Services

Detective Richard Nanan
Manchester Police Department

Linda Parker
Bureau of Drug and Alcohol Services

Jennifer Pierce Weeks, RN, SANE-P, SANE-A
NH Coalition Against Domestic & Sexual Violence

Deb Pullin , CPNP
Dartmouth Hitchcock Medical Center

Amy Roy, MD
New Hampshire's Hospital for Children

Lynda Ruel*
State Office of Victim/Witness Assistance

Debra Samaha
Injury Prevention Center at Dartmouth

Thomas Schutzius
NH Fire Marshall's Office

Marcia Sink
CASA of NH

Danielle Snook*
State Office of Victim/Witness Assistance

Nancy Wells
Department of Education

*denotes Executive Committee Member

REVIEW AND ANALYSIS OF DATA

The citation for this report is as follows: Data Source: New Hampshire Department of Health and Human Services, Injury Prevention Program. Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2005-2015. 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, 2005-2015 (Table 1). This was also the case for the year 2015 (63%, Table 2). Infants under age one comprised the majority of deaths due to natural causes (70%, Chart 1). Adolescents 15-18, on the other hand, account for the majority of injury related deaths (56%, Chart 1).

Table 1: Number of New Hampshire Resident Natural and Injury Deaths by Age Group, 0-18, 2005-2015

Age Group	Natural	Injury	Other/ Unknown	Total
<01	584	28	80	692
01 to 04	73	24	8	105
05 to 09	51	27	4	82
10 to 14	53	49	11	113
15 to 18	75	166	1	242
Total	836	294	104	1234
Percent	**68%**	**24%**	**8%**	**100%**

Chart 1:

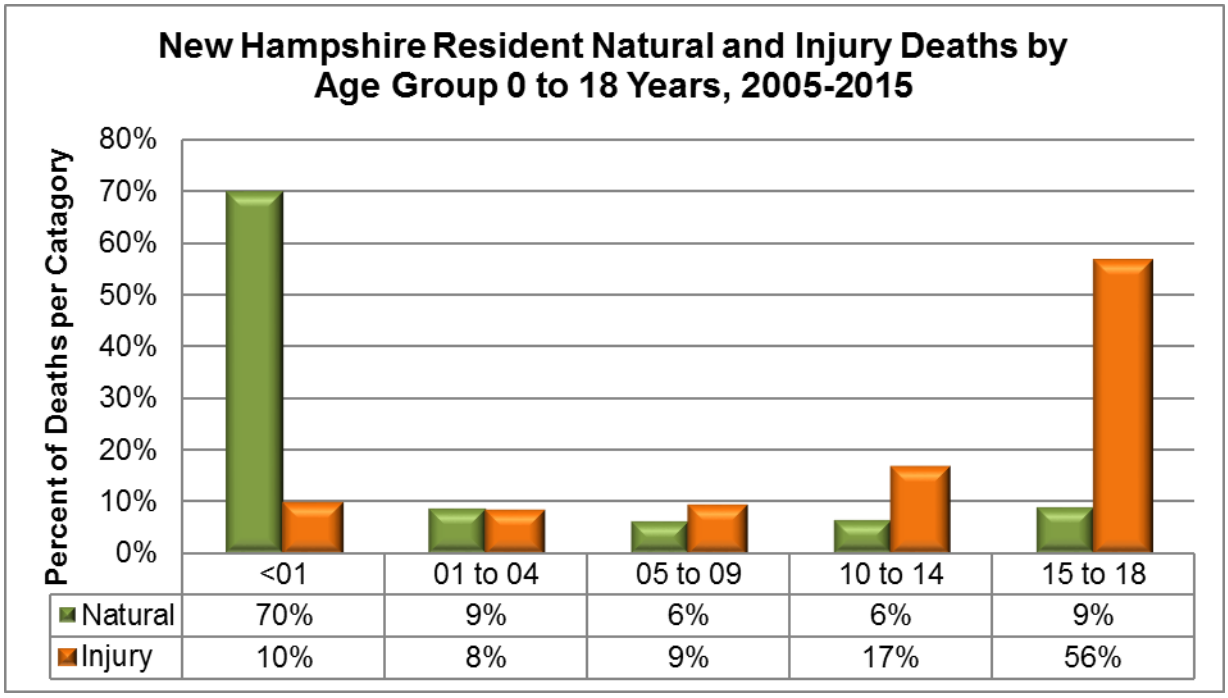


Table 2: Number of New Hampshire Resident Natural and Injury Deaths by Age Group, 0-18, 2015

Age Group	Natural	Injury	Other/ Unknown	Total
<01	39	4	9	52
01 to 04	5	3	1	9
05 to 09	4	3	0	7
10 to 14	5	3	0	8
15 to 18	7	13	0	20
Total	60	26	10	96
Percent	**63%**	**27%**	**10%**	**100%**

As was stated previously, infants less than one year of age died primarily from natural causes. The number one cause of deaths in the aggregated eleven year time period (Table 3) were due to newborns affected by maternal factors and by complications of pregnancy, labor and delivery. This category made up 47% of natural deaths.

