THE STATE OF NEW HAMPSHIRE

CHILD FATALITY REVIEW COMMITTEE

NINTH ANNUAL REPORT

Presented to
The Honorable John H. Lynch
Governor, State of New Hampshire
October 2006

Funding for this report and for the activities of the Child Fatality Review Committee comes from the U.S. Department of Health and Human Services Administration on Children, Youth and Families through the Children's Justice Act Grant (#G-05NHCJA1) which is administered by the New Hampshire Department of Justice.

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DEDICATION

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

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

Dear Friends of New Hampshire's Children:

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

The following is the Committee's Ninth Annual Report. This report reviews the work of the Committee for the calendar year 2005 and presents fatality data for the calendar year 2004 that has been collected and analyzed by the Bureau of Health Statistics and Data Management. We have also included, as we did in our Eight Annual Report, a look at three years (2002 – 2004) of data. Since there are relatively few child fatalities in New Hampshire each year, we hope that a three-year data analysis will present a better look at any trends.

Included in this report is a brief description from the committee's representative from the New Hampshire Health and Human Services, Division of Behavioral Health, on how that agency fits into the child death review process. As in previous reports, we continue to have representatives from the committee give a brief overview of their work and its relevance to the committee's work. We hope that this will give the reader of our reports a better sense of the rationale for the make-up of the membership of the committee.

As in previous years, members of the New Hampshire Child Fatality Review Committee have made presentations in New Hampshire and nationally on the issues of child fatalities and on the work of the New Hampshire committee. We have been recognized nationally for our work and many states are interested in learning more about how we conduct our reviews and how we gather and respond to recommendations generated by these reviews. Additionally we meet annually with the teams from Maine and Vermont to conduct joint reviews and to talk about ways to make our work more efficient and effective. At last year's meeting we invited representatives from the other three New England States to attend and give an overview of their work. These joint meetings help give all of us an overview of the problems and solutions that the teams from other states encounter in trying to prevent child fatalities. Additionally, we published an article in the "Unified Response" newsletter about our Northern New England meeting.

As Chair, I would like to acknowledge the hard work and dedication of the members of the Committee. I especially want to acknowledge Audrey Knight who has worked particularly hard this year to help the committee run smoothly. Through the commitment of all our members, we have been able to build a collaborative network to foster teamwork and share the recommendations with the larger community.

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

On behalf of the Committee,

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

THE NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

MISSION STATEMENT

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

OBJECTIVES

1. To describe trends and patterns of child death in New Hampshire.

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

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

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

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

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

CHILD FATALITY REVIEW COMMITTEE MEMBERSHIP
January to December 2005

Chair: Marc Clement, PhD
Colby-Sawyer College

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

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

Paul Boisseau, Executive Secretary
NH Board of Pharmacy

*George Bowesoxm
NH Board of Pharmacy

William Boyle, MD
Dartmouth Hitchcock Medical Center

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

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

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

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

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

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

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

Karen Gorham, Senior Attorney General
NH Department of Justice

*Linda Griebsch, Public Policy Director
NH Coalition Against Domestic & Sexual Violence

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

Honorable David Huot
Laconia District Court

Trooper Kathy Kimball
NH State Police
NH Department of Safety

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

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

Honorable Willard Martin
NH Family Court Division

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

Grace Mattern, Executive Director
NH Coalition Against Domestic & Sexual Violence

*Susan Meagher
CASA of New Hampshire

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

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

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

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

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

Nancy Rollins, MS, Director
Division for Children, Youth & Families
NH Department of Health & Human Services

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

Marcia Sink, Executive Director
CASA of New Hampshire

Paul Spivack, MD
Hitchcock Clinic

Robert Stafford
NH Police Standards and Training Council

Steve Varnum, Public Policy Director
Children's Alliance of New Hampshire

*=Alternate

I. EXECUTIVE SUMMARY

This report reflects the work of the Committee during the 2005 calendar year. The work of the Committee and the purpose of the recommendations that are produced during the reviews are to reduce preventable child fatalities in New Hampshire.

Last year's Eighth Annual Report summarized the work of the 2005 calendar year. Additionally in this report is a 3-year data summary for 2002 – 2004.

This report begins with the Committee's Mission Statement and Objectives, followed by a listing of the Committee members and their affiliations. There is then a short report from the representative from Children's Mental Health Services. Following this is a review and analysis of the 2004 New Hampshire child fatality review data and a look at the last three years of data (2002 – 2004). The recommendations and finding from the 2005 reviews are presented along with the responses to the 2004 findings and recommendations.

II. STATEMENT OF ACCOUNTABILITY

The New Hampshire Child Fatality Review Committee was established in 1991 by an Executive Order of then Governor Judd Gregg. In 1995, then Governor Merrill signed an Executive Order (Appendix B) reestablishing the Committee under the official auspices of the New Hampshire Department of Justice. To provide support to the review process, the department heads of the New Hampshire Department of Justice, the New Hampshire Department of Health and Human Services, and the New Hampshire Department of Safety signed an Interagency Agreement (Appendix C) that defined the scope of information sharing and confidentiality within the Committee. Additionally, individual Committee members and invited participants are required to sign Confidentiality Agreements (Appendix D) in order to participate in the review process.

The New Hampshire Child Fatality Review Committee is funded by the New Hampshire Department of Justice through the Children's Justice Act (CJA) Grant, which is administered by the United States Department of Health and Human Services. In order to receive funding through the CJA Grant, which also supports the Attorney General's Task Force on Child Abuse and Neglect, the State is required by statute to establish a child fatality review panel "to evaluate the extent to which agencies are effectively discharging their child protection responsibilities." The New Hampshire Child Fatality Review Committee meets the criteria for this review panel (Appendix E).

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

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

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

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

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

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

III. AGENCY VIGNETTES

The Committee is comprised of professionals from the medical, law enforcement, judicial, legal, victim services, public health, mental health, child protection, and education communities. For this report one of the representing agencies were asked to describe their agency's participation on the Committee.

A. NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES - BUREAU OF BEHAVIORAL HEALTH

The New Hampshire Department of Health and Human Services (DHHS), Bureau of Behavioral Health (BBH), as a partner in the Child Fatality Review Committee is dedicated to ensuring that the work of the Bureau furthers the mission of the Committee. The Bureau oversees the public community mental health system through contracts with ten community mental health centers and other providers including peer and family support agencies. Each Community Mental Health Center (CMHC) has a children's services program with a designated director. The Bureau coordinates its work closely with New Hampshire Hospital, which provides inpatient psychiatric services to persons with mental illness across the lifespan including children and adolescents. Patients are admitted to BHH through the CMHC system for both an emergency and planned admissions.

The Bureau of Behavioral Health has been actively involved with the Child Fatality Review Committee by providing key information for specific reviews and supporting state and local level involvement in prevention activities. Most CMHC children's programs are involved in community activities related to suicide and other crisis pre-and postvention services. BBH and CMHC staff has been involved with the Youth Suicide Prevention Assembly and the development of the state suicide prevention plan.

BBH coordinates with the Emergency Services' Directors of the ten CMHCs to facilitate crisis-oriented services to all ages. The Acute Care Services Coordinator acts as a liaison to the

Office of the Chief Medical Examiner's Office to track all CMHC consumer deaths and to develop postvention activities following suicides across the state to reduce the incidence of contagion in the community affected.

