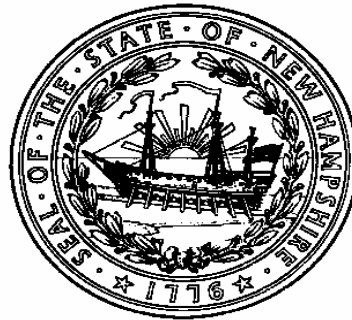


THE STATE OF NEW HAMPSHIRE



CHILD FATALITY REVIEW COMMITTEE

EIGHTH ANNUAL REPORT

*Presented to
The Honorable John H. Lynch
Governor, State of New Hampshire
October 2005*

Funding for this report and for the activities of the Child Fatality Review Committee comes from the U.S. Department of Health and Human Services Administration on Children, Youth and Families through the Children's Justice Act Grant (#G-02NHCJA1) which is administered by the New Hampshire Department of Justice.

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DEDICATION

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

LETTER FROM THE NATIONAL CENTER

Child Death Review - A Short History of Our Response
Michael Durfee MD,- June 2005

Fatal child abuse/neglect is ancient. Systematic response came later. Auguste Ambroise Tardieu, a French pathologist studied child homicide and wrote *Étude médico-légale sur l'infanticide*. in 1868. His work was well received but caused little social change. The medical literature, Index Medicus, did not index Child abuse until 1965 and Infanticide in 1970 about the time that Child Protective Services became a recognized profession. News in the 1990s, almost all from female reporters, spoke of a "new" phenomenon, parents killing children. .

The first Child Death Review team in 1978 was housed in the LA County Interagency Council on Child Abuse and Neglect, ICAN. The process was based in part on adult death review in hospitals and multi-agency child abuse teams. The initial model of core multi-agency membership, inclusive intake, systematic review, and public reports with data with recommendations continues today.

Responses grew with time. San Diego formed a team in 1982. Other California Counties were followed in the mid 1980s by other states and a public health model, Fetal Infant Mortality Review (FIMR). The last state joined in 2001. ICAN NCFR became the National Center for Child Fatality Review in 1996 with support from USDOJ. HRSA formed a second national center in Michigan in 2003.

Australia, Canada, New Zealand and the Philippines have teams with other nations underway. 150 Nations have visited the ICAN NCFR web site, ican-ncfr.org. Almost 1,000 teams internationally address fatal family violence, adding Domestic Violence Fatality Review and Fatal Elder Abuse review.

New Hampshire as well as some other counties and states now review all child deaths from all causes. Various teams added new programs including state wide integrated systems, multi-county regional teams, sophisticated pediatric forensic literature and community based prevention programs. New Hampshire, Vermont and Maine created a model for multi-state prevention across state lines.

New prevention programs focus on, the hazards of co-sleeping, the hazards of shaking babies and safe surrender to avoid abandoned newborn.. Schools are learning to address suicide. Grief support programs are developing for surviving children. Data systems and the Internet connect professions and states.

Technology provides tools but human relationships between team members remain the center of child death review. Child death review provides profound lessons, when we listen and work together. Dr.Tardieu would be pleased.



NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

Dear Friends of New Hampshire's Children:

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

The following is the Committee's Eight Annual Report. This report reviews the work of the Committee for the calendar year 2004 and presents fatality data for the calendar year 2003 that has been collected and analyzed by the Health Statistics and Data Management Section (HSDMS), Bureau of Disease Control and Health Statistics, Division of Public Health Services, Department of Health and Human Services. We have also included, a look at three years (2001 – 2003) of data. Since there are relatively few child fatalities in New Hampshire each year, we hope that a three-year data analysis will present a better look at any trends.

This report has two new additions. We have included a letter from Dr. Michael Durfee, who is the Chief Consultant to the Interagency Council on Child Abuse and Neglect and the "father" of child death review. Included also are brief descriptions from the CASA program and a representative of the Public Health sector on how their agencies fit into the child death review process. We plan on having two of our representatives give a brief overview of their work and relevance to the committee's work in each of our annual reports. We hope that this will give the reader of this and subsequent reports a better sense of the rationale for the make-up of membership of the committee.

As in previous years, members of the New Hampshire Child Fatality Review Committee have made presentations in New Hampshire and nationally on the issues of child fatalities and on the work of the New Hampshire committee. We have been recognized nationally for our work and many states are interested in learning more about how we conduct our reviews and how we gather and respond to recommendations generated by these reviews. Additionally we meet annually with the teams from Maine and Vermont to conduct joint reviews and to talk about ways to make our work more efficient and effective. Last September we conducted a joint review with the New Hampshire Domestic Violence Fatality Review Committee and are one of the few state teams to conduct such joint review.

As Chair, I would like to acknowledge the hard work and dedication of the members of the Committee. Through their commitment, we have been able to build a collaborative network to foster teamwork and share the recommendations with the larger community. I would also like to thank David Reichel, Injury Surveillance Manager from the Health Statistics and Data Management Section of the Division of Public Health Services for obtaining and analyzing the data for this report.

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

On behalf of the Committee,

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

THE NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

MISSION STATEMENT

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

OBJECTIVES

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

CHILD FATALITY REVIEW COMMITTEE MEMBERSHIP

January to December 2004

Chair: Marc Clement, PhD
Colby-Sawyer College

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

Paul Boisseau, Executive Secretary
NH Board of Pharmacy

*George Bowesoxm
NH Board of Pharmacy

William Boyle, MD
Dartmouth Hitchcock Medical Center

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

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

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

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

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

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

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

Trooper Scott Gilbert
NH State Police
NH Department of Safety

*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

*Susan Meagher
CASA of New Hampshire

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

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

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

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

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

Robert Reece, MD
Children's Hospital at Dartmouth
Dartmouth Hitchcock Medical Center

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

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

Marcia Sink, Executive Director

CASA of New Hampshire
Paul Spivack, MDHitchcock Clinic

Robert Stafford
NH Police Standards and Training Council

Jeffery Strelzin, Senior Attorney General
NH Department of Justice

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

*=Alternate

I. EXECUTIVE SUMMARY

This report reflects the work of the Committee during the 2004 calendar year. The work of the Committee and the purpose of the recommendations that are produced during the reviews are to reduce the preventable child fatalities in New Hampshire. Last year's Seventh Annual Report summarized the work of the 2003 calendar year and provided detailed data summaries for the most recent year of data available, 2002.

This report begins with the Committee's Mission Statement and Objectives followed by a listing of the Committee members and their affiliations. Following the Statement of Accountability, are two short reports from members of the Committee on their work on the New Hampshire Child Fatality Review Committee, followed by the review and analysis of the 2003 New Hampshire child fatality data and a look at the last three years of data (2001 – 2003). The recommendations and finding from the 2004 reviews are presented along with the responses to the 2003 findings and recommendations.

