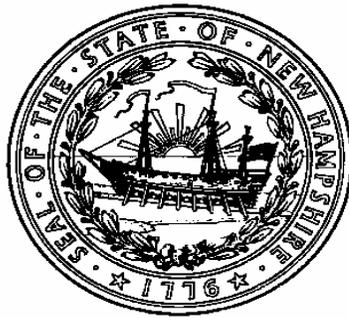


**THE STATE OF NEW HAMPSHIRE**



**CHILD FATALITY REVIEW COMMITTEE**

**FIFTH ANNUAL REPORT**

*Presented to  
The Honorable Jeanne Shaheen  
Governor, State of New Hampshire  
October 2002*

## **DEDICATION**

This, our Fifth Annual Report, is dedicated to the children of the State of New Hampshire and to those who work to improve their health and lives. Though our work is difficult at times, we are 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.



## **NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE**

Dear Friends of New Hampshire's Children,

As we present this, our Fifth Annual Report, it is a good time to reflect on the work the New Hampshire Child Fatality Review Team has accomplished in the last few years. The Committee has been actively reviewing child fatality cases since January of 1996. Since that time we have reviewed over 45 cases. These reviews are conducted by a multidisciplinary team of volunteers who represent a variety of public and private agencies whose aim is to protect children. From these reviews we have generated a number of different recommendations to help prevent child fatalities in the state of New Hampshire. This report reflects what we feel is an accurate representation of our work of the last year and a summation of the recommendations and responses of the last five years.

Members of the Committee have made both formal and informal presentations of our work to outside agencies, at national conferences, and to our colleagues who work with children. Additionally we meet annually with the teams from Vermont and Maine to share ideas and to explore ways that we can better cooperate to protect children in Northern New England. We feel that this education component is very important in publicizing our work and in also helping to strengthen the network of individuals who can have a significant impact on the prevention of child fatalities. We have been recognized nationally as having an active and productive team that has procedures and policies that other teams around the country have emulated to become more effective in their work.

In recognition of the commitment and dedication of the members of the Committee, it is with great pride that as Chair, I present the Fifth Annual Report to the Honorable Jeanne Shaheen, Governor of the State of New Hampshire.

On behalf of the Committee,

Marc A. Clement, Ph.D.  
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.



# JANUARY TO DECEMBER 2001

## CHILD FATALITY REVIEW COMMITTEE MEMBERSHIP

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

\*Jacqui Abikoff, ACSW, LADC  
Horizon's Counseling Center

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

Kelly Ayotte, JD, Senior Assistant Attorney General  
NH Attorney General's Office

Don Bliss, State Fire Marshall  
NH State Fire Marshall's Office  
NH Department of Safety

\*Lisa Bujno, MSN, ARNP, Prenatal & Adolescent  
Program Chief, Bureau of Maternal & Child Health  
NH Department of Health & Human Services

\*Detective John Cody  
NH Department of Safety

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

\*Katherine Descheneaux, Chief Forensic Investigator  
Office of the NH Chief Medical Examiner

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

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

Carol Frechette, RN  
Concord Hospital

\*Linda Griebisch, 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

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

Sgt. Kelly McClare  
Family Services Unit  
NH Department of Safety

Nancy Mogielnicki, PA, MPH  
Community Health Center  
Dartmouth Hitchcock Medical Center

Cheryl Molloy, Executive Director  
Prevent Child Abuse New Hampshire

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

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

Joe Perry, Administrator  
Children's Mental Health Services  
Div. of Behavioral Health Services  
NH Department of Health & Human Services

\*Suzanne Prentiss, Trauma Coordinator  
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

Kenneth Roos, MSPH, MBA, Former Supervisor  
Bureau of Health Statistics & Data Management  
NH Department of Health & Human Services

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

David Ross, MD  
Concord Pediatrics  
\*David Sandberg, JD  
CASA of New Hampshire

\*Vignia St. Martin, M.A.T.  
HIV/Health Education Consultant  
NH Department of Education

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

Martin Singer, MPS, Director  
Division of Emergency Medical Services  
NH Department of Safety

Marcia Sink, Executive Director  
CASA of New Hampshire

Karin Strand-Pelich  
Bureau of Quality Improvement  
Division for Children, Youth & Families  
NH Department of Health & Human Services

Elizabeth Thompson, RN, Medical Consultant  
Medicaid Administration Bureau,  
NH Department of Health & Human Services

Neil Twitchell,  
Injury Prevention Program  
Office of Community and Public Health

\*=Alternate

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## **I. EXECUTIVE SUMMARY**

This is the Fifth Annual Report of the New Hampshire Child Fatality Review Committee. It generally follows the format of our four previous reports, but also includes a summary of our work of the last five years.

The report begins with our Mission Statement and Objectives. The focus of the Committee is to reduce preventable child fatalities in New Hampshire. The members of the Committee and their affiliations follow this section.

Our Statement of Accountability reviews the work of the committee and reviews two observed trends that we've noted and are concerned about: deaths of infants and adolescent suicide.

A major component of the report is the Review and Analysis of Data. We have included the data for calendar year 2000 along with data for the previous four years. This section increases our understanding by analyzing child fatalities by the cause of death, age and gender and included comments discussing major findings.

The heart of this report is the recommendations that we're generated from our reviews. We list our 2001 Findings and Recommendations along with the responses to our 2000 Recommendations. Since this is our Fifth Annual Report, we also have included a 5-Year Retrospective Review of the recommendations and responses from our 4 past reports.

The report concludes with a series of Appendices: *Appendix A: History, Background and Methodology; Appendix B: Executive Order; Appendix C: Interagency Agreement; Appendix D: Confidentiality Agreement; Appendix E: Statutory Authority; Appendix F: Case Review Protocol; Appendix G: ICD-10 Codes.*

## **II. STATEMENT OF ACCOUNTABILITY**

### **A. History**

In 2000, the latest year for which data are available there were 156 deaths of children through age 18 in the state of New Hampshire. The data section of this report describes child fatalities for the year 2000 and then the years 1996 to 2000 are combined.

The 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 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 E).

The Committee membership (Page iii) 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 a 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.

Each year for the past five years the Committee has published an Annual Report. The main components of the report are the Data section and the section on recommendations that are generated during our 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's mission is to develop, as appropriate, recommendations to the Governor and relevant state agencies with the intent of effecting change in state policy or practice, or to cause the development of new initiatives which could lead to the reduction of preventable deaths in children and youth.

During the operating year of 2001 the Committee met on February 2<sup>nd</sup>, April 6<sup>th</sup>, June 1<sup>st</sup>, August 3<sup>rd</sup>, September 28<sup>th</sup>, and December 7<sup>th</sup> to review eight cases that included death by fire, snowmobile, asphyxiation and drug overdose. The process by which cases are reviewed is outlined in Appendix E: 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.

## ***B. OBSERVED TRENDS AND CHILD AND ADOLESCENT MORTALITY***

From time to time the Committee becomes aware of significant patterns, trends or data based on information that relate to child and adolescent deaths and accordingly uses this report to alert the Governor and state agencies to such matters.

For infant cases reviewed during the past five years, it was noted that the frequency with which preventable deaths seemed to relate to poverty, substance abuse, lack of education and mental illness, particularly among single parents and younger mothers, was alarming. The presence of mental illness among caregivers, which crosses all socioeconomic strata, may be a factor in the deaths of neonates, infants, and young children more frequently than previously thought. Clearly, families that have such risk factors will have more difficulty parenting in a safe and effective manner, especially when caring for a newborn child, which can be exceptionally challenging. The 2000 Kids Count Online indicates that negative social conditions have a greater impact on the first year of life than subsequent years due to the precarious nature of this time period ([www.aecf.org/kidscount](http://www.aecf.org/kidscount) <<http://www.aecf.org/kidscount>> ).

Unintentional injuries are the 7th leading cause of infant mortality in the United States, accounting for 3% of total deaths (National Vital Statistics Report, 49(8), CDC 2001). In our state, between 1996 and 2000 we had 5 unintentional deaths and 3 homicides among infants (Table 7). The types of infant deaths reviewed by the Committee, although rare, were of great concern because they were preventable. Accordingly, they warrant the development of better means to analyze case findings to define cause of death and develop strategies for intervention and assistance in order to prevent the unnecessary loss of infants and young children in future years.

Lessons learned from the review of adolescent deaths from similar causes can have significant importance when considered over time. During the previous five years, the Committee has reviewed many deaths of adolescents by suicides and motor vehicle crashes. Factors that seem to be related to these causes of death include substance abuse, depression and difficulties in school, and the involvement with law enforcement or criminal justice systems. From 1996-2000, our state had 36 suicides among youth. In the year 2000 alone, 12 youth age 15-19 were occupants of motor vehicles and died in a crash (Table 3).

