New Hampshire Child Fatality Review Committee

Annual Report 2020

State of New Hampshire
Department of Health and Human Services

NH DIVISION OF
Public Health Services
Improving health, preventing disease, reducing costs *for all*

Acknowledgement

We would like to take a moment to acknowledge the hard work and dedication that every participant contributes to the efforts of child fatality review. Reviewing circumstances surrounding any death is never easy and it is that much more difficult when it is a child. Through your commitment to this program, recommendations are created in an effort to prevent similar unfortunate circumstances from occurring again.

Thank you.

Dedication

The New Hampshire Child Fatality Review Committee would like to dedicate this Annual 2020 Report to the children of New Hampshire and to those who work to improve their health and lives.

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Letter From Child Fatality Review Commission Co-Chairs

Dear Friends of New Hampshire Children,

The New Hampshire Child Fatality Review Committee (CFRC) has begun its 24th year of reviewing fatalities among New Hampshire children. The work of the committee is 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 CFRC's annual report, covering the work of the committee for the calendar year 2020, including data from the 2015-2019 calendar year. Because there are relatively few child fatalities in New Hampshire on a yearly basis, data from a single year could fluctuate greatly. Five-year data summaries are more likely to give a better indication of fatality trends.

The CFRC was established by an Executive Order of Governor Steven Merrill, and for more than 21 years it functioned under this Executive Order. In the 2018/2019 time frame it became clear that this Executive Order was not sufficient for the CFRC to function efficiently. Legislation (Senate Bill 118) was proposed to establish a "new" committee, and was passed and signed by Governor Christopher Sununu in August of 2019. This new legislation better clarified the membership and role of the committee and provided protections not specified in the former Executive Order. This legislation and subsequent legislation (HB1245) signed in August of 2020 can be found in Appendix A.

As the new committee began its work, the fall of 2019 was utilized to appoint and educate new committee members and to establish the workings of the new committee. Due to the COVID-19 pandemic, the committee's work in 2020 has been truncated with a modified meeting schedule. The committee met in person in January, but since that time, all committee reviews and communication/meetings among members and the Executive Committee have been held remotely. In many ways, this has made our work more difficult, but we have been able to hold all our scheduled review meetings. In addition, the Executive Committee has been diligently working on a variety of issues to enable the smooth functioning of the committee. Committee members continue to work effectively to protect the health and safety of New Hampshire's children and to reduce the probability of child deaths in our state.

In recognition of this commitment and dedication, it is with great pride that as Co-Chairs, we present this our 17th Report to: Governor Christopher T. Sununu, Governor of the State of New Hampshire; State Senate President Honorable Chuck Morse; Acting Speaker of the House of Representatives Honorable Sherman Packard; The Health and Human Services Oversight Committee: and the people of the State of New Hampshire.

Debra A. Samaha Marc Clement

Executive Summary

This report reflects the work of the New Hampshire Child Fatality Review Committee (CFRC) during the calendar year 2020. The work of the committee and the purpose of recommendations produced during our reviews is to reduce preventable child fatalities from intentional and unintentional injury in New Hampshire. Child fatality reviews are grounded in the belief that a child's preventable death is a community's responsibility. It is a sentinel event that should raise a call to action. The primary goal is to learn what happened and prevent harm to other children.

New Hampshire's child mortality rate continues to be below the national average. This report provides a detailed summary of state-level trends from death certificate data among children birth through the age of 21 who were residents of the state of New Hampshire. Deaths due to natural causes (due to underlying medical conditions, unrelated to any external factors) comprised 50 percent of the deaths in 2019 for children from birth through age 21, and about 48 percent of deaths were from injuries. The highest number of deaths occurred in the age group less than one year old and the majority of those were due to natural causes. The next highest death rate was among those 19 to 21 years old and most of their deaths were caused by injuries.

The Committee held six(6) review meetings focusing on suicide and drowning. Suicide accounts for 88 percent of intentional injury deaths among ages 1 to 21. Six percent of unintentional deaths among ages 1 to 21 are related to drowning, with children ages 1 to 14 at particular risk.

Recommendations, and their follow-up activities, drive the work of the committee in their quest to prevent future injuries and deaths. Recommendations are listed along with the responsible party/ agency to follow up and implement the recommendations. Each recommendation is tiered as High/Medium/Low priority.

Purpose

The New Hampshire Department of Health and Human Services (DHHS), in conjunction with the Office of the Chief Medical Examiner (OCME) and in accordance with RSA 611-B and RSA 132:41, has established a Child Fatality Review Committee (CFRC) to conduct comprehensive, multidisciplinary reviews of preventable infant, child, and youth deaths in New Hampshire for the purpose of identifying factors associated with the deaths, and to make recommendations for system changes to improve services for infants, children, and youth.

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.

The CFRC recognizes that the responsibility for responding to and preventing child fatalities lies with communities, not with any single agency or entity. The 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 CFRC was established in 1991 by an Executive Order of Governor Judd Gregg. After reviewing the study findings and initiatives from other states, the CFRC was restructured to accommodate the demands of an ongoing review process. In 1995, in an effort to support the restructuring, Governor Steven Merrill signed an Executive Order reestablishing the CFRC. The CFRC began reviewing cases of child fatalities in January 1996 and provided its first Committee report in 1998.

An Interagency Agreement was established to provide support to the review process. Leadership from the Department of Justice (DOJ), the DHHS, and the Department of Safety (DOS) signed an agreement that defined the scope of information sharing and confidentiality within the CFRC. This was renewed as needed. The CFRC was administered by the DOJ and funded through the Children's Justice Act (CJA) Grant, through the US Department of Health and Human Services.

Additionally, CFRC members and invited participants were required to sign Confidentiality Agreements in order to participate in the review process. The CFRC respected the right to confidentiality for families who lost children.

Throughout its more than twenty year history, the CFRC has played an important role in reducing child deaths by improving communication and coordination among state and community agencies, and has helped improve the delivery of services to children and families. The CFRC has increased public awareness and advocacy for the issues that affect the health and safety of every child in the state.

In November of 1998, in addition to the regular meeting schedule, the CFRC began hosting a yearly one-day joint meeting with the Child Fatality Teams from Vermont and Maine. The remaining three New England states and the eastern provinces of Canada were added to the meeting a few years later. These regional meetings provided a forum for participants to come together and learn about some of the issues that other teams encountered in their efforts to review child deaths. They also offered an opportunity for members to establish contacts with their counterparts in other states. The meetings were expanded to two days 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. Vermont hosted the most recent meeting in 2018.