II. STATEMENT OF ACCOUNTABILITY

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

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

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

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

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

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

During the operating year of 2004 the Committee met to review seven cases that included death by suicide, accidental overdose, accidental asphyxiation and car accident. The process by which cases are reviewed is outlined in Appendix F: Case Review Protocol. The right to confidentiality for families who lost children is respected in the work of the Committee.

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

III. AGENCY VIGNETTES

The Committee is comprised of professionals from the medical, law enforcement, judicial, legal, victim services, public health, mental health, child protection, and education communities. For this report two of the representing agencies were asked to describe their agency's participation on the Committee. The agencies selected are Court Appointed Special Advocates (CASA) and New Hampshire Department Of Health And Human Services, Division of Public Health Services.

A. CASA

Being able to look at the tragic death of children, whether accidental or deliberate, has given us a deeper understanding of many of the issues that surround the critical work that we at CASA do in our advocacy do in our advocacy for young victims.

The child fatality review process and analysis, as well as this report, help to illustrate how a multitude of systems how a multiple of systems, including the CASA program, can better address, when possible, the very real needs of families in New Hampshire.

We will never be able to prevent all child deaths, tragedies will continue to occur regardless of how long and hard we look at these cases. However as a result of this collaborative, multidisciplinary review, the "systems" that touch the lives of children at risk will be better equipped to interrupt certain patterns and break cycles that may have led to the death of more of our children. Our work will never be complete, the lives of children will continue to end unnecessarily, however this state is not allowing the death of any children to remain a silent tragedy.

**B. NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES,
DIVISION OF PUBLIC HEALTH SERVICES**

The New Hampshire Department of Health and Human Services (DHHS), Division of Public Health Services, has been a key member of the Child Fatality Review Committee since the Committee began in 1996.

Division staff provide a link between public health and clinical practice, especially to those in state and federally funded community health centers, prenatal, child health and home visiting programs that provide services primarily to low income, un/under-insured women, adolescents and children, and services provided to children with special health care needs. Participating staff also represent specialized programs such as the Division's Injury Prevention Program and the Sudden Infant Death Syndrome (SIDS) program, which impact a broader, more population-based audience in developing educational material, training, and specific projects targeting identified needs or health priorities, such as safe sleeping for infants, youth suicide, motor vehicle accidents, etc.

Over the years, many recommendations that have come forth from case reviews by the Child Fatality Review Committee have been directly implemented by the Division of Public Health Services. Some have had a more indirect impact, such as review of the Women, Infants and Children (WIC) Nutrition Program policy for screening and referring at-risk children. Protocols for suspected cases of Sudden Infant Death Syndrome (SIDS) were developed and distributed to hospitals and medical providers statewide with a follow up survey assessing impact and use, and, the SIDS Program Coordinator worked with the Chief Medical Examiner and the Director of the state's Emergency Medical Services to carry out a series of train-the-trainer in-services on SIDS.

For other committee recommendations, Division of Public Health Services representatives collaborated with coalitions or workgroups in which they were members to impact change. Through the Youth Suicide Prevention Assembly, a daylong workshop was held for the media on responsible reporting of youth suicide. Through the work of the state's Child Health Month Coalition, a handout was developed and distributed to over 5,000 health, social service, child care and school professionals on the dangers of games resulting in accidental asphyxiation. A handout on the dangers of infants sharing beds or couches during sleep with an adult will be distributed in the fall 2005 Child Health Month Coalition packet, in follow up to the review of several such deaths. Through participation on the Child Fatality Review Committee, Division of Public Health staff can learn of health issues that need attention and carry out strategies via public health infrastructure-level and population-based actions, which can reduce risks and work to prevent further deaths from occurring.

IV. REVIEW AND ANALYSIS OF DATA

A. CHILD FATALITIES IN NEW HAMPSHIRE - 2003

This report contains information on deaths of New Hampshire residents, ages 0-18. In the year 2003, there were 111 child deaths. Of this number 72% were due to natural causes and 28% were due to injuries. Of the injury deaths, 81% were unintentional injuries (i.e. motor vehicle traffic crashes, drownings, fires, etc.) 16% were deaths by suicide and 3% were homicide.

The analysis in this report is based on vital statistics death data from the New Hampshire Bureau of Vital Records of the Secretary of State's Office.

The Health Statistics and Data Management Section (HSDMS), Bureau of Disease Control and Health Statistics, Division of Public Health Services, Department of Health and Human Services completed the data analysis for this report. The Bureau's mission is to acquire and maintain complete and accurate health data for analysis and dissemination to New Hampshire communities.

This report presents deaths among children who are residents of New Hampshire. The data can be broken into two major classifications of death, natural causes and injuries. Both types of deaths are analyzed in this report. For a list of the codes used for classifications of these deaths, please see Appendix G.

During 2003, 72% of all child deaths were due to natural causes. Infants (<1 year) represented 50% of all natural deaths among children through age 18 (See Table 1). Adolescents account for the majority of injury-related deaths, with deaths from unintentional injuries more frequent than those from intentional (i.e. homicide and suicide) injuries.

Table 1

New Hampshire Resident Natural and Injury Deaths by Age Groups 0-18, 2003

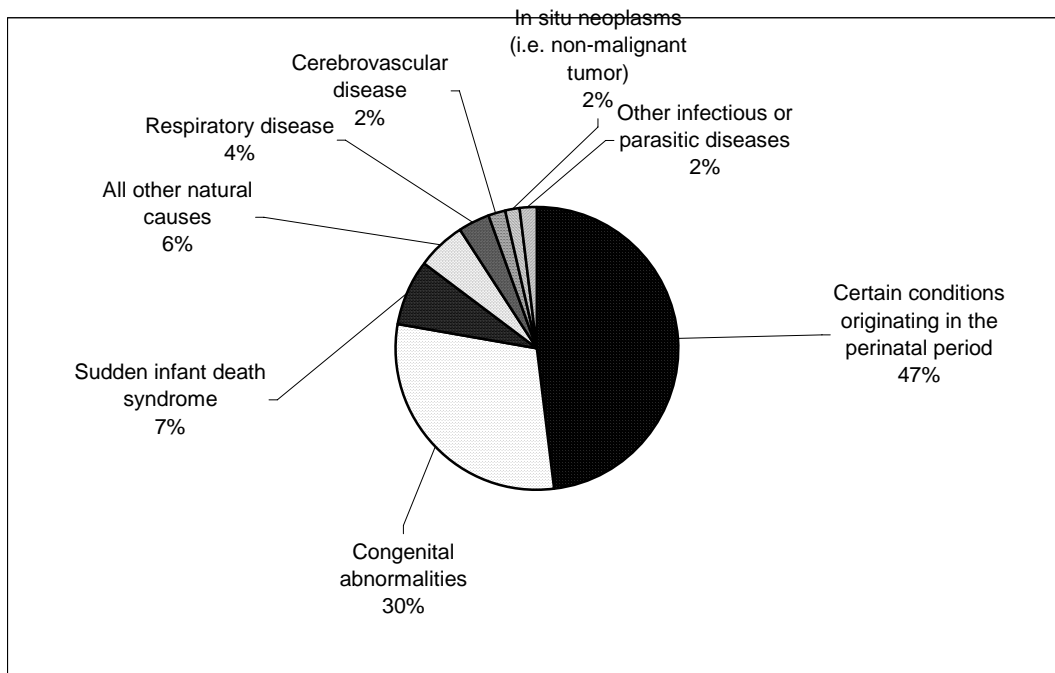
Age Group	Natural	Injury	Total
<1	54	2	56 (50%)
1 - 4	7	3	10 (9%)
5 - 9	5	2	7 (6%)
10 - 14	5	5	10 (9%)
15 - 18	9	19	28 (25%)
Total	80 (72%)	31 (28%)	111