New Hampshire's 2001 Youth Risk Behavior Survey (YRBS) Aggregate School-Wide Report explored substance use in detail and most notably indicated that in the previous month 31% of teens completing the survey, drank more than 5 drinks at a time, 27% indicated that they had ridden in a vehicle driven by someone who had been drinking, and 28% reported using marijuana. Forty two percent of the teens surveyed in this report were measured to have a depressed mood and 28% reported feeling sad or hopeless for two weeks or more in the previous year. A depressed mood was captured by combining 4 questions related to depression, thoughts of suicide, a plan for suicide, and a reported suicide attempt (Alcohol and Drug Abuse Prevention and Recovery, NH DHHS, 2002). A close look at the data indicates that many New Hampshire adolescents are engaging in high risk behaviors that endanger their well-being and the well-being of others.

The Child Fatality Review Committee recognizes that the loss of even one child from a preventable cause has an enduring consequence for parents, family, the school, communities, and the state. The National Center for Injury Prevention and Control notes that the difference between a non-fatal and fatal event may be only a few feet, a few inches, or a few seconds ([www.cdc.gov/ncipc](http://www.cdc.gov/ncipc) <<http://www.cdc.gov/ncipc>> ). The haunting aftermath of loss experienced by significant others focuses on the effect of this unrequited momentum of realization and the unending questions of - if only - or why. It is the hope of the Committee that the work of the past five years has brought insight into the reasons of the preventable loss of children and made progress through its recommendations in reducing such losses in New Hampshire families.

### III. REVIEW AND ANALYSIS OF DATA

#### A. CHILD FATALITIES IN NEW HAMPSHIRE – 2000

This report examines child fatality data for calendar year 2000, with a total of 156 fatalities among children ages 0 – 18 years, who were residents of New Hampshire at the time of their deaths. Of this total, 70% were due to natural causes and 22% were due to unintentional injuries. Suicides accounted for 6% of deaths and 1% were homicides. (Note: the total does not equal 100% due to rounding). The data presented in this report is based on reports to the New Hampshire Bureau of Vital Records as of August 2002. Data for year 2001 is not yet complete, due to normal delays in receiving final information for deaths among New Hampshire residents that occurred out-of-state.

The following data has been collected and analyzed by the Bureau of Health Statistics and Data Management (BHSDM). BHSDM is located within the Office of Community and Public Health at the New Hampshire Department of Health and Human Services (DHHS). The mission of the BHSDM is to acquire and maintain complete and accurate health data for analysis and dissemination to New Hampshire communities. Please refer to Appendix G for a list of ICD-10 codes used for this report.

This report presents fatalities among children as resulting from two major causes, those from natural causes and those from injuries. Most deaths from natural causes occurred among infants less than age one. During 2000 infants represented 74% of all natural deaths among children through age 18. Adolescents account for the vast majority of injury-related deaths, with deaths from unintentional injuries more frequent than those from intentional (i.e. homicide and suicide) injuries.

**Table 1**  
**Natural vs. Injury Deaths by Age Group\***

II. Intent	Age		Total
	< 1 year	1-18 years	
Natural	81	29	110

Injury			
Unintentional	1	34	35
Homicide	2	0	2
Suicide	0	9	9
<b>Total</b>	<b>84</b>	<b>72</b>	<b>156</b>

*\*NH Residents 2000*

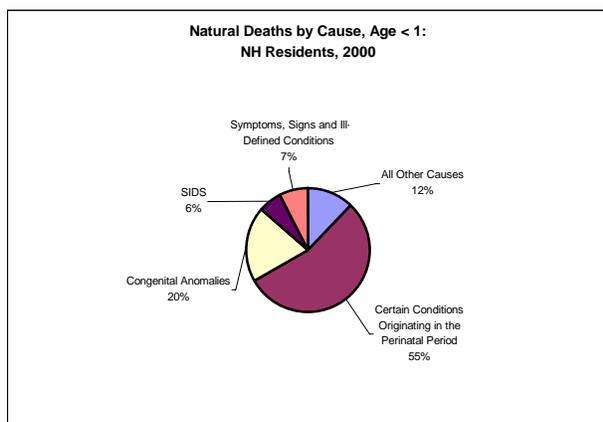
While infants are more likely to die from natural causes than are older children and adolescents, the causes of natural deaths also differ between these two groups. Conditions originating in the perinatal period and congenital anomalies represent the leading causes of death among infants and neoplasms (i.e. malignant tumors) accounted for the largest number of deaths among children ages 1 to 18. Table 2 reports the number of deaths from different natural causes by age group, while charts number 1 and 2 show the percentage by cause within each age group.

**Table 2**  
**Causes of Natural Deaths by Age Group\***

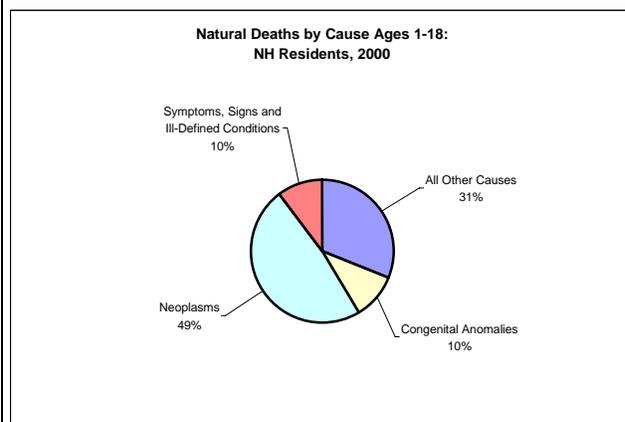
Cause of Death	0-1	1-18	Total
Certain Conditions Originating in the Perinatal Period	44	0	44
Congenital Anomalies	16	3	19
Neoplasms (i.e. malignant tumors)	0	14	14
Symptoms, Signs, and Ill-Defined Conditions	6	3	9
Sudden Infant Death Syndrome (SIDS)	5	0	5
All Other Causes	10	9	19
<b>Total</b>	<b>81</b>	<b>29</b>	<b>110</b>

*\*NH Residents 2000*

**Chart 1**



**Chart 2**



Unintentional injuries result in a greater number of deaths among New Hampshire

children than do intentional injuries. The majority of these deaths are seen among older children and adolescents.

Motor vehicle crashes are the leading cause of death for children and adolescents in New Hampshire and in the United States. The use of age-appropriate restraints, such as infant and booster seats, reduces the risk of serious injury or death from crashes. Inexperienced drivers are at an increased risk for crashes.

In New Hampshire, suicides account for a larger number of deaths from intentional injuries among children and adolescents than do homicides. Use of firearms and hanging are the most frequent methods used by youth to commit suicide.

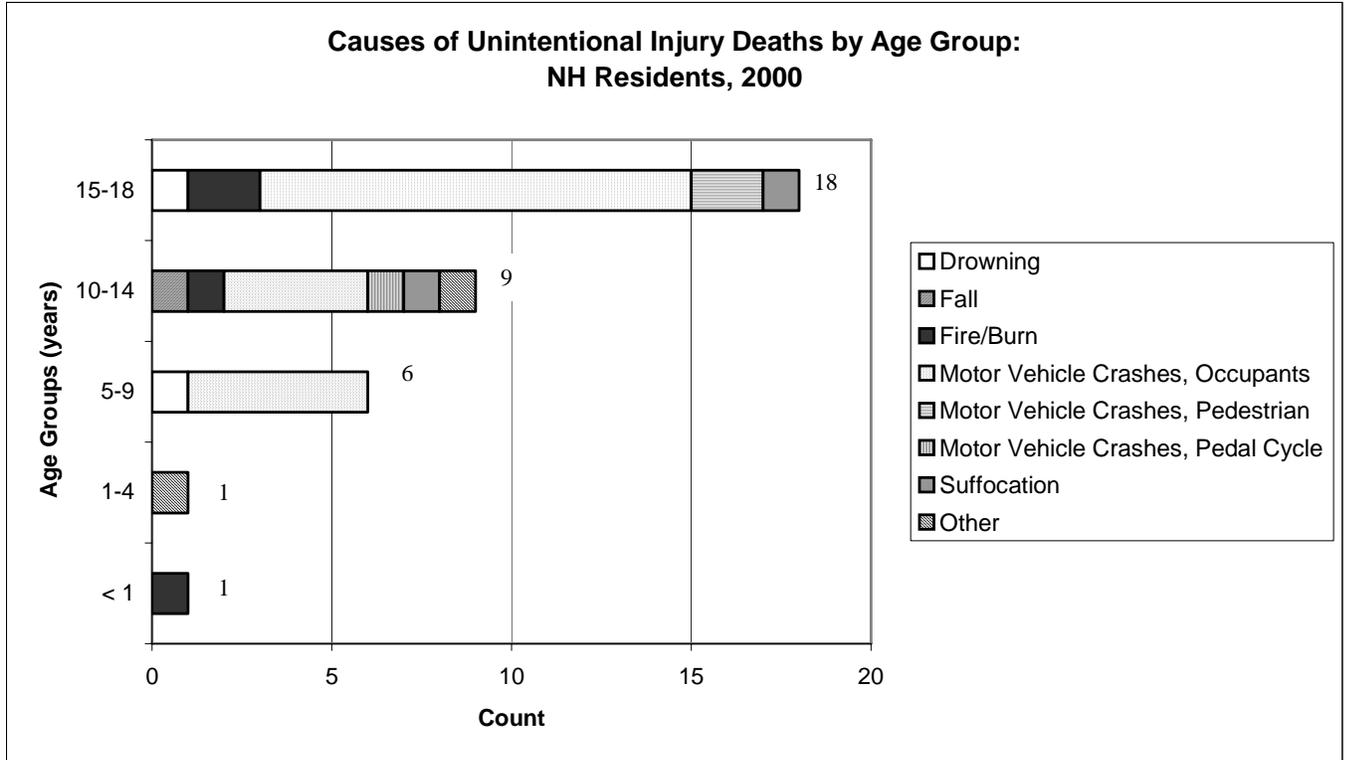
Table 3 reports the number of deaths from specific causes of injuries by age group. This same information is presented visually in chart 3 for unintentional injuries and chart 4 for suicides.

