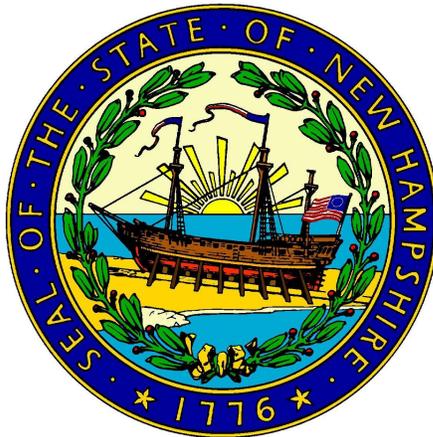


**THE STATE OF NEW HAMPSHIRE**



**TWELFTH REPORT OF THE  
CHILD FATALITY REVIEW COMMITTEE**

*Presented to  
The Honorable John H. Lynch  
Governor, State of New Hampshire  
September 2011*

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-0901NHCJA1) which is administered by the New Hampshire Department of Justice.

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## **DEDICATION**

The New Hampshire Child Fatality Review Committee dedicates this Twelfth Report, to the children of New Hampshire and to those who work to improve their lives and health. For the last 15 years that the Committee has been performing child death reviews, we have been sustained in the knowledge that what we do will improve the safety of New Hampshire's children and help to reduce the number of preventable deaths of children in our state.





## NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

September 2011

The New Hampshire Child Fatality Review Committee has begun its 15<sup>th</sup> 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 two-year report covering the work of the committee for the calendar years 2009 and 2010. Fatality data, provided by the Health Statistics and Data Management Section of the Division of Public Health Services, are presented for calendar years 2003 through 2008. Because we have relatively few child fatalities in New Hampshire, it is necessary to look at the data summaries to get a better indication of fatality trends, and not at a single year, which could fluctuate greatly from year to year.

As in previous years, members of the New Hampshire Child Fatality Review Committee have made presentations locally and nationally on the issues related to reducing child fatalities and on the work of our committee. Members have contributed to writing new national web-based curricula for new child death review members. We, again as in previous years, have been recognized nationally for our work in conducting successful reviews and in how we gather and respond to recommendations generated by these reviews. We meet annually here in New Hampshire with the teams from the other New England states. These joint meetings help give all of us an overview of the problems and solutions that the teams from these other states encounter in trying to prevent child fatalities. Finally, many of our members have written articles for newsletters and other publications regarding our recommendations for helping to reduce and prevent child fatalities.

As Chair, I would like to acknowledge the hard work and dedication of the members of the committee. I especially want to thank Danielle Snook, our staff assistant from the Attorney General's Office, for keeping the committee running smoothly and for all of the time and energy she has spent on preparing this annual report.- I also want to acknowledge two members of the committee from the Division of Public Health Services, Maternal and Child Health Section, for their work on this report: Audrey Knight, who has been working for years to improve the recommendations process for the committee's death reviews and Rhonda Seigal, who prepared and analyzed the data for this report. I would also like to acknowledge those who have completed their service on the committee since our last report: Paul Boisseau, William Boyle, Ed DeForrest, Elaine Frank, David Huot, Willard Martin, John McDermott, Joe Perry, Sue Prentiss, Katherine Rannie, Paul Spivack and Robert Stafford.

In recognition of this commitment and dedication, it is with great pride that as Chair, I present this, our Twelfth Report, to the Honorable, Governor of the State of New Hampshire.

On behalf of the committee,

*Marc Clement, PhD*

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.



**NEW HAMPSHIRE CHILD FATALITY REVIEW  
COMMITTEE MEMBERSHIP  
January 2009 to December 2010**

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

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

Judge Susan Ashley  
Family Division

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

\*Lorraine Bartlett  
Division for Children, Youth & Families  
Department of Health & Human Services

Vicki Blanchard  
Division of Emergency Medical Services  
Department of Safety

Lieutenant Mark Bodanza  
NH Police Standards and Training

\*George Bowersox  
Board of Pharmacy

Peg Clifford  
Board of Pharmacy

Deb Coe, MA  
NH Coalition Against Domestic & Sexual Violence

J. William Degnan, State Fire Marshall  
State Fire Marshall's Office

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

\*Jennie Duval, Deputy Chief Medical Examiner  
Office of the Chief Medical Examiner  
Department of Justice

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

Detective Matt Fleming  
Bedford Police Department

Wendy Gladstone, MD  
Pediatrician

\*Lieutenant Jill Hamel  
NH Police Standards and Training

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

\*Trooper Sara Howard  
NH State Police

Jane Kendall, RN  
Medical Consultant II - Benefits Specialist  
Office of Medicaid Business and Policy

Audrey Knight, MSN, RN, Child Health Nurse Consultant and  
SIDS Program Coordinator  
Division of Public Health Services, DHHS

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

\*Susan Meagher  
CASA of New Hampshire

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

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

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

\*Robin Raycraft-Flynn  
Division of Behavioral Health  
Department of Health & Human Services

Sergeant Jill Rockey  
NH State Police

Deb Samaha, Program Director  
Injury Prevention Center at Dartmouth

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

Rhonda Siegel, MSED  
Injury Prevention, Adolescent Health, and Prenatal Program  
Division of Public Health Services, DHHS

Marcia Sink, Executive Director  
CASA of New Hampshire

\*= Alternate



## I. EXECUTIVE SUMMARY

This report reflects the work of the New Hampshire Child Fatality Review Committee (hereafter referred to as “Committee”) during the 2009 and 2010 calendar years. The work of the Committee and the purpose of the recommendations that are produced during the reviews are to reduce preventable child fatalities in New Hampshire. During 2009 and 2010, the Committee held 12 meetings, which involved the review of a total of 13 cases.

The report begins with the Committee’s Mission Statement and Objectives, followed by a listing of the Committee members and their affiliations. There are a few short reports from representatives on the Committee on some of the initiatives they’ve been involved in related to child fatality. These include a federal grant to pilot a web-based Sudden Unexpected Infant Death Registry, participation on a national team to develop a Program Manual for Child Death Review which was made into a web-based curriculum, numerous articles in professional newsletters, and a variety of local, national, and international presentations and workgroups related to the review and prevention of infant and child deaths.

A review and analysis of the 2003 – 2008 New Hampshire child fatality review data shows that the majority of deaths in New Hampshire children (0 to 18 years of age) have been due to natural causes. New Hampshire has been consistent with national data in ranking Sudden Infant Death Syndrome (SIDS), as one of the leading causes of infant deaths. Cancer (malignant neoplasms) continues to be the leading cause of natural death for ages one through 18. Adolescents make up the majority of injury deaths with motor vehicle traffic crashes being the major cause. And suicides in children and adolescents are primarily due to suffocation, which differs from national statistics where the primary cause is firearm deaths.

A description of the responses to the recommendations generated from the 2009-2010 case reviews demonstrate follow up actions that range from exploring the feasibility of installing rumble strips on a New Hampshire roadway to developing an educational handout on swimming pool safety. In keeping with the New England spirit, the committee attempts to develop recommendations that are “S.A.F.E.R.” (Specific to the case being discussed, and Sustainable; Aceptable to the community and the political system; Feasible without too much effort; Effective and not too Expensive; and Risk free, i.e. no unintended consequences).

The work of the New Hampshire Child Fatality Review Committee has received national recognition on numerous occasions for its work in not only taking a look at what deaths have occurred, and why, but for developing and following up on recommendations that will hopefully make a difference in preventing or reducing the risks of further such deaths from occurring.

## II. STATEMENT OF ACCOUNTABILITY

The New Hampshire Child Fatality Review Committee was established in 1991 by an Executive Order of then Governor Judd Gregg. Please refer to [Appendix A](#) for a summary of the history, background, and methodology of the Committee. 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 right to confidentiality for families who lost children is respected in the work of the Committee.