Table 3: Number of New Hampshire Residents,

Top Ten Leading Causes of Natural Deaths in 2015, Infants (under age 1 year)

Leading Causes of Natural Infant Death	2005-2015	2015
Newborn affected by maternal factors and by complications of pregnancy, labor and delivery	273	19
Congenital malformations, deformations and chromosomal abnormalities	90	6
SUID-Undetermined R99	51	8
SUID-Sudden infant death syndrome (SIDS) R95	47	0
Diseases of the nervous system	13	2
Certain infectious and parasitic diseases	11	0
Diseases of the respiratory system	11	1
SUID-Accidental suffocation and strangulation in bed W75	11	1
Endocrine, nutritional and metabolic diseases	10	2
Diseases of the circulatory system	8	2
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	8	0

In the past, 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 "Safe to Sleep" campaign (previously called the "Back to Sleep" campaign), reminding parents, childcare providers, and anyone caring for an infant, to put the baby to sleep alone, on its back, on a firm, flat mattress, the rate of SIDS cases nationally and in New Hampshire, dropped significantly since the early 1990's. However, although SIDS has declined, the rate of deaths from SUID – or Sudden Unexpected Infant death, has increased both nationally and in New Hampshire.

New Hampshire is one of twelve states receiving a grant from the Centers for Disease Control and Prevention (CDC) to participate in a Sudden Unexpected Infant Death (SUID) Case Registry project to better understand the contributing factors of why babies are dying suddenly and unexpectedly.

The SUID category includes those deaths due to SIDS, Accidental Suffocation and Strangulation in Bed, and those deemed "Undetermined" in unsafe sleep situations. 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. For example, in 2015, out of 14 "Undetermined" infant death cases noted in the death certificate data based on the ICD codes, only 9 met the Centers for Disease Control and Prevention (CDC) criteria for being categorized as a SUID. Manner of death in these cases was accidental or undetermined. Compared to all natural manner of death cases, 9 cases of SUID would put it as the second leading cause of death (Table 4) with death due to complications of pregnancy and delivery as the leading cause of natural infant death.

Table 4: New Hampshire Residents, Causes of Death Counts,

Infants (under age 1 year), 2014 to 2015

Cause of Death	Manner of Death	2014		2015		Total	
		Count	%	Count	%	Count	%
Newborn affected by maternal factors and by complications of pregnancy, labor and delivery	Natural	14	33%	19	43%	33	38%
SUID- ICD10 Codes R95, R99, W75	Undetermined	9	21%	8	18%	17	20%
	Natural	1	2%	0	0%	1	1%
	Accidental	0	0%	1	2%	1	1%
Congenital malformations, deformations and chromosomal abnormalities	Natural	7	16%	6	14%	13	15%
Diseases of the nervous system	Natural	3	7%	2	5%	5	6%
Diseases of the circulatory system	Natural	1	2%	2	5%	3	3%
Assault	Homicide	1	2%	2	5%	3	3%
Endocrine, nutritional and metabolic diseases	Natural	0	0%	2	5%	2	2%
Neoplasms	Natural	1	2%	1	2%	2	2%
Diseases of the respiratory system	Natural	0	0%	1	2%	1	1%
Unknown Unspecified	Natural	3	7%	0	0%	3	3%
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	Natural	1	2%	0	0%	1	1%
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	Natural	1	2%	0	0%	1	1%
Cerebrovascular diseases	Natural	1	2%	0	0%	1	1%
	Pending	0	0%	0	0%	0	0%
Total		**43**	**100%**	**44**	**100%**	**87**	**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 5). This is consistent with both the national data and previous years.

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

Causes of Death	2005 - 2015	2015
Neoplasms	86	3
Congenital malformations, deformations and chromosomal abnormalities	31	4
Diseases of the nervous system	28	5
Diseases of the circulatory system	25	3
Diseases of the respiratory system	20	1
Endocrine, nutritional and metabolic diseases	20	3
Certain infectious and parasitic diseases	7	
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	7	1
Unknown Unspecified	7	
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	5	
Diseases of the digestive system	4	1
Newborn affected by maternal factors and by complications of pregnancy, labor and delivery	3	
Cerebrovascular diseases	2	
Diseases of the musculoskeletal system and connective tissue	2	
Diseases of the genitourinary system	1	
Pregnancy, childbirth and the puerperium	1	
Suffocation	1	
Viral infections of the central nervous system	1	
Not Stated	12	1
Total	**263**	**22**

Reviewing unintentional injury deaths in children (Tables 6 and 7, Chart 2); motor vehicle traffic was the leading cause of death. This cause exceeded even those due to natural causes (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 6: New Hampshire Residents, Unintentional Injury Deaths, Ages 0-18, 2005-2015

Cause of Injury	<01	01 to 04	05 to 09	10 to 14	15 to 18	Total
Motor vehicle traffic			6	2	36	44
Other land transport accidents			3	3	32	38
Drowning	2	6	4	5	7	24
Poisoning					24	24
SUID-Accidental suffocation and strangulation in bed	10	1		1		12
Exposure to smoke, fire and flames		3	2	4		9
Pedestrian vs Motor Vehicle			2	4	3	9
Suffocation	2	3		2	1	8
Pedal cyclist vs Motor Vehicle			2		2	4
Struck by or against				3	1	4
Newborn affected by maternal factors and by complications of pregnancy, labor and delivery	3					3
Pedestrian - other				1	2	3
Pedal cyclist - other			1	1		2
SUID-Undetermined	2					2
Diseases of the nervous system				1		1
Exposure to forces of nature	1					1
Falls					1	1
Machinery			1			1
Mental and behavioral disorders				1		1
Unknown/Unspecified Accidental Injury		2		1	6	9
Total	**20**	**15**	**21**	**29**	**115**	**200**