BBH has been a partner with the Department of Education's initiative to bring Positive Behavioral Interventions and Supports (PBIS) to local New Hampshire schools. Schools that embrace a PBIS framework create positive school environments for all students that enable schools to provide early identification and intervention to those students needing targeted behavioral and other supports. BBH is working to improve the linkage of CMHCs to local schools through the PBIS initiative.

IV. REVIEW AND ANALYSIS OF DATA

A. CHILD FATALITIES IN NEW HAMPSHIRE – 2004

This report contains information on deaths of New Hampshire residents, ages 0-18 for the calendar year 2004. There were 156 child deaths reported during this time period. Of this number, 65% were due to natural causes and 35% were due to injuries. Of the injury deaths, 81% were unintentional injuries (i.e. motor vehicle traffic crashes, drownings, fires, etc.) 11% were deaths by suicide, 6% were homicide and 2% were unspecified.

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

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

During 2004, 65% of all child deaths were due to natural causes. Infants (<1 year) represented 50% of all natural deaths among children through age 18 (See Table 1). Adolescents account for the majority of injury-related deaths, with deaths from unintentional injuries more frequent than those from intentional (i.e. homicide and suicide) injuries.

Table 1

New Hampshire Resident Natural and Injury Deaths by Age Groups 0-18, 2004

Age Group	Natural	Injury	Total
<1	76	3	79 (50%)
1 - 4	7	10	17 (11%)
5 - 9	6	3	9 (6%)
10 - 14	8	4	12 (8%)
15 - 18	5	34	39 (25%)
Total	**102 (65%)**	**54 (35%)**	**156**

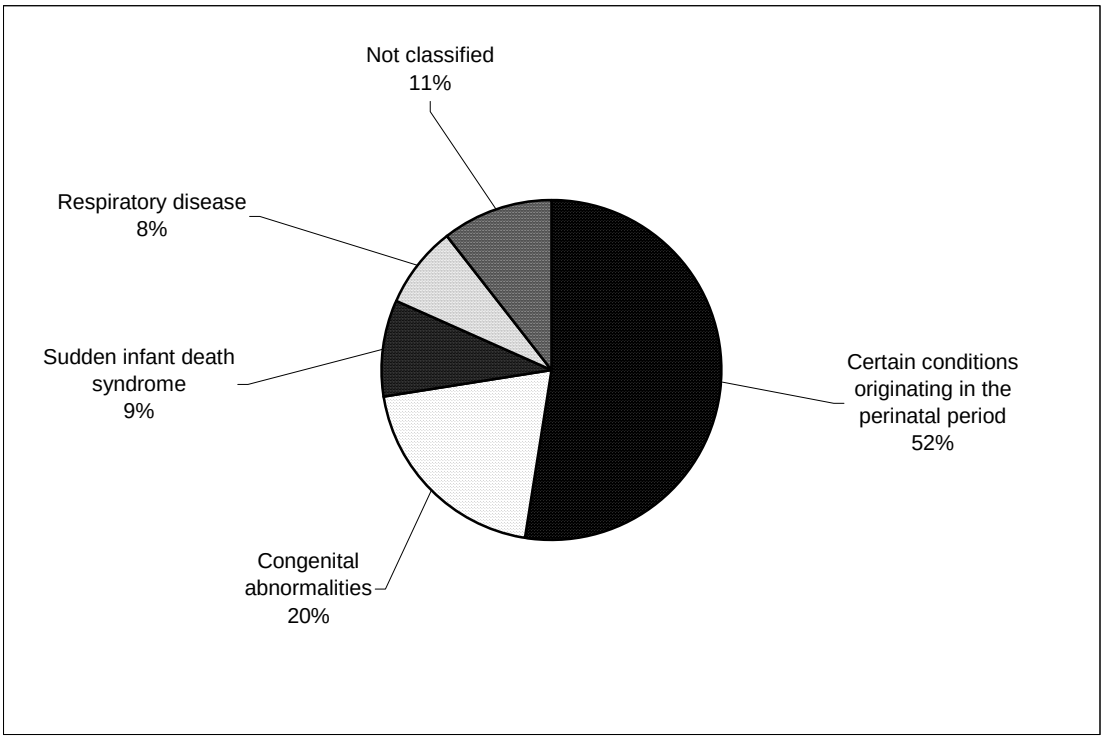
Infants are more likely to die from natural causes than older children. The major cause of death for infants is "Certain Conditions Originating in the Perinatal Period" which makes up 53% of all natural infant deaths. "Congenital Abnormalities" and "Sudden Infant Death Syndrome (SIDS)" are the next two leading causes of natural death for infants (See Table 2 and Figure 1).

Table 2

New Hampshire Resident Deaths by Natural Causes
<1 year of age, 2004

Natural Cause of Death	<1 Yr
Certain conditions originating in the perinatal period	40
Congenital abnormalities	15
Sudden infant death syndrome	7
Respiratory disease	6
Not Classified	8
Total	**76**

Figure 1

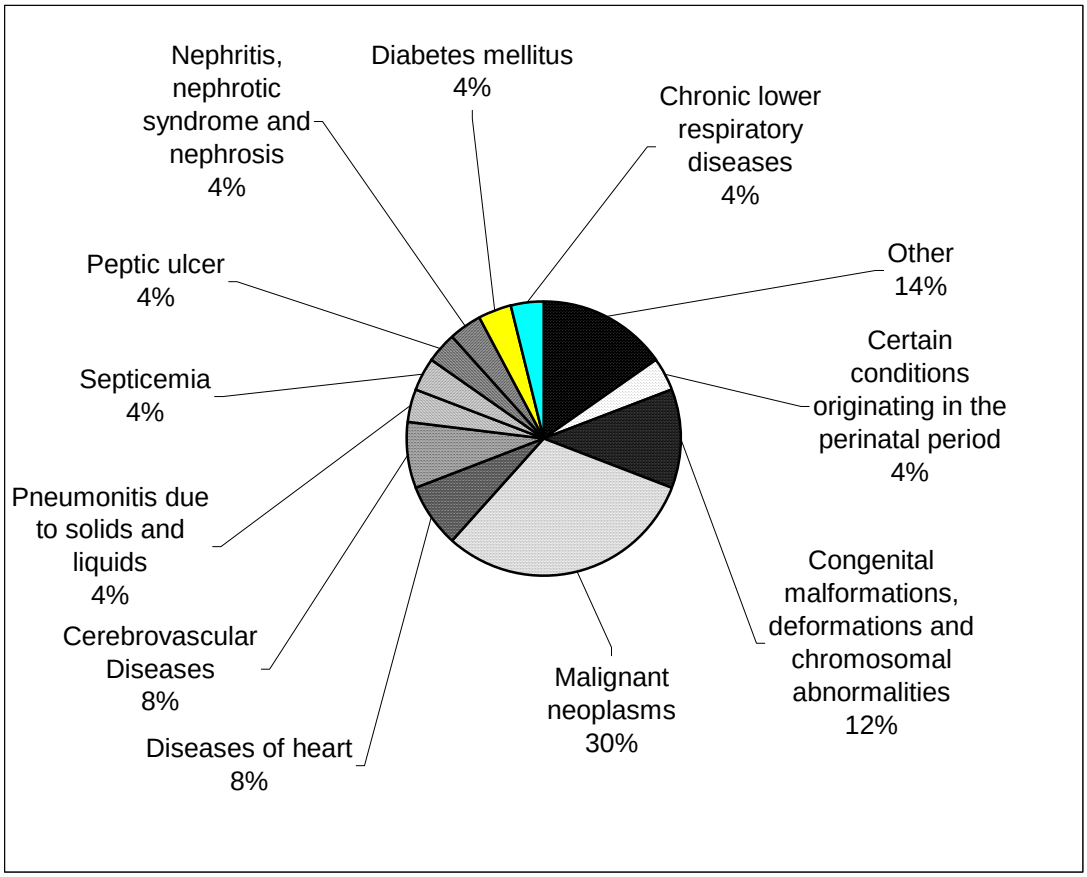


Certain conditions originating in the perinatal period was the second leading cause of natural death for children ages 1-18. Most of the other natural causes of death for this age group are spread out among many different causes. (Table 3 and Figure 2)

