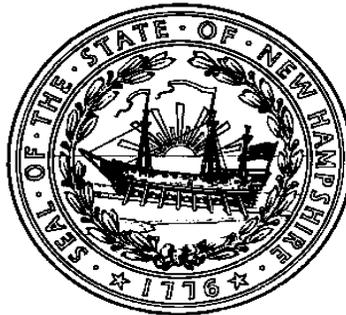


THE STATE OF NEW HAMPSHIRE



CHILD FATALITY REVIEW COMMITTEE

FOURTH ANNUAL REPORT

*Presented to
The Honorable Jeanne Shaheen
Governor, State of New Hampshire
November, 2001*

DEDICATION

The Fourth Annual Report of the New Hampshire Child Fatality Review Committee is dedicated to the children of New Hampshire. Though our work is difficult at times, we are sustained in the knowledge that what we do will improve the health and safety of New Hampshire's children.

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

October 25, 2001

Dear Friends of New Hampshire Children,

Since January of 1996, the New Hampshire Child Fatality Review Committee has been actively reviewing child fatality cases. The Committee conducts in-depth examinations of how and why children die in hopes that the Committee's findings and recommendations can help to reduce the number of preventable child fatalities in our state. Additionally, the Committee meets annually with the Child Fatality Review Teams from Maine and Vermont, to share experiences, information and to review a case that involves services from more than one state.

Members of the Committee have given a series of presentations on the Committee's work, presenting at the Annual New Hampshire Attorney General's Task Force Child Abuse Conferences, the Governor's Kids Cabinet, Pediatric Grand Rounds at Dartmouth Hitchcock Medical Center, and the Middlesex County Attorney General's Office in Massachusetts. These presentations have not only publicized the Committee's work and findings, but have also better refined the way we review child fatalities.

The members of this multidisciplinary team are volunteers who have given generously of their time and experience and who represent both public and private agencies that have an interest in the welfare of the children of New Hampshire. Through their commitment, the Committee has been able to build a collaborative network to foster teamwork and to share the recommendations with the larger community.

The Committee has made great strides in the last few years, but there is still work to be done. The Committee will continue to look for ways to implement our recommendations and to maximize the impact of these recommendations on the actions and policies of the agencies and individuals who work with and for our children.

The Committee would like to acknowledge the many contributions made by Marie Kiely, formerly of the Division of Public Health, Injury Prevention Program, who was an invaluable asset in gathering and interpreting our data. We wish her well in her new endeavors.

In recognition of the commitment and dedication of the members of the Committee, it is with great pride that as Chair, I present the Fourth 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.

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*=Alternate

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I. HISTORY, BACKGROUND AND METHODOLOGY

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 Third Annual Report to the Governor begin on page ten of this report.

II. 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, 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.

III. REVIEW AND ANALYSIS OF DATA

The Fourth Annual Report examines the data on child fatalities from 1999, in which there were 143 child fatalities in the State of New Hampshire. Of this total, 76% were from natural causes, 18% from unintentional injuries, 4% suicide and 2% homicide. This data was provided by the New Hampshire Department of Health and Human Services’ Bureau of Health Statistics and Data Management.

NATURAL DEATHS: AGE 0-18, 1999

Cause of Death Group	Age		Total
	0 - 1	1 - 18	
Certain Conditions Originating in the Perinatal Period	47	1	48
Congenital Anomalies	15	3	18
Neoplasms	1	9	10
Symptoms, Signs, and Ill-Defined Conditions	6	1	7
All Other Causes	11	14	25
Total	80	28	108

INJURY DEATHS: AGES 0-18, 1999

Unintentional	26
Homicide	3
Suicide	6
Other	0
Total	35

INJURY DEATHS: 0-18 YEARS, 1999

	AGES IN YEARS					
Unintentional	0	1-4	5-9	10-14	15-18	Total
Drowning	0	2	0	0	0	2
Fall	0	0	0	0	1	1
Fire/Burn	0	1	0	0	0	1
MV Crashes, Occupant (includes driver or passenger)	0	0	2	1	14	17
MV Crashes, Pedestrian	0	0	0	1	0	1
Suffocation	1	0	0	1	0	2
Other	0	0	0	2	0	2
Total	1	3	2	5	15	26
Homicide	0	1-4	5-9	10-14	15-18	Total
Hanging, strangulation, suffocation	0	1	0	0	0	1
Smoke, flames, fire	0	0	1	0	0	1
Other	1	0	0	0	0	1
Total	1	1	1	0	0	3
Suicide	0	1-4	5-9	10-14	15-18	Total
Firearm	0	0	0	0	2	2
Hanging	0	0	0	1	3	4
Total	0	0	0	1	5	6