**Table 3  
Causes of All Injury Deaths by Age Group\***

Cause of Death	Age in Years					Total
	< 1	1-4	5-9	10-14	15-18	
<b>Unintentional Injuries</b>						
Drowning	0	0	1	0	1	2
Fall	0	0	0	1	0	1
Fire/Burn	1	0	0	1	2	4
Motor Vehicle Crashes, Occupants	0	0	5	4	12	21
Motor Vehicle Crashes, Pedestrian	0	0	0	0	2	2
Motor Vehicle Crashes, Pedal Cycle	0	0	0	1	0	1
Suffocation	0	0	0	1	1	2
Other	0	1	0	1	0	2
<b>Total – Unintentional Injuries</b>	<b>1</b>	<b>1</b>	<b>6</b>	<b>9</b>	<b>18</b>	<b>35</b>
<b>Suicide</b>						
Firearms	0	0	0	0	4	4
Hanging	0	0	0	2	2	4
Poisoning	0	0	0	0	1	1
Other	0	0	0	0	0	0
<b>Total – Suicide</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>7</b>	<b>9</b>
<b>Homicide</b>						
Firearm	1	0	0	0	0	1
Hanging, suffocation, strangulation	0	0	0	0	0	0
Other maltreatment syndromes	1	0	0	0	0	1
<b>Total – Homicide</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>

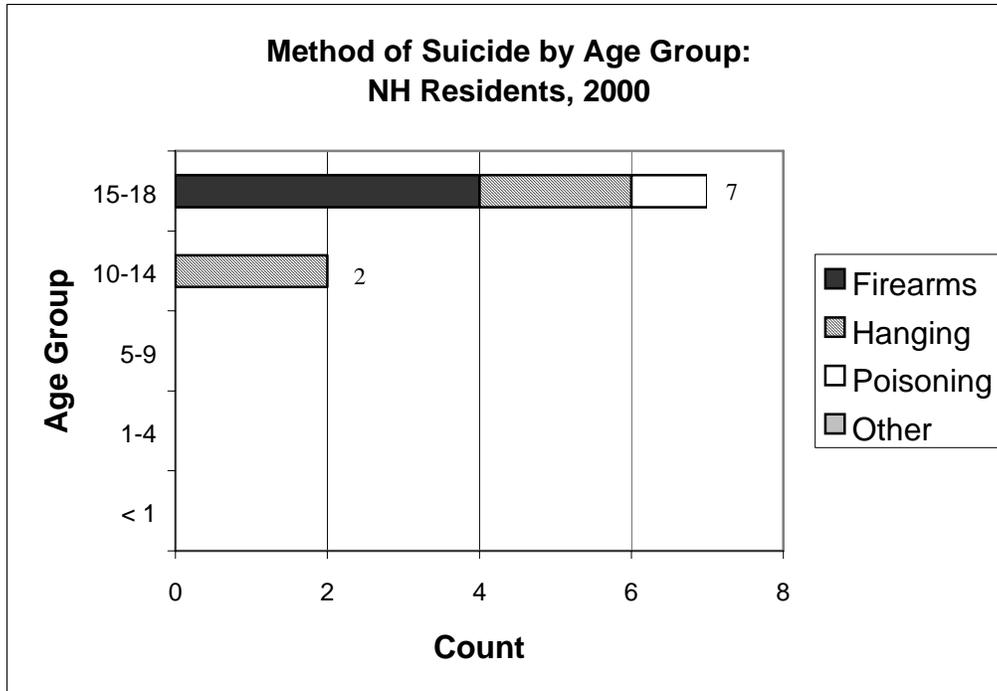
\*NH Residents 2000

**Chart 3**



*\*NH Residents, 2000*

**Chart 4**



*\*NH Residents 2000*

As seen in Table 4, males are more likely to die from injury than females. In the year 2000, all suicides were completed by males, with the greatest number in the 15-18 year age group.

**Table 4**  
**Injury Deaths by Intent, Age Group, and Gender\***

<b>Unintentional Injuries</b>			
Age Group	Male	Female	Total
< 1	0	1	1
1 - 14	11	5	16
15 - 18	10	8	18
Total	21	14	35
<b>Suicide</b>			
Age Group	Male	Female	Total
1 - 14	2	0	2
15 - 18	7	0	7
Total	9	0	9
<b>Homicide</b>			
Age Group	Male	Female	Total
< 1	1	1	2
1 - 14	0	0	0

15 -18	0	0	0
Total	1	1	2

\* NH Residents, 2000

Table 5 provides more specific information for the causes of all deaths among infants less than age 1 than do Table 2 (natural deaths) and Table 3 (injury deaths). Conditions originating in the perinatal period represent 52% of all infant deaths and congenital malformations, deformations and chromosomal abnormalities resulted in 10% of the infant deaths.

**Table 5**  
**Causes of Death for Infants less than Age 1**

Causes of Death for Infants Less Than Age 1*	
Cause of Death	Number
Certain Infectious and Parasitic Diseases	1
Endocrine, Nutritional, and Metabolic Diseases	1
Diseases of the Nervous System	2
Diseases of the Circulatory System	1
Diseases of the Respiratory System	2
Diseases of the Digestive System	3
Certain Conditions Originating in the Perinatal Period (Total = 44)	
Newborn affected by maternal factors and by complications of pregnancy, labor, and delivery	18
Disorders related to length of gestation and fetal malnutrition	9
Respiratory and Cardiovascular disorders specific to the perinatal period	15
Other	2
Congenital malformations, deformations, and chromosomal abnormalities	16
Sudden Infant Death Syndrome (SIDS)	5
Other ill-defined and unspecified causes of mortality	6
Unintentional Injury	1
Assault (Homicide)	2
<b>Total</b>	<b>84</b>

\*NH Residents 2000

Sudden Infant Death Syndrome (SIDS) is the sudden and unexplained death of a baby under one year of age. Most SIDS deaths occur in infants who are 2 to 4 months old. Infants placed on their stomachs to sleep and babies whose mother smoked during pregnancy are at an increased risk of SIDS. One SIDS fatality was reported with an infant who was sleeping in a bed with an adult.

**Table 6**  
**Position of Infants for SIDS Deaths\***

Position at the Time of Discovery	Number
On Stomach	3
On Side	0

On Back	1
Unknown	1
<b>Total</b>	<b>5</b>

\*NH Residents 2000

**B. Child Fatalities In New Hampshire, 1996 – 2000**

As part of this comprehensive fifth annual report, the CFRC wanted to include some information on all child fatalities occurring in the last five years. This report contains the most current information available from the Bureau of Vital Statistics, and may include additional out-of-state fatalities reported after previous CFRC Annual Reports were published. This data, with current information reflecting the responses to recommendations made by the CFRC during that time, provide a strong foundation on which the state can move forward to address critical priorities to reduce child fatalities.

As reported for 2000, total fatalities during the five-year period show that most deaths from natural causes occur among infants less than age one and that unintentional injuries account for most injury related deaths. Suicides also continue to account for the majority of deaths from intentional injuries.