Infants are more likely to die from natural causes than older children. The major cause of death for infants is “Certain Conditions Originating in the Perinatal Period” which makes up 47% of all natural infant deaths. “Congenital Abnormalities” and “Sudden Infant Death Syndrome (SIDS)” are the next two leading causes of natural death for infants (See Table 2 and Figure 1).

Table 2
New Hampshire Resident Deaths by
Natural Causes, <1 year of age, 2003

Natural Cause of Death	<1 Yr
Certain conditions originating in the perinatal period	26
Congenital abnormalities	16
Sudden infant death syndrome	4
All other natural causes	3
Respiratory disease	2
Cerebrovascular disease	1
In situ neoplasms (i.e. non-malignant tumor)	1
Other infectious or parasitic diseases	1
Total	54

Figure 1

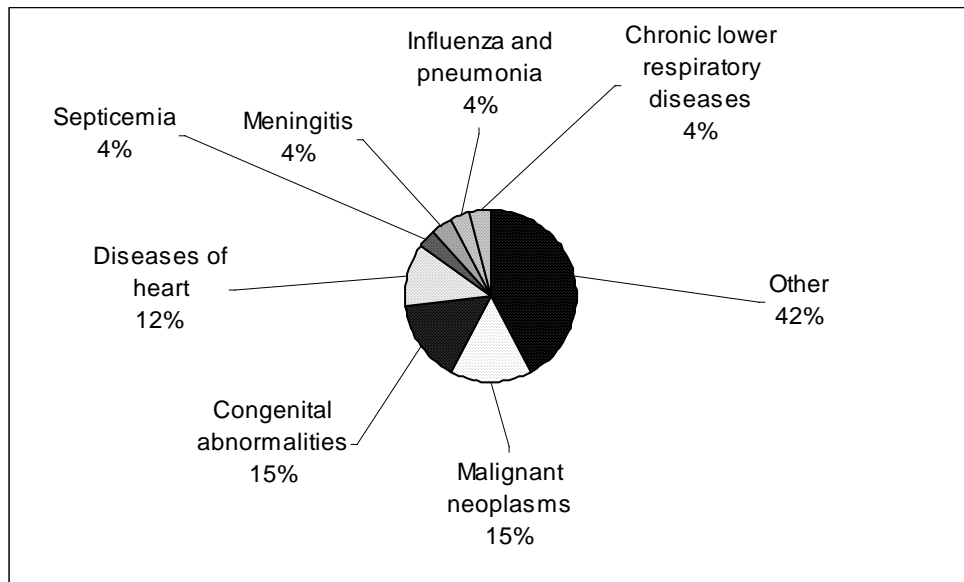


Neoplasms (malignant tumors) are the leading cause of natural death for children ages 1-18, responsible for 26% of the natural deaths. Most of the other natural causes of death for this age group are spread out among many different causes. (Table 3 and Figure 2).

Table 3
New Hampshire Resident Deaths by Natural Causes,
ages 1-18 years, 2003

Natural Cause of Death	1-18 yrs
Other	11
Malignant neoplasms	4
Congenital abnormalities	4
Diseases of heart	3
Septicemia	1
Meningitis	1
Influenza and pneumonia	1
Chronic lower respiratory diseases	1
Total	26

Figure 2



The majority of the deaths of older children are due to injury. Motor vehicle traffic crashes are the leading cause of death for children and adolescents in both New Hampshire and the United States. The use of age-appropriate restraints, such as infant and booster seats, reduces the risk of serious injury or death from crashes. Beginning January 1, 2004, New Hampshire state law requires that all children up to age 18 be restrained in some way and that they be in approved child safety seats if they are less than 6 years old and less than 55 inches (RSA 265:107-a).

In New Hampshire, suicides account for a number of adolescent deaths. The mechanisms of suicide deaths are firearms, suffocation (hanging), and poisoning (See Table 4).

Table 4
New Hampshire Resident Injury Deaths by Intent, Mechanism, and Age Group, 2003

Unintentional Injuries

Cause of Death	<1	1 - 4	5 - 9	10 - 14	15 - 18	Total
Drowning	-	1	1	1	1	4
Fire/hot object or substance-fire/flame	-	-	-	1	-	1
Firearm	-	-	-	-	1	1
Motor vehicle traffic	-	2	-	1	12	15
Other land transport	-	-	-	1	-	1
Other transport	-	-	1	1	-	2
Suffocation	1	-	-	-	-	1
Total - Unintentional Injuries	1	3	2	5	14	25 (81%)

Suicide

Cause of Death	<1	1 - 4	5 - 9	10 - 14	15 - 18	Total
Firearm	-	-	-	-	1	1
Poisoning	-	-	-	-	1	1
Suffocation	-	-	-	-	3	3
Total - Suicide	-	-	-	-	5	5 (16%)

Homicide

Cause of Death	<1	1 - 4	5 - 9	10 - 14	15 - 18	Total
Other specified classifiable	1	-	-	-	-	1
Total - Homicide	1	-	-	-	-	1 (3%)

Looking at Table 5, male children are more likely than female children to die from injury. In 2003, almost three times as many males died from unintentional injury than females.

Table 5
New Hampshire Resident Injury Deaths
by Intent, Gender, and Age Group,
Ages 0-18, 2003

Unintentional Injury Deaths

Age Group	Male	Female	Total
<1	0	1	1
1 - 4	3	0	3
5 - 9	2	0	2
10 - 14	4	1	5
15 - 18	10	4	14
Total	19	6	25

Suicide

Age Group	Male	Female	Total
15 - 18	3	2	5
Total	3	2	5

Homicide

Age Group	Male	Female	Total
<1	1	0	1
Total	1	0	1

All Injury Deaths (All Intentions)

Age Group	Male	Female	Total
Total	23 (74%)	8 (26%)	31

Table 6 gives specific information on the causes of death for infants (less than age 1). “Congenital malformations, deformations and chromosomal abnormalities” are responsible for almost 30% of all infant deaths. “Disorders related to short gestation and low birth weight, not elsewhere classified” are the second leading cause of infant death responsible for 19% of infant deaths.