Chart 2:

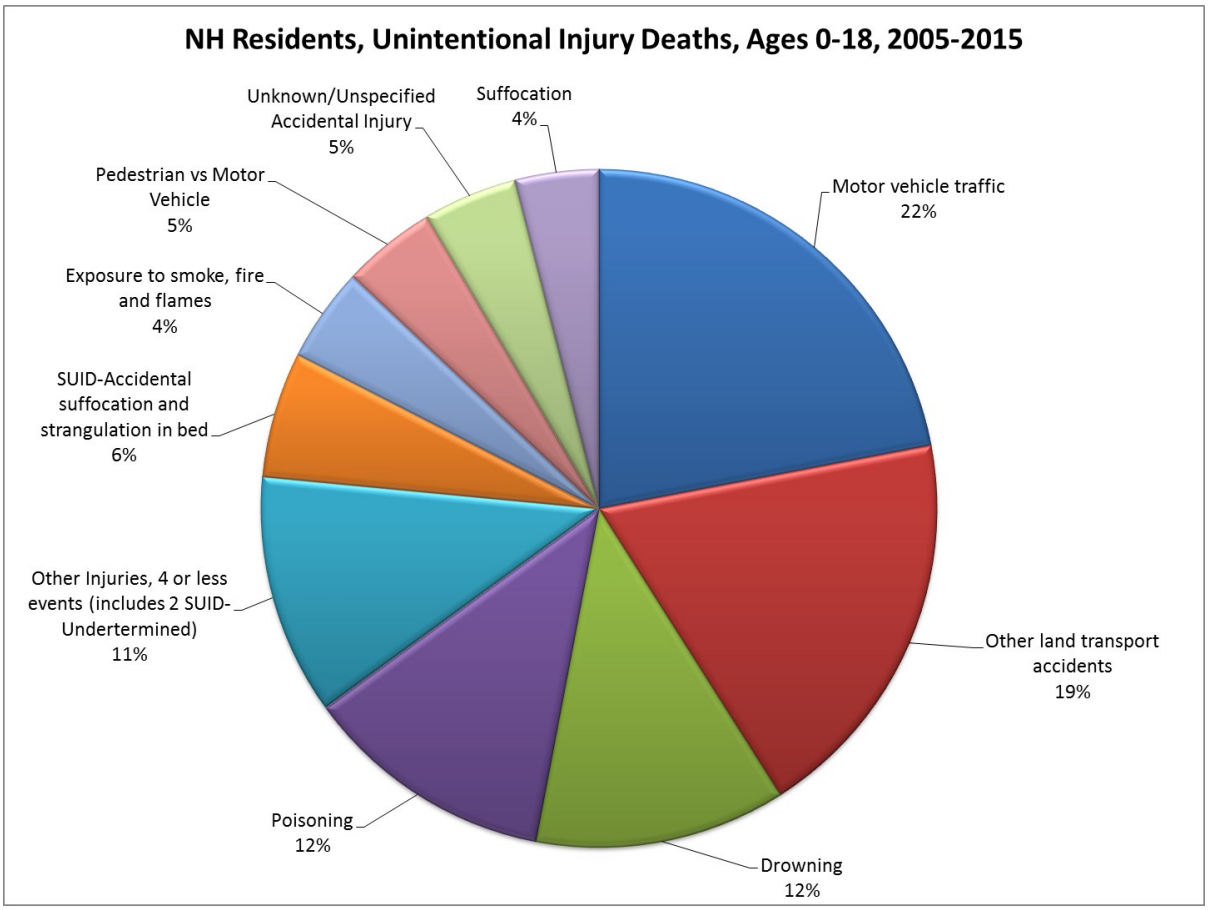


Table 7: New Hampshire Residents, Unintentional Injury Deaths, Ages 0 to 18, 2015

Cause of Death	<01	01 to 04	05 to 09	10 to 14	15 to 18	Total
Drowning		2	1	1		4
Mental and behavioral disorders				1		1
Other land transport accidents					2	2
Pedestrian vs. Motor Vehicle					1	1
Poisoning					5	5
SUID-Accidental suffocation and strangulation in bed	1					1
Total	**1**	**2**	**1**	**2**	**8**	**14**

Suicide is the leading cause of intentional injury deaths for children and adolescents (Tables 8 and 9). 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 10 and 11).