New Child Fatality Review Committee

For more than twenty years, the work and data of the CFRC has helped change policies and practices that we now take for granted, including policies about car seats for infants and children, how we train child care and health care providers to put infants to sleep, and seat belt laws for children and adolescents. It is hard to imagine a time when those practices did not exist, but progress in each of those areas was made with the help of the data and thoughtful recommendations of the CFRC.

In 2019, the New Hampshire Legislature codified and established the CFRC under RSA132:41. The law also changed the "host" of the Child Fatality Review from the DOJ to DHHS, specifically to the Division of Public Health Services (DPHS). This recommendation came from both agencies to better focus on the population-based, public health focus of the reviews.

The RSA132:41 created legislative authority, provided additional legal protections, clarifies the role of data sharing, expands membership of the CFRC, and placed the Sudden Unexplained Infant Death (SUID) and the Sudden Death in Youth (SDY) committees as sub-committees under the CFRC with the same protections and responsibilities.

The CFRC now has an expanded authority to subpoena witnesses, records, documents, reports, reviews, recommendations, correspondence, data, and other evidence that the committee reasonably believes is relevant to the committee's objectives.

Rather than a biennial report, as the former CFRC produced, the new CFRC was legislated to produce an annual report on or before December 15th of each year. The first report of the new committee was submitted on December 15, 2019 and the first case review was conducted in January 2020.

Modifications to the function of the committee were made by HB 1245 (Appendix A), which was passed and signed into law in June of 2020. The CFRC Membership is included in Appendix B.

Objectives

The objectives of the CFRC as outlined in Senate Bill 118 and amended in House Bill 1245 are to:

(a) Describe the trends and patterns of child deaths in New Hampshire, including sudden unexpected infant deaths (SUID) and sudden deaths in the young (SDY).

(b) Identify and investigate the prevalence of risks and risk factors among the populations of deceased children.

(c) Evaluate the service and system responses for children and families and offer recommendations for improvement of those services.

(d) Improve the quality and comprehensiveness of child fatality data by enhancing and integrating information obtained from autopsies, death scene investigations, death certificates, police reports, medical records, and other relevant sources.

(e) Enable state agencies, law enforcement, heath care providers, and community-based organizations to more effectively prevent and investigate child fatalities.

Case Selection Methodology

Each child death is reviewed using the following review process:

(a) The Office of the Chief Medical Examiner (OCME) 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.

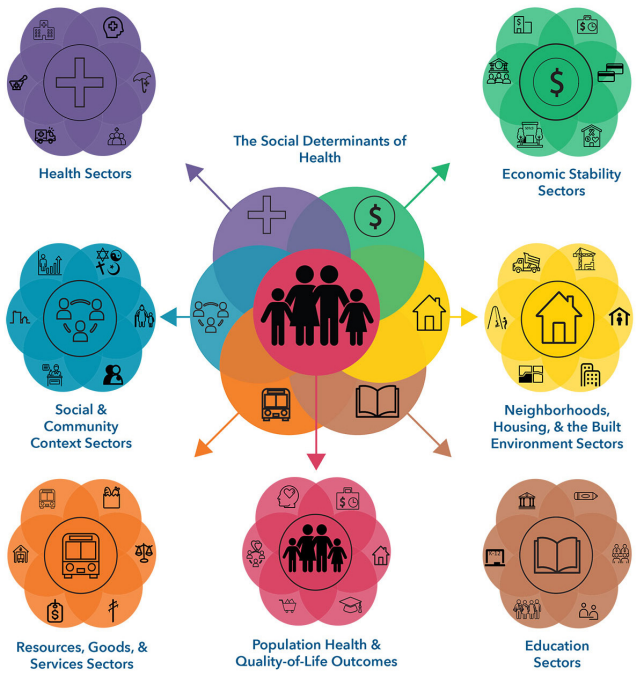
(b) The CFRC discusses service delivery prior to the death, and the investigation process post death.

(c) The CFRC 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.

Framework of CFRC Review Process

The cornerstone of the child fatality review process is a public health approach to preventing similar fatalities from happening in the future. A public health approach to child fatality reviews requires a holistic understanding of their root causes. The CFRC uses the shared risk and protective factor (SRPF) approach to look at child fatality in New Hampshire[1]. Risk factors are characteristics and conditions that increase the likelihood of experiencing an adverse health or quality-of-life outcome. Protective factors are the inverse: these characteristics and conditions decrease or mitigate the likelihood of experiencing an adverse outcome or increase the likelihood of experiencing a positive outcome. Our populations do not exist in isolation. They are surrounded by policies, systems and physical and social environments which have an impact on their health and quality of life.

Shared Risk and Protective Factor (SRPF) Approach Conceptual Model: The Complete Conceptual Model



https://www.safestates.org/page/ConnectionsLab

An SRPF approach engages partners and requires work across multiple disciplines and sectors. SRPF approaches can include working with a state department of safety on reducing teen substance abuse as part of an effort to reduce motor vehicle crashes involving teens. SRPF approaches can also include working with businesses and non-profit organizations to increase affordable housing to address neighborhood poverty and to reduce community violence. To implement SRPF approaches, organizations may choose to formally share their resources or leverage funding streams across multiple departments and divisions. An example of an SRPF approach would be, "instead of implementing a program to only reduce teen suicide, we would focus on implementing an intervention that addresses teen suicide and at least one other outcome, such as substance abuse among teens. SRPF approaches can also simultaneously address a health outcome (such as bullying) and a quality-of-life outcome (such as educational achievement)"[2].

1 https://www.safestates.org/page/ConnectionsLabDefiningSRPFApproach

2 Ibid.

In addition, the SRPF approach impacts social determinants of health (SDOH) in ways that are positive and equitable. Positively impacting the SDOH involves intervening in damaging cycles (e.g., poverty, economic inequality, structural racism, historical trauma) and reinforcing beneficial cycles (e.g., equitable access to quality education, de-stigmatized mental healthcare, community culture, resilience, and engagement). SRPF approaches can include interventions across the Social Ecological Model to influence social determinants at many levels, such as those impacting individuals, families, entire communities, or the larger public.

Further, the CFRC has discussed the impact of Adverse Childhood Events (ACEs) as we reviewed our cases. These are potentially traumatic events that occur in childhood (0-17 years). Examples include: experiencing violence or abuse, witnessing violence in the home or community, or having a family member attempt or die by suicide. ACEs also include aspects of a child's environment that can undermine their sense of safety, stability, and bonding such as growing up in a household with substance misuse, mental health problems, or instability due to parental separation or household members being in jail or prison. ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood.

Child Fatality Data Report

Data presented in this report represent state-level trends from death certificate data among children from birth through the age of twenty-one (21) who were residents of the state of New Hampshire. Rates for the United States are included for comparison purposes; United States rates are from the CDC WONDER Online Database of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics.