Table 3
New Hampshire Resident Deaths by Natural Causes, ages 1-18 years, 2004

Natural Cause of Death	1-18 yrs
Other	4
Malignant neoplasms	8
Congenital malformations, deformations and chromosomal abnormalities	3
Diseases of heart	2
Cerebrovascular Diseases	2
Certain conditions originating in the perinatal period	1
Pneumonitis due to solids and liquids	1
Septicemia	1
Peptic ulcer	1
Nephritis, nephrotic syndrome and nephrosis	1
Diabetes mellitus	1
Chronic lower respiratory diseases	1
Total	**26**

Figure 2



The majority of deaths of older children are due to injury. Motor vehicle traffic crashes remain the leading cause of death for children and adolescents in both New Hampshire and the United States. 50% of all unintentional injury deaths of New Hampshire residents ages 1-18 in 2004 were due to motor vehicle crashes. Of that number over 90% were ages 15-18.

In New Hampshire suicides account for almost 11% of adolescent deaths. The mechanisms of 21suicide deaths include firearms and suffocation (hanging). See Table 4.

Table 4
New Hampshire Resident Injury Deaths by Intent, Mechanism, and Age Group, 2004

Unintentional Injuries

Cause of Death	<1	1 – 4	5 - 9	10 - 14	15 - 18	Total
Drowning	-	2	-	-	2	4
Fire/hot object or substance- fire/flame	-	1	1	-	-	2
Motor vehicle traffic	-	-	-	2	20	22
Other land transport	-	-	1	1	3	5
Other transport	-	-	1	-	1	2
Suffocation	3	2	-	-	-	5
Other specified classifiable	-	-	-	-	-	0
Pedestrian, other	-	1	-	1	-	2
Poisoning	-	-	-	-	1	1
Struck by or against	-	-	-	-	1	1
Total - Unintentional Injuries	**3**	**6**	**3**	**4**	**28**	**44 (81%)**

Suicide

Cause of Death	<1	1 – 4	5 - 9	10 - 14	15 - 18	Total
Firearm	-	-	-	-	2	2
Suffocation	-	-	-	-	4	4
Total - Suicide	**0**	**0**	**0**	**0**	**6**	**6 (11%)**

Homicide

Cause of Death	<1	1 – 4	5 - 9	10 - 14	15 - 18	Total
Cut/pierce	-	2	-	-	-	2
Unspecified	-	1	-	-	-	1
Total - Homicide	**0**	**3**	**0**	**0**	**0**	**3 (6%)**

Undetermined

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

Looking at table 5, male children are more likely to die than female children from injury. In 2004 about 25% more males died from unintentional injuries than females.

Table 5

New Hampshire Resident Injury Deaths by Intent, Gender, and Age Group, Ages 0-18, 2004

Unintentional Injury Deaths

Age Group	Male	Female	Total
<1	-	3	3
1 - 4	5	1	6
5 - 9	2	1	3
10 - 14	2	2	4
15 - 18	19	9	28
Total	**28**	**16**	**44**

Suicide

Age Group	Male	Female	Total
15 - 18	4	2	6
Total	**4**	**2**	**6**

Homicide

Age Group	Male	Female	Total
1 - 4	2	1	3
Total	**2**	**1**	**3**

Undetermined

Age Group	Male	Female	Total
<1	0	-	0
1 - 4	0	1	1
Total	**0**	**1**	**1**

All Injury Deaths (All Intents)

Age Group	Male	Female	Total
Total	**34 (63%)**	**20 (37%)**	**54**

Table 6 gives specific information on the causes of death for infants (less than age 1). "Disorders related to short gestation and low birth weight, NEC" are responsible for 24% of all infant deaths.

Table 6
New Hampshire Resident Deaths by Cause of Death for Infants <1 year of age, 2004

Natural Cause of Death	Total
Disorders related to short gestation and low birth weight, NEC	18
Other Causes	15
Congenital malformations, deformations and chromosomal abnormalities	15
Newborn affected by maternal complications of pregnancy	8
Sudden infant death syndrome	7
Newborn affected by complications of placenta, cord and membranes	5
Other respiratory and cardiovascular disorders	5
Respiratory distress of newborn	2
Necrotizing entercolitis of newborn	1
Total	**76**

B. CHILD DEATHS IN NEW HAMPSHIRE, 2002-2004

This section of the report contains information on the most recent three years of child fatalities. Similar to the data for 2004, total deaths during this three-year period, 2002-2004, show that most deaths from natural causes, occur among infants (< 1 year). In addition, unintentional injuries account for most injury-related deaths.

Table 8
New Hampshire Resident Natural and Injury Deaths by Age Groups 0-18 2002-2004

Age Group	Natural	Injury	Total
<1	157	7	164 (43%)
1 - 4	45	14	59 (15%)
5 - 9	26	9	35 (9%)
10 - 14	17	16	33 (9%)
15 - 18	20	73	93 (24%)
Total	**265 (69%)**	**119(31%)**	**384**