Table 8*: New Hampshire Residents, Intentional Injury, Ages 0 to 18, 2005-2015

Gender	Intentional Injury	<01	01 to 04	05 to 09	10 to 14	15 to 18	Total
Males	Homicide	5	5	1	0	3	14
	Suicide	0	0	1	11	37	49
Females	Homicide	1	4	4	3	1	13
	Suicide	0	0	0	6	10	16
Total		6	9	9	20	51	92

Table 9*: New Hampshire Residents, Intentional Injury, Ages 0 to 18, 2015

Gender	Intentional Injury	<01	01 to 04	05 to 09	10 to 14	15 to 18	Total
Males	Homicide	2					2
	Suicide					5	5
Females	Homicide		1	2			3
	Suicide				1		1
Total		**2**	**1**	**2**	**1**	**5**	**11**

Table 10: New Hampshire Residents, Suicide Deaths, Ages 0 to 18, 2005-2015

Mechanism of Death	Total
Cut/pierce	1
Firearm	27
Poisoning	4
Suffocation	31
Total	**63**

Table 11: New Hampshire Residents Suicide Deaths, Ages 0 to 18, 2015

Mechanism of Death	Total
Firearm	4
Poisoning	1
Suffocation	1
Total	**6**

Undetermined manner deaths are a category for deaths in which no manner of death can be discerned. They are not homicide nor suicide, and also cannot be deemed an accident with the available evidence. This category can be further puzzling when the cause of death is also unknown or unspecified. Manner denotes the intention (homicide, suicide, accidental, undetermined) of how the death occurred and the cause of death is the disease or external force that was found to cause the death, such as diabetes, motor vehicle crash, unknown or unspecified. Tables 12 and 13 show the age group and gender counts for undetermined manner deaths.

Table 12*: New Hampshire Residents, Undetermined Manner of Injury, Ages 0 to 18, 2005-2015

Gender	Intentional Injury	<01	01 to 04	05 to 09	10 to 14	15 to 18	Total
Males	Undetermined	35	2	1	2	3	43
Females	Undetermined	30	4	0	0	3	37
Total		65	6	1	2	6	80

Table 13*: New Hampshire Residents, Undetermined Manner of Injury, Ages 0 to 18, 2015

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

Looking at seasonal variations of injury deaths by mechanism (Table 14), 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. 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 (Table 14 and Chart 3). It is interesting to note that among the intentional (all of the firearms, majority of suffocation, and some of the poisoning) injury deaths, many occur in the spring (Table 15 and Chart 4). These would include the suicide and homicide deaths.

Table 14: Mechanism of Injury Deaths by Season, New Hampshire Residents, Age 0 to 18 years, 2005-2015

Cause of Injury	Dec-Jan-Feb	Mar-Apr-May	Jun-Jul-Aug	Sep-Oct-Nov	Total
Cut/pierce			3		3
Drowning	1	2	24	1	28
Fall			1		1
Fire or hot object/ substance	5	3	1		9
Firearm	7	12	7	7	33
Machinery	1				1
Motor vehicle traffic	20	23	29	23	95
Natural/ environmental			1		1
Other land transport	1	2	1		4
Pedal cyclist - other		2			2
Pedestrian - other			2		2
Poisoning	8	11	6	7	32
Struck by or against		3		1	4
Suffocation	12	18	16	12	58
Unspecified	31	21	22	32	106
Total	**86**	**102**	**113**	**83**	**379**

*Since the original printing of this report in October 2017, Tables 8 and 9 have been amended and Tables 12 and 13 to provide additional clarity regarding undetermined deaths.

Chart 3:

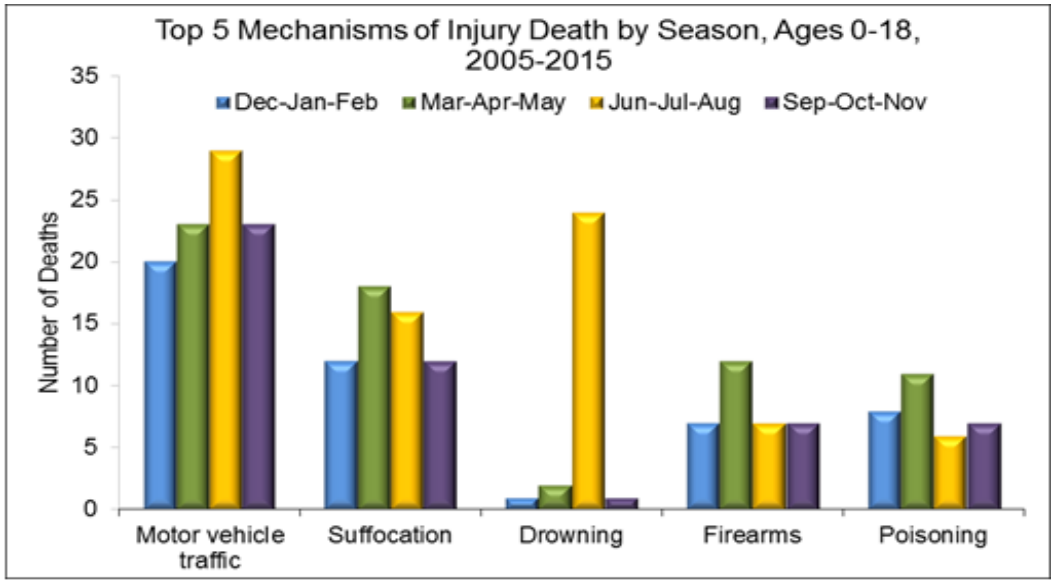
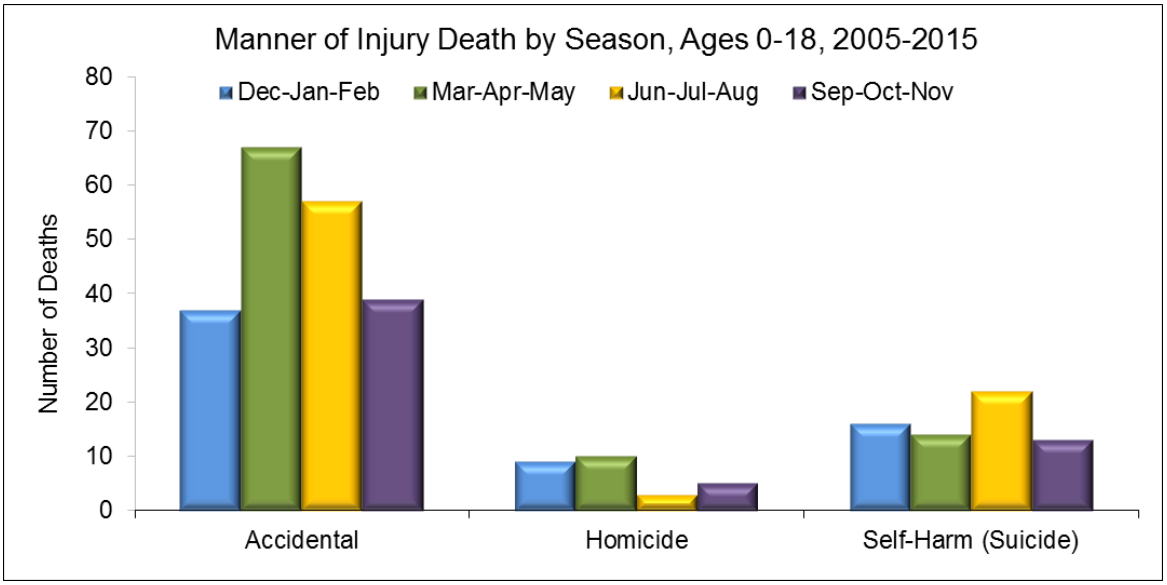