Data Definitions

All deaths are classified according to cause and manner of death. There are many complexities involved in determining cause and manner of death, beginning with the definition of each term. **Cause of death** refers to the disease process or injury which set into motion the series of events which eventually lead to death. **Manner of death** refers to the circumstances under which death occurred. In New Hampshire, deaths are classified on the death certificate as resulting from one of the following manners of death: natural (due to underlying medical conditions, unrelated to any external factors), accident (injury or poisoning without intent to cause harm or death), suicide, homicide, (suicide or homicide are cases with confirmed intent to cause death), or could not be determined (insufficient information is available to determine a manner of death). When the manner of death is listed as "pending." further investigative, historical, or laboratory information is expected before a determination of manner of death can be made.

For this report, death data is broken into two classifications of death: **natural causes** and **injuries**. 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), and conditions originating in the perinatal period (such as low birth weight and prematurity). The second 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 further classified as **unintentional** (such as in accidental drowning) or **intentional** (suicide or homicide).

For this report we have not disaggregated data by race and ethnicity due to small numbers. Counts of ten or fewer events 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.

General Overview

Approximately half of the deaths (51%) in New Hampshire children from birth through age 21 were due to natural causes over the last 5 year period, 2015-2019 (Table 1). This was also the case for calendar year 2019 (50%, Table 1).

Table 1: Number of New Hampshire Resident Child Deaths by Cause, 2015-2019 and 2019

Cause of Death	2015-2019		2019	
	Numbers	Percent	Numbers	Percent
Natural	330	51%	62	50%
Injury	292	45%	60	48%
Other / Unknown	29	4%	2	2%
Total	**651**	**100%**	**124**	**100%**

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, 2015-2019.

The first year of life continues to be the most perilous for New Hampshire children, accounting for 35 percent of all deaths among children under the age of one (Table 2) from 2015-2019. Young adults ages 19 to 21 years represented the next highest percentages of deaths at 28 percent (Table 2).

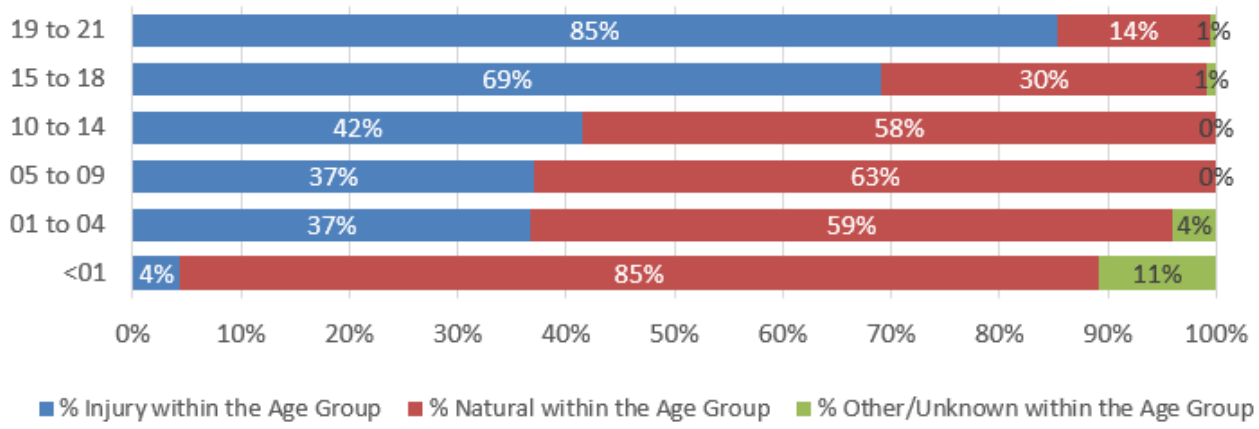
Table 2: Number of New Hampshire Resident Child Deaths by Cause and Age Group, 2015-2019

Age Group	Natural	Injury	Other/Unknown	Total	Total % by Age Group
<01	194	10	25	229	**35%**
01 to 04	29	18	2	49	**8%**
05 to 09	17	10		27	**4%**
10 to 14	31	22		53	**8%**
15 to 18	33	76	1	110	**17%**
19 to 21	26	156	1	183	**28%**
Total	**330**	**292**	**29**	**651**	

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,

The majority of deaths in infants under age one were due to natural causes (85%, Figure 1). Conversely, for young adults 19 to21, injury accounted for the majority deaths (85%, Figure 1).

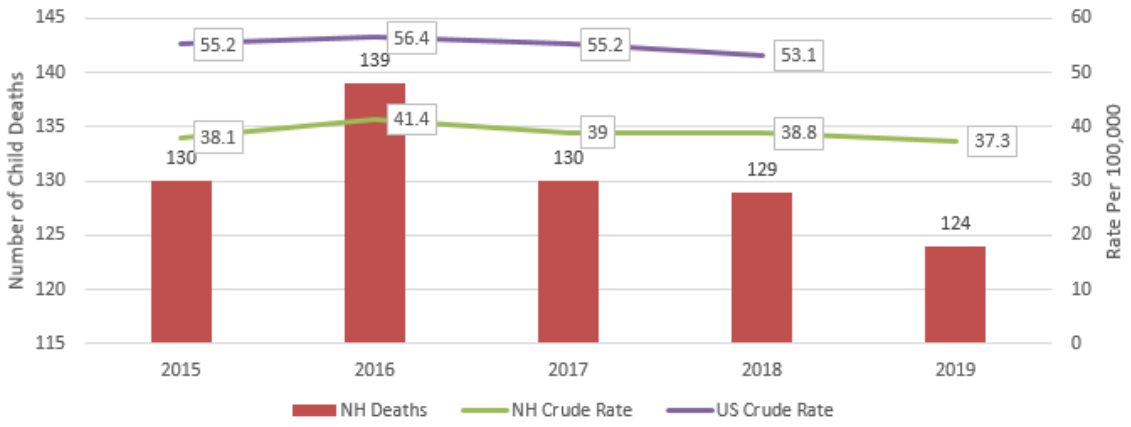
Figure 1: Distribution of Cause of Deaths by Age Group 2015-2019



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, 2015-2019.

The 2019 child mortality rate for New Hampshire was 37.3 child deaths per 100,000 children (0-21 years of age). The rate did not change significantly compared to the 2018 rate of 38.8 per 100,000 children. New Hampshire's child mortality rate continues to be below the national rate. Figure 2 shows the number and rate of child deaths in New Hampshire and the U.S. between 2015 and 2019. The US Crude Rate is not available for 2019.