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 vii) 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, which meets in the alternate months. The case review protocol can be found in ([Appendix F](#)). The purpose of the committee is to develop, as appropriate, recommendations to the Governor and relevant state agencies, with the intent of effecting change in state policy or practice, or to cause the development of new initiatives which could lead to the reduction of preventable deaths in children and youth. 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.

The Committee also hosts an annual Northern New England Child Fatality Review Meeting. This day-long meeting convenes the Child Fatality Review teams from Maine, Vermont, Massachusetts, Connecticut, and Rhode Island to discuss child fatalities that involved more than one New England state, share ideas and experiences to improve the functioning of the teams, and explore how information can be more effectively shared by different state agencies.

This is the Twelfth Report of the Committee, and as in previous reports, the main components of the report are the data section and the section on recommendations 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 over the previous year. These responses are published along with the recommendations. During 2009 and 2010, the Committee held 12 meetings, which involved the review of a total of 13 cases.

### **III. OTHER ACTIVITIES RELATED TO THE CHILD FATALITY REVIEW COMMITTEE**

The following is a description of several of the activities carried out in 2009 and 2010 related to the work of the Committee.

## **Sudden Unexpected Infant Death Web-based Registry Pilot Grant**

New Hampshire is one of seven states receiving a grant from the Centers for Disease Control (CDC) to pilot a web-based data system of Sudden Unexpected Infant Deaths (SUID). To better understand how and why these infants die, and to try to prevent further deaths from occurring, CDC has issued funding to monitor trends and characteristics associated with SUID. New Hampshire and Minnesota were funded only for the second and third years (August 2010 – July 2012) of this three-year grant, joining the five states that had started the project in the first year. New Hampshire and Minnesota began entering cases of infants whose deaths occurred as of January 1, 2011.

In addition to entering de-identified information about the death, grantees are required to do a review of all the sudden and unexpected infant deaths during the grant cycle. Supplemental Child Fatality Review Committee members who have expertise in areas related to perinatal care or services impacting infants, such as an obstetrics, midwifery, breast feeding, childbirth education, etc. were invited to attend the Child Fatality Review Committee meetings that are specific to the review of infants who died suddenly and unexpectedly. The first of these SUID-specific review meetings was held in June 2011.

The grant, awarded to the New Hampshire Department of Health and Human Services, Division of Public Health Services, Bureau of Population and Community Health Services, Maternal and Child Health Section, is being carried out in collaboration with the New Hampshire Department of Justice, Office of the Chief Medical Examiner.

## **National Child Death Review Conference**

In April 2011 the National Center for Child Death Review sponsored a National Meeting of Child Death Review Program Coordinators. This meeting, held in Atlanta, Georgia, entitled “*Opportunities to Improve Infant and Child Death Reviews*”, brought together the coordinators from 49 states and four Canadian provinces to discuss ways to improve the child death review process. The Chair of the New Hampshire team was on an ad hoc committee that set the agenda for the conference. He also made numerous presentations and led roundtable discussions on the work of the New Hampshire team, particularly in the area of follow-up on recommendations that result from our reviews. New Hampshire was cited for our pioneering efforts in creating team procedures and protocols for child death reviews.

## **Web-Based Curriculum for Child Death Review**

In the fall of 2005, the chair of the New Hampshire Child Fatality Review Committee was a member of a collaborative team that wrote a Program Manual for Child Death Review. The manual was written to provide information and tools needed to establish, manage, and evaluate effective review teams and team meetings. In the fall of 2010 a small group of child death review professionals, representing various states, convened in Colorado, under the auspices of the National Center for Child Death Review. The purpose of the meeting was to use the program manual as a basis to write a web-based child death review curriculum. The chair of the New Hampshire team was a member of that group. Over a three-day period, working in small groups, the participants developed a draft of this curriculum. The product was then taken back to

the National Center and the various sections were melded together and voice over was added. The completed sections were previewed at the April 2011 national meeting in Atlanta.

### **Professional Articles In Follow up to the Recommendations**

At the conclusion of the New Hampshire Child Fatality Review Committee reviews, recommendations are generated that hopefully, if implemented, will reduce the probability of similar deaths occurring in the future. These recommendations are sent to the appropriate agencies and responses to the recommendations are generated. These recommendations and responses are described in each report. In addition to the formal recommendations, a number of committee members use the recommendations to generate articles, which are then published in the newsletters of their professional organizations. These articles are also released, when appropriate, to the public via press releases, pamphlets, or brochures. Some examples include articles written on: car seat safety, the dangers of BB guns, legal requirements for swimming pool fencing, ATV and snowmobile safety and laws.

Articles have been written by committee member, Dr. Wendy Gladstone, for the Granite State Pediatrician, newsletter of the New Hampshire Pediatric Society, which is the New Hampshire Chapter of the American Academy of Pediatrics. The articles are to increase the awareness of pediatricians in New Hampshire about topics discussed in the Child Fatality Review Committee, and share recommended strategies for decreasing deaths or preventing injuries. The newsletter is sent electronically to all pediatricians who are members of the chapter, almost all pediatricians in the state (about 220). The newsletter is also posted on the Chapter's website: [www.nhps.org](http://www.nhps.org).

### **Activities of the Office of the Chief Medical Examiner**

New Hampshire's Chief Medical Examiner, Dr. Thomas Andrew, remains committed to the work done by the Child Fatality Review Committee and continues to be an active participant. In addition to the day-to-day casework involving the investigation of deaths in childhood, he is involved in educational and awareness-raising efforts of various types, including participation in New Hampshire's Youth Suicide Prevention Assembly, the recently formed New Hampshire Suicide Prevention Council, and the Abusive Head Trauma Coalition. Beyond New Hampshire, Dr. Andrew is a member of the American Academy of Pediatrics' Subsection on Child Abuse and Neglect, the Helper Society, the Sudden Unexpected Death in Childhood (SUDC) Advisory Council and currently is on the Board of Directors of the Association of SIDS and Infant Mortality Programs.

Dr. Andrew is a regular contributor to *The Quarterly Child Abuse Medical Update*, and has recently published an Update on "The Choking Game" with co-authors Dr. Andrew Macnab of Vancouver, British Columbia, and Dr. Patricia Russell of Tacoma, Washington in the *Journal of Pediatrics*. He has been an invited speaker on numerous areas that impact the work of the Child Fatality Review Committee, including:

- 1) Presentations on the use of social networking websites in suicide prevention efforts and the dissemination of Suicide Survivor packets at the 42<sup>nd</sup> annual meeting of the National Association of Medical Examiners

- 2) Regularly scheduled lectures on child abuse and neglect at Colby-Sawyer College in New London, New Hampshire and the University of New England in Portland, Maine,
- 3) Numerous state, regional, and national presentations on asphyxial games in children and adolescents including one in Paris, France,
- 4) Serving as a co-presenter in a seminar on postmortem pediatric toxicology at the 63<sup>rd</sup> annual meeting of the American Academy of Forensic Sciences
- 5) speaking on sudden unexpected infant death and the bed sharing conundrum at the American Trauma Society , Pennsylvania Division Conference, and
- 6) The development, in cooperation with the Research Triangle Institute, the Centers for Disease Control, and the National Association of Medical Examiners, an instructional webinar on normal infant growth and development, which was presented live three times, then made available on-demand for continuing education credits.

### **Bereavement Packets**

Starting in the fall of 2009, in follow up to a recommendation of the Committee, the Office of the Chief Medical Examiner began the practice of sending bereavement packets to families of those children whose deaths fall under their jurisdiction. The packets, which contain information and resources on getting through the painful and difficult time after a child's death, are sent in collaboration with the Division of Public Health's Maternal and Child Health Program.

These packets are not sent to families of infants whose death is initially considered to be a possible SIDS, who are sent a similar packet from the Division of Public Health's SIDS Program. The bereavement packets are also not sent to families of children who died from suicide, as those families receive a Suicide Survivor packet (see description of the Suicide Survivor packet on page 23). From November 2009 through December 2010, 18 bereavement packets have been sent.