Table 15: Manner of Injury Deaths by Season, New Hampshire Residents, Age 0 to 18 years, 2005-2015

Manner of Injury	Dec-Jan-Feb	Mar-Apr-May	Jun-Jul-Aug	Sep-Oct-Nov	Total
Accidental	37	67	57	39	200
Homicide	9	10	3	5	27
Self-Harm (Suicide)	16	14	22	13	65
Total	**62**	**91**	**82**	**57**	**292**

Chart 4:



CFRC RECOMMENDATIONS AND RESPONSES, 2015-2016

The purpose of recommendations made during a review is to take case specific facts and create broader recommendations for system improvement.

For ease of organizing the recommendations, once a recommendation is made it is sorted into one of the following areas: **Policy**, **Professional Collaboration, Education/Training, CFRC Internal** and **Statements of Support**.

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) Explore proposing legislation to change DCYF's record retention policy.	During the 2016 legislative session, SB537 was introduced which would have extended the length of time that DCYF could keep records. The legislation proposed increasing screened-out cases from 1 to 7 years, unfounded cases from 3 to 10 years, and founded cases from 7 years to indefinitely. These extended record retentions would have allowed DCYF to identify patterns of potential maltreatment which are important for protection against further abuse or neglect. While this bill had the support of many public and private agencies, the bill ultimately did not pass. In 2017 SB63 was introduced, which again proposed extending record retention time. At publication time of this report, the bill was currently on hold in the legislature.
2) Revisit the State Policy Action Plan on the intersection of domestic violence and healthcare.	Best practices have changed since the State Policy Action plan was first developed. The plan should be reviewed, along with existing protocols and policies relative to this issue, to ensure consistency and the promotion of best practices. It is suggested that a small workgroup convene over the next year to address this recommendation.
3) Advocate that Electronic Medical Records (EMR) systems include a screen for domestic violence and child abuse and information on appropriate referrals.	Discussions occurred with hospital CIOs and Case Managers who confirmed that screening is required in all their settings, though some use paper versus EMR. If a response is positive, hospital Social Workers either make referrals or provide resources for local assistance and support. All New Hampshire hospitals use different EMRs and are in various stages of upgrades, so a standard uniform method of documentation is not achievable at this time. Dartmouth Hitchcock Medical Center is exploring the possibility of piloting a screen for domestic violence and child abuse in its EMR.
4) Explore legislation for involuntary treatment of substance use disorders.	No successful action has been taken on this recommendation to date.

