

State of New Hampshire

Child Fatality Review Committee

Annual Report

State Fiscal Year 2023

NEW HAMPSHIRE DHHS
DEPARTMENT OF HEALTH & HUMAN SERVICES

NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs *for all*

Acknowledgement

We, the committee, would like to take a moment to acknowledge the hard work and dedication that every participant contributes to the efforts of the child fatality review.

Reviewing circumstances surrounding any death is never easy and it is that much more difficult when it is a child.

Through your commitment to this program, recommendations are created to prevent similar circumstances from occurring again.

Thank you.

Table of Contents

Executive Summary 1
Overview and Protocol 2
Understanding Child Death Data 4
Data Definitions 4
Deaths of Children In New Hampshire 5
Deaths of Infants in New Hampshire 8
Child, Adolescent, and Young Adult Deaths (Ages 1 To 21 Years) in New Hampshire 9
Intentional Injury Deaths 9
Unintentional Injury Deaths 11
Undetermined Manner of Death 12
Context and Recommendations 13
Fatalities Related to Motor Vehicles & Other Land Transport Vehicles 13
Fatalities Related To Poisoning /Overdose 15
Fatalities Related To Fires 16
Appendix A: Child Fatality Review Committee Members July 2022-June 2023 17
Appendix B: Additional CFRC Activities in SFY 2023 19
Appendix C: Additional SFY 2023 CFRC Recommendations 20
Appendix D: 2020-2023 Child Fatality Review Committee Recommendations 21
Appendix E: Resources 30

Letter from Child Fatality Review Commission Co-Chairs

Dear Friends of New Hampshire Children,

The New Hampshire Child Fatality Review Committee (CFRC) has begun its 27th year of reviewing fatalities of New Hampshire children. Our shared commitment is to better understand the patterns and circumstances of child deaths in our state to more effectively prevent future tragedy.

Under an Executive Order of Governor Stephen Merrill in 1996, New Hampshire began systematically reviewing the preventable deaths of New Hampshire children to identify risks and provide feasible recommendations for opportunities for prevention. This Executive Order guided the work of the CFRC for more than 20 years. The CFRC was then re-established in 2019 and put into statute with support from Governor Chris Sununu. The Committee is comprised of representatives from the medical, law enforcement, judicial, legal, victim services, public health, mental health, child protection and education communities (RSA 132:41).

The following is the CFRC annual report, covering work for the fiscal year of July 1st, 2022 through June 30th, 2023. The report also summarizes data from the 5-year period between 2018 and 2022, along with single-year data from 2022 where possible. Because there are relatively few child fatalities in New Hampshire on a yearly basis, single-year data can fluctuate greatly from year to year. Five-year analyses are more stable and can provide a better picture of any data trends. During this reporting period, the CFRC reviewed cases from four specific causes of death that are reflected in this report: poisonings, overdoses, motor vehicle crashes, and fire deaths.

The CFRC recognizes that each child fatality impacts a community and a family who suffered the loss of a child. We respect those impacted by these deaths. We hope the difficult work of conducting comprehensive case reviews will lead to recommendations that can prevent further tragedies, such as the ones presented here.

In recognition of the Committee's commitment and dedication to this important work, it is with great pride we present the 20th Annual Report of the Child Fatality Review Committee to: Christopher T. Sununu, Governor of the State of New Hampshire; New Hampshire State Senate President Jeb Bradley; Speaker of the New Hampshire House of Representatives Sherman Packard; the Health and Human Services Oversight Committee; and the people of the State of New Hampshire.



Josephine Porter, MPH, Co-Chair



Marc Clement, PhD, Co-Chair

Executive Summary

**In 2022, 114 children in New Hampshire died before their 21st birthday.
Of those, 45 died of injuries or other potentially preventable causes**

For the past five years, the top six causes of preventable death for children included:



motor vehicles | poisoning/ overdose | drowning | fire | falls | suffocation

The Child Fatality Review Committee comes together using data and the collective experiences of its members to help answer the question of what we could have done better to prevent these tragedies.

CFRC recommendations in this report include:

Fatalities Related To	Recommendations
Motor Vehicles and Other Land Transport Vehicles	• Promote affordable driver education • Increase prevention efforts regarding unsafe driving practices by teen drivers • Increase messaging and public awareness efforts by CFRC members and community partners to inform parents and adolescents about impaired driving • Increase the number of social media posts encouraging prevention of unsafe driving practices by CFRC/DPHS and community partners
Poisonings and Overdoses	• Increase the number of social media posts encouraging prevention of overdose fatalities by CFRC/DPHS and community partners • Increase awareness of supports for mental health and substance misuse for young adults by promoting resources of community partners • Promote increased availability, distribution and utilization of lock boxes and other measures for families to limit exposure to medications by children and youth
Fires	• Promote fire safety education to children and families via the New Hampshire Fire Marshal's Office and the Red Cross • Include specific fire safety education and assessment for families involved with DCYF • Increase the number of social media posts encouraging fire safety prevention by CFRC/DPHS and community partners

Overview and Protocol

RSA 132:41 re-established a statewide Child Fatality Review Committee (CFRC) to conduct comprehensive, multidisciplinary reviews of preventable infant, child, and adolescent deaths in New Hampshire. A **preventable death** is one in which a reasonable intervention, based on the conditions, circumstances, or resources available at the time, might have prevented the death. These reasonable interventions may be medical, educational, social, legal, or psychological in nature.