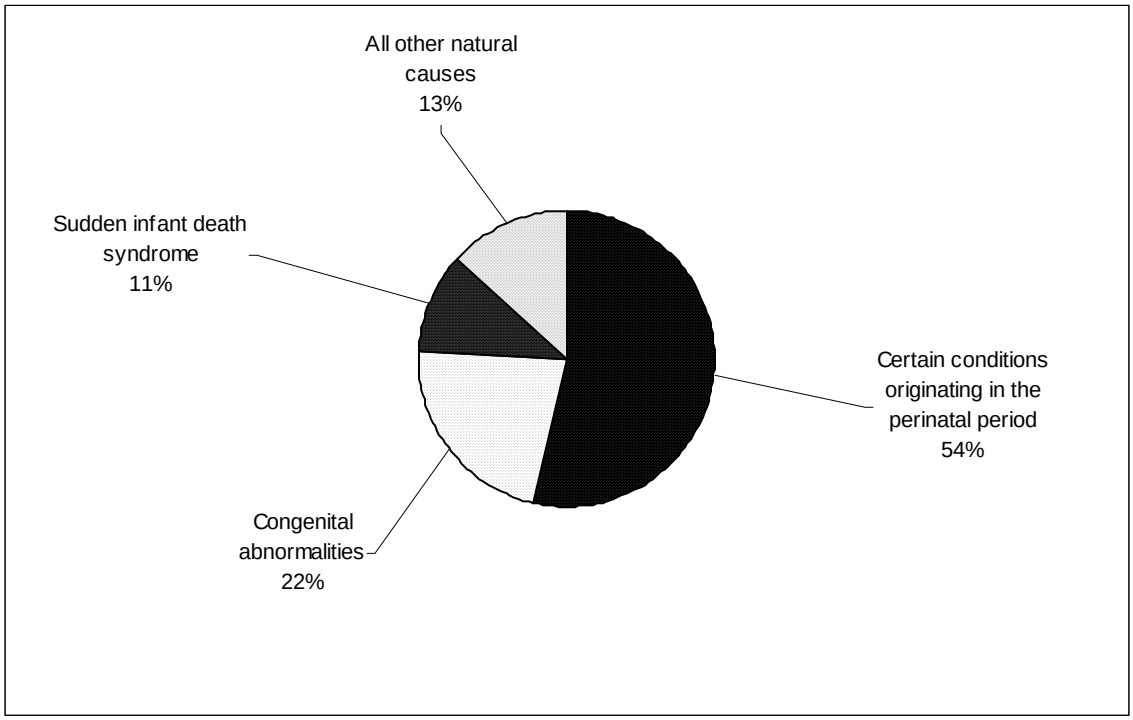
The major cause of death for infants is "Certain conditions originating in the perinatal period" which makes up 54% of all natural infant deaths. "Congenital abnormalities" and "Sudden infant death syndrome" make up the next two leading causes of natural death for infants (see Table 9).

Table 9

New Hampshire Resident Deaths by Natural Causes
<1 year of age, 2002-2004

Natural Cause of Death	<1 Yr
Certain conditions originating in the perinatal period	84
Congenital abnormalities	35
Sudden infant death syndrome	17
All other diseases (Residual)	4
Not Classified	5
Respiratory disease	2
Cerebrovascular disease	2
Pneumonia	2
In situ neoplasms (i.e. non-malignant tumor)	1
Diseases of heart	1
Nephritis, nephrotic syndrome and nephrosis	1
Other diseases of arteries, arterioles and capillaries	1
Other and unspecified infectious and parasitic diseases	1
Septicemia	1
Total	**157**

Figure 3

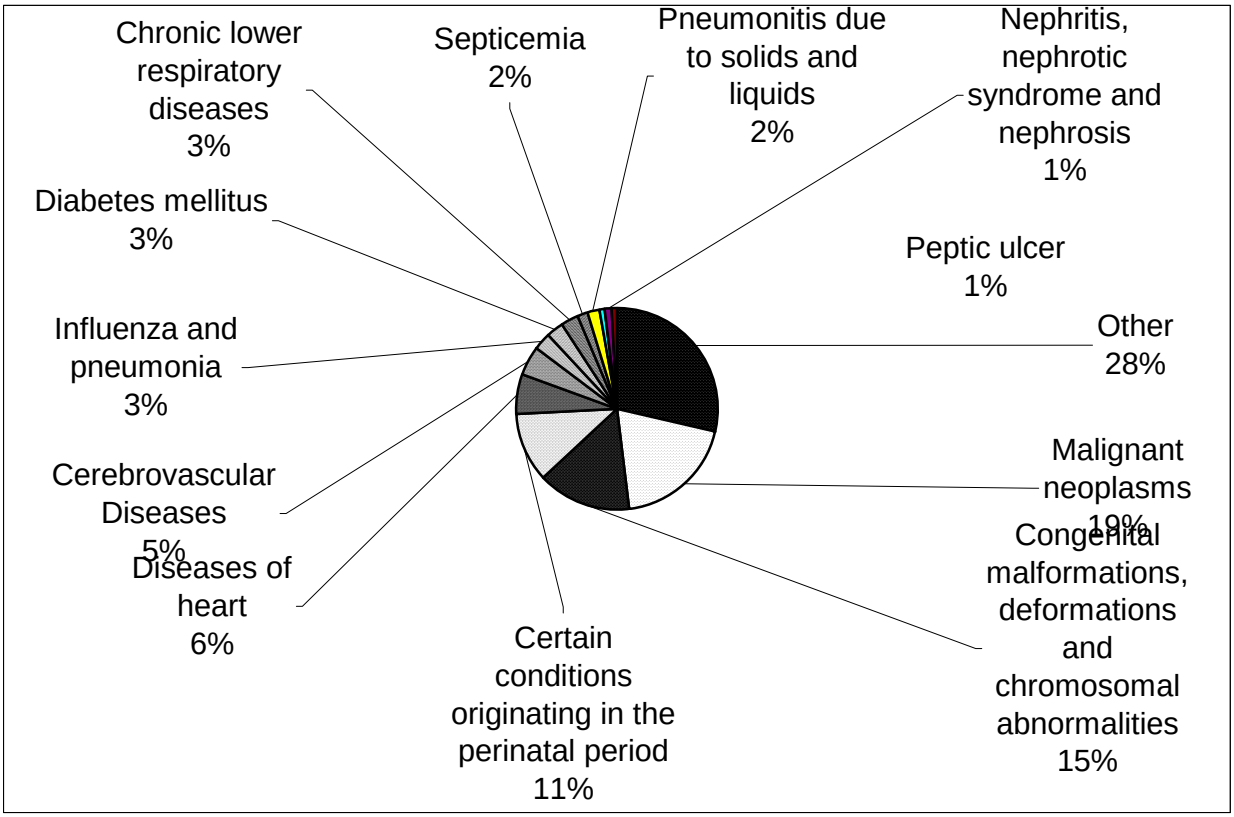


Malignant neoplasms (tumors) are the second leading causes of natural death for children ages 1-18, responsible for 19% of the natural deaths. (Table 10 and Figure 4)

Table 10
New Hampshire Resident Deaths by Natural Causes, ages 1-18 years, 2002-2004

Natural Cause of Death	1-18 yrs
Other	31
Malignant neoplasms	21
Congenital malformations, deformations and chromosomal abnormalities	16
Certain conditions originating in the perinatal period	12
Diseases of heart	7
Cerebrovascular Diseases	5
Influenza and pneumonia	3
Diabetes mellitus	3
Chronic lower respiratory diseases	3
Septicemia	2
Pneumonitis due to solids and liquids	2
Peptic ulcer	1
Nephritis, nephrotic syndrome and nephrosis	1
Meningitis	1
Total	**108**

Figure 4



The majority of the deaths to older children are due to injury. Motor vehicle traffic crashes are the leading cause of death for children and adolescents in both New Hampshire and

the United States. In New Hampshire, suicides account for a large number of adolescent deaths. The most common mechanisms of suicide are firearms, suffocation (hanging), and poisoning (See Table 11).