**Table 7**  
**Natural vs. Injury Deaths by Age Group, 1996-2000\***

	< 1 year	1-18 years	<b>Total</b>
Natural	336	138	<b>474</b>
Injury			
Unintentional	5	123	<b>128</b>
Homicide	3	11	<b>14</b>
Suicide	0	36	<b>36</b>
<b>Total</b>	<b>344</b>	<b>308</b>	<b>652</b>

*\*NH Residents*

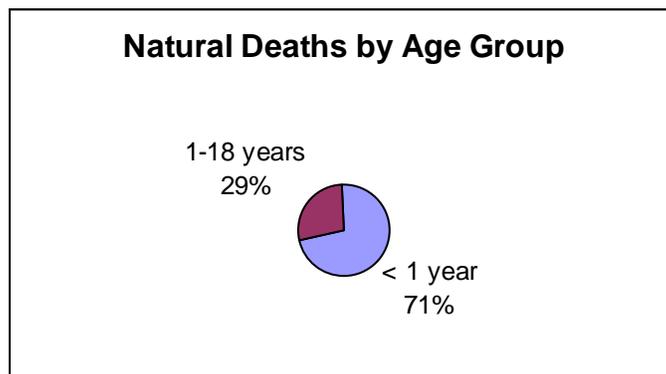
Table 8 shows that neoplasms (i.e. tumors) are the leading cause of death among children ages 1 to 18, where conditions originating in the perinatal period account for most deaths among infants. Congenital anomalies are the second leading cause of natural deaths among both age groups. Chart 6 shows the percent of all natural deaths combined by age group.

**Table 8**  
**Causes of Natural Deaths by Age Group, 1996-2000\***

Causes of Death	< 1 year	1-18 years	<b>Total</b>
Certain Conditions Originating in the Perinatal Period	179	4	183
Congenital Anomalies	74	16	90
Neoplasms (i.e. Malignant Tumors)	3	53	56
Symptoms, Signs, and Ill-Defined Conditions	12	10	22
SIDS	30	0	30
All Other Causes	38	55	93
<b>Total</b>	<b>336</b>	<b>138</b>	<b>474</b>

*\*NH Residents*

### Chart 6



During the five-year period, males accounted for twice the number of injury-related fatalities than did females. In both the 1-14 and 15-18 age groups, males account for a higher percentage of deaths than females.

### Table 9

**Age Distribution of Injury Deaths by Gender, 1996-2000\***

Age Group	Male	Female	Total
< 1	2	6	8
1-14	45	25	70
15-18	72	29	101
<b>Total</b>	<b>119</b>	<b>60</b>	<b>179</b>

*\*NH Residents*

No additional information regarding specific causes of deaths from unintentional injuries can be provided for the 1996-2000 period, due to changes made to the national coding system in 1999.

### Table 10

**Sudden Infant Death Syndrome (SIDS) Sleeping Position, 1996-2000**

Position at time of Discovery**	
On Stomach	12
On Side	8
On Back	10
Unknown	4
<b>Total</b>	<b>34</b>

*\* NH Residents*

*\*\* Data based on values published in previous Child Fatality Review Committee Annual Reports*

## IV. 2001 FINDINGS AND RECOMMENDATIONS

During calendar year 2001, the Committee reviewed eight cases that included death by fire, snowmobile, asphyxiation and drug overdose. Based on these comprehensive case reviews, 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. Outlines of some of the reviewed fatalities are outlined in sidebars.

### A. PUBLIC HEALTH AND HEALTHCARE

#### **“Angela”, age 2 months**

In the early morning hours, a fire accidentally broke out in an apartment where Angela, her sibling and her mother were sleeping. The home was converted into six apartments and the family resided in the 3<sup>rd</sup> floor attic apartment. A heating device in a pet boa constrictor’s terrarium apparently caught fire to cause the blaze. Several neighbors failed to gain access to the apartment before the fire fighters arrived. The smoke alarms in the attic apartment had been disconnected. Angela died from smoke inhalation.

- Expand efforts to educate the public to read the manufacture’s guidelines and follow the recommendations for proper use of appliances and products.
  - Continue public education efforts to discourage people from disabling smoke detectors.
  - Support public education efforts to encourage practicing fire drills, following a variety of routes to escape from burning houses.
  - Support public education efforts regarding avoiding placement of products that could cause a fire or block an exit.
- Encourage medical providers to routinely discuss fire safety and prevention during office visits with adults and children.
  - Support efforts of any public agency that provides home visits (i.e. Mental Health, Division of Children Youth and Families, Division of Family and Community Health) to train staff to educate families about fire safety and injury prevention. These agencies could expand our systems of educating families in “prevention” practices rather than “intervention” after problems exist. Use of a safety checklist is recommended.
  - Develop a resource guide for agencies that provide home visits and identify a fire safety hazard, such as resources guide for families who can’t afford smoke detectors.
  - Educate parents, children and the general public about the dangers of drugs associated with Raves.
  - Provide outreach to hospitals, emergency room personnel, EMT’s etc. regarding the Poison Control Center.
  - Provide education and resources for parents, educators etc. on the high risk factors for suicide.
  - Support a comprehensive community suicide prevention protocol.
  - Encourage parents to take CPR/First Aid courses.

- Encourage the Chief Medical Examiner’s Office to consult with another pathologist or physician on all atypical sudden infant deaths.
- Infants admitted to a hospital with an “Apparent Life Threatening Event” (ALTE) without a clear diagnosis should have a child abuse consultation.
- Hospitals should have policies on how to deal with the use of in-house videotaping in cases where it may be used as evidence to protect a child.
- Develop protocols/best practices for medical facilities to contact the Poison Control Center in cases where there is a known ingestion.

**B. EMERGENCY MEDICAL SERVICES**

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

**C. MENTAL HEALTH**

- The Office of the Chief Medical Examiner should pursue conducting psychological profiles for all youth suicides.
- Provide education and resources for parents, educators etc. on the high risk factors for suicide.
- Create/support an investigative team that would include mental health, victim witness and law enforcement personnel to investigate youth suicides.
- Support a comprehensive community suicide prevention protocol.
- Encourage parents to take CPR/First Aid courses.

**“Michael”, 16**

Michael was a student who was successful in academics, participated in a variety of sports, and was well liked and admired by his peers. One day he ingested an overdose of aspirin but then decided that he had made a “bad decision” and went to his school nurse for assistance. He received treatment in the hospital for his overdose and began to stabilize, feeling extremely thankful that he was recovering. Then, unexpectedly the next morning, his health rapidly deteriorated, and he died. His parents described this as a “tragic twist of fate”.

**D. EDUCATION SYSTEM**

- Continue to support fire safety and prevention programs in the school systems. Expand the Risk Watch program by continuing to offer program materials and Department of Education consultant time to schools.
- Health Science and Technology teachers should continue to teach fire safety and injury prevention to all their classes.
- Educate parents, children and the general public about the dangers of drugs associated with Raves.
- Include information on the Poison Control Center in the Youth Suicide Prevention Protocol.
- Educate people working with youth regarding the Poison Control Center.
- Increase education efforts with children to help them focus on the future. Encourage them to discuss life concerns with teachers, parents and other responsible adults that cause them or any of their peers, to feel hopeless or helpless.

- Provide education and resources for parents, educators etc. on the high risk factors for suicide.
- Encourage parents to take CPR/First Aid courses.

### ***E. CHILD PROTECTIVE SERVICES***

- Support efforts of any public agency that provides home visits (i.e. Mental Health, Division of Children, Youth and Families, Division of Family and Community Health) to train staff to educate families about fire safety and injury prevention. These agencies could expand our systems of educating families in “prevention” practices rather than “intervention” after problems exist. Use of a safety checklist is recommended.
- Develop a resource guide for agencies that provide in home visits and identify a fire safety hazard, such as resources for families who can’t afford smoke detectors.
- Educate parents, children and the general public about the dangers of drugs associated with Raves.
- Educate people working with youth regarding the Poison Control Center.
- Provide education and resources for parents, educators etc. on the high risk factors for suicide.

### ***F. DISTRICT COURT AND LAW ENFORCEMENT***

- Expand efforts to educate the public and landlords to ensure their knowledge and compliance with National Fire Protection Association Life Safety Codes (adopted in the NH State Fire Code).

**“Kate”, age 13**  
 Kate was reported to be an energetic, healthy young teenager. One evening she was playing with two friends and strangled herself with a dog leash in her bedroom closet. The community felt that this was a bizarre accident

- Identify resources for local enforcement agencies to force landlords to correct identified fire and safety hazards.
- Assess the uniformity in drug testing procedures in New Hampshire and look into best practices in other states.
- Increase the awareness of law enforcement of what to look for at Raves.
- During the law enforcement investigation of an untimely death of a child, a thorough history (further back than the 24-48 hour period that is commonly used) should be performed.
- Create/support an investigative team that would include mental health, victim witness and law enforcement personnel to investigate youth suicides.

### ***G. LEGISLATION***

- Consider legislation regarding photo-electric detectors in proximity to showers and appliances similar to Massachusetts.