5) Explore current Emergency Medical Services (EMS) and law enforcement protocols for assessing other children when responding to an incident. Any injury or concern of potential abuse of a child would trigger an assessment of other children in the home.	The Bureau of Emergency Medical Services updated its protocol in 2017. In the "Victims of Violence" Protocol the following language was added under the "Suspected Disabled Person/Elder/Child Abuse or Neglect" section: *Assess all children carefully for physical injury whenever another household member is injured/abused in a domestic violence incident, and/or if the scene suggests a mechanism of injury such as broken glass or furniture.* *If physically uninjured, children should be sheltered from further harm on scene, e.g., witnessing patient care or police interaction with the suspected abuser, or view of the crime scene. EMS may assist law enforcement with caring for the uninjured child until appropriate arrangements have been made by law enforcement.* All EMS providers will receive an update on this protocol as part of their licensing process. A presentation was given at the Central New Hampshire EMS conference, on the importance of reporting all concerns of child abuse and/or neglect, which includes the other children in a home where there is a child suspected to be the victim of maltreatment. This presentation was attended by approximately 100 people. New Hampshire EMS held a continuing education class in 2017 entitled "Reporting Child Abuse and Neglect". Thirty EMS providers attended this training. The Attorney General's Office is updating its *Model Protocol on Response to Domestic Violence Cases* and its *Child Abuse and Neglect Protocol* and this issue will be explored in each of those publications.
6) Pursue making education about the recognition and reporting of child abuse mandatory for professionals as part of their licensure renewal process.	This topic was discussed within the Commission to Review Child Abuse Fatalities to explore potential legislation and at present no action has been taken. States receiving federal Child Care Development Funds (CCDF) are now required to have licensed child care staff and any provider receiving CCDF, trained in eleven key health and safety topics including child abuse and neglect focusing on recognizing and reporting. An on-line continuing education module was developed and is now available for child care providers. Additionally, New Hampshire administrative rules now mandate training on recognizing and reporting child abuse and neglect for license-exempt child care providers receiving CCDF funding. (Child Care Enrollment Requirements He-C 6914). Proposed administrative rules mandate training on recognizing and reporting child abuse and neglect for all licensed child care providers and staff providing supervision of children or required to meet child to staff ratios. (Child Care Licensing Rule He-C 4002).

7) Ensure statewide implementation of the Lethality Assessment Program (LAP) in all police departments in New Hampshire.	The Lethality Assessment Program—Maryland Model (LAP) was created by the Maryland Network Against Domestic Violence (MNADV) in 2005 as an evidence-based innovative strategy to prevent domestic violence homicides and serious injuries. Since 2009, the New Hampshire Attorney's General's Office adopted the LAP as a model response for domestic violence cases in New Hampshire and has encouraged police departments throughout the state to utilize it. There isn't a mechanism to mandate that law enforcement agencies use LAP, therefore participation is voluntary. In 2014 a LAP Steering Committee was created to assist the efforts of implementing the LAP statewide. The Committee has met regularly to assess the status of the program and develop a strategy to move it forward by focusing on outreach, training, and data collection. Through the efforts of the LAP Steering Committee, over 900 people have been trained on LAP in New Hampshire since 2014. Departments were asked, beginning in January 2015, to submit to the Attorney General's Office how many LAP screens they conducted each quarter. According to that data, in 2015, 978 LAP screens were completed by approximately 60 police departments. In 2016 that number went up to 1,660 screens administered by roughly 85 departments.

PROFESSIONAL COLLABORATION RECOMMENDATIONS	
1) Encourage the Attorney General's Task Force on Child Abuse and Neglect to investigate creating a centralized data collection mechanism from multiple reporting sources, on incidents of child abuse and neglect.	It was determined that the Attorney General's Task Force on Child Abuse and Neglect does not have the capacity to create such a data clearinghouse. However, during the 2016 legislative session HB1651 passed which directed the commission to review child abuse fatalities to identify all potential sources of child abuse and neglect data and recommend a comprehensive system for coordinated reporting to a central source.
2) Improve the ability of agencies to communicate with one another by providing education and information on the difference between HIPAA and breach of confidentiality laws.	DCYF has developed a brochure that explains the application of HIPAA regulations to the sharing of patient information in child abuse and neglect cases. This brochure will be utilized by DCYF staff when they make collateral contacts with medical providers as part of their case assessment. This brochure may also be utilized when DCYF conducts mandated reporter training to provide clarification to other allied professionals on the intersection of HIPAA, confidentiality and child abuse and neglect investigations.

EDUCATION/TRAINING RECOMMENDATIONS

1) Continue efforts to educate the public and professionals on the mandated reporting requirements for child abuse, which includes children exposed to domestic violence.	Training on the mandated child abuse reporting statute, which includes children exposed to domestic violence, is an ongoing effort of many agencies throughout the state. It is acknowledged that part of this outreach effort must include education on how domestic violence affects children. Highlights of the efforts made in this area include: • Through a grant funded by HNH Foundation, the New Hampshire Coalition Against Domestic and Sexual Violence (NHCADSV) trained 140 DCYF staff and over 800 other professionals (teachers, school bus drivers, police recruits, schools nurses etc.) on children exposed to domestic violence. This included information on the impact of emotional abuse. • The DCYF Community Guide was updated to include information that assault on family members is the most common type of victimization and disrupts the safety and development of children. • The NHCASV wrote an op-ed piece on the Adverse Child Experience (ACE) study and the long term impact exposure to domestic violence has on children. • The NHCADSV has worked with the media to feature stories during domestic violence and sexual assault awareness months which included collaboration with Senator Shaheen and Glamour magazine to feature a story about domestic violence in New Hampshire, and efforts to end domestic violence. Highlights of efforts made to increase public and professional awareness of the mandated reporting statute include: • During fiscal years 2015 and 2016, DCYF conducted twenty six (26) speaking engagements in communities across New Hampshire with a total of one-hundred seventy seven (177) attendees. Audiences have included schools, medical providers, social service agencies and child care providers. • The mandated reporting guide was provided at the 2016 New Hampshire Celebrate Early Childhood conference. • DCYF created public service announcements and posted mandated reporting requirements on the DHHS website during April 2016, which is Child Abuse Prevention month. • The article “Exposure to Domestic Violence Can Hurt Children - It Should be Reported to Child Protection Services” was published in the May/June 2016 Granite State Pediatrician, newsletter of the New Hampshire Pediatric Society. • The Granite State Children’s Alliance, through its Know and Tell Campaign has developed public service announcements, materials and has offered professional development training opportunities regarding mandatory reporting requirements throughout the state. • Information on mandatory reporting was distributed to school nurses throughout the state on a school nurse listserv. • Administrative rules were filed in December 2016 that would ensure that licensed and license exempt child care environments post the mandated reporting law. • A one-hour e-module that addresses abusive head trauma, sentinel injuries, Period of PURPLE Crying and reporting child abuse, was developed for child care providers and home visitors. All entities acknowledged that additional funding would be needed to launch additional public awareness, training and education efforts.