Figure 2: Number and Rate of Child Deaths for Ages 0-21 Years in New Hampshire, 2015-2019



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, 2015-2019. National Rates: CDC Wonder

Infant Death Data Review

Infants less than one year of age died primarily from natural causes. More specifically, the most common cause of deaths in the aggregated five-year time period (Table 3) was "certain conditions originating in the perinatal period," including certain maternal factors and by complications of pregnancy, labor and delivery. This category made up 68% of all natural deaths.

Table 3: New Hampshire Residents, Top Five Leading Causes of Natural Deaths, Infants (under age 1 year), and 2015-2019

Leading Causes of Infant Death	2015-2019	% of Total Cases
Certain conditions originating in the perinatal period	131	68%
Congenital malformations, deformations and chromosomal abnormalities	23	12%
Diseases of the circulatory system	18	9%
Diseases of the respiratory system	8	4%
Diseases of the nervous system	3	2%
Sudden Infant Death Syndrome (SIDS)	3	2%
All Other Natural Causes of Death	8	4%
Grand Total	**194**	

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, 2015-2019

Sudden Unexpected Infant Death (SUID) Review

New Hampshire is one of twelve states receiving a grant from the CDC to participate in a Sudden Unexpected Infant Death (SUID) Case Registry to monitor SUID trends and characteristics that may affect the risk of SUID, such as infant sleep position. Monitoring SUID rates is vital to identifying new risk factors and tracking progress toward reducing infant deaths. Reviews improve the quality and consistency of SUID investigation data, which helps states develop informed prevention activities.

The SUID Committee reviews SUID category deaths that includes deaths due to Sudden Infant Death Syndrome (SIDS) and Accidental Suffocation and Strangulation in Bed (ICD10 codes: R95=SIDS and W75=Suffocation). Undetermined deaths (ICD10 code R99), under one (1) year old can be grouped and counted in the category of "Sudden Unexpected Infant Death" and are reviewed by the SUID committee. From 2015-2019, New Hampshire had 29 SUID cases and all of these cases were reviewed by SUID Committee (Table 4).

Table 4: New Hampshire Residents, SUID Death Counts by Year, 2015-2019

Cause of Death	2015	2016	2017	2018	2019	Total
SUID (ICD10 Code: R95, R99, & W75)	7	7	4	5	6	29

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, 2015-2019

Children, Adolescents and Young Adult Deaths Review (Ages 1 to 21)

For children between one(1) and 21 years of age, data are presented by cause of death and manner of death. In this age group, the leading cause of death in this age group is due to injury (Intentional or Unintentional). Natural causes of death accounted for 33% of deaths, and malignant neoplasms (cancer) is the leading cause of the natural deaths (Table5).

Table 5: New Hampshire Residents, Leading Causes of Death, Age 1 to 21, 2015-2019

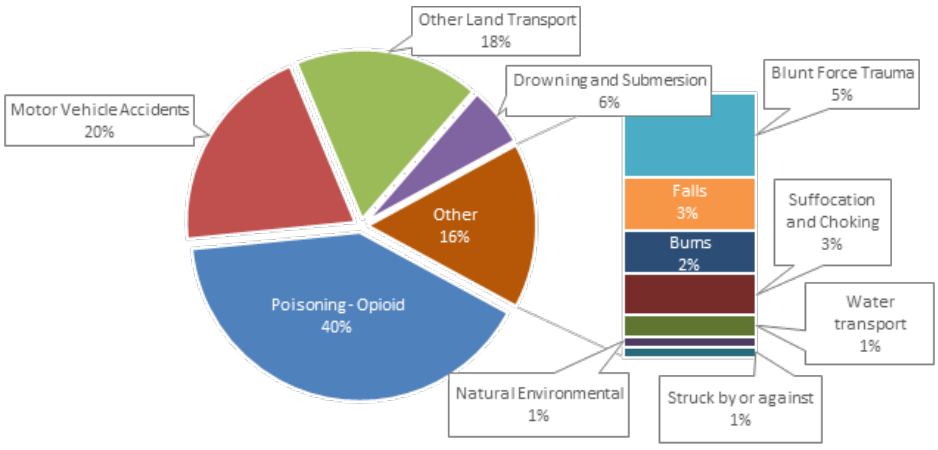
Cause of Death	Counts	Percentage
Natural	136	33%
Intentional	106	25%
Unintentional	158	38%
Undetermined	16	4%

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, 2015-2019

Unintentional Injury Deaths (Ages 1 to 21)

The top five causes of unintentional injury death among children and youth ages 1 to 21 (Figure 3) are: poisoning deaths due to opioids (40%); motor vehicle accidents (20%); other land transport (ATVs, snow mobile related accidents) (18%); drowning and submersion (6%); and blunt force trauma (5%).

Figure 3: Distribution of Unintentional Injury by Manner of Death, Ages 1-21, 2015-2019



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, 2015-2019.

Poisoning deaths due to opioids accounted for 40% of all unintentional deaths among ages 1 to 21, and all of those deaths are among adolescents and young adults ages 15 to 21. A similar pattern is seen in deaths due to motor vehicle accidents and other land transport accidents. The impact of drowning deaths is higher in ages 1 to 14.

Table 6: New Hampshire Residents, Types of Unintentional (Accidental) Injury Deaths, Ages 1-21, 2015-2019

	01 to 04	05 to 09	10 to 14	15 to 18	19 to 21	Total	Total %
Poisoning - Opioid				11	53	64	**40%**
Motor Vehicle Accidents	1	2	0	9	20	32	**20%**
Other Land Transport			3	12	13	28	**18%**
Drowning and Submersion	5	1	2	1		9	**6%**
Blunt Force Trauma	1			2	5	8	**5%**
Falls			2	1	2	5	**3%**
Burns	2	1		1		4	**3%**
Suffocation and Choking		1	1	2		4	**3%**
Water transport				1	1	2	**1%**
Natural Environmental	1					1	**1%**
Struck by or against					1	1	**1%**
Grand Total	**10**	**5**	**8**	**40**	**95**	**158**	

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, 2015-2019.