## **IV. REVIEW AND ANALYSIS OF DATA**

The citation for this report is as follows: Data Source: New Hampshire Department of Health and Human Services, Office of Health Statistics and Data Management (HSDM), Death Certificate Data provided by the Department of State, Division of Vital Records Data Source: Bureau of Data and Systems Management (BDSM), Office of Medicaid Business and Policy (OMBP), Office of Health Statistics and Data Management (HSDM), New Hampshire Department of Health and Human Services (NH DHHS), and New Hampshire Department of State, Division of Vital Records Administration, 2003-2008. The Centers For Disease Control and Prevention/National Center for Health Statistics protocol "*ICD-10 Cause-of-Death Lists for Tabulating Mortality Statistics*," was used in preparing this report. That protocol can be found at: <http://www.cdc.gov/nchs/data/dvs/Part9InstructionManual2011.pdf>

Counts of events at 10 or less per year may be due to chance alone and do not produce reliable statistics. One should use caution when interpreting small numbers and percentages derived from them.

Please also note that three infant deaths from 2008 are still uncoded, as are two deaths in the same year between one and 17 years of age. These five children are not included in the data set.

This report presents deaths among children birth through the age of eighteen who were residents of the state of New Hampshire. The data can be broken into two major classifications of death, natural causes and injuries. Both types of death are analyzed in this report. Death by natural causes is a strictly defined term utilized when the cause of death is due *exclusively* to disease with no contribution by any injury or other exogenous factor. It encompasses, but is not limited to, diseases of the heart, malignant neoplasms (i.e.; cancer), conditions originating in the perinatal period (such as low birth weight and prematurity) and some sudden infant deaths. The other category of death is injury which refers to death from damage done to the structure or function of the body caused by an outside agent or force, which may be physical (as in a fall) or chemical (as in a burn or poisoning). Injury deaths are also classified as unintentional (such as in accidental drowning) or intentional (suicide or homicide).

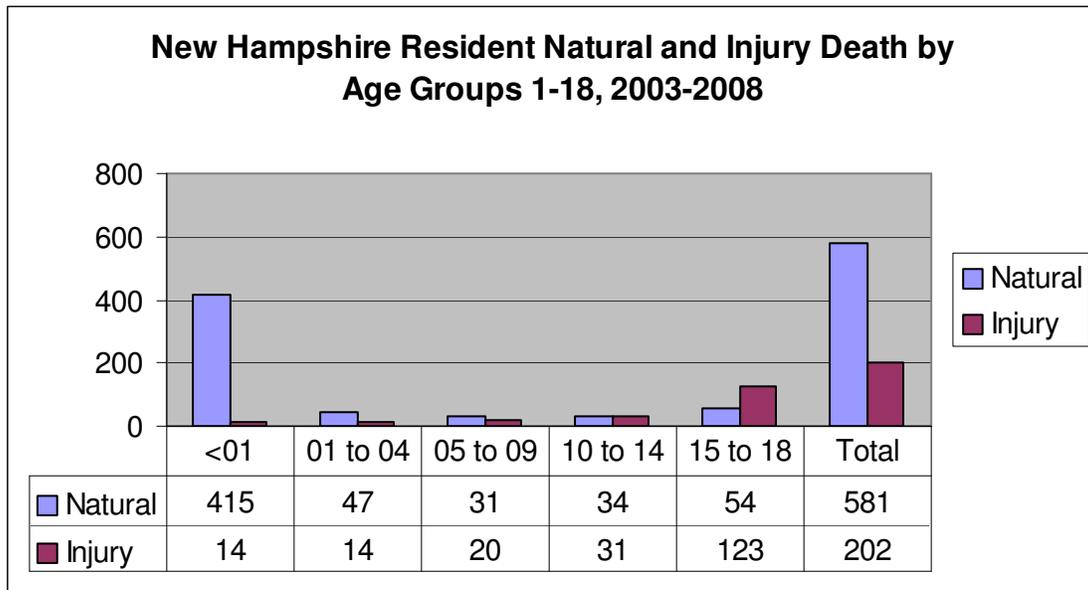
The majority of deaths (74%) in children from birth through age eighteen were due to natural causes over the six year period, 2003-2008 (Table 1). This was also the case for the year 2008 (70%, Table 2). Infants under age one comprised the majority of deaths due to natural causes in each time frame, 71% and 67% respectively (Chart 1). Adolescents (10-18), on the other hand, account for the majority of injury related deaths, also in each period, 76% and 75% respectively (Chart 1).

**Table 1**

**New Hampshire Resident Natural and Injury Deaths  
By Age Groups, 0-18, 2003-2008**

<b>Age Group</b>	<b>Natural</b>	<b>Injury</b>	<b>Total</b>
<01	415	14	<b>429</b>
01 to 04	47	14	<b>51</b>
05 to 09	31	20	<b>51</b>
10 to 14	34	31	<b>65</b>
15 to 18	54	123	<b>177</b>
<b>Total</b>	<b>581 (74%)</b>	<b>202 (26%)</b>	<b>783 (100%)</b>

Chart 1



**Table 2  
New Hampshire Resident Natural and Injury Deaths  
By Age Groups, 0-18, 2008**

Age Group	Natural	Injury	Total
<01	51	2	<b>53</b>
01 to 04	9	1	<b>10</b>
05 to 09	6	5	<b>11</b>
10 to 14	3	8	<b>11</b>
15 to 18	7	16	<b>23</b>
<b>Total</b>	<b>76 (70%)</b>	<b>32 (30%)</b>	<b>108 (100%)</b>

As was stated previously, infants less than one year of age died primarily from natural causes. The number one causes of deaths in the aggregated six year time period (Table 3) were due to congenital malformations, deformations, and chromosomal abnormalities. However, this category made up only 21% of natural deaths.

**Table 3**  
**New Hampshire Residents, Leading Causes of Natural Death,**  
**Infants**

<b>Natural Causes of Death</b>	<b>2003-2008</b>	<b>2008</b>
Congenital malformations, deformations and chromosomal abnormalities	82	9
Disorders related to short gestation and low birth weight, not elsewhere classified	69	5
Sudden infant death syndrome (SIDS)	43	5
Newborn affected by maternal complications of pregnancy	28	7
Newborn affected by complications of placenta, cord and membranes	24	3
Diseases of the circulatory system	15	0
Respiratory distress of newborn	9	0
Atelectasis	8	0
Gastritis, duodenitis, and noninfective enteritis and colitis	8	0
Neonatal hemorrhage	8	3
Bacterial sepsis of newborn	8	0
Other causes	87	13
<b>Total</b>	<b>389</b>	<b>45</b>

In reviewing infant death data, New Hampshire has been consistent with national data in ranking Sudden Infant Death Syndrome (SIDS), as one of the leading causes of infant deaths. SIDS is defined as the death of an infant less than one year of age, which remains unexplained after a thorough case investigation, including a complete autopsy, death scene investigation, and a review of the infant’s clinical history.

With the success of the national “Back to Sleep” campaign, reminding parents and childcare providers to put infants to sleep on their backs on a firm, flat mattress, the SIDS rate has been dropping significantly since the early 1990’s; however, although SIDS has declined, the rate of sudden and unexpected infant deaths, or SUID, has increased. This category includes those thought of as injury related including deaths from overlaying, suffocation, wedging, and other unsafe sleep situations. According to a study in *Pediatrics*, 2009<sup>1</sup>, the number of deaths from accidental suffocation and strangulation in bed quadrupled in the past two decades.

Deaths from several codes that include SIDS, “Undetermined”, and deaths from accidental suffocation and strangulation in a bed setting (R95, R99 and W75) as a cause of death can now be grouped in the category of “Sudden Unexpected Infant Death” (SUID). With such clustering, deaths from SUID now rank number one for the cause of infant deaths in the state in 2008 (Table 4), making up 28% of the natural deaths.