Table 6
New Hampshire Resident Deaths by Cause of Death for
Infants <1 year of age, 2003

Natural Cause of Death	Count
Congenital malformations, deformations and chromosomal abnormalities	16
Disorders related to short gestation and low birth weight, not elsewhere classified	11
Other ill-defined and unspecified causes	5
Sudden infant death syndrome	4
Newborn affected by complications of placenta, cord and membranes	3
Bacterial sepsis of newborn	2
Intrauterine hypoxia and birth asphyxia	2
Necrotizing enterocolitis of newborn	2
Neonatal hemorrhage	2
Congenital pneumonia	1
Diseases of the circulatory system	1
Gastritis, duodenitis, and noninfective enteritis and colitis	1
In situ neoplasms, benign neoplasms, neoplasms of uncertain or unknown behavior	1
Influenza and pneumonia	1
Newborn affected by maternal complications of pregnancy	1
Newborn affected by noxious influences transmitted via placenta or breast milk	1
Accidents (unintentional injuries)	1
Assault (homicide)	1
Total	56

B. CHILD DEATHS IN NEW HAMPSHIRE, 2001-2003

This section of the report contains information on the most recent three years of child fatalities. Similar to the data for 2003, total deaths during this three-year period, 2001-2003, show that most deaths from natural causes occur among infants (< 1 year). In addition, unintentional injuries account for most injury-related deaths.

Table 8
New Hampshire Resident Natural and Injury Deaths by Age Groups 0-18, 2001-2003

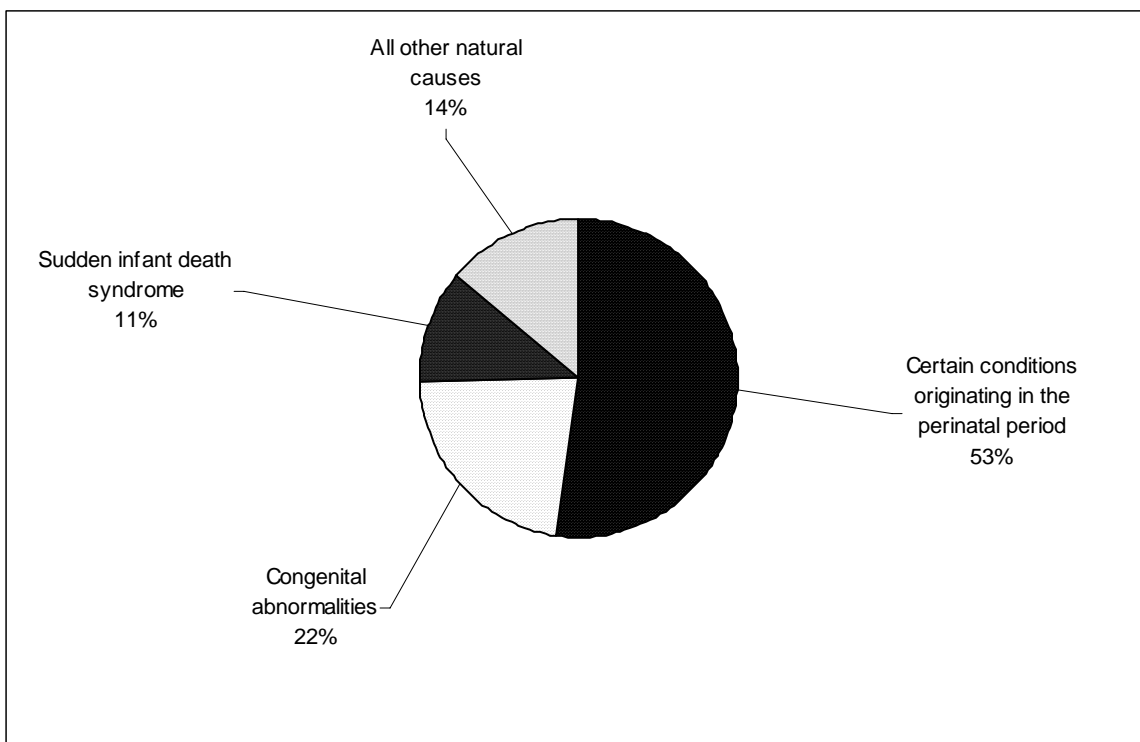
Age Group	Natural	Injury	Total
<1	174	9	183 (49%)
1 - 4	29	12	41 (11%)
5 - 9	18	10	28 (7%)
10 - 14	12	24	36 (10%)
15 - 18	26	62	88 (23%)
Total	259 (69%)	117 (31%)	376

The major cause of death for infants is “Certain Conditions Originating in the Perinatal Period” which makes up 53% of all natural infant deaths. “Congenital Anomalies” and “Sudden Infant Death Syndrome (SIDS)” are the next two leading causes of natural death for infants (See Table 9 and Figure 3).

Table 9
New Hampshire Resident Deaths by Natural Causes, <1 year of age, 2001-2003

Natural Cause of Death	<1 Yr
Certain conditions originating in the perinatal period	91
Congenital abnormalities	39
Sudden infant death syndrome	20
All other natural causes	11
Respiratory disease	4
Cerebrovascular disease	2
In situ neoplasms (i.e. non-malignant tumor)	2
Diseases of heart	1
Hernia	1
Nephritis, nephrotic syndrome and nephrosis	1
Other infectious or parasitic diseases	1
Septicemia	1
Total	174