2) Explore firearm awareness trainings for parents as it relates to suicide prevention in adolescents.	Outreach and exploration was conducted with the Means Matter Program from Harvard Injury Prevention Center. The booklet, "*Holding on to Life*" which gives tips on how to make a residence safer if there is a child of risk for suicide, was obtained and shared with the Committee, who in turn shared it with their contacts.
3) Offer to conduct Counseling on Access to Lethal Means (CALM) training to school districts.	An e-mail was sent to all the school Superintendents in New Hampshire with the offer of free 2-hour CALM trainings to be conducted at their schools. During 2015-2016 school years, ten schools accepted this offer resulting in 151 school personnel trained.
4) Educate emergency department staff on the importance of assessing other young household members when there's a critically injured infant/child (under age 5) by submitting an article to the New Hampshire chapter of American College of Emergency Physicians newsletter.	No successful action taken to date on this recommendation.
5) Encourage the Community Mental Health Centers (CMHC) to remind family and friends of their clients, especially those that are parents, to inform the CMHC of any changes in the patient.	An e-mail was sent to the State's ten CMHCs and hospitals that have inpatient psychiatric units. The message encouraged providers to speak with family and friends of clients, especially those that are parents, to stress contacting the provider about any change in behaviors. Centers were reminded of situations when it is permissible to breach confidentiality (safety issues) and that when they cannot breach it, nothing prevents them from listening to family and friends.
6) Advise treatment facilities to educate supportive family and friends to be vigilant about increase risk of relapse and overdose in the interval prior to admission.	An e-mail was sent to all Substance Use Disorder (SUD) programs and Recovery Support Services funded by the Bureau of Drug and Alcohol Services.
7) Increase education to professionals on the importance of referrals to mental health treatment and to domestic violence crisis centers if there's a positive screen for depressive symptoms and a suspicion of Intimate Partner Violence (IPV).	A reminder that depression is the second most common diagnosis for victims of IPV, was shared with the state's ten Community Mental Health Centers, the hospitals in New Hampshire that have a psychiatric unit, and staff from the New Hampshire Peer Support Agencies. The contact information for the state's domestic and sexual violence crisis centers was provided, along with the reminder that individuals receiving services from these crisis centers are less likely to be hurt or killed by their partner. A message was also shared with the New Hampshire Medical Society members, the state's school Superintendents, and school nurses that depression in students and/or parents may indicate a need for services with mental health providers and/or crisis centers if there is a suspicion of IPV. Contact information for the Community Mental Health Centers and domestic and sexual violence crisis centers was included, along with a reminder that individuals receiving crisis center services are less likely to be killed or hurt in intimate partner violence and that treatment for depression is less likely to result in a death by suicide.

8) Explore what education is currently being offered to school age children regarding substance misuse.	Every school in New Hampshire is required to address substance abuse as part of their health curriculum. The curriculum is written by local districts and therefore is not standardized throughout the state. The Department of Education (DOE) has recently developed a special unit, the Office of Student Wellness, which is dedicated to the health, safety, and wellness of students. The Office of Student Wellness has a website with many resources. The DOE also has two Substance Abuse and Mental Health Services Administration (SAMHSA) grants dedicated to the behavioral health of students through the Safe Schools/Healthy Students and Project Aware grants. Both initiatives can be found on the Office of Student Wellness website. The Bureau of Drug and Alcohol Services (BDAS) is the recipient of the Partnership for Success grant and has implemented Student Assistance Programs in 38 middle and high schools and is seeking more schools to adapt the program via a recently released Request For Application. In addition, BDAS has a contract with the New Hampshire Inter-Athletic Association to implement the Life of an Athlete program in high schools throughout the state. This program is designed to change attitudes, perceptions, and school climate regarding substance misuse using student athletes and leaders. BDAS also funds 16 Juvenile Diversion programs throughout the state which is a restorative justice model for first time offending juveniles under the age of 17. The Governor's Commission on Substance Abuse's Prevention Taskforce is also reviewing substance abuse prevention education in early childhood programs.
9) Share school guide for disaster response (suicide, natural disaster) with schools.	*After a Suicide: Toolkits for Schools* and *Preventing Suicide: A Toolkit for High Schools* were shared with the Superintendents. The topics covered suicide response for different school ages as well as the template for New Hampshire's school disaster guide that addresses more general disasters.
10) Enhance efforts to educate the public and professionals on mandated reporting requirements for elderly and incapacitated adults.	During calendar year 2016, Adult Protective Services gave presentations to 25 different organizations which included: home care agencies, medical providers, police, fire, nursing facilities, and community agencies such as Meals on Wheels providers, senior centers, Sexual Assault Nurse Examiner (SANE) nurses, a Sexual Assault Resource Team (SART) and a county attorney's office. Adult Protective Services will also present a workshop at the 2017 Partnering for a Future Without Violence Conference on "The Role of Adult Protective Services".