<sup>1</sup> Shapiro-Mendoza, C.K., Kimball, M., Tomashek, K.M., Anderson, R.N., and Blanding, S. (2009) US Infant Mortality Trends Attributable to Accidental Suffocation and Strangulation in Bed From 1984 Through 2004: Are Rates Increasing?. *Pediatrics*, 123, 533–539.

**Table 4**  
**New Hampshire Residents Five Leading Causes of Death,**  
**Under Age One, 2008**

<b>Five Leading Causes of Death</b>	<b>Total</b>
Sudden unexpected infant death (SUID)	11
Congenital malformations, deformations, and chromosomal abnormalities	9
Disorders related to short gestation and low birthweight, not elsewhere classified	5
Newborn affected by maternal complications of pregnancy	7
Unintentional injuries (taking out R99)	7
<b>Total</b>	<b>39</b>

This change in cause of infant deaths indicates a need to increase educational outreach to new and expectant parents, and all infant care providers, on the importance of a safe sleep environment. The American Academy of Pediatrics is expected to release its revised and updated recommendations on reducing the risk of SIDS and promoting safe sleep environment in late 2011. Once released, efforts will be made by the New Hampshire Division of Public Health Services, in collaboration with the New Hampshire Child Fatality Review Committee, to share the new recommendations with the general public and a broad variety of health and child care professionals.

New Hampshire is one of seven states receiving a grant from the Centers for Disease Control to pilot a Sudden Unexpected Infant Death registry to better understand the contributing factors of why babies are dying suddenly and unexpectedly. Please refer to the report section “Additional Related Activities” for more information on this grant.

Looking at natural causes of death for children and adolescents one through 18, malignant neoplasms or cancer is the leading cause for both the aggregated time period and 2008 (Table 5). This is consistent with both the national data and previous years.

**Table 5**

**New Hampshire Residents, Leading Causes of Natural Death,  
Ages 1-18**

<b>Leading Causes of Death</b>	<b>2003-2008</b>	<b>2008</b>
Malignant neoplasms	50	7
Congenital malformations, deformations and chromosomal abnormalities	24	6
Diseases of heart	13	0
In situ neoplasms, benign neoplasms and neoplasms of uncertain or unknown behavior	6	0
Certain conditions originating in the perinatal period	4	1
Influenza and pneumonia	4	1
Alzheimer's disease	3	0
Pneumonitis due to solids and liquids	3	1
Chronic lower respiratory diseases	3	1
Meningitis	2	0
Septicemia	2	0
Other or unknown causes	52	10
<b>Total</b>	<b>166</b>	<b>27</b>

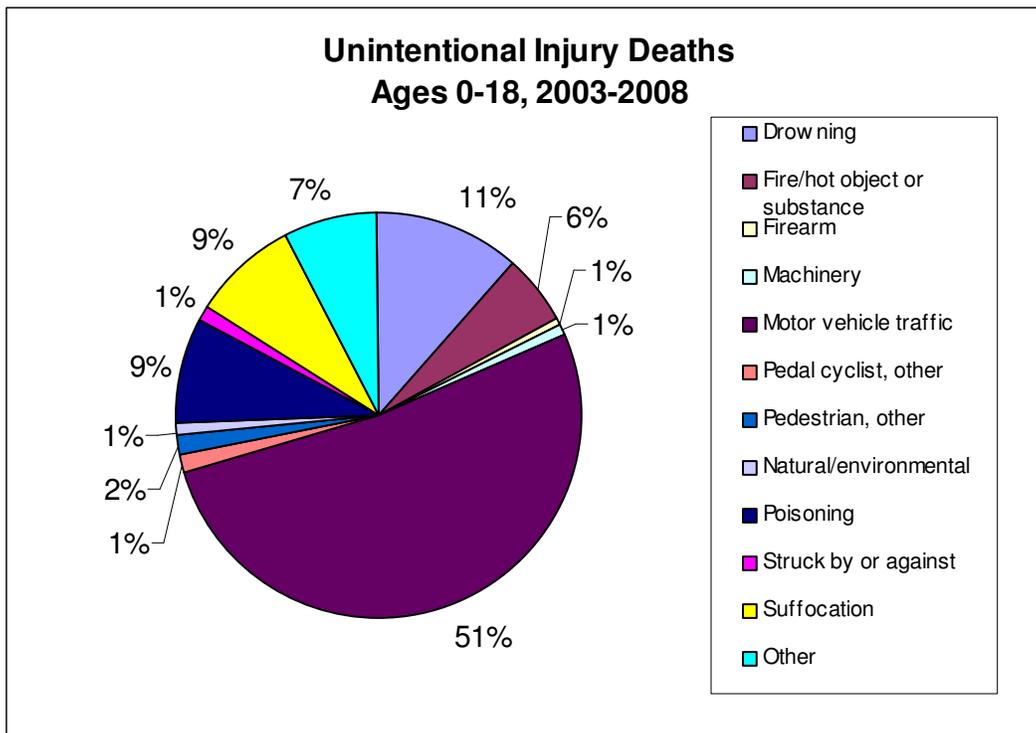
Reviewing unintentional injury deaths in children (Tables 6 and 7, Chart 2), motor vehicle traffic was the leading cause of death. This cause exceeded even those due to natural causes (Tables 1 and 2) to show that for adolescents, motor vehicle crashes are the leading cause of death. More adolescents died due to motor vehicle crashes than all other unintentional injuries combined. Drowning, poisonings, and suffocation are also top causes of death. Unintentional injury deaths in adolescents for these causes are greater than for any other age group.

The poisoning deaths of adolescents 15-19 have unfortunately been climbing. This is primarily due to the increase in deaths coded X42, which is accidental poisoning by and exposure to narcotic and psychodysleptics (hallucinogens), not elsewhere classified.

**Table 6**  
**New Hampshire Residents, Unintentional Injury Deaths**  
**Ages 0 to 18, 2003-2008**

Cause of Death	Ages Group					Total
	<01	01 to 04	05 to 09	10 to 14	15 to 18	
Drowning	1	3	3	3	9	<b>19</b>
Fire/hot object or substance	0	1	3	5	0	<b>9</b>
Firearm	0	0	0	0	1	<b>1</b>
Machinery	0	0	1	0	0	<b>1</b>
Motor vehicle traffic	0	3	8	9	64	<b>84</b>
Pedal cyclist, other	0	0	1	1	0	<b>2</b>
Pedestrian, other	0	1	0	1	1	<b>3</b>
Natural/environmental	1	0	0	0	0	<b>1</b>
Poisoning	0	0	0	0	14	<b>14</b>
Struck by or against	0	0	0	1	1	<b>2</b>
Suffocation	11	2	0	1	0	<b>14</b>
Other	0	0	3	2	7	<b>12</b>
<b>Total</b>	<b>13</b>	<b>10</b>	<b>19</b>	<b>23</b>	<b>91</b>	<b>162</b>