Table 11
New Hampshire Resident Injury Deaths by Intent, Mechanism, and Age Group
2002-2004

Unintentional Injuries

Cause of Death	<1	1 - 4	5 - 9	10 - 14	15 - 18	Total
Drowning	1	3	1	1	3	9
Fire/hot object or substance-fire/flame	-	1	2	1	-	4
Firearm	-	-	-	-	1	1
Motor vehicle traffic	-	3	3	6	39	51
Natural/environmental	1	-	-	-	-	1
Other land transport	-	-	-	2	4	6
Other transport	-	-	2	1	1	4
Pedestrian, other	-	1	-	-	-	1
Poisoning	-	-	-	1	4	5
Struck by or against	-	-	-	-	1	1
Suffocation	4	3	1	-	-	8
Total - Unintentional Injuries	**6**	**11**	**9**	**12**	**53**	**91(76%)**

Suicide

Cause of Death	<1	1 - 4	5 - 9	10 - 14	15 - 18	Total
Firearm	-	-	-	1	4	5
Poisoning	-	-	-	-	2	2
Suffocation	-	-	-	2	12	14
Total - Suicide	**0**	**0**	**0**	**3**	**18**	**21(18%)**

Homicide

Cause of Death	<1	1 - 4	5 - 9	10 - 14	15 - 18	Total
Cut/pierce	-	2	-	-	-	2
Other specified classifiable	1	-	-	-	-	1
Total - Homicide	**1**	**2**	**0**	**0**	**0**	**3(3%)**

Undetermined

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

Looking at Table 12, male children are more likely than female children to die from injury. In 2002-2004, more than twice the deaths from unintentional injuries were males and more than 70% of completed suicides were also males.

Table 12

New Hampshire Resident Injury Deaths by Intent, Gender, and Age Group, Ages 0-18, 2002-2004

Unintentional Injury Deaths

Age Group	Male	Female	Total
<1	3	3	6
1 - 4	8	3	11
5 - 9	5	4	9
10 - 14	9	3	12
15 - 18	40	13	53
Total	**65**	**26**	**91**

Suicide

Age Group	Male	Female	Total
10 - 14	3	0	3
15 - 18	12	6	18
Total	**15**	**6**	**21**

Homicide

Age Group	Male	Female	Total
<1	1	0	1
1 - 4	1	1	2
Total	**2**	**1**	**3**

Undetermined

Age Group	Male	Female	Total
1 - 4	0	1	1
10 - 14	0	1	1
15 - 18	1	1	2
Total	**1**	**3**	**4**

All Injury Deaths (All Intents)

Age Group	Male	Female	Total
Total	**83(70%)**	**36(30%)**	**119**

Looking at the injury deaths by season, there is some fluctuation in the total number of deaths among the different seasons and there are some differences in the mechanism/cause of injury for the different seasons (See Table 13). For example, most of the drownings occurred in the summer and most of the burns occurred in the winter. Motor vehicle traffic crash deaths were slightly higher in summer, with only slightly fewer occurring in the spring and fall.

Table 13

Mechanisms of Injury Deaths by Season (Ages 0-18), 2002-2004

Mechanism/Cause of Death	Fall	Spring	Summer	Winter
Cut/pierce	2	0	0	0
Drowning	2	3	4	0
Fire/hot object or substance-fire/flame	0	0	1	3
Firearm	2	1	2	1
Motor vehicle traffic	11	14	19	7
Natural/environmental	0	1	0	0
Other land transport	0	2	2	2
Other specified classifiable	0	1	1	0
Other transport	0	2	2	0
Pedestrian, other	0	1	0	0
Poisoning	4	1	3	1
Struck by or against	0	0	0	1
Suffocation	6	9	4	3
Unspecified	0	0	0	1
Total	**27**	**35**	**38**	**19**

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

Table 14 gives specific information on the causes of death for infants (less than age 1). "Congenital malformations, deformations and chromosomal abnormalities" are responsible for 22% (35 of 157) of all infant deaths. "Disorders related to short gestation and low birth weight, NEC" are the second leading cause of infant death responsible for 21% of infant deaths (33 of 157).

Table 14
New Hampshire Resident Deaths by Cause of Death for Infants <1 year of age, 2002-2004

Natural Cause of Death	< 1yr
Congenital malformations, deformations and chromosomal abnormalities	35
Disorders related to short gestation and low birth weight, NEC	33
Others	18
Sudden infant death syndrome	17
Newborn affected by complications of placenta, cord and membranes	9
Intrauterine hypoxia and birth asphyxia	8
Respiratory distress of newborn	6
Newborn affected by maternal complications of pregnancy	5
Bacterial sepsis of newborn	4
Diseases of the circulatory system	4
Necrotizing entercolitis of newborn	3
Influenza and pneumonia	2
Slow fetal growth and fetal malnutrition	2
Neonatal hemorrhage	2
Birth trauma	1
Congenital pneumonia	1
Gastritis, duodenitis, and noninfective enteritis and colitis	1
Hydrops fetalis not due to hemolytic disease	1
Interstitial emphysema and related conditions originating in the perinatal period	1
Newborn affected by noxious influences transmitted via placenta or breast milk	1
Renal failure and other disorders of kidney	1
Septicemia	1
In situ neoplasms, benign neoplasms	1
Total	**157**

V. 2005 FINDINGS AND RECOMMENDATIONS

In the calendar year 2005, the Committee reports the following findings and recommendations, which are intended to help reduce child fatalities through enhanced policy development and service delivery within and among the agencies that serve children and families. Recommendations are grouped by social system.

A. PUBLIC HEALTH AND HEALTHCARE

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

B. EMERGENCY MEDICAL SERVICES

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

C. MENTAL HEALTH

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

D. EDUCATION SYSTEM

- The Department of Education will continue to support the development of school emergency response plans and suicide response plans that address incidents at school as well as away from school.
- The Department of Education will recommend that school districts consider changing school start times to better accommodate adolescent sleep needs and patterns thereby promoting academic success and reducing high risk activities that often take part as a result of sleep depravation as well as specifically occurring in unsupervised afternoon hours.
- The Department of Education will include the teen institute web site on its list of internet resources for school nurses as well as disseminate any program offerings to appropriate school personnel.

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E. CHILD PROTECTIVE SERVICES

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

F. DISTRICT COURT AND LAW ENFORCEMENT

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

G. LEGISLATION

There were no recommendations made for Legislation this past year.

H. CHILD FATALITY REVIEW COMMITTEE

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

VI. RESPONSES TO 2004 RECOMMENDATIONS

The Eighth Annual Report to the Governor, published in October 2005, listed recommendations generated from specific case reviews conducted in 2004. As with the previous reports, the appropriate agencies and/or disciplines were given a chance to address the recommendations and have provided the following responses.

A. PUBLIC HEALTH AND HEALTHCARE

- ***During well child and other visits, where substance use/abuse is routinely discussed, explore including caffeine use/misuse as part of the discussion.***

  Many physicians are familiar with the resources and recommendations of "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents", and a subsequent resource, Bright Futures in Practice: Nutrition". These were developed under the leadership of the federal Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau in collaboration with a multidisciplinary group of health professionals and representatives of federal agencies and national organizations, including the American Academy of Pediatrics. They contain recommendations to address the topics of drug, alcohol, and tobacco use, the dangers of performance-enhancing products, as well as high soft drink consumption and unsafe weight loss methods (including use of diet pills) but do not include specific guidelines on caffeine intake.

  The American Medical Association has developed "Guidelines for Adolescent Preventive Services (GAPS) that also touch on these topics, but not caffeine intake specifically. Several tools have been designed to support the implementation of these guidelines, by using questionnaires to elicit the information in the clinical setting. There are three sets of questionnaires - one for the younger adolescent, the middle-older adolescent, and one for the parent/guardian, in both English and Spanish. It is not known how prevalent the use is of these tools in the medical community. In the state-funded community health centers, substance use/abuse is a required anticipatory guidance topic but has not, in the past, specifically included caffeine intake for children and adolescents. The electronic medical record system for the Elliot Hospital and its affiliated private

practices ("EPIC") does include limiting caffeine as a talking point in some of their age appropriate forms.