## V. RESPONSES TO 2000 RECOMMENDATIONS

The Fourth Annual Report to the Governor, published in November 2001, listed recommendations, which were generated from specific case reviews conducted in 2000. As with the previous report, 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

- *Support the expansion of “Sudden Death Response Teams” throughout the state.*

Aside from the three teams active in Strafford, Rockingham and Carroll Counties, no new teams have been started. There is not an identified funding source for coordinating or starting up such teams statewide.

- *Use the media to promote educational and prevention efforts after an accidental death occurs.*

The Injury Prevention Center at Dartmouth Hitchcock Medical Center responds to media inquiries in response to deaths from unintentional injuries. Depending on the specific situation, the Center may also issue an educational press release following such events. Various state agencies may also respond in a similar manner depending on the specific situation.

- *Encourage hospitals to offer up-to-date product safety information to new parents upon discharge.*

Providing up-to-date product safety information would be a time consuming activity, which would require hospitals to distribute recent Consumer Product Safety Commission (CPSC) recall notices to parents. This type of outreach would also not be an efficient way to reach parents who own a specific product. General home and product safety information is included in a “Growing Up Healthy” resource book, which is distributed by participating hospitals to all new parents, as well as through Department of Health and Human Services funded clinics and home visiting programs.

- *Support efforts for periodic public awareness campaigns targeting product safety.*

The Office of Community and Public Health’s Injury Prevention Program collaborates with the United States Consumer Products Safety Commission (CPSC) to implement awareness campaigns targeting product safety. The two programs collaborate on CPSC’s annual “Recall Round-Up” each June. The Injury Prevention Program is a resource to local media outlets following up on nationwide press releases issued by the CPSC. In June 2002, the Injury Prevention Program worked with the New Hampshire Campground Owners Association to develop and release an article discussing the hazards of portable kerosene heaters, which are widely used by campers.

- ***Review model legislation pertaining to thrift store product safety.***

Model legislation developed by the CPSC has been reviewed and deemed not to be feasible for New Hampshire. Currently, only the state of Illinois has any statutes applying to used products in general. However, educational efforts discussing safety issues with used products have been conducted by the Healthy Child Care New Hampshire initiative.

- ***Develop bereavement packets to be given to families in which a child has died suddenly and unexpectedly (age birth to 18).***

A workgroup consisting of parents whose children died suddenly and unexpectedly, a psychologist, a pediatric social worker, the Director of the Injury Prevention Center, the Coordinator of the New Hampshire Sudden Infant Death Syndrome (SIDS) Program, and the Chief Medical Examiner met to discuss and begin the development of a packet and review potential pieces. When completed, the packet will be provided by the New Hampshire SIDS Program for distribution by the Office of the Chief Medical Examiner to newly bereaved families where a child has died suddenly and unexpectedly from a cause other than SIDS.

- ***Enhance primary care physicians' awareness of and education about the need for counseling to accompany use of psychotropic drugs.***

There has been no specific action taken on this to date.

- ***Collaborate with the Office of the Chief Medical Examiner (OCME) to review the existing SIDS program and determine the feasibility of expanding that program to include the provision of services to families and communities impacted by the sudden and unexpected death of a child.***

The current practice of the Department of Health and Human Services' SIDS Program is to provide information, resources and support services including home visits by trained local community health nurses only for those deaths suspected to be from SIDS. Expanding services would require additional resources, i.e. state and community level staff and a source for funding the coordination and direct services. The SIDS Program is currently developing a bereavement packet for such situations that would be distributed directly by the OCME as appropriate.

## ***B. EMERGENCY MEDICAL SERVICES***

- ***Support efforts to incorporate Risk Watch Programs (injury prevention/risk behavior) into existing school curricula statewide.***

The Department of Safety and the Emergency Medical Services for Children Program at the Children's Hospital at Dartmouth (ChaD) have partnered with seven schools to successfully implement the "Risk Watch" curriculum during the 2001-2002 school year.

Between seven and ten additional schools are committed to implement the curriculum during the next school year. The Department of Safety has also analyzed how the curriculum frameworks, may be used to increase the likelihood of schools adopting the curriculum.

- ***Provide training and re-certification in Basic First Aid and CPR to all middle and high school students.***

The Department of Education (DOE) encourages training in first aid through minimum standards in elementary and middle school health education but certification in these topics is not required. First aid and CPR are not part of the current minimum standards for high school. The DOE does not provide training directly to schools and does not have current plans to do so.

- ***Provide schools with materials relating to age appropriate safety issues (Risk Watch).***

The Risk Watch curriculum is made available at no cost to schools that have committed to implement all or part of the program and at-cost to other schools. In addition, the New Hampshire Child Health Month Coalition includes all school nurses in its annual “Child Health Month” mailing of educational materials, which includes injury prevention/safety materials every fall.

- ***Incorporate a lethality checklist into training curriculum for First Responders.***

There has been no progress on this recommendation.

### ***C. MENTAL HEALTH***

- ***Explore strategies to reduce waiting lists for community mental health centers.***

Eliminating waiting lists at community mental health centers remains a priority for the Division of Behavioral Health (DBH). DBH continues to have waiting lists episodically throughout the year due to persistent recruitment and retention issues.

- ***Support increased prevention programming through community mental health system.***

The Division of Behavioral Health, with its systems partners, has developed fourteen local early childhood mental health teams which are working to align resources for early identification and access to mental health services and supports. The teams are at various stages of development. These early childhood systems of care will develop slowly and are currently not a point for service access.

- ***Enhance primary care physicians’ awareness of and education about the need for counseling to accompany use of psychotropic drugs.***

The Division of Behavioral Health is initiating a pilot project through the Community Alliance Reform Effort (CARE NH) system of care grant initiative to develop a model to bring psychiatric consultation and education to the primary care community.

- ***Support the development and implementation of comprehensive school and community-based suicide prevention protocols.***

The Division of Behavioral Health is initiating pilot programs in at least two regions of the state to use a mental health screening tool with local schools. DBH is working with the Youth Suicide Prevention Advisory Assembly to support the development of pre- and post-vention suicide protocols.

- ***Encourage development of peer-outreach programs to target a wide range of high-risk issues facing youth.***

The Division of Behavioral Health, in conjunction with the Community Alliance Reform Effort (CARE NH), is in the second year of training youth who have been consumer of mental health services as peer leaders. These youth are trained to participate in peer outreach programs as well as many levels of advocacy for service system development.

#### ***D. EDUCATION***

- ***Support efforts to incorporate Risk Watch Programs (injury prevention/risk behavior) into existing school curricula statewide.***

The Department of Education is one of the participating State agencies (the Fire Marshall's office is the leader, with State Police and State EMS also participating) in the promotion and incorporation of the Risk Watch curriculum into schools, grades K-8. New Hampshire has completed its second year as a Risk Watch participant, with seven districts in the program. Last year, the schools documented an average 15% knowledge gain regarding unintentional injuries. Training has just been presented to ten additional districts that will conduct the program over the next school year.

- ***Provide schools with materials relating to age appropriate safety issues (Risk Watch).***

The Department of Education (DOE) is a Risk Watch participant and has, to this point, provided assistance in the form of staff in promoting the program and providing training. However, the program is growing rapidly and is in need of additional funding. The Fire Marshall's Office has requested \$4,200 from the Department to purchase student workbooks. The DOE business office is now examining this request.

- ***Provide training and re-certification in Basic First Aid and CPR to all middle and high school students.***

The Department of Education encourages training in first aid through minimum standards in elementary and middle school health education but certification in these topics is not required. First aid and CPR are not part of the current minimum standards for high school. The Department of Education does not provide training directly to schools and does not have current plans to do so.

- ***Support the development and implementation of comprehensive school and community-based suicide prevention protocols.***

The Department of Education maintains representation on the statewide Youth Suicide Prevention Advisory Assembly. This group consults with schools and community organizations to provide suicide prevention resources. Currently the group is embarking on a “Frameworks Project” and has hired a project manager to take the lead. Protocols for suicide prevention will be drafted in the next few months and pilot tested before broad dissemination.

## ***E. CHILD PROTECTIVE SERVICES***

- ***Establish a regional database for the border states of New Hampshire to include each state’s child protection agency (i.e. New Hampshire’s Division for Children, Youth and Families). This database would be accessible to DCYF, the Courts and hospitals.***

While New Hampshire DCYF has an automated case management information system, there has not been a commitment of resources available to pursue linkages with other states, courts or hospitals. However, for the past eight years, the New England Child Protection agencies have worked toward a goal of expeditiously sharing information of maltreatment concerns when the children are presently in a neighboring state and are considered to be currently at risk because of suspected child abuse/neglect. DCYF’s current practice, which has been reviewed and approved by the DCYF legal staff, is if a neighboring state’s child protection agency contacts New Hampshire DCYF regarding concerns of a child currently in that neighboring state, DCYF can provide information such as founded case information that confirms that the child had been harmed in New Hampshire by the same caretaker currently involved with the child. DCYF has agreements that the neighboring state will treat the confidential information in the same manner as New Hampshire DCYF.