Figure 3

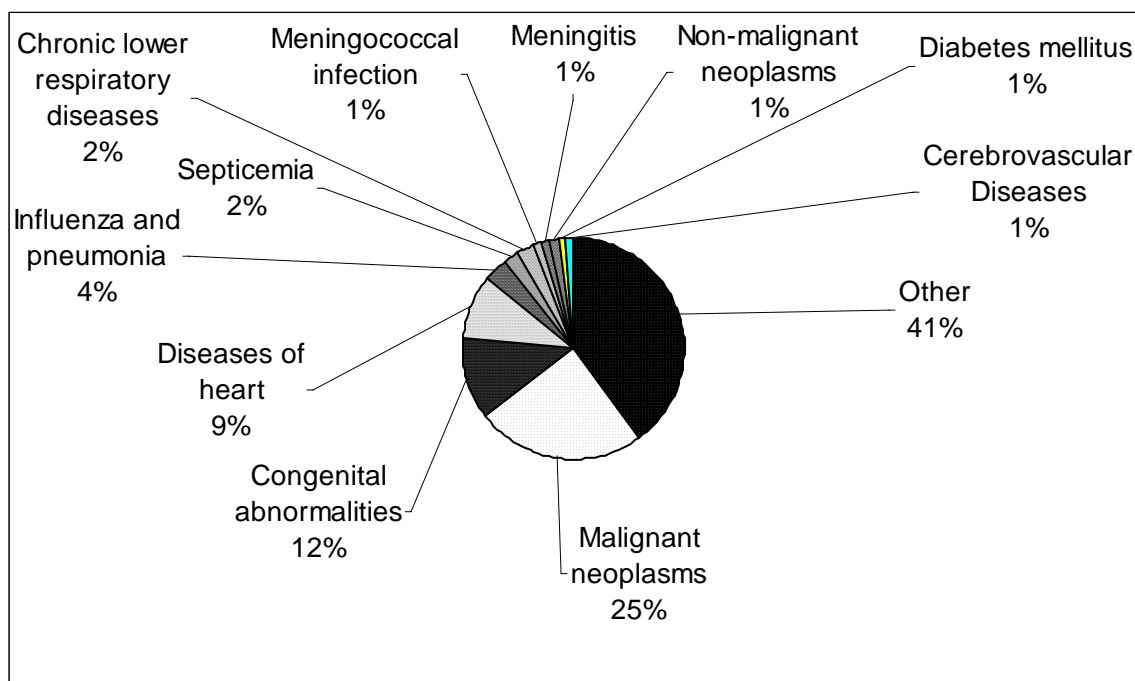


Neoplasms (malignant tumors) are the leading cause of natural death for children ages 1-18, responsible for 40% of the natural deaths. (Table 10 and Figure 4).

Table 10
New Hampshire Resident Deaths by Natural Causes,
ages 1-18 years, 2001-2003

Natural Cause of Death	1-18 yrs
Other	34
Malignant neoplasms	21
Congenital abnormalities	10
Diseases of heart	8
Influenza and pneumonia	3
Septicemia	2
Chronic lower respiratory diseases	2
Meningococcal infection	1
Meningitis	1
Non-malignant neoplasms	1
Diabetes mellitus	1
Cerebrovascular Diseases	1
Total	85

Figure 4



The majority of the deaths to older children are due to injury. Motor vehicle traffic crashes are the leading cause of death for children and adolescents in both New Hampshire and the United States. In New Hampshire, suicides account for a large number of adolescent deaths. The most common mechanisms of suicide deaths are firearms, suffocation (hanging), and poisoning (See Table 11).

Table 11
New Hampshire Resident Injury Deaths by Intent, Mechanism, and Age Group, 2001-2003

Unintentional Injuries

Cause of Death	<1	1 - 4	5 - 9	10 - 14	15 - 18	Total
Drowning	1	6	2	2	1	12
Fall	-	-	-	1	-	1
Fire/hot object or substance-fire/flame	-	2	2	2	-	6
Firearm	-	-	-	-	1	1
Machinery	-	-	-	1	1	2
Motor vehicle traffic	-	3	3	4	32	42
Natural/environmental	1	-	-	-	-	1
Other land transport	-	-	-	2	2	4
Other transport	-	-	1	1	-	2
Pedestrian, other	-	-	1	-	-	1
Poisoning	-	-	-	1	3	4
Suffocation	5	1	1	4	1	12
Total - Unintentional Injuries	7	12	10	18	41	88

Suicide

Cause of Death	<1	1 - 4	5 - 9	10 - 14	15 - 18	Total
Firearm	-	-	-	2	6	8
Poisoning	-	-	-	-	4	4
Suffocation	-	-	-	4	8	12
Total - Suicide			0	6	18	24

Homicide

Cause of Death	<1	1 - 4	5 - 9	10 - 14	15 - 18	Total
Other specified classifiable	2	-	-	-	-	2
Total - Homicide	2	-	-	-	-	2

Undetermined

Cause of Death	<1	1 - 4	5 - 9	10 - 14	15 - 18	Total
Other specified classifiable	-	-	-	-	1	1
Poisoning	-	-	-	-	2	2
Total - Undetermined	-	-	-	-	3	3

Looking at Table 12, male children are more likely than female children to die from injury. In 2001-2003, nearly 3/4 of the deaths from unintentional injuries were males and more than 79% of completed suicides were also males.

Table 12
New Hampshire Resident Injury Deaths
by Intent, Gender, and Age Group,
Ages 0-18, 2001-2003

Unintentional Injury Deaths

Age Group	Male	Female	Total
<1	4	3	7
1 - 4	10	2	12
5 - 9	6	4	10
10 - 14	13	5	18
15 - 18	32	9	41
Total	65	23	88

Suicide

Age Group	Male	Female	Total
10 - 14	4	2	6
15 - 18	15	3	18
Total	19	5	24

Homicide

Age Group	Male	Female	Total
<1	1	1	2
Total	1	1	2

Undetermined

Age Group	Male	Female	Total
15 - 18	2	1	3
Total	2	1	3

All Injury Deaths (All Intentions)

Age Group	Male	Female	Total
Total	87	30	117

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

Table 13
Mechanisms of Injury Deaths by Season (Ages 0-18), 2001-2003

Mechanism/Cause of Death	Winter	Spring	Summer	Fall
Drowning	-	1	9	2
Fall	-	-	1	-
Fire/hot object or substance- fire/flame	3	-	1	2
Firearm	2	4	1	2
Machinery	1	1	-	-
Motor vehicle traffic	5	12	13	12
Natural/environmental	-	1	-	-
Other land transport	1	2	1	-
Other specified classifiable	-	1	1	-
Other specified nec	-	-	1	-
Other transport	-	2	-	-
Pedestrian, other	-	1	-	-
Poisoning	1	3	4	2
Suffocation	5	9	5	5
Total	18	37	37	25

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

Table 14 gives specific information on the causes of death for infants (less than age 1). “Congenital malformations, deformations and chromosomal abnormalities” are responsible for 21% of all infant deaths (39 of 183). “Disorders related to short gestation and low birth weight, NEC” are the second leading cause of infant death responsible for 15% of infant deaths (28 of 183).