Intentional Injury Deaths (Ages 1 to 21)

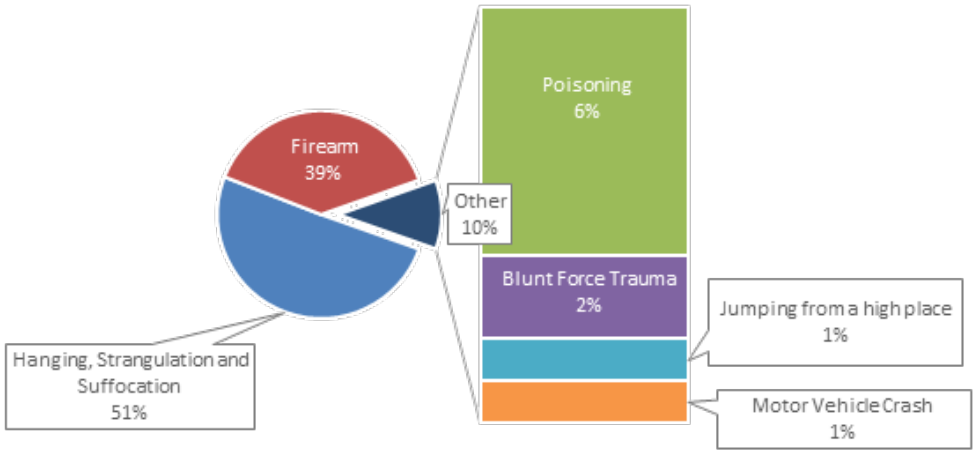
Suicide (88%) is the leading cause of intentional injury deaths in children ages 1 to 21, and the incidence of suicide deaths is highest among young adults ages 19 to 21 (Table7). The method of death in more than half of the suicides is hanging/asphyxiation (51%), followed by firearms (39%), and poisoning (6%) (Figure 4).

Table 7: New Hampshire Residents, Intentional Injury Deaths, Ages 1 to 21, 2015-2019

	1 to 04	5 to 9	10 to 14	15 to 18	19 to 21	Total	Total %
Homicide	5	4		1	3	**13**	**12%**
Suicide			11	33	49	**93**	**88%**
Total	**5**	**4**	**11**	**34**	**52**	**106**	

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, 2015-2019.

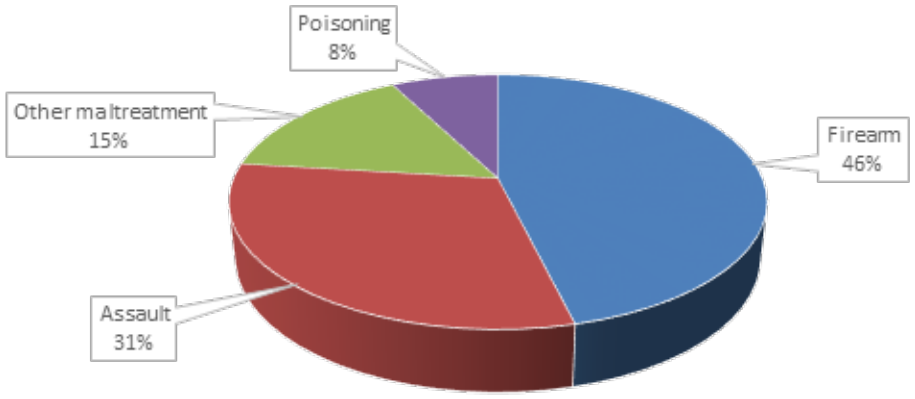
Figure 4: Distribution of Suicide Deaths by Method, Ages 1-21, 2015-2019



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, 2015-2019.

For more information about suicide, please refer to the NH Suicide Prevention Annual Report 2019. This report is one of the most up to date resources available on suicide and suicidality in New Hampshire [3]. A new report is released each fall, summarizing data from the previous

Figure 5: Distribution of Homicide Deaths by Method, Ages 1-21, 2015-2019



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, 2015-2019.

3 https://theconnectprogram.org/wp-content/uploads/2020/11/2019-Annual-Suicide-Report-Final-11-19-20.pdf

calendar year. The report is the collaborative work of many organizations in New Hampshire that have dedicated time and resources to study the issue of suicide in our state.

Among intentional injury deaths related to homicide, 46% were caused by firearms, 31% due to assault, and 15% due to maltreatment (Figure 5).

Undetermined Deaths (Ages 1 to 21)

Undetermined manner deaths are a category for deaths in which no manner of death can be discerned. Undetermined manner deaths are included as a separate category and should not be included when discussing injury deaths. Undetermined manner means that accidental or suicide/homicide intent could not be determined with the available evidence. These deaths are neither homicide nor suicide, and also cannot be deemed an accident with the available evidence. Table 8 show the counts for undetermined manner deaths by age group.

Table 8: New Hampshire Residents, Undetermined Manner of Deaths, Ages 1 to 21, 2015-2019

	1 to 4	5 to 9	10 to 14	15 to 18	19 to 21	Total
Total	**5**	**1**	**3**	**1**	**6**	**16**

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, 2015-2019.

CFRC Activities and 2020 Policy Recommendations

CFRC recommendations are categorized as organizational development and policies to improve the function of the CFRC and those relating specifically to cases involving the death of a child in New Hampshire.

Examples of recommendations to improve the effectiveness of the committee included items such as:

- Recommending the CFRC receive training and resources in several topics to help ground its work, such as the role of vicarious trauma and self-care for members and inclusion of the role of health equity in child fatality review.
- Recommending the creation of an orientation document to onboard new members and their alternates.
- Recommending an invitation to the primary care provider to attend the meetings to share medical history and insights.
- Recommending the request for at least the most current three years of medical records to help inform the review.
- Recommending that the CFRC explore the feasibility of entering New Hampshire data into the National Child Fatality Review Data set.

Implementation of these recommendations has begun and will help guide the CFRC's future reviews. The information on meetings and other information about the committee is available on our website: https://www.dhhs.nh.gov/dphs/bchs/mch/cfrc/index.htm.

CFRC 2020 Recommendations

The CFRC focused on two types of deaths this past year, suicide and drownings. The CFRC reviewed four suicides and three drowning cases. This report will not identify case specific risk and protective factors , objective findings, and or discuss case specific Adverse Childhood Experiences (ACEs). It is noteworthy that many deaths were among individuals with multiple ACEs. The following recommendations are presented in a tiered fashion, indicating the top priorities over the next year. The tier system chosen here reflects the public health impact in improving the lives of children of New Hampshire and the impact on improving the efficacy and efficiency of the agencies identified under recommendations. The recommendations identified as high priority are expected to have higher public health impact and increase efficiency and efficacy of the work of agencies identified.