In the future, an article could be written for the newsletters of the state's pediatric and family practice physician organizations that could emphasize the importance of including caffeine use/misuse specifically in their routine anticipatory guidance.

- ***Increase awareness of caffeine use, overuse and adverse effects by incorporating it into current drug awareness campaigns.***

  Due to the reorganization of the Department of Health and Human Services in 2004, alcohol and drug treatment and prevention services were relocated in the Division of Public Health Services, in separate bureaus. Therefore, this recommendation was not accomplished. Media campaigns are generally under prevention services rather than the treatment services section. The Child Fatality Review Committee currently only has alcohol and other drug treatment representation and may want to consider adding representation from alcohol and other drug prevention services.

- ***Collaborate and develop a one-page handout that encourages safe co-sleeping to be distributed to pregnant women and new moms***.

  A one-page handout, "Sleeping With Your Baby", was developed by the Child Health Month Coalition and was included in the annual mailing of the Coalition packet to over 5,000 health and social service providers, including pediatricians, obstetricians, family practitioners, and parenting groups. Representatives provided input from the New Hampshire Department of Health and Human Services' WIC Program and the New Hampshire Breast Feeding Task Force. Included in the handout was the recommendation "Have the baby sleep in his own safety-approved crib, bassinette or co-sleeper, next to your bed." Several weeks after the packet was distributed, the American Academy of Pediatrics issued a new policy statement "The Changing Concept of Sudden Infant Death Syndrome: Diagnostic Coding Shifts, Controversies Regarding the Sleeping Environment, and New Variables to Consider in Reducing Risk", that acknowledged that bedsharing between an infant and adult was a controversial topic, stressed the hazards of adults sleeping with an infant in the same bed, and recommended a separate but proximate sleeping environment.

- ***Explore non-conventional ways of outreach to new moms (i.e. ducklings program in New Hampshire supermarkets) on co-sleeping issues***.

  Health care and parent support providers continue to educate new mothers on co-sleeping issues through the traditional avenues. No non-conventional outreach methods have been explored to date. However, as infants continue to die in sleep situations involving bedsharing, it is critical that this education must continue, if not be increased.

- ***All health care providers should be encouraged to conduct universal screening of all teenagers for child abuse and neglect, domestic violence and suicidality***.

  "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents", and a subsequent resource, Bright Futures in Practice: Mental Health" (see previous description) include child abuse and neglect, domestic violence, and emotional concerns (depression, anxiety, confusion about sexual orientation, low self esteem, threat of suicide, and attempted suicide) among the issues that should be discussed during an adolescent visit.

In addition, the American Medical Association has developed "Guidelines for Adolescent Preventive Services" (GAPS) which also touches on these topics. As mentioned above, several tools have been designed to support the implementation of these guidelines, by using questionnaires to elicit the information in the clinical setting. There are three sets of questionnaires - one for the younger adolescent, the middle-older adolescent, and one for the parent/guardian, in both English and Spanish. It is not known how prevalent the use is of these tools in the medical community. In the state-funded community health centers, these topics are required as part of the anticipatory guidance/risk assessment component.

The State Suicide Prevention Plan includes outreach to and professional training for medical staff in screening for suicide within the adolescent patient population. The Adolescent Health Program of the Division of Public Health Services (PPHS) has begun conducting outreach and training to health center staff. Chart Audits on adolescent patients are conducted by DPHS at all Maternal and Child Health funded health centers to ensure appropriate screening is conducted.

In the future, an article could be written for the newsletters of the state's pediatric and family practice physician organizations that could emphasize the importance of doing universal screening of all adolescents for child abuse and neglect, domestic violence, and suicidality in their routine anticipatory guidance.

- ***Existing efforts by agencies such as the New Hampshire Department of Public Health and the Frameworks Suicide Project should be coordinated to provide universal "Gatekeeper" training on how to respond to disclosures of significant risk, such as child abuse and neglect, suicidality, domestic violence, eating disorders, substance abuse, sexual assault and firesetting.***

In April 2005, Commissioner of the New Hampshire Department of Health and Human Services, John Stephen, named NAMI New Hampshire (New Hampshire Chapter of the National Alliance for Mental Illness) as the state's designee in applying for a Garrett Lee Smith Grant. This grant was to implement the New Hampshire Suicide Prevention Plan. The grant funds the implementation and evaluation of the youth focused objectives of the state plan. The application has the additional focus of coordination among state agencies, NAMI (the sponsor of the Frameworks Project), the Youth Suicide Prevention Assembly and community stakeholders.

Commissioner Stephen also created the New Hampshire Suicide Prevention Council. The council is a public-private partnership bridging various state programs together with community partners. A work plan and timeline for the implementation of specific objectives has been developed and is overseen by the Suicide Prevention Council.

B. EMERGENCY MEDICAL SERVICES

There were no recommendations for Emergency Medical Services this year.

C. MENTAL HEALTH

There were no recommendations for Mental Health this year.

D. EDUCATION SYSTEM

- ***Explore bringing firearm safety into schools through the use of the DARE program, School Resource Officers or similar avenues***.

  The Department of Education was a partner in the development and dissemination of two DVDs about firearm safety targeting middle and high school students. The Department will continue to promote these videos in the upcoming school year.

- ***Encourage the Department of Education to explore curriculum regarding safe co-sleeping, prenatal and newborn care to be incorporated into high school health curriculum.***

  The Department of Education will consider including such curriculum in subsequent revisions of the recommended Health Education Curriculum. Family and Consumer Science programs also often cover these issues for students in those programs. This would be covered in Child Development, Parenting and possibly in Early Childhood Education classes.

- ***Existing efforts by agencies such as the New Hampshire Department of Public Health and the Frameworks Suicide Project should be coordinated to provide universal "Gatekeeper" training on how to respond to disclosures of significant risk, such as child abuse and neglect, suicidality, domestic violence, eating disorders, substance abuse, sexual assault, and firesetting.***

  A Department of Education representative continues to be part of the Youth Suicide Frameworks Project and protocols have now been piloted. When the Gatekeeper training becomes available, the department will disseminate it broadly to appropriate school personnel. The Department of Education is also represented on the Attorney General's Task Force for Child Abuse and Neglect which was instrumental in the development of the joint protocol "*Child Abuse and Neglect: Guidelines for New Hampshire School Employees: Recognizing and Reporting Child Abuse and Neglect*". This protocol is endorsed by the Attorney General, the Department of Education and the Division for Children Youth and Families, and is used throughout the state for training all professionals, not just educators, on how to respond in the event of a disclosure of child abuse or neglect.

- ***The Department of Education should continue to support the expansion and sustainability of Peer Outreach Programs in all schools to provide outreach and peer support for at risk students.***

  The Department supports Peer Outreach within the scope of approvable activities in the Safe and Drug-Free Schools (SDFS) State Grant Program. Decisions for programming with SDFS funds are made at the local level. This response comes from the Bureau of Integrated Programs. There may be other programs within the Department that could also speak to this recommendation. The Bureau doesn't foresee having the resources to support expansion and sustainability in all schools as the recommendation is currently written.