**Chart 2**



**Table 7**  
**New Hampshire Residents, Unintentional Injury Deaths,**  
**Ages 0 to 18, 2008**

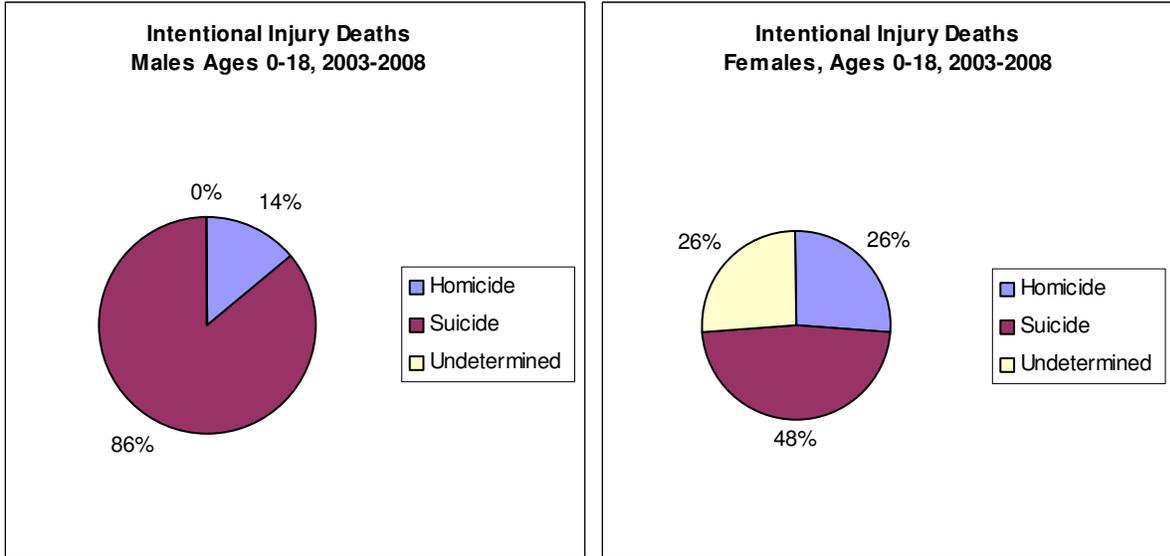
Cause of Death	Age Group					Total
	<01	01 to 04	05 to 09	10 to 14	15 to 18	
Drowning	0	0	0	1	2	3
Fire/hot object or substance	0	0	1	2	0	3
Machinery	0	0	1	0	0	1
Motor vehicle traffic	0	1	1	1	5	8
Pedal cyclist, other	0	0	1	0	0	1
Pedestrian, other	0	0	0	1	1	2
Poisoning	0	0	0	0	2	2
Suffocation	2	0	0	0	0	2
Other	0	0	1	0	1	2
<b>Total</b>	<b>2</b>	<b>1</b>	<b>5</b>	<b>5</b>	<b>11</b>	<b>24</b>

Suicide is the leading cause of intentional injury deaths for children and adolescents (Tables 8 and 9, Charts 3 and 4). The incidence of suicide amongst males is greater than females, primarily because their choice of method is more lethal (e.g. firearm versus poisoning). Hanging/Asphyxiation was the leading mechanism of suicide death in both males and females (Tables 10 and 11). On a national level, firearm deaths make up a greater percentage of suicide deaths in this young age group than in New Hampshire.

**Table 8**  
**New Hampshire Residents, Intentional Injury**  
**Ages 0-18, 2003-2008**

	<01	01 to 04	05 to 09	10 to 14	15-19	Total
<b>Males</b>						
Homicide	1	1	0	0	1	3
Suicide	0	0	0	5	13	18
Undetermined	0	0	0	0	0	0
<b>Females</b>						
Homicide	0	1	1	2	1	5
Suicide	0	0	0	1	8	9
Undetermined	0	2	0	0	3	5
<b>Total</b>	<b>1</b>	<b>4</b>	<b>1</b>	<b>8</b>	<b>26</b>	<b>40</b>

**Charts 3 and 4**



**Table 9**

**New Hampshire Residents, Intentional Injury, Ages 0-18, 2008**

	<01	01 to 04	05 to 09	10 to 14	15-19	Total
<b>Males</b>						
Homicide	0	0	0	0	1	<b>1</b>
Suicide	0	0	0	3	1	<b>4</b>
Undetermined	0	0	0	0	0	<b>0</b>
<b>Females</b>						
Homicide	0	0	0	0	0	<b>0</b>
Suicide	0	0	0	0	1	<b>1</b>
Undetermined	0	0	0	0	2	<b>2</b>
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3</b>	<b>5</b>	<b>8</b>

**Table 10**

**New Hampshire Residents, Suicide Deaths, Ages 0-18, 2003-2008**

Cut/pierce	1
Firearm	4
Poisoning	3
Suffocation	19
<b>Total</b>	<b>27</b>

**Table 11**  
**New Hampshire Residents, Suicide Deaths,**  
**Ages 0-18, 2008**

Suffocation	5
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Looking at seasonal variations of injury deaths by mechanism (Table 12) (again taking into account low numbers), there is an increased incidence of child deaths due to fire or hot object/substance (i.e. burns) in the winter. This agrees with national data and is due primarily to fires ignited by alternate heating mechanisms, often misused, such as a space heater.

Another seasonal difference can be seen in the increase in drowning in the summer. Most drownings in the state occur in natural bodies of water, such as rivers and lakes, where summer is the high season for exposure.

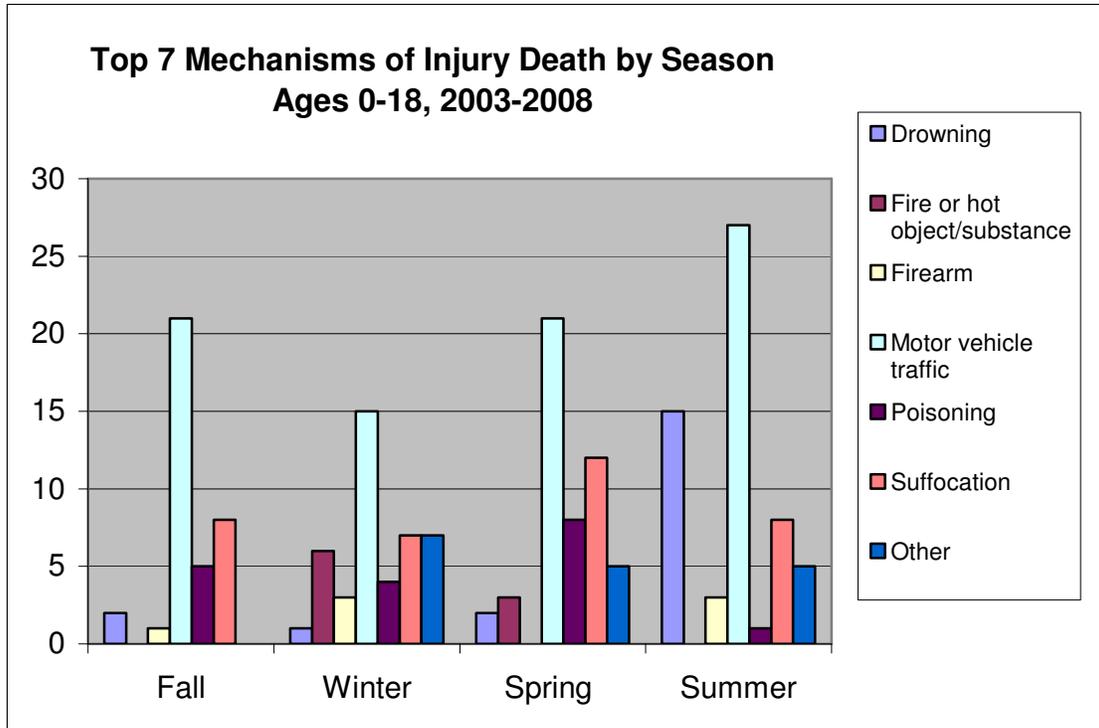
Motor vehicle crashes were slightly higher in the summer, similar to national data, probably due to the larger number of vehicle miles traveled.

It is interesting to note that among the intentional (all of the firearm, majority of suffocation, and some of the poisoning) injury deaths, there is little if any variation amongst seasons. These would include the suicide and homicide deaths.