CFRC 2020 Recommendations

Priority	Recommendation	Responsible Party
HIGH	Establish and Inter-Agency workgroup on feasibility of sharing child deaths data across the agencies.	Inter-Agency Workgroup: Department of Health and Human Services (DHHS)-Division of Public Health (DPHS)/Division for Children Youth and Families (DCYF), Department of Education (DOE), Department of Safety (DOS), and the Office of the Child Advocate (OCA), and Office of the Attorney General (OAG).
HIGH	Utilize the Know and Tell Training available now for stakeholders to enhance awareness for ALL to report child abuse/neglect.	DCYF and Granite State Children's Alliance
HIGH	Recommend exploring an online decision making tool for professionals/teachers/childcare/police to ensure reporting and encourage appropriate referrals to care.	DCYF and CFRC Co-Chair
HIGH	When a child fatality occurs and where there is suspected abuse or neglect in NH, a referral may be made to the CAPP program by DCYF for record review and recommendations.	DCYF & Child Advocacy and Protection Program (CAPP)
HIGH	Establish a legislative study committee to explore residential pool safety laws for NH.	DHHS
HIGH	Explore the use of the National Child Fatality Suicide Death Investigation Form.	Office of the Chief Medical Examiner's Office (OCME) and CFRC Co-Chair
HIGH	Share American Academy Of Pediatrics (AAP) Drowning Prevention Tool kit and Poolsafely/ Safe Kids resources with Child Fatality Review Team members and ask to disseminate. Consider recommendations for child care providers, home visiting, and parents/grandparents.	CFRC Co-Chair and Home Visiting Programs
HIGH	Share AAP Drowning Prevention Tool kit and Poolsafely/Safe Kids resources with Medical Providers. Recommend health care providers follow AAP Drowning Prevention Toolkit recommendations regarding promoting water competency / drowning prevention.	New Hampshire Pediatric Society and New Hampshire Medical Society
HIGH	In the event a community or organization is exploring sponsoring or creating a Life Jacket Loaner Station in NH they can reach out to NH Marine Patrol for support in obtaining child sized life jackets.	New Hampshire Marine Patrol

CFRC 2020 Recommendations

Priority	Recommendation	Responsible Party
MEDIUM	Establish a consistent mechanism to inform primary care providers of deaths.	DHHS/OCME
MEDIUM	Recommend communities explore programs focused on reducing child abuse and maltreatment such as Community Collaborations and Adverse Childhood Experiences Response Team (ACERT) Programs to increase referrals for children exposed to vicarious trauma.	DHHS/NH Charitable Foundation
MEDIUM	Review resources sent to families after death of child. Explore "grief packets" state issues.	DHHS and Other State Agencies
MEDIUM	Explore feasibility of referral from animal control and police to DCYF if child is present during animal cruelty incident.	DCYF Office of the Child Advocate/ DCYF
MEDIUM	Add questions regarding water competency training when doing death scene investigation.	OCME
MEDIUM	Explore asking Commissioners of Safety and Natural and Cultural Resources to convene a work group to continue to identify hazardous swimming sites in NH and create signage and GPS locations to assist in responding to swimming emergencies.	NH CFRC Executive Committee/DOS/Natural and Cultural Resources/Fish and Game/911
LOW	Notify FDA if death occurs during use of medications that include a black box warning related to death.	TBD
LOW	Recommend all healthcare organizations review unanticipated deaths of their pediatric patients, especially those that die by suicide.	New Hampshire Medical Society
LOW	Recommend all primary care practices establish a policy/protocol to address missed appointments of patients.	New Hampshire Medical Society
ON HOLD	Explore Epping Police policy regarding following up with families when notified of DCYF involvement. Determine if this is a best practice and should be shared with other departments. At the Request of DCYF this recommendation will be followed up in future.	DCYF awaiting rollout of the newest addition of protocols from the Attorney General's office and will be basing their best practice models on these directives.

Sudden Unexpected Infant Death (SUID) and Sudden Death in Young (SDY) Review Committee, Activities, and Recommendations 2020

The SUID and SDY Review Committees use New Hampshire data to increase the understanding of the prevalence, causes, and risk factors for infants, children, and young adults who die suddenly and unexpectedly and to inform strategies to prevent future deaths. Due to the COVID-19 pandemic, the SUID and SDY Committees had a limited meeting schedule, but data collection, case reviews and education continued.

The SUID/SDY Program Coordinator at the DHHS made four visits to new parent support groups throughout New Hampshire to educate infant caregivers on safe sleep practices. The Program Coordinator presented information about safe sleep products such as bassinets, pack 'n' plays, and cribs and provided education about unsafe sleep practices such as putting an infant in a car seat to sleep, or on an adult bed or couch. The Program Coordinator talked with new parents about how to safely dress their infants for sleep, and included demonstrations on how to properly swaddle an infant. The end of each educational session featured an open discussion and time for questions and answers.

The DHHS ran two safe sleep social media campaigns providing general education and information related to the COVID-19 pandemic and stay-at-home orders. The DHHS web page on Safe Sleep has been updated to include items such as the New Hampshire Public Health Issue Brief on Safe Sleep which was most recently published in May of 2019[4]. An additional safe sleep poster[5] was developed as part of the COVID-19 response and was published on the state's COVID-19 website and distributed to New Hampshire birthing facilities and other state agencies, including the DCYF.

The membership for these two committee are included in appendices D (SUID Committee) and E (SDY Committee.)

4 https://www.dhhs.nh.gov/dphs/bchs/mch/sids.htm
5 https://www.dhhs.nh.gov/dphs/cdcs/covid19/documents/covid-infant-safety.pdf

Appendices

Appendix A: NH CFR Legislation

Child Fatality Review Committee

Section 132:41

132:41 Child Fatality Review Committee Established.

I. The department of health and human services, in conjunction with the office of the chief medical examiner and in accordance with RSA 611-B, shall establish a child fatality review committee to conduct comprehensive, multidisciplinary reviews of preventable infant, child, and youth deaths in New Hampshire for the purpose of identifying factors associated with the deaths and to make recommendations for system changes to improve services for infants, children, and youth.

II. The objectives of the child fatality review committee shall be to:

(a) Describe trends and patterns of child deaths in New Hampshire, including sudden unexpected infant deaths (SUID) and sudden death in the young (SDY).

(b) Identify and investigate the prevalence of risks and risk factors among the populations of deceased children.

(c) Evaluate the service and system responses for children and families and to offer recommendations for improvement of those services.

(d) Improve the quality and comprehensiveness of child fatality data by enhancing and integrating information obtained from autopsies, death scene investigations, death certificates, police reports, medical records, and other relevant sources.

(e) Enable state agencies, law enforcement, health care providers, and community-based organizations to more effectively prevent and investigate child fatalities.

III. The child fatality review committee shall consist of the following members:

(a) The attorney general, or designee.

(b) The chief medical examiner, or designee.

(c) The director of maternal and child health, division of public health services, department of health and human services, or designee.

(d) The director of the injury prevention program, division of public health services, department of health and human services, or designee.

(e) The director of the division for children, youth and families, department of health and human services, or designee.

(f) The director of the division for behavioral health, department of health and human services, or designee.

(g) The director of the division of family assistance, department of health and human services, or designee.

(h) The commissioner of the department of health and human services, or designee.

(i) The commissioner of the department of safety, or designee.

(j) The commissioner of the department of education, or designee.

(k) One representative of the judicial branch, appointed by the chief justice of the supreme court.