E. CHILD PROTECTIVE SERVICES

- ***Development and dissemination of public awareness campaign regarding mandatory reporting of child abuse and neglect cases.***

DCYF has been involved with numerous efforts to assure consistent public awareness of mandatory reporting of child abuse and neglect. These included but are not limited to the publication of posters in English and other languages to be posted within the communities. DCYF also established a "speakers bureau" to establish and train statewide speakers within the Division to provide reliable and consisted presentations on reporting.

The Division has also updated the community reporting and resource guide, which has a wide distribution and advises the public of their rights and responsibilities relative to reporting.

- ***Support DCYF accreditation process.***

DCYF contacted and engaged in an analysis and on-site review completed by the Child Welfare League of America (CWLA) to determine the feasibility of accreditation. As a result it was determined that the Division was meeting many of the accreditation requirements however the benefits of becoming accredited would not outweigh the resource demand it would place on the agency. There is also no solid research that demonstrated accreditation resulted in better outcomes for states on federal reviews indicating better practice.

- ***Conduct an analysis on the feasibility of providing a 24-hour centralized intake for DCYF.***

DCYF has changed its contractor for the 24-hour reporting capacity. This revised contract has allowed for an enhanced capacity to provide placement resources after hours as well emergency reporting and information.

- ***Explore a Memorandum of Understanding between DCYF and the New Hampshire Department of Corrections for sharing information.***

DCYF has established and continues to revise " protocols" between DCYF and law enforcement to enhance not only information but procedures followed in investigations. As part of agency policy DCYF contacts law enforcement to determine background and criminal records as appropriate. Most initial investigations now include that criminal inquiry.

F. DISTRICT COURT AND LAW ENFORCEMENT

- ***Require mandatory gun safety courses to all people under age 18, either through formal classroom instruction, through an internet course or other means.***

The feasibility of implementing this recommendation is being reviewed. It is uncertain what legislative action, if any, would be needed in order to require mandatory training.

- ***Review and examine current firearm laws related to juveniles.***

This recommendation needs further clarification of its intent before it can be implemented.

G. LEGISLATION

There were no recommendations made for Legislation this past year.

H. CHILD FATALITY REVIEW COMMITTEE

There were no recommendations made for the Child Fatality Review Committee this past year

I. DEPARTMENT OF HEALTH AND HUMAN SERVICES

- ***The Department should encourage the enhancement of training and information for parents who adopt young children from other countries, particularly countries known to "warehouse" infants and young children in orphanages. Information would include warning signs of developmental and mental health problems often associated with early maltreatment.***

New Hampshire Department of Health and Human Services is actively working with adoption agencies regarding education and training for people interested in adopting children from other countries. The directors of the New Hampshire Adoption Child Placing Agencies meet every two months. International adoption is a topic that is discussed often, as most of the private agencies provide services for this population. Agencies are consistently concerned about how to help prospective adoptive families understand the complex issues involved in adopting a child from another country.

The training and home study process is the forum for discussing issues and helping families determine what type of child will be a good match for the family. Post adoption services are discussed with the family. The New Hampshire Child Placing Rules (He-C 6448) support good practice in this area. Specifically, under He-C 6448.12, Provision of Adoption Services, the rules assert: "The primary focus of adoption services shall be to protect the rights and meet the needs of the children for whom it accepts responsibility by offering services to the child, biological and legal parents, and the adoptive parents." The rules mandate training that includes education for people planning to adopt so that they understand as much as possible the implications of adoptions and special issues that children may have as a result of events that may have occurred prior to the adoption. In the case of international adoptions this training can include information about issues that children may have experienced in their home countries that may result in individual needs that can emerge later in childhood.

VII. CONCLUSION

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

APPENDIX A. HISTORY, BACKGROUND AND METHODOLOGY

(As printed in the Fourth Annual Report)

In 1999, there were 143 deaths in the state of New Hampshire involving children up to the age of 18. This compares with 134 deaths in 1997 and 119 deaths in 1998. The data presented here and in the Committee's first three annual reports shows that the great majority of the child fatalities in New Hampshire are from natural causes and that relatively few children die of preventable injury. These are the children that are of concern to the Committee and it is the task of the Committee to determine whether certain actions could have been taken to prevent these tragedies.

The Committee's First Annual Report provided an overview of the history of child fatality review committees, from their founding in Los Angeles County in 1978. In 1991, then Governor Judd Gregg signed an Executive Order creating a multidisciplinary Child Fatality Review Committee in New Hampshire. To assist with the initial implementation of the Committee, the University of New Hampshire Family Research Laboratory was commissioned to conduct a base-line study of child deaths in New Hampshire and to provide recommendations for how the Committee should operate.

After reviewing the study findings and initiatives from other states, the Committee was restructured to accommodate the demands of an on-going review process. In 1995, in an effort to support the restructuring, then Governor Stephen Merrill signed a new Executive Order (Appendix A) re-establishing the Committee under the official auspices of the New Hampshire Department of Justice. The Executive Order authorizes the Committee to have access to all existing records regarding child deaths, including social service reports, court documents, police records, autopsy reports, mental health records, hospital or medical data and other information that may be relevant to the review of a particular child death. To provide further support to the review process, the department heads of the New Hampshire Department of Justice, the New Hampshire Department of Health and Human Services and the New Hampshire Department of Safety signed an Interagency Agreement (Appendix B) that defined the scope of information sharing and confidentiality within the Committee. Additionally, individual Committee members and invited participants are required to sign Confidentiality Agreements (Appendix C) in order to participate in the review process.

The New Hampshire Child Fatality Review Committee is funded by the New Hampshire Department of Justice through the Children's Justice Act (CJA) Grant, which is administered by the US Department of Health and Human Services. In order to receive funding through the CJA Grant, which also supports the Attorney General's Task Force on Child Abuse and Neglect, the State is required by statute to establish a child fatality review panel "to evaluate the extent to which agencies are effectively discharging their child protection responsibilities." The New Hampshire Child Fatality Review Committee meets the criteria for this review panel (Appendix D).

The Committee membership is comprised of representation from the medical, law enforcement, judicial, legal, victim services, public health, mental health, child protection and education communities. Currently, the Committee has a dual structure consisting of the full

Committee, which convenes bimonthly to conduct in-depth reviews of specific cases involving child fatalities, and the Executive Committee, which convenes on alternate months to select cases for review, collect data and provide organizational support to the Committee.

The Committee began reviewing cases of child fatalities in January of 1996. In addition to the regular meeting schedule, the Committee hosted a joint meeting in November of 1998 with Child Fatality Review Teams from Vermont, Maine and Massachusetts. This meeting provided a forum for participants to come together and learn about some of the issues that other teams encounter in their efforts to review child deaths. It also offered an opportunity for members to establish contacts with their counterparts in other states. Participants from Maine, New Hampshire and Vermont continue to meet annually to further explore areas of common interest and to examine in more detail how each state conducts case reviews.

In New Hampshire, cases to be reviewed by the full Committee may be selected by individual members or agencies. The Committee does not review cases that have criminal and/or civil matters pending. After a case is found to be appropriate for review, the Executive Committee begins to gather information and invite participants from outside the committee who have had direct involvement with the child or family prior to the child's death.

Each child death is reviewed using the following review process (see Case Review Protocol, page three):

- The Medical Examiner's Office presents a clinical summary of the death. Other participants who had prior involvement with the child and family then present relevant medical, social and legal information.