**Table 12**  
**Mechanism of Injury Deaths by Season, New Hampshire Residents,**  
**Age 0 to 18 years, 2003-2008**

Cause of Injury Death	Fall	Winter	Spring	Summer	Total
Cut/pierce	2	0	0	1	3
Drowning	2	1	2	15	20
Fire or hot object/substance	0	6	3	0	9
Firearm	1	3	0	3	7
Machinery	0	1	0	0	1
Motor vehicle traffic	21	15	21	27	84
Pedal cyclist, other	0	0	2	0	2
Pedestrian, other	0	0	1	2	3
Natural/environmental	0	0	0	1	1
Poisoning	5	4	8	1	18
Struck by or against	0	1	1	0	2
Suffocation	8	7	12	8	35
Other	0	7	5	5	17
<b>Total</b>	<b>39</b>	<b>45</b>	<b>55</b>	<b>63</b>	<b>202</b>

Chart 5



## V. RESPONSES TO RECOMMENDATIONS FROM CHILD FATALITY COMMITTEE (CFRC) REVIEWS CONDUCTED IN 2009 AND 2010

The CFRC uses a *Recommendation Development Worksheet Form* ([Appendix G](#)) developed from forms used by other states, to record recommendations resulting from the case reviews conducted by the Committee. Once a recommendation is made, it is sorted into the following categories:

- Public Awareness
- Training and Education
- Policy
- Professional Collaboration

Each recommendation is then assigned to the appropriate committee member responsible for taking the recommendation back to the agency that is capable of responding to and/or implementing that recommendation.

A summary of the responses and follow up to these recommendations follows. Cases reviewed included deaths from motor vehicle crashes, suicides, drowning, fire and off road vehicles which had occurred within the past five years.

### **PUBLIC AWARENESS RECOMMENDATIONS AND RESPONSES**

1. Increase public awareness of preventing Shaken Baby Syndrome and of the dangers of touching a child in anger through the mechanism of public service announcements (PSA's).

***RESPONSE:*** *In April 2010, The New Hampshire Brain Injury Association of New Hampshire, with funding from the federal American Recovery and Reinvestment Act of 2009 grant of the New Hampshire Bureau of Developmental Services, convened a group to work on the prevention of Shaken Baby Syndrome. The Abusive Head Trauma (AHT) Coalition, which includes several members of the CFRC, was launched from the workgroup and has been meeting frequently. The coalition has been reviewing current data on AHT, assessing resources available, and discussing prevention strategies. The coalition discussed obtaining PSA's from national organizations, but voted not to pursue that strategy, and instead, chose to focus initially on using the limited grant funds available to assist several hospitals in the state to implement The Period of Purple Crying, a nationally recognized primary prevention program. This is an evidence-based, multi-stage prevention program that has been utilized in numerous states. Public awareness is a component of this program and will be utilized within the scope of the project as indicated. Use of radio PSA's, transit ads, newspaper ads, posters, etc. have begun to be utilized as part of several New Hampshire hospitals' implementation plans in the summer of 2011.*

*In addition, a pediatrician member of the CFRC published an article on Shaken Baby Syndrome in the Granite State Pediatrician, newsletter of the New Hampshire Pediatric Society.*

2. Increase educational efforts on child passenger safety throughout the state.

***RESPONSE:*** *Announcements of upcoming car seat inspection certification courses are currently mailed to all police and fire departments within the state. In addition, announcements are sent to all hospitals including their Birthing Units and Health Education Units. Two certification courses are provided each year. These four-day courses are held in different parts of the state to meet the geographic challenges of the state. The New Hampshire Child Passenger Safety Program will expand their announcements to their website listed under Children's Hospital at Dartmouth, the New Hampshire Automotive Dealership Association, the New Hampshire School Nurses' listserv, the Safe Kids New Hampshire email list, and the New Hampshire Public Health Networks. The certification training course is nationally standardized, and cannot be altered. It requires classroom and hands-on skill development and testing which does not lend itself to become an on-line course. A shortened course, Operation Kids, is in revision after being piloted in fall 2009. This course provides knowledge and can raise awareness about child passenger safety. It does not provide sufficient training to become a certified technician.*

*The National Child Passenger Safety Board has developed and distributed a community education tool kit to assist and encourage certified technicians in providing community education. Certified technicians are expected to provide community education. This new tool kit provides them with the resources to do so. Access to this tool has been made available to the 150 certified technicians in New Hampshire.*

3. Disseminate information to schools and health care providers about winter sports safety.

***RESPONSE:*** *Each fall, the Injury Prevention Center at Dartmouth sends out packets of winter sports safety information to approximately 300 school nurses via the school nurse listserv. This packet also includes information on purchasing low cost ski helmets. Additionally, a joint press release was drafted with staff from the Department of Fish and Game regarding snowmobile safety and was submitted for release via the public affairs office at the Children's Hospital at Dartmouth.*

*In addition, member of the CFRC published an article on winter sports safety in the Granite State Pediatrician, newsletter of the New Hampshire Pediatric Society.*

4. Increase public education on the need for working smoke detectors and doing practice fire drills in the home and other living and sleeping areas.

***Response:*** Posters on fire safety were printed by the New Hampshire Fire Marshall's Office and distributed to state-funded community health centers, home visiting programs, and WIC clinics. Fire safety posters were also added to Injury Prevention Center at Dartmouth's web site at: [http://chad.dartmouth-hitchcock.org/documents/pdf/smoking\\_home\\_fires\\_poster.pdf](http://chad.dartmouth-hitchcock.org/documents/pdf/smoking_home_fires_poster.pdf))

*Information was also submitted on fire safety resources via the school nurse listserv.*

5. Increase public awareness regarding proper use of power strips (i.e. use quality ones, do not overload them etc.).

***RESPONSE:*** No action successfully taken.

6. Increase awareness of general population on dangers of air rifles.

***RESPONSE:*** An article was written on this topic for Granite State Pediatrician, newsletter of the New Hampshire Pediatric Society. The article was shared with the Community Mental Health Centers and was also disseminated to the 400+ mailing list of the Youth Suicide Prevention Assembly. Future plans include re-sending this to the afore-mentioned groups before Christmas to coincide with the showing of "A Christmas Story" in which the line, "You'll shoot your eye out" references the possible dangers of an air rifle.

*The Injury Prevention Center at Dartmouth has added an air gun statement to their firearm safety section.*

## **TRAINING RECOMMENDATIONS AND RESPONSES**

7. Improve documentation of suspected child abuse in the medical record detailing the circumstances.

***RESPONSE:*** No action successfully taken

8. Improve the reporting of suspected child abuse/neglect by hospital emergency room staff.

***RESPONSE:*** No action successfully taken

9. Promote training programs and resiliency training for victims of bullying.

***RESPONSE:*** New Hampshire RSA 193-F: 4, the Pupil Safety and Violence Prevention Act, was updated, effective July 1st, 2010. The law further defines bullying, outlines a reporting structure and requires school administrative units (e.g. school districts) to have a written bullying and cyber bullying policy. The law also mandates staff and student training on bullying.

10. Promote safe storage of firearms.

***RESPONSE:*** *An annual Mortality Report outlining the deaths of mental health consumers is written for the Bureau of Behavioral Health and disseminated to the ten Community Mental Health Centers. One of the recommendations for “Suicide” deaths is to encourage clinicians to remind their consumers to store any firearms they (or anyone with whom they share a residence) own safely. This is not only for themselves, but others who may be at risk who also live in the residence, or visit. This is also mentioned regularly in various e-mails that go out to the Mental Health Centers promoting avenues of suicide prevention. The Annual Report compiled by the Suicide Prevention Council lists proven strategies of suicide prevention; “restricting access to lethal means” is one cited.*

*Information on “Counseling on Access to Lethal Means (“CALM”) will be posted on the Injury Prevention Center at Dartmouth’s web site. CALM is a two-hour workshop designed to help mental health providers implement counseling strategies to help clients and their families reduce access to lethal means, particularly (but not exclusively) firearms. Training is required.*

11. Promote training on “Connect”.

***RESPONSE:*** *The Bureau of Behavioral Health contracted with the New Hampshire Chapter of the National Alliance for the Mentally Ill (NAMI) to train some school nurses in “Connect”, a suicide prevention curriculum.*

12. Encourage car dealerships to become a resource for passenger safety information.

***RESPONSE:*** *The New Hampshire Child Passenger Safety Program will contact the New Hampshire Automotive Dealership Association to provide educational materials regarding protection of all occupants in vehicles. They will offer educational materials on child passenger safety and offer to provide training to staff at dealerships. They will personally contact dealerships with whom they have a relationship to offer an educational session to their staff.*

13. Explore having the New Hampshire Department of Fish and Game do in-service at Police Standards and Training Council on Off-Highway Recreational Vehicle rules and regulations.