Table 14
New Hampshire Resident Deaths by Cause of Death for
Infants <1 year of age, 2001-2003

Natural Cause of Death	Count
Congenital malformations, deformations and chromosomal abnormalities	39
Disorders related to short gestation and low birth weight, NEC	28
Sudden infant death syndrome	20
Other ill-defined and unspecified causes	17
Newborn affected by complications of placenta, cord and membranes	11
Intrauterine hypoxia and birth asphyxia	10
Accidents (unintentional injuries)	7
Bacterial sepsis of newborn	6
Respiratory distress of newborn	5
Newborn affected by maternal complications of pregnancy	5
Diseases of the circulatory system	3
Interstitial emphysema and related conditions originating in the perinatal period	3
Neonatal hemorrhage	3
Newborn affected by other complications of labor and delivery	3
Chronic respiratory disease originating in the perinatal period	2
Influenza and pneumonia	2
In situ neoplasms, benign neoplasms, neoplasms of uncertain or unknown behavior	2
Atelectasis	2
Assault (homicide)	2
Congenital pneumonia	2
Necrotizing enterocolitis of newborn	2
Birth trauma	1
Anoxic brain damage NEC	1
Gastritis, duodenitis, and noninfective enteritis and colitis	1
Hydrops fetalis not due to hemolytic disease	1
Newborn affected by noxious influences transmitted via placenta or breast milk	1
Renal failure and other disorders of kidney	1
Septicemia	1
Slow fetal growth and fetal malnutrition	1
Hernia of abdominal cavity and intestinal obstruction without hernia	1
Total	183

V. 2004 FINDINGS AND RECOMMENDATIONS

- During well child and other visits, where substance use/abuse is routinely discussed, explore including caffeine use/misuse as part of the discussion.
- Increase awareness of caffeine use, overuse and adverse effects by incorporating it into current drug awareness campaigns
- Collaborate and develop a one-page handout that encourages safe co-sleeping to be distributed to pregnant women and new moms
- Explore non-conventional ways of outreach about safe sleeping environments for infants to new moms (i.e. Ducklings program in New Hampshire supermarkets).
- Support existing efforts by lead agencies such as the New Hampshire Department of Public Health and the Frameworks Suicide Project to provide universal "Gatekeeper" training on how to respond to disclosures of significant risk, such as child abuse and neglect, suicide potential, domestic violence, eating disorders, substance abuse, sexual assault, and firesetting by making educational opportunities available to school personnel (teachers, school nurses, administrators)
- All health care providers should be encouraged to conduct universal screening of all teenagers for child abuse and neglect, domestic violence and suicidality.
- Further promote bringing firearm safety into schools through the use of the DARE program, Risk Watch, School Resource Officers or similar avenues.
- The Department of Education should continue to support the expansion and sustainability of Peer Outreach Programs in all schools to provide outreach and peer support for at risk students.
- Support the development and dissemination of public awareness campaign regarding mandatory reporting of child abuse and neglect cases
- Support the DCYF accreditation process.
- Conduct an analysis on the feasibility of providing a 24-hour centralized intake for DCYF.
- Explore a Memorandum of Understanding between DCYF and the New Hampshire Department of Corrections for sharing information.
- The Department of Health and Human Services should encourage the enhancement of training and information for parents who adopt children from other countries, particularly countries where children have been adopted from orphanages or situations where background information is limited. Information would include signs of developmental and mental health problems often associated with early maltreatment.
- Require mandatory gun safety courses to all people under age 18, either through formal classroom instruction, through an internet course or other means.
- Review and examine current firearm laws related to juveniles.

- The Guardian ad Litem Board should develop a protocol for GAL's for conducting universal screening of children for child abuse and neglect, domestic violence and suicide potential. This protocol should incorporate indicators at different levels of risk assessment.
- The Public Education Committee of the Governor's Commission on Domestic and Sexual Violence should develop a public awareness campaign to increase the awareness of the importance of reporting incidents of domestic violence and child abuse and neglect. The focus of this campaign should emphasize that bystanders should not assume that the incident has already been reported.

VI. RESPONSES TO 2003 RECOMMENDATIONS

The Seventh Annual Report to the Governor, published in October 2004, listed recommendations generated from specific case reviews conducted in 2003. As with the previous reports, the appropriate agencies and/or disciplines were given a chance to address the recommendations and have provided the following responses.

A. PUBLIC HEALTH AND HEALTHCARE

- *The Office of Chief Medical Examiner should pursue conducting psychological profiles for all youth suicides.*

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

- *Medical facilities or practices seeing families and children with complex disabilities such as autism, serious and profound retardation or clients with a dual diagnosis (i.e. psychosis), should have case managers or family consultants who have specialized knowledge in working with the population or someone who has in-depth awareness of child and family patterns and their needs as related to the disability.*

The New Hampshire Department of Health and Human Services' Special Medical Services Bureau has an initiative to increase the workforce capacity for supporting appropriate respite and childcare for this population in order to reduce family stress. The American Academy of Pediatrics also has the Medical Home Initiative and has worked with several pediatric practices in New Hampshire to support care coordinators in the physicians' offices. Special Medical Services has worked closely with the Medical Home Initiative at Crotched Mountain, which is a public-private initiative.

- *Medical facilities with multiple locations should have protocols to ensure patients know which site, entrance, etc. they are expected to go to - especially in urgent care situations. Optimally these protocols would require that the caller in acute situations have a chance to repeat back specific directions regarding where the visit will be held.*

The New Hampshire Pediatric Society will seek the cooperation of the New Hampshire Medical Society to communicate with its members that this information needs to be shared with patients. This recommendation can be disseminated through the auspices of the Granite State Pediatrician, and the Physicians' Bimonthly, the respective newsletters of the above organizations.

- ***Medical and/or legal investigators looking into child deaths should contact the child's primary care physician, especially if there are known medical issues/conditions relative to the child.***

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

- ***Medical and pharmaceutical personnel should explain to patients and their parents the importance of prescriptions and of monitoring them.***

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

- ***For youth with chronic health problems, physicians, as part of routine patient care, should work to transition them from parents managing their illness to self-management.***

The New Hampshire Department of Health and Human Services' Special Medical Services has grant funding to work on this initiative to transition youth. A Care-Coordinator exists. The American Academy of Pediatrics, as part of the Medical Home initiative, has been working hard to help the membership work on this issue. Training, conferences, handouts and office related models exist and are made available to Pediatric offices. Youth transition is part of the federal Maternal and Child Health Bureau's Title V National Health Performance Measure for Children With Special Healthcare Needs. Special Medical Services has grant funding to work on this initiative. The New Hampshire Healthcare Transition Project is working with pediatric practices in the state to accomplish this, including a statewide coalition to develop future planning needs. The Medical Home Initiative at Crotched Mountain is also involved in this initiative.

- ***Encourage the use of pharmaceutical software programs that communicate patient prescription information at 6th grade level language and terms.***

The major companies that produce pharmaceutical software programs have been identified. A preliminary inquiry discovered that there isn't consistency in the level at which the different programs are written. Further exploration of this recommendation is needed.

- ***Encourage the New Hampshire Board of Pharmacy to seek more effective ways to monitor prescribing practices across, among and between pharmacies.***

The Board of Pharmacy Compliance Officers tried to discourage drug diversion and stop "Doctor Shoppers", who use different methods to try to obtain legal controlled drugs. In response to this growing issue the Compliance officers came up with the "Pharm-Alert" system which is a telephone pyramid where each store makes 2 calls to other pharmacies to inform that there is an alert and to watch for a bogus script or a certain person. While the concept is good, it is inherently flawed. The alert is broken down by geographic region and therefore if a person crosses to a different area the alert will not catch them or if a pharmacy does is unable to make the two calls on their list, the Alert is broken.

The Board is also currently looking into is a Prescription Monitoring Program for Controlled Substances which are rapidly growing in number throughout the country.