(l) The director of the office of the child advocate, or designee.

(m) The director of the women, infants, and children program, division of public health services, department of health and human services, or designee.

(n) The director of the division of fire standards and training and emergency medical services, department of safety, or designee.

(o) A member of the New Hampshire Pediatric Society, appointed by the society.

(p) An early childhood education specialist, appointed by the commissioner of the department of health and human services.

(q) A maternal and child health specialist, appointed by the commissioner of the department of health and human services.

(r) A representative of a child advocacy center, appointed by the commissioner of the department of health and human services.

(s) A representative of Court Appointed Special Advocates (CASA), appointed by the director of CASA.

(t) A psychiatrist or psychologist licensed in this state, appointed by the commissioner of the department of health and human services.

(u) A representative of a parent advocacy organization, appointed by the commissioner of the department of health and human services.

(v) An epidemiologist from a New Hampshire college or university, appointed by the commissioner of the department of health and human services.

(w) A domestic violence specialist, appointed by the commissioner of the department of health and human services.

(x) A representative of a statewide law enforcement officers' advisory council, appointed by the commissioner of the department of health and human services.

(y) A representative of a family resource center or home visiting program, appointed by the commissioner of the department of health and human services.

(z) A member of the public, appointed by the commissioner or the department of health and human services.

(aa) A representative of the New Hampshire Hospital Association, appointed by the association.

(bb) A representative of the New Hampshire Coalition Against Domestic and Sexual Violence, appointed by the coalition.

(cc) A representative from the fire marshal's office, appointed by the fire marshal.

IV. Members of the child fatality review committee appointed under subparagraphs III(a)-(n) shall serve a term coterminous with their term in office. Members appointed under subparagraphs III(o)-(bb) shall serve a 6-year term, provided that initial appointments shall be for staggered terms of one to 6 years.

(a) The committee shall elect 2 chairpersons from among its members. The first meeting of the committee shall be called by the commissioner of the department of health and human services, or designee, and shall be held within 45 days of the effective date of this section.

(b) The committee may create additional subcommittees focused on specific populations such as for SUID and SDY. These subcommittees shall be subject to the same protections and responsibilities as the child fatality review committee. Membership of these subcommittees shall be determined by the co-chairpersons.

(c) Members of the committee shall sign confidentiality statements that prohibit any unauthorized dissemination of information except when disclosures may be necessary to enable the committee to carry out its duties under this subdivision. No material shall be used for reasons other than for which it was intended.

(d) The department of health and human services shall provide administrative support to the committee.

(e) The chairpersons may invite any expert or member of the public to committee meetings.

V. The child fatality review committee shall:

(a) Meet no fewer than 6 times per year to conduct reviews of child fatalities, including sudden unexpected infant deaths (SUID) and sudden death in the young (SDY). Subcommittees shall meet as determined by the co-chairpersons.

(b) Utilize case identification with the sole purpose of notification and data collection among state agencies. Each of the state agencies represented on the committee shall share relevant case information regarding decedents known to or enrolled in state agency programs or services. The review committee shall have access to all records of the division for children, youth and families, including case records, third party records, which include the healthcare and education records of any child receiving services from a state agency, and court records. The committee may review existing records and other information regarding the child from relevant agencies, professionals, and providers of medical, dental, prenatal, and mental health care. The information shared shall include, but not limited to, reports from health care providers, social service providers, law enforcement, and the medical examiner's office.

(c) Study the adequacy of statutes, rules, training, and services to determine what changes are needed to decrease the incidence of preventable child fatalities and, as appropriate, take steps to implement these changes.

(d) Educate the public regarding the incidence and causes of child fatalities and the public's role in preventing these deaths.

(e) Complete an annual statistical report on the incidence and causes of child fatalities in this state during the past fiscal year and submit a copy of this report, including its recommendations for action, to the governor, the senate president, the speaker of the house of representatives, and the health and human services oversight committee established in RSA 126-A:13. The committee shall submit the report on or before December 15 of each year.

VI. The committee may subpoena witnesses, records, documents, reports, reviews, recommendations, correspondence, data, and other evidence that the committee reasonably believes is relevant to the committee's objectives.

VII. (a) The committee shall maintain the confidentiality of all records pursuant to RSA 169-C:25, RSA 170-G:8-a, and all other related confidentiality laws.

(b) The information and records obtained and created in execution of the child fatality review committee's official functions shall be exempt from disclosure pursuant to RSA 91-A and shall be privileged and exempt from use or disclosure in any criminal or civil matter or administrative proceeding. No person who participates in the official functions of the committee shall be compelled to testify or produce evidence in any judicial or administrative proceeding with respect to any matter involving exercise of his or her official duties.

(c) [Repealed.]

(d) Any person who knowingly discloses case records or other information obtained from committee proceedings shall be guilty of a misdemeanor.

Source. 2019, 302:1, eff. July 29, 2019. 2020, 37:43, 144-147, eff. July 29, 2020.

Appendix B: Child Fatality Review Committee Membership January 2020- December 2020

Honorable Susan Ashley
NH Circuit Court - Family Division

Joy Barrett
Granite State Children's Alliance

Skip Berrien
Member of general public

Vicki Blanchard*
Bureau of Emergency Medical Services

Christine Brennan
Department of Education

Steven Chapman
Pediatrics - Dartmouth-Hitchcock

Dianne Chase
Bureau of Child Development

Marc Clement*#
Colby-Sawyer College

Anne Diefendorf
New Hampshire Hospital Association

Jennie Duval*
Chief Medical Examiner

Adam Fanjoy
New Hampshire Fire Marshal's Office

Katja Fox
Director, Division of Behavioral Health, Department of Health and Human Services

Ann Landry*
Associate Commissioner for Medicaid and Population Health, Department of Health & Human Services

Moira O'Neill
Office of the Child Advocate

Resmiye Oral
Child Advocacy and Protection Program
Dartmouth-Hitchcock

David Parenteau
Statewide Law Enforcement Officers' Advisory Council

Sylvia Pelletier
New Hampshire Family Voices

Catherine Pinos*
Office of the Attorney General

James Potter
New Hampshire Pediatric Society

Josephine Porter
Epidemiologist - UNH

Joseph Ribsam*
Director, Division for Children, Youth, and Families, Department of Health and Human Services

Schelley Rondeau
Home Visiting Program

Debra Samaha*#
Injury Prevention Center - Dartmouth-Hitchcock

Christine Santaniello
Director, Division of Economic and Housing Stability, Department of Health and Human Services

* Executive Committee Member; # Committee Co-Chair

Appendix B, continued

Rhonda Siegel*
Administrator, Maternal and Child Health,
Division of Public Health Services, Department of
Health and Human Services

Marcia Sink
Court Appointed Special Advocates (CASA) of
New Hampshire

Lissa Sirois
Women, Infants, and Children Nutrition Services,
Division of Public Health Services, Department of
Health and Human Services

Catherine Shackford
New Hampshire State Police

Joi Smith
NH Coalition Against Domestic & Sexual Violence

Appendix C: New Hampshire Child Fatality Review Committee Confidentiality Agreement

Acknowledgment of Confidentiality for The New Hampshire Child Fatality Review Committee Members

The New Hampshire Child Fatality Review Committee (the Committee) was established to conduct comprehensive, multidisciplinary reviews of preventable infant, child, and youth deaths in New Hampshire for the purpose of identifying factors associated with the deaths and to make recommendations for system changes to improve services for infants, children, and youth.