***RESPONSE:*** *The Director of the Police Standards and Training Council has agreed to coordinate this training for in-service officers, and personnel from the Department of Fish and Game have agreed to assist in the course. Dates are being selected for this class and are being placed in the training calendar.*

14. Provide education to healthcare providers on the dangers of firearms for children especially at risk due to behavioral issues.

***RESPONSE:*** *A pediatrician member of the CFRC published an article on air guns in the Granite State Pediatrician, newsletter of the New Hampshire Pediatric Society.*

## **POLICY RECOMMENDATIONS AND RESPONSES**

15. Address failure to report suspicions of serious abuse and neglect by hospital emergency care providers.

***RESPONSE:*** *An informal survey was conducted among staff of three New Hampshire hospital emergency rooms. The staff indicated that they believe they are more sensitized to the issue of abuse than any other medical personnel. They also reported that all of their hospital personnel are trained in identifying abuse and in the requirement to report suspected abuse. The three hospitals have protocols for reporting suspected abuse.*

*Staff from the Department of Children, Youth and Families wrote an article describing New Hampshire's reporting requirements that was submitted for publication in the Board of Medicine's July, 2009 newsletter.*

*The CFRC has attempted several times in the past ten years to get representation from the New Hampshire Hospital Association at the CFRC meetings but has been unsuccessful.*

16. Investigate feasibility of installation of rumble strips in the Route 16 area of Albany.

***RESPONSE:*** *The Department of Transportation was contacted, and it was found that they had done an analysis of this road site to determine the feasibility of installing rumble strips (edge and center). The Department of Transportation has three considerations for the installation of rumble strips:*

- 1) If run off Road and Center line Encroachment crashes exceeds the expected number.*
- 2) If the asphalt cross section can support the installation.*
- 3) The town supports the installation.*

*Route 16 in Albany meets considerations (1) & (3); however, the asphalt cross section will not support the installation.*

*The Department of Transportation was in agreement that a rumble strip was indicated and would be an effective counter measure to install. The next time this section is overlaid, the cross section may be improved to support the installation. It was suggested that the CFRC should send a letter to the town of Albany requesting that the next time the road was paved, that this counter*

*measure be installed as the current pavement would not support this treatment at this time.*

17. Explore augmenting snowmobile registration forms to include an informational safety checklist.

***RESPONSE:*** *The New Hampshire Department of Fish and Game was consulted regarding changing the form to include a helmet safety message. The form would allow a few additional characters to be included but no major changes due to space constraints. The Department of Fish and Game representative on the CFRC suggested that a letter of request be sent to him asking to incorporate this safety message into the future form revisions.*

18. Obtain more information about adoption of international building codes for pools and how they related to the state code. Contact the Association of Pool and Spa Professionals regarding public awareness efforts with SAFE KIDS.

***RESPONSE:*** *No action successfully taken*

19. Obtain more information about enforcement of building codes.

***RESPONSE:*** *The Injury Prevention Center made contact with the Chair of the New Hampshire Building Code Commission and the two organizations jointly developed a public awareness document called “Swimming Pools: Keeping Your Kids Safe”. It was distributed via the school nurse listserv state wide and was posted on the Injury Prevention Center at Dartmouth’s web site at [http://chad.dartmouth-hitchcock.org/documents/pdf/swimming\\_pools.pdf](http://chad.dartmouth-hitchcock.org/documents/pdf/swimming_pools.pdf)*

20. Contact the professional associations of home inspectors, real estate realtors, and insurance companies regarding what they do regarding pool safety, pool covers etc.

***RESPONSE:*** *Home Inspectors, who are licensed by the state, adhere to Administrative Rule 600, Standards of Practice; however, many areas are not required by rule. One area not required is any “Recreational facilities”, i.e. any spas, saunas, steam baths, swimming pools, entertainment, athletic, playground or other similar equipment and associated accessories.*

*Realtors are also licensed by the State, RSA 331-A: 3, and governed by Administrative rules. When reviewing what a Realtor asks a seller of a home, in the Property Disclosure forms, there are no questions asked about pools or fencing. There is usually no effort to ask about proper pool permitting and required fencing because it is an area of liability for which they do not “own” a responsibility; however, there is “due diligence” to make sure the property is in compliance to the extent of the disclosure of the property holder.*

*The Insurance Association described a general outline regarding policy underwriting. If the policy is a new homeowner’s policy then the property is*

*subject to inspection, but only for the first 90 days, and then the insurance company loses some ability to inspect the property with conditions of termination of the policy. If the property owner discloses they have added a pool, then the insurance company can set conditions in which they would insure the property, (i.e. putting up a four foot enclosure around the pool with a self locking door). Unless the property is mortgaged, no one is required to carry homeowners insurance. Additionally, if they do not disclose the information to the insurance company, and they stay with the same company, they will probably not be subject to another property inspection.*

*None of the above claims a responsibility to ensure that the homeowner is in compliance with this “safety regulation”. The possibility of legislation, administrative rule, or enforced town ordinance may be the only conveyance to remedy the potential hazards of not having the proper enclosure around a pool.*

*The codes that have been adopted by the state building code relative to protective enclosures for pools were reviewed. These codes are in full force statewide. They are adopted pursuant to RSA 155-A the State Building Code and are enforced by the local building official and in communities without a building official through the Fire Marshall’s office. The code not only has a provision for safety enclosures but also has a provision for the pool drain not being able to hold a child down due to the suction.*

21. Change current legislation regarding smoke alarms.

***RESPONSE: Legislation to require smoke alarm verification failed. The suggestion is to work with stakeholders, i.e. fire and building officials, in conjunction with realtors, to have legislation reconsidered in the future.***

22. Enter into discussion with Local Government Center and Primex as to how they can be more involved in building code enforcement.

***RESPONSE: The New Hampshire State Fire Marshall’s office will pursue the encouragement of a discussion between representatives of Local Government Center & Primex, and with fire and building officials, to enhance the effectiveness of code enforcement.***

23. Explore adding a member of the Division of Parks and Recreation’s Trails Bureau and the Department of Fish and Game to the Child Fatality Review Committee.

***RESPONSE: This recommendation is presently being pursued.***

24. Explore instituting dust control measures at critical points on ATV trails as routine maintenance.

***RESPONSE: The Division of Parks and Recreation’s Bureau of Trails has responsibility to "Provide the planning, development and maintenance of the***

*state trail system according to state statute. (Chapter 215-A).*

*The only reference to trail design is in Section 215-A: 42 z:” that the proposed trail layout has a safe and appropriate trail design”. These administrative rules do not reference any safety criteria, and expire in 2016. There is an opportunity between now and 2016 to work with the Bureau of Trails to develop some definitive safety criteria for trails.*

25. Encourage review and clarification/streamlining rules and/or statutes regarding ages at which persons are able to operate off road recreational vehicle (OHRV).