AGE DISTRIBUTION OF INJURY DEATHS BY GENDER: 0-18: 1999

	Male	Percent Male	Female	Percent Female	Total	Percent Total
Under Age 1	0	0%	2	14%	2	6%
1 - 14	8	38%	5	36%	13	37%
15 - 18	13	62%	7	50%	20	57%
Total	21	100%	14	100%	35	100%

CAUSES OF DEATH FOR INFANTS: 1999

Infant Death	Count
Accidental Suffocation and Strangulation in Bed	1
Cerebrovascular Disease	2
Certain Conditions Originating n the Perinatal Period	48
Congenital Anomalies	15
Convulsions	1
Diseases of the Heart	1
Malignant Neoplasms	1
Nephritis, Nephrotic Syndrome, Nephrosis	2
Other Internal or Unspecified	4
Pneumonia and Influenza	2
Sudden Infant Death Syndrome	5
Total	82

SUDDEN INFANT DEATH SYNDROME (SIDS): 1999

Position at Time of Discovery	1999
On Stomach	1
On Side	0
On Back	3
Unknown	2
TOTAL	6*

***1999 Of the six cases, two infants were bed sharing with a parent, one infant was sharing a couch with a parent and one infant was bed sharing with a twin. One of the six deaths was of a Vermont resident.**

IV. 2000 FINDINGS AND RECOMMENDATIONS

During the calendar year 2000, the Committee reviewed eight child fatality cases. These reviews included two cases of children who died from what can be described as “high risk taking” behavior, including “huffing” or sniffing dangerous chemicals. These reviews were preceded by an educational presentation from a Committee member who participated in the 1999 New Hampshire Youth Risk Behavior Survey.

Additionally, the Committee reviewed the cases of two very young children who had died from accidental asphyxiation in their homes. The final reviews were of children who had committed suicide. These reviews were conducted in conjunction with the Committee’s

sponsorship in a youth suicide conference entitled “Getting the Story Right”. This conference focused on how the media reports youth suicide and the effect of media reports on suicide contagion.

In addition to the reviews that occurred at the Committee’s regular meetings, a child death review was conducted at the annual joint meeting with the Child Fatality Review Teams from both Vermont and Maine. This involved a case of a child who had contact with both Maine and New Hampshire social service agencies.

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.

A. PUBLIC HEALTH AND MEDICAL

- Support the expansion of “Sudden Death Response Teams” throughout the state.
- Use the media to promote educational and prevention efforts after an accidental death occurs.
- Encourage medical care providers to offer up-to-date product safety information to new parents upon discharge from the hospital.
- Support efforts for periodic public awareness campaigns targeting product safety.
- Review model legislation pertaining to thrift store product safety.
- Develop bereavement packets to be given to families in which a child has died suddenly and unexpectedly and Sudden Infant Death Syndrome (SIDS) is not suspected to be the cause (age birth to 18).
- Enhance primary care physicians’ awareness of and education about the need for counseling to accompany use of psychotropic drugs.
- 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.

B. EMERGENCY MEDICAL SERVICES

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

- Recommend that training and re-certification in Basic First Aid and CPR be offered to all middle and high school students.
- Provide schools with materials relating to age appropriate safety issues (Risk Watch).
- Incorporate a lethality checklist into training curriculum for First Responders.

C. *MENTAL HEALTH*

- Explore strategies to reduce waiting lists for community mental health centers.
- Support increased prevention programming through community mental health system.
- Enhance primary care physicians' awareness of and education about the need for counseling to accompany use of psychotropic drugs.
- Support the development and implementation of comprehensive school and community-based suicide prevention protocols.
- Encourage development of peer-outreach programs to target a wide range of high-risk issues facing youth.