- ***Explore lowering the standard for subsequent intervention when there is a prior finding of abuse.***

DCYF incorporated into its structured decision making assessments of child safety evidence of prior founded cases of abuse. Each case is still assessed according to the information provided on a specific allegation of abuse and neglect. DCYF staff must note in the record that a possible history of past findings has been explored in the context of each assessment.

- ***Explore consistent inclusion in the Child Protective Services Central Registry of people responsible for child fatalities due to abuse/neglect.***

Currently, the record of people found to be responsible for the abuse/neglect of a child is held in the central registry only when it is a result of a DCYF abuse/neglect assessment. At times individuals have been found to be responsible for the death of a child due to abuse/neglect by the criminal system, but not through DCYF, because in those cases there was no collateral DCYF assessment. Cases involving child fatalities when there are no other children in the household are not typically accepted for assessment as per recommendations made by DCYF legal staff. The reason for this is that while there may have been certain concerns about caretaker's actions that resulted in the death of a child, there are no current child protection issues; DCYF is a child protection agency responsible for civil matters as opposed to an investigative agency responsible for criminal matters. A person convicted of a crime resulting in the death of a child would be detected through a criminal record check which is mandated by RSA 170-E-3,7,29, and 170-G:8.

- ***Current legislation allows DCYF to expand assessments to include other children living in the home where abuse allegations have been reported. DCYF staff should continue to conduct interviews with all children in the home as part of an assessment.***

DCYF staff continues to conduct interviews with all children in the home as part of an assessment. RSA 169-C:34 mandates that DCYF determine in every report whether there is ..."cause to believe that any child in the household is abused or neglected". DCYF assessment structured decision-making policy asserts that we assess every child in the household.

- ***Review current DCYF central registry system to identify opportunities for improvement.***

The Central Registry was the subject of a review by a legislative committee in Spring 2002. As a result, legislation will take effect in January 2003, which will change the operation of the registry to reflect the recommendations of that committee. Senate Bill 409 will go into law relative to the length of time that reports of child abuse and neglect are maintained in the state's central registry. Under the bill, founded reports are still retained for seven years but an individual can petition the district court to have their name removed or expunged from the registry at prescribed intervals (after one year and thereafter, after three years). The bill also contains a provision, which makes it a violation level offense for an employer, other than those identified in statute, to require as a condition of employment, that the employee submit their name for a central registry check.

- ***Revise DCYF and Court Appointed Special Advocates (CASA) training curricula to require the inclusion of home safety information.***

DCYF has recently renewed its monthly meetings with CASA administrative staff to discuss policy and practice. Discussions are underway to develop a co-training with each respective staff that will include a review of the necessity of home safety assessment from a

public health perspective (evidence of lead pain; sleeping arrangements of newborns, etc.) to be incorporated into traditional child protection assessments.

#### ***F. DISTRICT COURT AND LAW ENFORCEMENT***

- ***Establish a statewide linking database for the Family Courts.***

Juvenile data by its nature is very restricted. The access to this data or data that is cross referenced to this is still in question. The number of family courts is limited and their status is in question. What has been learned in the limited number of family courts has resulted in numerous changes in all the courts in the family arena. A new computer based case management system is being set up. The Request For Proposal is just about to be released and work is progressing on the part of the court related to this recommendation.

#### ***G. LEGISLATION***

*There were no recommendations made for Legislation this year.*

#### ***H. CHILD FATALITY REVIEW COMMITTEE***

- ***Establish a sub-Committee to include members of the both the Child Fatality and Domestic Violence Fatality Review Committees to review the Senate Study Committee Report on DCYF.***

There has been no specific action taken on this recommendation to date.

- ***Convene a sub-Committee to discuss and develop home safety materials to be included in DCYF Training Curriculum.***

There has been no specific action taken on this recommendation to date.

- ***Offer workshops at the annual child abuse conference on child safety issues.***

There has been no specific action taken on this recommendation to date.

### **VI. 5 YEAR RETROSPECTIVE REVIEW**

For this year's report, the Committee decided to take the opportunity to reflect on the past four reports and review the recommendations and progress that has been made, or not, since the recommendations were first published. Due to the number of recommendations made over the years, the responses were broken into categories for reflection. They are listed below.

## ***A. PUBLIC HEALTH AND HEALTHCARE***

- ***Training professionals, including the media***

Numerous trainings have been provided to a variety of health professionals including first responders, hospital personnel, health care providers, and community health clinic staff. Training topics were selected in response to specific case review recommendations and included identifying child abuse, organ donation, Shaken Baby Syndrome and Sudden Infant Death Syndrome. A May 2000 conference for representatives of the media addressed the responsible reporting of youth suicide.

There has been no action taken to review and update the current Child Abuse and SIDS components of the Police Standards and Training Curriculum.

- ***Amending laws/supporting legislation***

In 2002 the New Hampshire Legislature amended sections of RSA 263 that pertain to youth operators of motor vehicles. The amendment increased, from three to six months, the time during which no more than one non-family member under age 25 is allowed in the vehicle. The holder of a youth operator license is now also required to remain conviction-free for twelve months before being allowed to apply for any other form of license.

As of August 2002, the NH Legislature is studying a bill to increase the number of children required to be restrained in booster seats while riding in a vehicle.

- ***Protocols/policies/guidelines/ tools***

Several significant protocols and training curricula were revised and updated with subsequent statewide stakeholder training sessions and informational mailings. These included protocols by the Attorney General's Task Force on Child Abuse and Neglect to standardize the medical examinations of children suspected of being abused, and protocols for suspected SIDS cases for hospital staff, developed by the state's Chief Medical Examiner and the SIDS Program Coordinator.

The "Frameworks" Project, funded by the NH Department of Health and Human Services, and the Suicide Prevention Partnership, is developing a set of eight discipline-specific, but interrelated, procedures for responding to suicidal events (attempts, ideation, and completed suicides) among youth. Community teams will receive training in the procedures, and then tailor them based on community resources and capacity. Pilot testing in two communities will occur in 2003, with statewide training and implementation in 2004.

There has been no action taken on the recommendation to encourage hospitals and other medical facilities to develop and implement protocols for dealing with non-patient unattended death.

- ***Activities pertaining to the Office of the Chief Medical Examiner***

The Office of the Chief Medical Examiner (OCME) continues to file a death certificate for cases without an immediately demonstrable cause of death, as "Pending further studies" until all test results are available, at which time an "Amended Death Certificate" listing the determined cause of death is issued. An "Undetermined" finding, for the cause and manner of the death of a child less than 18 years, is unusual, (four instances since the related recommendation was issued). Risk to siblings and other children in the home while a case is pending continues to be best handled by interdisciplinary cooperation among law enforcement and child protective services. The OCME aspires to conduct complete autopsies on all reportable deaths under age 18, including traumatic deaths, and/or those resulting from "high risk" behaviors. However, there is decided reluctance among some families toward an autopsy being performed, when the cause of death is already believed to be known.

- ***New or improved screening/referrals***

The WIC Nutrition Program has developed policies to address suspected child abuse or neglect among the families they serve, with documentation and follow up on children or parents whose behavior is of concern to the staff.

A recommendation to have school based health clinics provide risk assessments and referral services for identified high-risk students has not been accomplished, as no statewide system of funding has been identified. A flagging system, to be used by emergency room physicians to help track cases where child abuse is suspected, has been developed due to questionable legal implications. No specific action has been taken to encourage hospital staff and others involved in care of newborns to make referrals to the infant's primary care/community health provider when discharging newborns with identifiable risk factors.

- ***Improved communication/information sharing***

A public relations campaign will be implemented beginning in October 2002 to educate teens and parents about the changes to the youth motor vehicle operator law. A handout on this topic will also be included in the 2002 Child Health Month Coalition mailing, which reaches over 6,000 health and social service providers, school nurses and licensed child care providers.

To improve information sharing among appropriate care providers when there is a child involved with Child Protective Services and multiple systems, the current form used by DCYF needs to be revised.

No formal actions have been taken to encourage primary care and mental health providers to communicate more closely when working with shared clients identified as being at-risk.

- ***Improving access/ quality/quantity of existing services***

Home Visiting New Hampshire, a preventive program providing health, education, support and linkages to other community services to Medicaid eligible pregnant women and their families in their home, began in 2001 and is expanding in 2002 from 13 to 19 programs throughout the state.

## ***B. MENTAL HEALTH***

- ***Involvement in the Child Fatality Review Committee:***

With the passage of HB 1463, the Division of Behavioral Health is able to share case specific information relevant to Child Fatality Review Committee reviews.