***RESPONSE:*** *Age is addressed in Section 215-A: 29 OHRV Operation and License, of the statute. There is brochure that addresses some of these concerns. Because it is a statute, it will be more difficult to modify. The Department of Fish and Game was contacted and they will discuss this matter with the OHRV Safety Committee when they resume meeting in August 2011.*

## **PROFESSIONAL COLLABORATION RECOMMENDATIONS AND RESPONSES**

26. Encourage school nurses to connect with the local Community Mental Health Centers and vice versa.

***RESPONSE*** *Twice a year (spring and fall), an e-mail is sent to the ten Community Mental Health Centers’ Children’s Directors encouraging them, if they have not already done so, to make connections with all the schools in their catchment areas. Suggestions are made to specifically reach out to the schools’ guidance counselors and the school nurses.*

27. The New Hampshire Child Fatality Review Committee endorses the work of the Suicide Prevention Council and the Suicide Survivor packet.

***RESPONSE:*** *The mission of the State Suicide Prevention Council is to reduce the incidence of suicide in New Hampshire by accomplishing the goals of the State Suicide Prevention Plan:*

- \* Raise public and professional awareness of suicide prevention;*
- \* Address the mental health and substance abuse needs of all residents;*
- \* Address the needs of those affected by suicide; and*
- \* Promote policy change*

*The Bureau of Behavioral Health funds the dissemination of “Survivor Packets” that are mailed out approximately one month after the suicide of anyone who dies in New Hampshire. These packets contain general information about grieving and list suicide-specific websites for information and other resources. The packets also contain information about Survivor of Suicide support groups in the state and the contact information for the ten Community Mental Health Centers. A CD of music, produced by the father of a son who died by suicide, is also enclosed in the packet.*

28. Promote the use of ‘Critical Incident Stress Management (CISM)’ and other post-vention efforts for First Responders.

***RESPONSE*** *It has been the practice of many Fire Departments, Police Departments, EMS and hospital Emergency Departments to offer debriefings following SIDS. The use of the Granite State Critical Incident Stress Management Team for other child fatalities varies somewhat among the different parts of the state. Most calls for debriefings are in response to the deaths of children or young adults. Debriefings are one part of CISM. CISM offers a variety of services and is a concept that it is a practice not just a response.*

29. Encourage snowmobile clubs to promote more safety activities.

***RESPONSE:*** *The Department of Fish and Game personnel reported that there is a volunteer trail patrol. They are able to identify hazards, assist with lost or broken down vehicles and report dangerous behavior. They are not able to be involved in any enforcement activities.*

30. Encourage Community Mental Health Centers to include talking to families of high-risk children about access to pools and open water.

***RESPONSE:*** *E-mail is sent out twice a year to the provider disciplines within the ten Community Mental Health Centers encouraging clinicians to address pool and water safety concerns with their consumers. This “safety message” is not just for their consumers’ children, but also for others who may frequent their residences.*

31. Remind law enforcement to review local ordinances and make recommendations to their officers.

***RESPONSE:*** *An article was written for the Police Standards and Training Council Bulletin.*

32. Support efforts to strengthen enforcement of statewide building and fire codes.

***RESPONSE:*** *Efforts could include enhanced training to the fire and building code enforcement community; providing information to the legislature to stop the erosion of the code effectiveness; and encouraging the Building Code Review Board and the Board of Fire Control to be more aware of the end product of code enforcement by strengthening the enforcement.*

33. Increase awareness of building and fire code requirements.

***RESPONSE:*** *No action successfully taken.*

34. Increase awareness of the New Hampshire Department of Recreation and Economic Development regarding recommendations of the New Hampshire Child Fatality Review Committee.

***RESPONSE: The head of the Department of Parks and Recreation has been added to the distribution list to receive the CFRC report.***

35. The New Hampshire Child Fatality Review Committee endorses greater collaboration between schools and the Community Mental Health Centers regarding early identification and referral of youth with emerging mental health issues.
36. The New Hampshire Child Fatality Review Committee endorses increasing the funding to Community Mental Health Centers to increase the number of providers available to meet community needs.
37. The New Hampshire Child Fatality Review Committee endorses the continuation and expansion of funding and support of school based early identification and referral programs.

## **VII. CONCLUSION**

This report has highlights the important work of the New Hampshire Child Fatality Review Committee. We hope 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 29<sup>th</sup> day of September in the year of our Lord, one thousand nine hundred and ninety-five.

  
Governor of New Hampshire

## **APPENDIX C: INTERAGENCY AGREEMENT**

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

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

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

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

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

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

- 1) To describe trends and patterns of child deaths in New Hampshire.
- 2) To identify and investigate the prevalence of a number of risks and potential risk factors in the populations of deceased children.
- 3) To evaluate the service and system responses to children and families who are considered to be high risk, and to offer recommendations for improvement in those responses.
- 4) To characterize high risk groups in terms that are compatible with the development of public policy.
- 5) To improve the sources of data collection by developing protocols for autopsies, death investigations and complete recording of cause of death on the death certificates.
- 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, education, with specific membership designated agencies to include, but not to be limited to: the Office of the Chief Medical Examiner, the New Hampshire Pediatric Society and the New Hampshire SIDS Program; and



**APPENDIX D: CONFIDENTIALITY AGREEMENT**

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

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

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

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

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Print Name

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Authorized Signature

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Witness

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Date



## **APPENDIX E: STATUTORY AGREEMENT**

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

As a condition for receiving funds from the New Hampshire Department of Justice through the Children’s Justice Act Grant, administered by United States Department of Health and Human Services, the State of New Hampshire is required to establish a citizen/professional review panel to “evaluate the extent to which the agencies are effectively discharging their child protection responsibilities.” The New Hampshire Child Fatality Review Committee meets the criteria for this review process. 42 U.S.C. 5106a(c)(A). (CAPTA, Child Abuse Prevention & Treatment Act).

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

The 1996 CAPTA amendments require:

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

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

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



## **APPENDIX F: CASE REVIEW PROTOCOL**

1. The Committee will review data regarding all deaths of New Hampshire children up to and including 18 years old.
2. Comprehensive, multidisciplinary review of any specific cases may be initiated by the Department of Justice, the Department of Health and Human Services, the Department of Safety, or by any member of the New Hampshire Child Fatality Review Committee (CFRC).
3. The review process begins with obtaining a list of in-state child deaths from the New Hampshire Department of Health and Human Services and/or from the Office of the Chief Medical Examiner.
  - A. The deaths are then sorted by manner of death: natural, homicide, traffic, suicide, and accident other than traffic.
  - B. Prior to clinical review, relevant records (e.g.: autopsy reports, law enforcement, Division for Children Youth and Families) are obtained.
  - C. Cases may be selected for full Committee review by the Executive Committee from a variety of resources and documents which enumerate children's deaths and their cases from 1994 on.
  - D. The review focuses on such issues as:
    - Was the death investigation adequate?
    - Was there access to adequate services?
    - What recommendations for systems changes can be made?
    - Was the death preventable?\*
4. After review of all confidential material, the Committee may provide a summary report of specific findings to the Governor and other relevant agencies and individuals.
5. The CFRC will develop periodic reports on child fatalities, which are consistent with state and federal confidentiality requirements.
6. The CFRC will convene at times published.
7. Each CFRC member will have an alternate member from their discipline or agency and will ensure that one member will be present at every meeting.
8. Confidentiality Agreements are required of any individual participating in any CFRC meeting.
9. The CFRC Executive Committee, comprised of members of the CFRC, assesses case information to be reviewed by the CFRC and performs other business as needed.

### **\*WHAT IS A PREVENTABLE DEATH?**

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



**APPENDIX G: RECOMMENDATION DEVELOPMENT WORKSHEET**

**MEETING DATE:** \_\_\_\_\_

**TYPE OF DEATH(S)/PROBLEM(S) REVIEWED:**

**RECOMMENDATION(S) AND IMPLEMENTATION PLAN**

	<b>Recommendation:</b>	<b>Steps to implement:</b>	<b>Person responsible for implementing steps:</b>	<b>Timeline:</b>	<b>Additional Follow-Up:</b>	<b>Response/ Current Status</b>	<b>Category</b> *Public Awareness *Training/ Education *Policy *Professional Collaboration
1)							
2)							
3)							
4)							
5)							
6)							