D. *EDUCATION*

- Support efforts to incorporate Risk Watch Programs (injury prevention/risk behavior) into existing school curricula statewide.
- Recommend that training and re-certification in Basic First Aid and CPR be offered to all middle and high school students.
- Provide schools with materials relating to age appropriate safety issues (Risk Watch).
- Support the development and implementation of comprehensive school and community-based suicide prevention protocols.

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

- Explore consistent inclusion in the Child Protective Services Central Registry of people responsible for child fatalities due to abuse/neglect.
- 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.
- Review current DCYF central registry system to identify opportunities for improvement.
- Revise DCYF and Court Appointed Special Advocates (CASA) training curricula to require the inclusion of home safety information.

F. DISTRICT COURT AND LAW ENFORCEMENT

- Establish a statewide linking database for the Family Courts.

G. LEGISLATION

- Propose legislation that would allow DCYF to expand assessments to include other children living in the home where abuse allegations have been reported.

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.
- Convene a sub-committee to discuss and develop home safety materials to be included in DCYF Training Curriculum.
- Offer workshops at the annual child abuse conference on child safety issues.

V. RESPONSES TO 1999 RECOMMENDATIONS

The Third Annual Report to the Governor, published in October of 2000, listed recommendations, which were generated from specific case reviews conducted in 1999. 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 MEDICAL

- *Encourage hospitals and other medical facilities to develop and implement protocols for dealing with non-patient unattended death.*

To date the Office of the Chief Medical Examiner (OCME) has not been contacted by any health care facility regarding formulating or updating any existing policies regarding non-patient, unattended death. Whether or not this means no action has been taken on this recommendation is speculative, however, protocols dealing with such incidents need to be complex. These deaths should be treated as any unattended death under the law (RSA Ch. 611 and 611A), with notification of the local police department and assistant deputy medical examiner. The scene of death should, of course, never be altered prior to clearance of the scene by the investigating agencies.

- ***Promote school-based health clinics to include basic health education, reproductive health education and a mental health care component that provides risk assessment and referral services for identified high-risk students.***

There is no statewide system of funding school-based clinics. At the state level, the New Hampshire Department of Health and Human Services offers support and encouragement to local school-based health clinics. Educators in state and federally funded Family Planning Clinics are available to offer education and support upon request of their local schools. Currently, there are two Family Planning Clinics working with school based health clinics.

- ***Support efforts for continued and expanded funding for home visiting resources for newborns and families to provide a comprehensive safety net for at-risk families.***

Home Visiting New Hampshire is a preventative program based upon the model Home Visiting 2000 that provides health, education, support and linkages to other community services to Medicaid eligible pregnant women and their families in their homes. These services are provided by a multi-disciplinary team, from the time an eligible woman is pregnant until the child's first birthday. Home visits utilize Parents as Teachers' *Born to Learn* curriculum as well as supplemental educational materials that assist in health and safety promotion. Integral to the success of this model is the use of a team of professionals to oversee the progress of each family, ensuring that both the goals of the program are being addressed and the individual needs and goals of the family are met.

Starting May, 2001 thirteen agencies throughout New Hampshire are implementing this Model with six additional sites to be funded in State Fiscal Year 2002 to provide comprehensive home visits to Medicaid-eligible families throughout the state.

- ***Conduct autopsies for all child fatalities under age 18, excluding motor vehicle crashes. (This is the second year this recommendation has been made.)***

Responding to this recommendation for the second consecutive year is disappointing indeed. Despite the Committee recommendation in the 2000 report, there remains a decided reluctance to perform autopsies on children. In traumatic deaths the argument is often made, "We know the cause of death. There is no need for an autopsy". This attitude, while borne of compassion, is one that limits the ability to reconstruct fatal events with an eye toward prevention, whether the event is a vehicular crash (The New Hampshire Office of Chief Medical Examiner would include such incidents in the formal recommendation), a drowning,

a fire or the result of “high risk” behavior. The autopsy provides more than just the cause of death, and while the results of a single given examination may not yield a wealth of information, the cumulative knowledge of autopsies of similar incidents may well lead to insights not otherwise gleaned without benefit of a full postmortem examination. The potentially valuable contribution that an autopsy can make is too often undermined by the well meaning, but misguided notion that there is so little to be learned from such procedures that they may be avoided. Ultimately it is a disservice to our citizens if we miss opportunities for developing effective injury and death prevention strategies for lack of information that only a thorough, competent autopsy can provide.