11) Increase broad based training for medical providers on the impact of trauma on children (i.e. Adverse Childhood Events (ACE) study).	DCYF, through a contract with Dartmouth Medical School, trained approximately 300 professionals in trauma informed care and clinical treatments for children and families experiencing traumatic events. The New Hampshire Coalition Against Domestic and Sexual Violence (NHCADSV) regularly trains Sexual Assault Nurse Examiners (SANE) nurses on issues related to children exposed to domestic violence and participated in a web-based training for the International Association for Forensic Nurses. NHCADSV also provides ongoing training for DCYF's CPSWs on the Accessing the Mental Health Needs of Families, which is a training derived from the National Childhood Traumatic Stress Network's Child Welfare Trauma Training Toolkit. Additionally, NHCADSV presented at the School Nurses Association conference in the fall of 2016 and has additional training planned in the future. It is also exploring doing a web-based training for medical providers so that the information is accessible 24/7. Dartmouth Hitchcock Medical Center is also looking for funds to create a web-based training series for providers, as well as members of the multidisciplinary child abuse teams on medical evaluations. Part of this training series would include the ACE studies.

CFRC INTERNAL	
1) Increase the CFRC's understanding of the functioning and volume of the New Hampshire State Crime Lab to assess the need to formally support additional staffing.	A presentation was made by the State Crime Lab to the CFRC to provide an overview of its functioning and volume of cases handled. Legislation was passed that provides additional staffing. No formal support by the CFRC was needed.

STATEMENTS OF SUPPORT BY THE CFRC

1) Support funding for residential and community based substance abuse treatment for juveniles.	The State Youth Treatment-Planning (SYT-P) grant was awarded by SAMHSA to the Department of Health and Human Services in order to develop a three year strategic plan to increase access to evidenced-based screening, assessment, treatment, and recovery support services for youth and young adults (aged 12-25) with Substance Use and/or Co-Occurring Mental Health issues. The SYT-P Interagency Council is charged with developing the strategic plan, which includes workforce development and training, expansion of family/ youth structure, policy modification, social marketing and communication, and financial mapping. Key Accomplishments under the State Youth Treatment-Planning (SYT-P) grant include: • Creation of the Interagency Council (IC) with participation from all required State agencies and youth/family representatives. The IC has convened 5 meetings since March 2016. • Hiring of a full-time SYT-P Coordinator. • Development of Vision and Mission Statements of the IC • Completion of a Collaborative Agreement between SYT-P and the Department of Education System of Care (SOC) Expansion grant ("Fast Forward 2020") • Conducted Basic Culturally and Linguistically Appropriate Services (CLAS) training for Interagency Council Members • Formed and Convened Substance Use Disorder (SUD) Financing Subcommittee • Formed and Convened SYT-P Subcommittee • Expanded family and youth involvement on the Interagency Council Concurrent State Investments That Impact SYT-P • Development of RFP for hiring of LADC's, MLADC's and other Licensed Mental Health Professionals to work in each Division for Children, Youth, and Families (DCYF) District Offices (DOs). • Use of the same Cultural and Linguistic Competence (CLC) Coordinator on the current and future SOC grants. • Recent appointment of a Senior Policy Analyst for Substance Use Disorder Services in the Division of Behavioral Health. • Inclusion of SUD treatment and recovery support services in the New Hampshire Medicaid State Plan for all populations effective 7/1/2016.

2) The CFRC recommends the addition of a third board certified forensic pathologist for the Medical Examiner's Office.	Funding for an additional forensic pathologist was approved in the State FY2018 budget.
3) Explore supporting SB106 – restricting the sale or possession of synthetic drugs.	In July 2015, SB 106 was signed into law which, in part, created a new chapter within RSA359 entitled "Sale of Synthetic Drugs". The legislature recognized that the sale and use of certain synthetic drugs could be potentially dangerous to users and society since the long term effects are unknown. As these substances were not yet specifically listed as controlled drugs by the United States Food and Drug Administration and/or Drug Enforcement Administration, sellers could avoid the regulatory process for study before selling them for purposes other than their true nature (Ex. selling substances as "Bath salts", "incense", or "balms"). This legislation outlined substances that are prohibited and the penalties for those caught possessing, selling, advertising, or transporting them.
4) Support state funding for programs that offer Family Resource Centers and home visiting/ family support services to children and families.	DCYF continues to fund eight agencies in eleven sites for Comprehensive Family Support Services. These grants support services to pregnant women and families with children up to age 19 through activities at Family Resource Centers and home visits. No formal support was needed by the CFRC.

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 27th day of September in the year of our Lord, one thousand nine hundred and ninety-five.

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