- ***Abuse and Neglect Screening and Training***

The Division of Behavioral Health continues to support staff training in the areas of diagnosis and treatment of trauma as well as in reporting requirements when child abuse or neglect is suspected. Orientation for new staff in all programs at community mental health centers includes training on the legal and ethical mandates as well as reporting processes for suspected neglect and abuse. Community mental health centers are expected to prioritize services to youth involved with DCYF and Division for Juvenile Justice Services.

- ***Interagency Teams and Wraparound Service***

The Division of Behavioral Health continues to support the development of comprehensive community based systems of care for children who have serious emotional disturbance (SED) and their families. The primary initiatives for this purpose are the Community Alliance Reform Effort New Hampshire (CARE NH) and the fourteen infant mental health teams that continue to develop statewide. The interagency group, Children's Care Management Collaborative, consisting of administrators of children's programs from the Department of Education and Department of Health and Human Services supports these initiatives. Under the system of care initiatives, we continue to expand the availability of training on the wraparound process. The coordination of multi-agency supports and services through wraparound can occur in communities and schools.

- ***Work With Primary Care Providers***

The Division of Behavioral Health is initiating a pilot in one region to increase the relationship between community mental health centers and primary care providers in order to increase the availability of psychiatric and mental health services to youth.

- ***Outreach and Public Education***

The Division of Behavioral Health continues to work actively with National Alliance for the Mentally Ill (NAMI) New Hampshire on mental health awareness and an anti-stigma

campaign. Additionally, through CARE New Hampshire, Department of Behavioral Health is developing a comprehensive public information campaign to heighten communities' awareness of the mental health needs of their youth.

- ***Development of Prevention Activities and the Reduction of Waiting Lists***

The Division of Behavioral Health continues to share with the rest of the nation issues around funding for its community mental health systems. The Department has not succeeded in eliminating waiting lists at New Hampshire's community mental health centers. In FY 1995, public health centers served 6,409 children and youth. In FY 2001 they served 11,165 youth, an increase of almost 75%. The Department of Behavioral Health continues to develop plans for early identification and intervention for the early childhood population. The Department has not been able to develop a more comprehensive approach to early intervention and prevention or expanded approaches to treatment of youth diagnosed with both mental health and substance abuse issues, due to fiscal constraints.

#### ***D. EDUCATION***

- ***Data Collection and Sharing***

The New Hampshire Department of Education (DOE) continues to administer the Youth Risk Behavior Survey every other year to monitor priority health-risk behaviors that contribute to the leading causes of mortality, morbidity, and social problems among youth in New Hampshire. Findings are extensively shared with school districts and other interested groups and the results are used to develop and strengthen policies and school-based programs.

The DOE monitors the current status of school health education at the middle/junior and senior high schools level are used to develop and strengthen policies and school based programs.

Findings regarding child fatality trends and patterns have been shared with the members of the New Hampshire Department of Education's Safe Schools Committee, as well as school administrators. A comprehensive tool to assess the safety of schools was adapted by this group and distributed to school administrators in the spring of 1999. In addition, the Safe School Committee now has a web site linked to the DOE that will provide a variety of resources for districts.

- ***Training, Outreach and Public Education***

The School Health Service Manual, issued to all school nurses, contains the training protocol for reporting suspected cases of child abuse and neglect.

School nurses who are on the New Hampshire School Nurse List Serve were offered Child Abuse Prevention Packets to help plan various prevention activities. Approximately

40 nurses requested these packets. In addition, school nurses attending conferences over the winter of 1999 were also offered these packets.

With regard to driver's education, DOE's role has not been to directly provide education to parents but rather to share information with local programs so that they can conduct parent nights to solicit parent participation in teaching their children. A pamphlet "It's Your Choice Too" has been produced by the Governor's Highway Safety Agency and its use has been promoted by the Department of Education.

Annual conferences and workshops sponsored by the DOE or jointly sponsored with other organizations, continue to address pertinent issues. DOE provides information on new instructional materials and technology changes to enhance local programs and continues to serve as a lending resource center for some audiovisual and instructional materials. The agency has also promoted numerous programs such as the Sharing the Highway large vehicle awareness program with the New Hampshire Motor Transport Association and the Safety Belt Challenge with the New Hampshire Highway Safety Agency.

The New Hampshire Department of Education encourages school districts to avail themselves of the free training program in emergency management and crisis response provided by the New Hampshire Office of Emergency Management. Over one-third (1/3) of school districts in the state have participated in the program to date which is now being modeled in other states. The State Department of Education has also provided numerous copies of a crisis management booklet to School Guidance Counselors.

Through federal grant funds, the New Hampshire Department of Education provides districts with financial resources to acquire the services of qualified personnel who can help them develop appropriate policies and protocols for risk assessment for harmful behavior of at risk youth facing suspension or expulsion. The School Health Resource Manual (2000) also includes a variety of risk assessment models and recommendations to minimize risk. Information and resources are also disseminated to school Guidance Counselors via the Department of Education Office of Guidance and Counseling Web Page.

This issue of promoting increased access to mental health counseling through Medicaid funding, has not specifically been address by the DOE. However, the School Health Resources Manual (2000) does include a section describing a variety of Mental Health Disorders, indicating the signs and symptoms of the disorder, how common it is, who is at risk, what help is available for families and what parents can do.

- ***Legislation***

The Department of Education has supported the implementation of recent legislation, House Bill 491, requiring 20 hours of documented parent practice with a new driver for adolescents.

- ***Program, Policies and Procedures***

DOE supports the provision of quality driver education programs for beginning drivers in both the secondary and commercial motor vehicle driving schools through teacher certification activities; support of various professional development programs; development and provision of resources to support course content and delivery; and by providing technical assistance to local programs. DOE works with Keene State College to insure delivery of an appropriate, comprehensive teacher preparation program.

The DOE has endorsed DCYF's child abuse prevention protocols. A School Health Resource Manual released in April 2000 includes the protocols and provides a series of questions and answers about the state's requirements.

No written guidelines have been produced addressing the unique considerations of teens with special education issues who are preparing to become licensed drivers but guidance has been offered via multiple professionals development opportunities sponsored by the Department of Education. Special education teachers and professionals from the driver rehabilitation community have provided these trainings geared for driver education instructors.

The DOE does not endorse sharing the names of students who have not passed driver education courses with private companies due to privacy concerns. This recommendation has thereby not been addressed.

A School Health Resource Manual was issued to all school in March, 2000 that included a variety of medical and mental health guidelines. Frameworks for prevention and asset and asset building were included to assist staff to proactively prevent teenage sexual activity and other high-risk behaviors. Statewide guidelines to assist schools for responding to teenage pregnancy have not yet been issued.

National guidelines to promote confidentiality were shared broadly with school nurses in the state via formal presentations, discussions at meetings and individual consultation by the state school nurse consultant. Discussions with other school administrative personnel have also occurred. Many schools have begun to update confidentiality policies as a result. A model policy related to Confidentiality of Health Information in Schools was included in the School Health Resource Manual (2000).

Through federal grant funds, the New Hampshire Department of Education assists districts in providing risk assessment and referral services for identified high-risk students. Approximately \$600,000 is awarded to districts annually for the purpose of promoting a school-based and/or school linked health clinic approach to include health education, reproductive health education and a mental health care component that provides risk assessment and referral services for identified high risk students.

Through federal funds distributed by the Department of Education, there are a few districts that conduct mandatory parent programs as a condition of a suspension being reduced or as a condition of re-entry into school.

## **H. CHILD PROTECTIVE SERVICES**

- **Legislation**

New legislation was introduced and signed by the Governor May 15, 2002 to be in effect November 15, 2002, pertaining to destruction of DCYF's records. This legislation mandates DCYF to retain a screened out report for one year after which the department shall destroy all electronic and paper records of the report. The department shall retain an unfounded report for three years from the date the department determined the report unfounded, at which time, the department shall delete or destroy all electronic and paper records of the report. The department shall retain a founded report for seven years from the date the person has exhausted or failed to exercise his or her due process rights to appeal the determination of the founded report, after which time the department shall delete or destroy all electronic and paper record of that report. This will preclude the Division for Children Youth and Family from keeping records of founded perpetrators in our Central Registry for a longer time as well as keeping records of unfounded reports where children may be at risk of future harm.

- **Policy**

In 1999, DCYF embarked on a significant child protection practice reforms effort in New Hampshire. DCYF worked with the Children's Research Center (CRC), a division of the National Council on Crime and Delinquency (NCCD) to develop and train staff on a research based methodology for acquiring a greater deal of consistency, objectivity, and validity in child protection case decisions. Called Structured Decision Making Model (SDM) DCYF implemented this practice change in December 2001. SDM is a research-based model that has a number of assessment tools to be used by different Child Protection Social Worker (CPSW) categories – assessment, permanency and reunification. SDM, gives clear and objective criteria for screening of abuse/neglect reports regardless of reporter category. DCYF's revised assessment policy with the addition of the newly implemented Structured Decision Making practice requires each assessment CPSW to conduct face-to-face contacts with each child and adult in the household.