- ***Review the Women, Infant and Children Program (WIC) policies to determine if WIC can serve as a point of screening and referral for at-risk families.***

The WIC Nutrition Program recognizes that there are families receiving services who are at-risk for child abuse and neglect, and has developed policies to address this issue. Any local agency staff who suspect child abuse or neglect is required to report it to the Division of Children, Youth and Families, based on either staff observation or information reported by a parent or caretaker. Additionally, for high-risk families, policies are in place for referrals to social work staff within the agency, follow-up of missed appointments, documentation of concerns and notification of health care providers.

Under United States Department of Agriculture confidentiality requirements, either participant consent or subpoena are required before release of documented information in participant records.

In May, 2001, a representative from Parents Anonymous provided training and information to local WIC agency administrative staff on their community services and resources.

The following recommendations are being actively addressed by the agencies that are directly involved and impacted by them.

- ***Encourage hospital staff and others involved in the care of newborns to make referrals to the infant's primary care/community health provider when discharging newborns with identifiable risk factors.***
- ***Organize a training conference to be made available to media on reporting of suicide and other issues that may affect youth behavior.***
- ***Support the development of guidelines for responsible reporting of youth risk behaviors, fatalities and suicide.***
- ***Revise current policy to require Child Protective Service Workers (CPSW) and medical personnel to pursue signed releases when there is multi-system involvement with a child and share this information with appropriate care providers.***

- *Encourage primary care and mental health providers to communicate more closely when working with shared clients who are identified as at-risk.*

B. MENTAL HEALTH

- *Establish a substance abuse screening protocol for mental health providers to use when patients present with depression and/or anxiety.*

No standard substance abuse screening protocol has yet been identified for mental health providers. There has been consultation between the Division of Behavioral Health and the Division of Alcohol and Drug Abuse Prevention and Recovery on this issue. Additionally, a strategic plan has been developed with key stakeholders at the state level to improve access to mental health and substance abuse services for youth in the juvenile justice system. This plan includes a standard screening protocol that can be used statewide. This has potential to be expanded for use by other mental health providers.

- *Improve access and quality of substance abuse and psychiatric services for youth and adolescents, which includes in-patient, outpatient and follow-up services.*

As part of our comprehensive children's service initiative, the Community Alliance Reform Effort (CARE NH), the development of a training curriculum and practice models for employing a multi-agency wraparound approach for the identification and community based treatment of youth with dual diagnosis (mental health and substance abuse) is underway.

- *Improve interagency communication among community-based service providers working with children and families involved with the Division for Children, Youth and Families (DCYF).*

The CARE NH system of care development effort is being piloted in three regions of New Hampshire and has created regional collaboratives among community providers and families, including DCYF, for the purpose of improving communication and accountabilities for providers serving children and their families who receive services from multiple agencies.

- *Increase communication between physicians and mental health providers.*

Working with primary care providers will continue to be an important element for increasing the capacity for families to access mental health services. One of the prime venues to increase communication between physicians and mental health providers is the fourteen infant mental health teams that are continuing to develop statewide.

- *Develop policies regarding mental health services to surviving siblings and to children living in homes where domestic violence is present.*

The Victim Services Committee of the Governor's Commission on Domestic and Sexual Violence is discussing the development of services for child witnesses to violence. Additionally, the Greenbook Project, a federally funded demonstration site in Grafton County, will be developing policies to address collaborative interventions in families experiencing both domestic violence and child maltreatment.

- ***Support continued outreach efforts surrounding mental health and mental illness awareness.***

The Division of Behavioral Health is supporting the development of a statewide public information campaign on mental health awareness and anti-stigma. This initiative will target the mental health needs of all age groups, including children.

The following recommendation is actively being addressed by the agency that is directly involved and impacted by it.

- ***Require all mental health reports on court involved families to be forwarded to the courts, in addition to the Juvenile Service Officers (JSO).***

C. EDUCATION SYSTEM

- ***Encourage schools to develop and adopt crisis plans that are designed to assist school staff with managing information sharing with the press during highly stressful situations.***

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.