As a member of the Committee, I understand that I will have access to confidential information regarding decedents known to or enrolled in state agency programs or services as well as any child death meeting the definition of a Medico-Legal death in RSA 611-B, 11. Such confidential information will include records of the division for children, youth and families, including case records, third party records, which include the healthcare and education records of any child receiving services from a state agency, and court records. It will also include confidential information from the Office of the Chief Medical Examiner. Committee members may have access to and review confidential records and other information regarding the child from relevant agencies, professionals, and providers of medical, dental, prenatal and mental health care and schools. The information shared shall include, but not limited to, reports from health care providers, social service providers, law enforcement, schools, the medical examiner's office and any other information that may have a bearing on the involved child and family.

Having read the above, I the undersigned, member of the New Hampshire Child Fatality Review Committee, understand, acknowledge and agree that all information reviewed or accessed by me will remain confidential and not be used or disclosed for reasons other than that which was intended and authorized pursuant to NH RSA 132:41. Further, I understand, acknowledge and agree that no such confidential information or material may be taken from the committee meetings. I acknowledge that any knowing disclosure of confidential information or records obtained from committee proceedings is a misdemeanor and is grounds for immediate removal from the Committee.

Print Name: _____

Authorized Signature: _____

Witness: _____

Date: _____

Appendix D: SUID Review Group Membership

Jenn Alicea
Pediatric Inpatient RN, Elliot Hospital

Dierdra Batchelder
Office of the Chief Medical Examiner - SUID and SDY data analyst

Vicki Blanchard
Department of Safety, EMS

Karl Boisvert
Quality Assurance and Improvements, Department of Health and Human Services

Charles Cappetta
Dartmouth-Hitchcock, Pediatrician

Marc Clement
Child Psychologist, Colby-Sawyer College

Robert Darnall
DHMC, Neonatologist

Anne Diefendorf
New Hampshire Hospital Association

Jennie Duval
Chief Medical Examiner

Sherry Ermel
Bureau Chief of Field Services, Division for Children, Youth and Families, Department of Health and Human Services

Kim Fallon
Chief Forensic Investigator
Office of the Chief Medical Examiner

Elizabeth Fenner-Lukaitis
Bureau of Behavioral Health, Department of Health and Human Services

Victoria Flanagan
DHMC, perinatal outreach educator, Director of Operations, NNEPQIN

Anne Frechette
Association of Women's Health, Obstetric and Neonatal Nurse (AHWONN) Representative

Jonelle Gaffney
CASA NH

Wendy Gladstone, MD
Pediatrician

James Gray
Neonatologist, Dartmouth-Hitchcock,

Kristi Hart
Home Visiting, Division of Public Health Services, Department of Health and Human Services

Sara Hennessey
New Hampshire State Police

Courtney Keane
Maternal and Child Health, Division of Public Health Services, Department of Health and Human Services

JoAnne Miles-Holmes
Injury Prevention, Division of Public Health Services, Department of Health and Human Services

Paula Oliveira
New Hampshire Breastfeeding Association

Linda Parker
Bureau of Behavioral Health, Department of Health and Human Services

Debra Samaha
Injury Prevention Center, Dartmouth-Hitchcock

Kristiane Schott
Division of Economic and Housing Stability, Department of Health and Human Services

Rhonda Siegel
Administrator, Maternal and Child Health, Division of Public Health Services, Department of Health and Human Services

Lissa Sirois
Women, Infants, and Children Nutrition Services, Division of Public Health Services, Department of Health and Human Services

Sherry Stevens
Certified Professional Midwife

Appendix E: SDY Review Group Membership

Jenn Alicea
Pediatric Inpatient RN or designee

Dierdra Batchelder
Office of the Chief Medical Examiner-SUID and SDY data analyst or designee

Vicki Blanchard
EMS or designee

Michael Bullek
Pharmacist or designee

Marc Clement
Child Psychologist or designee

David Crowley MD
Pediatric Cardiologist or designee

Anne Diefendorf
New Hampshire Hospital Association or designee

Mary Beth Dinulos
Pediatrician/Pediatric Geneticist or designee

Deirdre Dunn
Special Medical Services or designee

Jennie Duval
Office of Chief Medical Examiner or designee

Emily Knight
Intensive Care Pediatric Nurse or designee

Kim Fallon
Office of the Chief Medical Examiner/Chief Forensic Investigator or designee

Elizabeth Fenner-Lukaitis
Bureau of Behavioral Health, Department of Health and Human Services or designee

Jonelle Gaffney
CASA NH or designee

Cornelia Gonsalves
DHMC Child Advocacy and Protection Program or designee

Michele Guertin
Child Care Licensing, Department of Health and Human Services or designee

Jill Hamel
Police Standards and Training or designee

Sara Hennessey
State Police or designee

Christine James
Associate Medical Examiner or designee

Courtney Keane
Maternal and Child Health, Division of Public Health Services, Department of Health and Human Services

Kristin Kraunnelis
Pediatric Mental Health Nurse or designee

Susan Moore
Nurse/Special Medical Services or designee

Richard Morse
Pediatric Neurologist or designee

Sylvia Pelletier
New Hampshire Family Voices or designee

Debra Samaha
Injury Prevention Center, Dartmouth-Hitchcock or designee

Kristiane Schott
Bureau of Housing and Economic Supports, Division of Economic and Housing Stability or designee

Rhonda Siegel
Administrator, Maternal and Child Health, Division of Public Health Services, Department of Health and Human Services or designee

Lissa Sirois
Women, Infants, and Children Nutrition Services, Division of Public Health Services, Department of Health and Human Services

Sherry Stevens
Certified Professional Midwife or designee

Appendix E, continued

Nancy Vaughn
American Heart Association or designee

TBD
Medicaid representative or designee

TBD
Insurance representative or designee

TBD
General pediatrics or designee

TBD
Pediatric Endocrinology or designee

TBD
Pediatric Pulmonology or designee