Prescription drug monitoring programs are systems in which prescription data for controlled substances are submitted to a central database administered by an authorized state agency. The submission of data from all pharmacies within the state usually takes place at monthly intervals. These programs help prevent and detect the diversion and abuse of pharmaceutical controlled substances, particularly at the retail level where no other automated information collection system exists.

States with prescription drug monitoring programs have the ability to collect and analyze prescription data much more efficiently than states without such programs, where the collection of prescription information requires the manual review of pharmacy files—a time-consuming and invasive process. The increased efficiency of prescription drug monitoring programs allows for the early detection of trends in abuse and possible sources of diversion. Analyzing the data collected also allows for the identification of outmoded prescribing practices, which may result in the development of new educational programs for medical professionals.

The purpose of the Prescription Drug Monitoring Program is to enhance the capacity of regulatory and law enforcement agencies to collect and analyze controlled substance prescription data. And to identify individuals who may need some intervention and treatment for a controlled substance abuse. Currently the New Hampshire Department of Justice has applied for a BJA Hal Rogers Federal Grant of \$50,000 to help New Hampshire study this program and to find an agency to act as a home for the program within the state.

- ***Develop educational materials to be distributed when medications are prescribed and dispensed on the dangers of prescription misuse.***

A brochure, regarding the use and misuse of prescriptions by teens and children has been drafted and is in the process of being reviewed by both the CFRC and the New Hampshire Board of Pharmacy before it is to be distributed to pharmacies throughout New Hampshire.

- ***Collaborate with the New Hampshire Alcohol and Drug Policy Office, the New Hampshire State Medical Examiner's Office and the New Hampshire Clearinghouse on Alcohol and Other Drug Abuse Information to develop informational packets for health care providers about the use and misuse of heroin and other opiates.***

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

- ***Make sure all postpartum visits include assessing whether there are adequate sleeping arrangements for the baby.***

Since pediatricians usually see new mother and infants at the two-week visit, this information can be conveyed to all state pediatricians through the Granite State Pediatrician, the newsletter of the New Hampshire Pediatric Society. Additionally, with the cooperation of the New Hampshire Academy of Family Physicians, and the New Hampshire Nurse Practitioner Association, the information could be disseminated to those providers, as well.

- ***More effectively market the message of safe sleeping arrangements to teen mothers through different avenues, including peer mentor/education from other teen mothers.***

A handout on safe sleeping for infants sharing a bed with an adult has been developed and will be disseminated in October 2005 as part of the 2005 Child Health Month Coalition packet. This packet is distributed to over 5,000 health, social service, child care and school personnel, parenting programs, domestic violence shelters, foster parents, home visiting programs and state-funded Community Health Centers, Prenatal Clinics, Child Health Clinics, WIC Clinics, and Family Planning Clinics.

- ***Implement a notification system to key stakeholders (mental health centers, schools, county attorneys, police etc.) when there is a youth suicide.***

There is no system in place at this time. This recommendation is under discussion at the Youth Suicide Assembly (YSPA).

B. EMERGENCY MEDICAL SERVICES

There were no recommendations for Emergency Medical Services this year.

C. MENTAL HEALTH

- ***Encourage mental health support and services for children who have lost a parent suddenly.***

The Community Mental Health Center children's programs statewide offer treatment, counseling and bereavement services appropriate to the needs of referred children. Through their linkages with other local child serving entities and community networks, referral and access to center services are facilitated for high risk and high need youth.

- ***Encourage and support the development of co-located mental health and substance abuse services in schools.***

Community Mental Health Centers all have relationship with local school systems including various levels of in-school presence by mental health service providers. Increasing service capacity within school settings is an ongoing goal for the children's mental health service system.

- ***Encourage and support community based systems of care that allow for regular meetings to identify high-risk children and families.***

Community Alliance Reform Effort (CARE) NH, the children's mental health System of Care initiative has been piloted in three regions of the state. Plans have been made to go statewide through a Federal grant application to develop regional System's of Care for children with intensive service needs and their families. Through the regional collaboratives, children who are at risk for out of school and out of community placement are identified for referral to coordinated services and supports.

- ***Implement a notification system to key stakeholders (mental health centers, schools, county attorneys, police etc.) when there is a youth suicide.***

There is no system in place at this time. This recommendation is under discussion at the Youth Suicide Assembly (YSPA).

D. EDUCATION SYSTEM

- ***Implement a notification system to key stakeholders (mental health centers, schools, county attorneys, police etc.) when there is a youth suicide.***

There is no system in place at this time. This recommendation is under discussion at the Youth Suicide Assembly (YSPA). When schools have reported a suicide to the Department of Education (DOE) in the past, the department has connected them with community resources on several occasions when appropriate.

- ***Encourage and support the development of co-located mental health and substance abuse services in schools.***

Community Mental Health Centers all have relationship with local school systems including various levels of in-school presence by mental health service providers. Increasing service capacity within school settings is an ongoing goal for the children's mental health service system.

- ***Implement student assistance program models to include middle schools.***

Some middle schools in New Hampshire are implementing student assistance programs. There is no central repository of information about Student Assistance Programs in New Hampshire. Some are funded locally, some are funded through the DOE's Safe and Drug-Free schools formula grant, and others are funded through the Bureau of Prevention Services, DHHS and the Governor's Commission funds. Currently there is no state level organization for student assistance programs.

- ***Encourage and support community based systems of care that allow for regular meetings to identify high-risk children and families.***

The New Hampshire DOE has a collaborative initiative with the Bureau of Behavioral Health, DHHS. CARE NH, the children's mental health System of Care initiative has been piloted in three regions of the state. Plans have been made to go statewide through a Federal grant application to develop regional System's of Care for children with intensive service needs and their families. Through the regional collaboratives, children who are at risk for out of school and out of community placement are identified for referral to coordinated services and supports.

- ***Develop and adopt a statewide suicide prevention plan.***

A statewide suicide prevention plan was adopted in November 2004. A team from New Hampshire attended the Suicide Prevention Resource center (SPRC) regional conference in June 2005 to begin to plan for implementation of the state suicide prevention plan.

- ***Encourage the development and compliance with the Protocols as developed by the Frameworks Suicide Project.***

The New Hampshire DOE has been participating in the development of the Frameworks project. After the protocols are evaluated, dissemination will take place and compliance will be encouraged. NAMI-NH continues to seek funding to support the next phases of the project. Suicide prevention is an approved activity in the Safe and Drug-Free Schools federal grant program.

E. CHILD PROTECTIVE SERVICES

There were no recommendations made for Child Protective Services this past year.

F. DISTRICT COURT AND LAW ENFORCEMENT

- *Medical and/or legal investigators looking into child deaths should contact the child's primary care physician, especially if there are known medical issues/conditions relative to the child.*

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

- *Ensure regular updates to the Police Standards and Training Council and law enforcement on current trends in drug use/abuse.*

Police Standards and Training Council would be able to disseminate this type of information to various law enforcement communities through their newsletter, *Articulable Suspicion*, and other avenues available.