Additionally, DCYF is revising the intake policy to better address DCYF's response to children living in households with Domestic Violence and, in cases where CPSWs cannot gain access to interview children to assess the immediate safety concerns in an abuse/neglect report. The policy will direct the CPSW to file an abuse/neglect petition in court instead of a motion to enter.

In the spring of 2002, DCYF created the Clinical Service Unit at State Office. This unit is a coordinated effort by DCYF to increase the clinical support to the field and improve access and coordination of behavioral health, educational services, and medical services to the children DCYF serves. The Unit includes a Clinical Administrator, a Senior Psychiatric Social Worker and the Foster Care Health Nurses.

DCYF continues to conduct internal Quality Assurance Case reviews in circumstance involving cases of child deaths or children with serious injuries.

DCYF is in the process of developing a Memorandum of Agreement between DCYF and the new Division for Juvenile Justice Services with the intent of assuring case coordination, and continuity of services in cases which jointly involve child protective and delinquency concerns.

- ***Staffing***

DCYF continues to address issues of recruitment and retention of professional child protection staff. According to national standards set by the Council on Accreditation for Children and Families Services, DCYF's staff to workload and staff to supervisor ratios still exceed the national standard. In the spring of 2002, DCYF was allocated funds to add 22 new assessment CPSWs, increasing the assessment staff state-wide by 28%. All District Offices in the state will be assigned at least one additional assessment staff. These positions will be in place during the summer of 2002. This effort will increase the potential for assigning assessments to a different CPSW in the case of multiple prior unfounded reports. Insufficient staffing levels in the various District Offices have in many instances precluded the supervisor from considering assignment to another CPSW.

DCYF has co-located Domestic Violence Program Specialists (DVPS) in each District Office assisting the CPSW with additional services to families experiencing domestic violence. A memorandum of agreement has been signed between DCYF and the New Hampshire Coalition against Domestic and Sexual Violence, which includes goals for reaching a common understanding of the Domestic Violence Program Specialists, regular communication between local crisis centers and child protection staff, and regular review of DCYF protocols concerning domestic violence. This memorandum of agreement will also be signed at each DCYF field office and community crisis center involved in the DVPS initiative. DCYF field staff and local crisis centers are currently drafting a standardized referral protocol that will define the roles and responsibilities of the Domestic Violence Program Specialists and the CPSWs when working jointly with open cases and assessments.

- ***Education***

DCYF has in various ways expanded efforts to educate and train the professional community regarding abuse/neglect criteria and the reporting law. DCYF Administrators have held Community Forums in each District Office in which members of the community, stakeholders and politicians were invited to attend. The purpose of the Forums was to present the newly implemented SDM practice effort, provide community-wide child protection statistics and demographic information and review the mandatory reporting policies and protocols. DCYF staff is attending annual Kids Safe Trainings where representatives from a variety of professionals are informed and educated on community – wide practices to enhance child safety. Every District Office has a Program Manager who in conjunction with the DCYF District Office Supervisor is responsible for reaching out to the community and conducting community education.

DCYF is taking part in the DHHS statewide effort to increase awareness of substance abuse by offering training to CPSW's on an on-going basis. In addition, DCYF, in conjunction with the University of New Hampshire Family Research Lab is conducting a five year demonstration project in the Manchester and Nashua District Offices offering substance abuse evaluation, treatment coordination and follow-up to clients with substance abuse as an identified risk factor.

DCYF Management staff worked with the Children's Research Center to develop new District Office Child Protection Supervisory Standards. These standards clearly delineate work performance expectations for supervisors encompassing local-level responsibility for leadership, education, management and service delivery in child protective services. Based on these standards, a competency-based supervisory training curriculum for all current and newly hired Supervisors was developed. The first eighteen – day training module was presented over the course of nine months in 2002. The second training module is scheduled to begin January 2003.

- ***Programming***

The impact of the parental reimbursement requirement has been explored by DCYF. The counties have implemented a sliding fee scale for parental reimbursement that takes into account parent's ability to pay. DCYF is also coordinating and communicating with the Division for Child Support in cases where parents are involved with both divisions with the intent of not having families unduly burdened financially by this requirement.

DCYF is continuing to fund comprehensive community-based family support programs through the Federal Family Preservation [now called Safe and Stable Families] funding. DCYF has also expanded its capacity to service families where there are no safety concerns through time limited voluntary service cases.

The Portsmouth District Office is the site for the pilot program Permanency Plus. It is an intensive reunification program with collaboration between DCYF, Easter Seals and Family Strength. The Program has significantly decreased the length of stay in foster care, increased the quality of service delivery to children in placement and provided placement stability.

## ***E. LAW ENFORCEMENT***

- ***Education***

The New Hampshire Police Academy teaches RSA 318-B:26 to the basic full time and part time Academies. As part of this curriculum, the Academy continues to review this complete statute including the liability part as it related to those who dispense drugs. They also review this statute in their classes specific to Drug Investigations and Drug Identification.

- ***Case Information and Sharing***

The federally funded demonstration site, the Greenbook Project in Grafton County, will allow an in-depth exploration of the information sharing and collaborations between courts, DCYF and domestic violence organizations. Some of the recommendations and issues this pilot project is exploring are: establishing a central data base or mechanism for compiling and providing information on any or all prior hearings including DCYF cases, family, civil and criminal court proceedings and the records of the same from other states.

Consensus could not be reached on how to address another recommendation: the improvement of case information management by having one court oversee the records relating to multi-system involved families, i.e. juvenile, abuse and neglect and CHINS.

Increasing multidisciplinary access to records, including court findings (probate, family, district ), and ensuring that courts are filing reports to DCYF when abuse or suspicion of abuse is indicated on Domestic Violence Petitions is still being explored. To date the judiciary has not made a decision on this issue.

Regarding the development of policies requiring that all service provider record be sent directly to the court and establishing a comprehensive case management which requires that all previous medical, mental health, residential and/or other provider records be accessed and reviewed by those in decision making roles, i.e. the courts, DCYF, CASA. As a matter of process the courts, DCYF and CASA will request the records if they feel that it is necessary to the case. It is not clear how they would know that these records even exist. The legality of whether or not this disclosure can be allowed is being explored.

Some recommendations that have been made over the years are still being explored. For instance, the legalities of releasing mental health reports on court involved families to the courts in addition to the Juvenile Service Officer (JSO) is still being determined.

- ***Policies***

The recommendation made, that parents be required to attend a certain number of parent education seminars when child abuse and neglect, CHINS, and/or juvenile petitions or school suspensions are involved, is still being evaluated. There are many issues that need to be considered including logistics, funding and penalty issues. At this time this remains merely a recommendation.

## **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.

At the end of each year, the appropriate agencies are asked to respond to the recommendations generated from the prior year's reviews. These responses are published in the subsequent year's annual report. Responses to the recommendations published in The Fifth Annual Report to the Governor begins on page sixteen of this report.

**APPENDIX B: EXECUTIVE ORDER**



## **APPENDIX C: INTERAGENCY AGREEMENT**



**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:

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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.

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Print Name

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Authorized Signature

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Witness

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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. 5106a(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**

Cause of Death Group	ICD-10 Code
Certain Infectious and Parasitic Diseases	A00 - B99
Neoplasms	C00 - D48
Endocrine, Nutritional, and Metabolic Diseases	E00 - E90
Diseases of the Nervous System	G00 - G99
Diseases of the Circulatory System	I00 - I99
Diseases of the Respiratory System	J00 - J99
Diseases of the Digestive System	K00 - K93
Certain Conditions Originating in the Perinatal Period	<b>P00 - P96</b>
Newborn affected by maternal factors and by complications of pregnancy, labor, and delivery	P00 - P04
Disorders related to length of gestation and fetal malnutrition	P05 - P08
Respiratory and Cardiovascular disorders specific to the perinatal period	P20 - P29
Congenital malformations, deformations, and chromosomal abnormalities	Q00 - Q99
Sudden Infant Death Syndrome (SIDS)	R95
Other ill-defined and unspecified causes of mortality	R99
Unintentional Injury	<b>V01 - X59</b>
Drowning	W65 - W74
Fall	W00 - W19
Fire/Burn	X00 - X19
Motor Vehicle Crashes, Occupants (includes both driver and passenger)	V20 - V89
Motor Vehicle Crashes, Pedestrian	V02 - V04, V09
Motor Vehicle Crashes, Pedal Cyclist	V12 - V14, V19
Suffocation	W75 - W84
Suicide	<b>X60 - X84</b>
Firearms	X72 - X74
Hanging	X70
Poisoning	X60 - X69
Homicide	<b>X85 - Y09</b>
Firearm	X93 - X95
Hanging, suffocation, strangulation	X91
Other maltreatment syndromes	Y07