- ***Promote school health services protocols to include medical and mental health guidelines designed to assist school staff in responding pro-actively to teen pregnancy.***

A School House Resource Manual was issued to all schools 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.

- ***Encourage development of protocols that address issues of disclosure of certain information for medical purposes including, but not limited to teen pregnancy cases.***

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).

- ***Promote 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 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 this purpose.

- ***Develop model policies for risk assessment for harmful behavior of at-risk youth facing suspension and expulsion, and encourage alternatives to minimize risk.***

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. 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.

- ***Promote increased access to mental health counseling through Medicaid funding in schools and increase communications where DCYF is involved. Develop policy and procedures to help move toward a mental health triage system.***

This issue has not specifically been addressed. 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.

- ***Encourage parents to attend a certain number of parent education seminars when child abuse and neglect, Children in Need of Services (CHINS) and/or juvenile petitions or school suspensions are involved.***

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.

D. CHILD PROTECTIVE SERVICES

- ***Develop policies regarding mental health services to surviving siblings and to children living in homes where domestic violence is present.***

Currently, Domestic Violence Program Specialists are in 10 of the 12 District Offices of DCYF. The Domestic Violence Program Specialists work for the local crisis center and promote cross system collaboration between DCYF and domestic violence agencies by working with the CPSWs to assist families where domestic violence is present. DCYF is also continuing efforts to develop a consistent approach state-wide to support families where domestic violence is one of the presenting problems, including but not limited to integrating Domestic Violence Protocols into policy.

DCYF has improved its own Quality Assurance Case Review process with newly written policy which strengthen the agency's own efforts in regards to identifying and providing services, including mental health services to surviving family members. The Quality Assurance Case Reviews are held internally, with identified field staff and State Office Staff in cases where a child fatality or serious injury has occurred. Both administrative and clinical case specific recommendations are made to ensure best practice.

The Victim Services Committee of the Governor's Commission on Domestic and Sexual Violence is discussing the development of services for children who witness violence. Additionally, the Greenbook Project, a federally funded demonstration site in Grafton County, will be developing policies to address collaborative interventions in families experiencing both domestic violence and child maltreatment.

- ***Require parents to attend a certain number of parent education seminars when child abuse and neglect, CHINS, and/or juvenile petitions or school suspensions are involved.***

DCYF continues to both educate and support parents in locating appropriate community support that can enhance their parenting abilities. Most DCYF involved cases have case plans with parenting education as one of the components. The parenting education is offered in various forms, designed and tailored to the individual needs of the family.

DCYF is currently awarding Incentive Funds, distributed by the counties to various community agencies all over the state to enhance preventative parenting skills programs available to at risk parents.

- ***Implement best practice standards to be applied to on-going monitoring of cases beyond court ordered reunification.***

DCYF supports best practice standards to be applied in all cases where reunification has occurred. This ensures that continuing services are in place for all children in the home until it is evident that all the conditions that lead to placement are ameliorated. The implementation of the Structured Decision Making Process in the fall of 2001 will also be an

additional quality enhancement feature that will ensure reunification with appropriate services in place for the family.

- ***Improve inter-state communication and information sharing regarding DCYF-involved children.***

There are current existing laws that govern the communication and information sharing between Child Protection Agencies in different states. DCYF is making specific internal efforts to improve and refine communication and information sharing when another state is requesting information by developing consistent internal procedures.

- ***Increase training and staff resources to support adequate and coordinated assessments and appropriate follow-up of all cases.***

DCYF will continue efforts on all levels to advocate for allocation of increased staff resources in the field.

- ***Develop a policy to support opening a case after multiple attempts to contact parent(s) are unsuccessful. Re-examine the statute regarding Motion to Enter.***

DCYF will make efforts to re-examine the use of the statute regarding Motion to Enter as well as develop policy to address practice issues in cases when several unsuccessful attempts to locate the family have been made.

- ***Improve overall case management by developing clearly defined policies and procedures which address case re-assignment and continuity when JSO and caseworker staff turnover occur.***

DCYF will review the current statewide practices of re-assignment of cases with recommendations to establish clear guidelines for case re-assignment. DCYF will revisit internal protocols to assure consistent oversight of this activity.