- The Committee discusses service delivery prior to the death, and the investigation process post death.

- The Committee identifies risk factors related to the death and makes recommendations aimed at improving systematic responses in an effort to prevent similar deaths in the future.

- The Committee provides recommendations to participating agencies and encourages them to take actions consistent with their own mandates.

APPENDIX B: EXECUTIVE ORDER

STATE OF NEW HAMPSHIRE

CONCORD, NEW HAMPSHIRE 03301

Executive Order Number 95-1

an order establishing a New Hampshire
child fatality review committee

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Stephen Merrill

Governor of New Hampshire

APPENDIX C: INTERAGENCY AGREEMENT

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

KELLY A. AYOTTE
ATTORNEY GENERAL

MICHAEL A. DELANEY
DEPUTY ATTORNEY GENERAL

INTERAGENCY AGREEMENT

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

This cooperative agreement is made between the New Hampshire Department of Justice, the New Hampshire Department of Health and Human Services and the New Hampshire Department of Safety.

WHEREAS, the parties hereto are vested with the authority to promote and protect the public health and to provide services which improve the well-being of children and families; and

WHEREAS, under RSA 125:9 II, the Department of Health and Human Services – Division for Public Health has the statutory authority to: "Make investigations and inquiries concerning the causes of epidemics and other diseases; the source of morbidity and mortality; and the effects of localities, employment, conditions, circumstances, and the environment on the public health;" and

WHEREAS, under RSA 169-C, the Department of Health and Human Services – Division for Children, Youth and Families has the responsibility to protect the well-being of children and their families; and

WHEREAS, the objectives of the New Hampshire Child Fatality Review Committee are agreed to be:

1) To describe trends and patterns of child deaths in New Hampshire.
2) To identify and investigate the prevalence of a number of risks and potential risk factors in the populations of deceased children.
3) To evaluate the service and system responses to children and families who are considered to be high risk, and to offer recommendations for improvement in those responses.
4) To characterize high risk groups in terms that are compatible with the development of public policy.
5) To improve the sources of data collection by developing protocols for autopsies, death investigations and complete recording of cause of death on the death certificates.

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

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

WHEREAS, all parties agree that the membership of the New Hampshire Child Fatality Review Committee needs to be comprised of the following disciplines: law enforcement, judiciary, medical, mental health, public health, child protection services, with specific membership from designated agencies to include, but not to be limited to: the Office of the Chief Medical Examiner, the New Hampshire Pediatric Society and the New Hampshire SIDS Program; and

WHEREAS, the parties agree that meetings of the New Hampshire Child Fatality Review Committee will be held no fewer than six (6) times per year to conduct reviews of child fatalities:

NOW, THEREFORE, it is hereby agreed that the New Hampshire Child Fatality Review Committee convenes under the official auspices of the New Hampshire Department of Justice. All members of the New Hampshire Child Fatality Review Committee will sign a confidentiality statement that prohibits any unauthorized dissemination of information beyond the purpose of the review process. The New Hampshire Child Fatality Review Committee shall not create new files with specific case-identifying information. Non-identified, aggregate data will be collected by the Committee. Case identification will only be utilized in the review process in order to enlist interagency cooperation. No material may be used for reasons other than that for which it was intended. It is further understood that there may be individual cases reviewed by the Committee which will require that a particular agency be asked to take the lead in addressing a systemic or quality of care issue based on that agency's clear connection with the issue at hand.

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

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

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

APPENDIX D: CONFIDENTIALITY AGREEMENT

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE CONFIDENTIALITY AGREEMENT

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

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

_____

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

_____
Print Name

_____
Authorized Signature

_____
Witness

_____
Date

APPENDIX E: STATUTORY AGREEMENT

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE STATUTORY AUTHORITY

As a condition for receiving funds from the New Hampshire Department of Justice through the Children's Justice Act Grant, administered by United States Department of Health and Human Services, the State of New Hampshire is required to establish a citizen/professional review panel to "evaluate the extent to which the agencies are effectively discharging their child protection responsibilities." The New Hampshire Child Fatality Review Committee meets the criteria for this review process. 42 U.S.C. S1Oba(c)(A). (CAPTA, Child Abuse Prevention & Treatment Act).

The membership is composed of "volunteer members who are broadly representative of the community in which such panel is established, including members who have expertise in the prevention and treatment of child abuse or neglect." 42 U.S.C. 5106a(c)(A)(B).

The 1996 CAPTA amendments require:

The amendments continue the requirement that, to receive funding, a state must have in effect methods to preserve confidentiality of records "in order to protect the rights of the child and of the child's parents or guardians." The persons and entities to which reports and records can be released include:

> (II) Federal, State, or local government entities, or any agent of such entities, having a need for such information in order to carry out its responsibilities under law to protect children from abuse and neglect;
>
> (III) child abuse citizen review panels;
>
> (IV) child fatality review panels;
>
> (V) other entities or classes of individuals statutorily authorized by the State to receive such information pursuant to a legitimate State purpose. (42 USC 5106a(b)(2(A)(v))

Confidentiality provisions prohibit the panel's disclosure "to any person or government official any identifying information about any specific child protection case with respect to which the panel is provided information" or making any other information public unless authorized by state statutes. The amendments further provide that the state shall establish civil penalties for violation of the confidentiality provisions, 42 USC 5106a(c)(4)(B).

APPENDIX F: CASE REVIEW PROTOCOL

1. The Committee will review data regarding all deaths of New Hampshire children up to and including 18 years old.

2. Comprehensive, multidisciplinary review of any specific cases may be initiated by the Department of Justice, the Department of Health and Human Services, the Department of Safety, or by any member of the New Hampshire Child Fatality Review Committee (CFRC).

3. The review process begins with obtaining a list of in-state child deaths from the New Hampshire Department of Health and Human Services and/or from the Office of the Chief Medical Examiner.

   A. The deaths are then sorted by manner of death: natural, homicide, traffic, suicide, and accident other than traffic.

   B. Prior to clinical review, relevant records (e.g.: autopsy reports, law enforcement, Division for Children Youth and Families) are obtained.

   C. Cases may be selected for full Committee review by the Executive Committee from a variety of resources and documents which enumerate children's deaths and their cases from 1994 on.

   D. The review focuses on such issues as:

      - Was the death investigation adequate?
      - Was there access to adequate services?
      - What recommendations for systems changes can be made?
      - Was the death preventable?*

4. After review of all confidential material, the Committee may provide a summary report of specific findings to the Governor and other relevant agencies and individuals.

5. The CFRC will develop periodic reports on child fatalities, which are consistent with state and federal confidentiality requirements.

6. The CFRC will convene at times published.

7. Each CFRC member will have an alternate member from their discipline or agency and will ensure that one member will be present at every meeting.

8. Confidentiality Agreements are required of any individual participating in any CFRC meeting.

9. The CFRC Executive Committee, comprised of members of the CFRC, assesses case information to be reviewed by the CFRC and performs other business as needed.

***WHAT IS A PREVENTABLE DEATH?**

A preventable death is one in which, by retrospective analysis, it is determined that a reasonable intervention (e.g., medical, educational, social, legal or psychological) might have prevented the death. "Reasonable" is defined as taking into consideration the conditions, circumstances, or resources available.

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

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

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

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