G. LEGISLATION

There were no recommendations made for legislation this past year.

H. CHILD FATALITY REVIEW COMMITTEE

- *Have the Child Fatality Review Committee adopt a succinct message that would relay the benefits and dangers of co-sleeping.*

A handout on safe sleeping for infants sharing a bed with an adult has been developed and will be disseminated in October 2005 as part of the 2005 Child Health Month Coalition packet. This packet is distributed to over 5,000 health, social service, child care and school personnel, parenting programs, domestic violence shelters, foster parents, home visiting programs and state-funded Community Health Centers, Prenatal Clinics, Child Health Clinics, WIC Clinics, and Family Planning Clinics.

- *Support hospice groups to establish sudden death response teams.*

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

VII. CONCLUSION

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

APPENDIX A. HISTORY, BACKGROUND AND METHODOLOGY

(As printed in the Fourth Annual Report)

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

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

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

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

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

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

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

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

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

- The Medical Examiner's Office presents a clinical summary of the death. Other participants who had prior involvement with the child and family then present relevant medical, social and legal information.
- The Committee discusses service delivery prior to the death, and the investigation process post death.
- The Committee identifies risk factors related to the death and makes recommendations aimed at improving systematic responses in an effort to prevent similar deaths in the future.
- The Committee provides recommendations to participating agencies and encourages them to take actions consistent with their own mandates.

APPENDIX B: EXECUTIVE ORDER

STATE OF NEW HAMPSHIRE

CONCORD, NEW HAMPSHIRE 03301

Executive Order Number 95-1

an order establishing a New Hampshire
child fatality review committee

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

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

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

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

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

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

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

1. To enable all interested parties to more effectively facilitate the prevention, investigation and prosecution of child fatalities.
2. To identify and investigate the prevalence of a number of risks and potential risk factors in the population of deceased children.
3. To evaluate the service system responses to children and families who are considered to be high risk, and to offer recommendations for any improvements in those responses.
4. To identify high risk groups for further consideration by executive, legislative or judicial branch programs.
5. To improve the sources of data collection by developing protocols for autopsies, death investigations and complete recording of cause of death on the death certificates.
6. To describe trends and patterns of child deaths in New Hampshire.

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


Governor of New Hampshire

APPENDIX C: INTERAGENCY AGREEMENT

ATTORNEY GENERAL DEPARTMENT OF JUSTICE

33 CAPITOL STREET
CONCORD, NEW HAMPSHIRE 03301-6397

PETER W. HEED
ATTORNEY GENERAL



STEPHEN J. JUDGE
DEPUTY ATTORNEY GENERAL

INTERAGENCY AGREEMENT

THE NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

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

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

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

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

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


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

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

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

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


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



Attorney General

4/28/03

Date



Commissioner, Health and Human Services

Date



Commissioner, Department of Safety

3/28/03

Date

APPENDIX D: CONFIDENTIALITY AGREEMENT

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE CONFIDENTIALITY AGREEMENT

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

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

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

Print Name

Authorized Signature

Witness

Date

APPENDIX E: STATUTORY AGREEMENT

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE STATUTORY AUTHORITY

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

List of ICD-10 Codes Used for Analysis

Cause of Infant Death Group (<1 year)	ICD-10 Code
Certain infectious and parasitic diseases	A00 - B99
Malignant neoplasms	C00 - C97
In situ neoplasms, benign neoplasms and neoplasms of uncertain or unknown behavior	D00 - D48
Dis. of blood and blood-forming organs and certain disorders involv. immune mech.	D50 - D89
Endocrine, nutritional, and metabolic diseases	E00 - E88
Diseases of the nervous system	G00 - G98
Diseases of the ear and mastoid process	H60 - H93
Diseases of the circulatory system	I00 - I99
Diseases of the respiratory system	J00 - J98
Diseases of the digestive system	K00 - K92
Diseases of the genitourinary system	N00 - N98
Certain Conditions Originating in the Perinatal Period	P00 - P96
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
Birth trauma	P10 - P15
Intrauterine hypoxia and birth asphyxia	P20 - P21
Respiratory distress of newborn	P22
Other respiratory conditions originating in the perinatal period	P23 - P28
Infections specific to perinatal period	P35 - P39
Hemorrhagic and hematological disorders of newborn	P50 - P61
Syndrome of infant of a diabetic mother and neonatal diabetes mellitus	P70.0 - P70.2
Necrotizing enterocolitis of newborn	P77
Hydrops fetalis not due to hemolytic disease	P83.2
Other perinatal conditions	Any other in range
Congenital malformations, deformations, and chromosomal abnormalities	Q00 - Q99
Congenital malformations and deformations	Q00 - Q89
Chromosomal abnormalities	Q90 - Q99
Symptoms, signs and abnormal clin and lab findings, not elsewhere class	R00 - R99
Sudden Infant Death Syndrome (SIDS)	R95
Other symptoms, signs and abnormal clinical and laboratory findings, nec	R00 - R53 R55 - R94 R96 - R99
Unintentional Injury	V01 - X59 Y85 - Y86
Suicide	X60 - X84 Y87.0, U03
Homicide	X85 - Y09 Y87.1, U01- U02
Undetermined Intent Injury	Y10 - Y34 Y87.2, Y89.9

List of ICD-10 Codes Used for Analysis

Cause of Death Group (1-18 years)	ICD-10 Code
Certain other intestinal infections	A04, A07-A09
Meningococcal infection	A39
Septicemia	A40 - A41
Other and unspecified infectious and parasitic diseases	A00, A05, A20-A36, A42-A44, A48-A49, A54-A79, A81-A82, A85.0-A85.1, A85.8, A86-B04, B06-B09, B25-B49, B55-B99
Malignant neoplasms	C00 - C97
In situ neoplasms, benign neoplasms and neoplasms of uncertain or unknown behavior	D00 - D48
Diabetes Mellitus	E10 - E14
Major cardiovascular diseases	I00 - I78
Influenza and Pneumonia	J10 - J18
Chronic lower respiratory diseases	J40 - J47
Other diseases of respiratory system	J00-J06, J30-J39, J67, J70 - J98
Infections of kidney	N10-N12, N13.6, N15.1
Certain conditions originating in the perinatal period	P00 - P96
Congenital malformations, deformations, and chromosomal abnormalities	Q00 - Q99
Symptoms, signs and abnormal clinical and laboratory findings, nec	R00 - R99
All other diseases (Residual)	Residual
Unintentional Injury	V01 - X59 Y85 - Y86
Suicide	X60 - X84 Y87.0, U03
Homicide	X85 - Y09 Y87.1, U01- U02
Undetermined Intent Injury	Y10 - Y34 Y87.2, Y89.9