- ***Improve all aspects of the wrap-around process including educating the professional community about a team's purpose/function and how to access it.***

DCYF will examine the various forms of wrap-around activities around the state and continue to support the different local initiatives to improve the relationship with the professional community.

- ***Examine the impact of the Parental Reimbursement requirement.***

DCYF is acknowledging that the Parental Reimbursement requirement is making an impact on families with DCYF involvement. DCYF will make diligent efforts to ensure that children and families involved with the agency are receiving services as needed.

- *Support efforts to increase funding to provide DCYF and related providers with the resources needed to effectively protect children and youth.*

DCYF is available on all levels to participate in discussions with the public, the legislature and other entities to inform, educate and discuss the current level of services provided by DCYF as well as the need for additional resources necessary to adequately protect children in the state.

E. DISTRICT COURT AND LAW ENFORCEMENT

- *Provide education/awareness to law enforcement and campus security regarding RSA 318-B:26, IX of the Controlled Drug Act. This statute addresses the liability of any person who manufactures, sells or dispenses a controlled drug in which a death results from the injection, inhalation or ingestion of that substance.*

Police Standards and Training Council can and does train on this issue in the Police Academy, and can disseminate the information to in-service law enforcement through the newsletter or electronic means, but would not be in favor of conducting face-to-face training because of the resources required and since length of the training would be so short as to be prohibitive. In general terms, this information is of some utility to police for use as an educational issue, but since it deals with a sentencing issue, law enforcement would have little or no direct involvement with it.

- *Develop a mechanism for compiling and providing to all parties and to a court-involved child/family, information on any and all prior hearings including, DCYF cases, family, civil and criminal court proceedings and the records of the same from other states.*
- *Improve case information management by having one court oversee the records relating to multi-system involved families, i.e. juvenile, abuse and neglect and CHINS*
- *Increase multidisciplinary access to records, including court findings (probate, family, and district), and ensure that courts are filing reports to DCYF when abuse or suspicion of abuse is indicated on domestic violence petitions, regardless of the current status of a case.*
- *Establish a policy requiring that all service provider records be sent directly to the court.*
- *Establish a policy for 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.*

These five recommendations can be reviewed by the Green Book Project in Grafton County. This federally funded demonstration site will allow an in depth exploration of information sharing and collaboration between the courts, DCYF and domestic violence organizations.

Note: The previous five recommendations do not apply to the information protected under RSA 173:C - Confidential Communications Between Victims and Counselors.

The following recommendations are being actively addressed by the agencies that are directly involved and impacted by them.

- ***Require all mental health reports on court involved families to be forwarded to the courts, in addition to the Juvenile Services Officer (JSO).***
- ***Require parents to attend a certain number of parent education seminars when child abuse and neglect, CHINS, and/or juvenile petitions or school suspensions are involved.***

F. LEGISLATION

- ***Support efforts to increase funding to provide DCYF and other providers with the resources needed to effectively protect children and youth.***

Efforts to allocate for increased resources are always a focus of agencies. However, due to budget pressures, on going efforts have focussed on preventing additional budget cuts in the victim services field rather than increasing funding.

- ***Support legislation to reduce youth access to firearms.***

This is an area that the Child Fatality Review Committee will need to explore. The Attorney General's Task Force on Child Abuse and Neglect Legislative Subcommittee is making efforts to get more involved in this area, and could collaborate efforts with the Committee.

- ***Support statewide expansion of the Family Court Division concept.***

Individual agencies represented on the Child Fatality Review Committee express their support for the Family Court Division concept.

VI. CONCLUSION

The Committee has made significant progress over the last five years in developing and refining the difficult work of reviewing child fatalities. As in previous years, the Committee continues to challenge the professional community and state legislature to act expeditiously in evaluating the policies, procedures, services and laws that impact their work with children and families. Steadfast in its mission, the Committee will continue to vigorously review cases and treat each as a critical step that brings it closer to the goal of reducing child deaths and helping children lead safe and healthy lives.

APPENDIX A. EXECUTIVE ORDER

APPENDIX B. INTERAGENCY AGREEMENT

APPENDIX C. CONFIDENTIALITY AGREEMENT

**NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE
CONFIDENTIALITY AGREEMENT**

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

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

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

Print Name

Authorized Signature

Witness

Date

APPENDIX D. 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 statutorially 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).