With the support of the New Hampshire Department of Health and Human Services (DHHS) and the Office of the Chief Medical Examiner (OCME) of the New Hampshire Department of Justice, the CFRC's charge is to identify factors associated with preventable deaths and to make recommendations for system changes to improve services for infants, children, and adolescents. The goal is not to investigate or adjudicate, but to learn from the past in order to take action to prevent future deaths. Recommendations focus on community-based prevention and should lead to effective multidisciplinary strategies to keep children healthy, safe, and protected.

The CFRC has co-chairs selected every two years by the full body and has an Executive Committee that meets every other month. The CFRC also has two formal subcommittees, one on Sudden Unexpected Infant Deaths (SUID) and one on Sudden Death in the Youth (SDY). For more information on these committees, please visit the DHHS Sudden Unexpected Infant Death website.

The Executive Committee develops protocols and selects cases for review based on data trends in the previous annual report and available information from the OCME. The CFRC is not obligated to review all child deaths. After case selection, the CFRC Executive Committee then uses the expertise and knowledge of CFRC members to discuss and potentially answer the following questions:

- What could have been changed that would have prevented the death?
- What changes are necessary to prevent future deaths?

The CFRC, as enabled by RSA 132:41, reviews information not only on the death of the child, but data on other deaths or injuries similar to the death being reviewed. Local and state resources, services, and programs relevant to the prevention of death are also discussed. Pursuant to RSA 91-A: 3, II (c) and RSA 91-A: 5, IV, the CFRC holds a non-public session during the case review. CFRC members sign an agreement stating they will not share any case-specific information or the nature of any discussion that took place during the non-public session with anyone not present at the case review. This ensures that the information secured in each review remains confidential.

In state fiscal year 2023 (SFY 23), there were six CFRC review meetings and 12 cases were reviewed. The 12 cases consisted of 13 child deaths caused by poisoning/overdose, motor vehicles and other land transport crashes, and fires. When reviewing these cases, community partners from the New Hampshire Fire Marshal's Office, the Northern New England Poison Control Center, and the Injury Prevention Center/Teen Driver Program provided essential education for committee members.

This report is a culmination of those efforts and includes data on causes of infant and child deaths, recommendations for the leading causes of unintentional injury death among children and youth, and other recommendations from the CFRC.

Understanding Child Death Data

Nationwide, deaths are classified according to cause and manner of death.

- **Cause of death** refers to the disease process or injury that set into motion the series of events which eventually lead to death.
- **Manner of death** refers to the circumstances under which death occurred.

In New Hampshire, deaths are classified on death certificates based on the following manners of death:

- **Natural**: due to underlying medical conditions and unrelated to any external factors
- **Accident**: injury or poisoning without intent to cause harm or death
- **Suicide/Homicide**: suicide or homicide are cases with confirmed intent to cause death.
- **Could not be determined**: insufficient information is available to determine a manner of death.
- **Pending**: further investigative, historical, or laboratory information is expected before a determination of manner of death can be made.

In this report, death data is broken into two classifications: **natural causes** and **injuries**.

- **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 factor. It encompasses, but is not limited to, diseases of the heart, malignant neoplasms (i.e., cancer), and conditions originating in the perinatal period (such as low birth weight and prematurity).
- **Injury** 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 further classified as **unintentional** (such as an accidental drowning) or intentional (as in suicide or homicide).

Data Saves Lives

To better understand how we can prevent child fatalities, communities must be aware of the scope and scale of the problem. The following data illustrate incidence and trends over time The data provide valuable context for state agencies, community partners, and policy makers to develop more tailored and effective prevention efforts

Because there are relatively few child fatalities in New Hampshire each year, single-year data can fluctuate and analyses of smaller subsets of data must be aggregated over time Use caution when interpreting small numbers and the percentages derived from them Despite these limitations, the data can tell a story of where we have opportunities to better keep New Hampshire children healthy, safe, and protected

For the purposes of this report, **children** are defined as individuals **between birth and age 21**. Data was not disaggregated by race and ethnicity due to the small number of deaths. Counts of ten or fewer events are considered unreliable. Use caution when interpreting small numbers and the percentages derived from them.

Data presented in this report represents state-level trends from death certificate data among children from birth through the age of 21 who were residents of the state of New Hampshire. Rates for the United States are included for comparison purposes; United States rates are from the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, from the CDC WONDER online database.

Deaths of Children in New Hampshire

Over the last five-year period from 2018-2022, approximately half of New Hampshire child deaths (52.3%) were due to natural causes (Table 1). This was also the case for calendar year 2022 (51.8%, Table 1).

Table 1: Count of New Hampshire Resident Child Deaths by Cause, 2013-2022

	2013-2022		2018-2022		2022	
Manner	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Natural (Illness)	695	53.1%	325	52.3%	59	51.8%
Injury (Accident, Homicide, Suicide, Undetermined-injury	533	40.7%	266	42.8%	45	39.5%
Undetermined-Not Injury	67	5.1%	28	4.5%	8	7.0%
Pending	15	1.1%	*	0.5%	*	1.8%
Total	1310	100%	622	100%	114	100%

Data Source: New Hampshire Department of Health and Human Services, Health Statistics and Data Management Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2013-2022 *Data is suppressed due to small numbers

The first year of life continues to be the most perilous for New Hampshire children. Individuals under one year of age accounted for 36.8% of all child deaths from 2018-2022. Young adults between 19 and 21 years of age accounted for the next highest share of child deaths at 25.2%, and teens between 15 and 18 years of age accounted for 17% of child deaths (Table 2).

Table 2: Count of New Hampshire Resident Child Deaths by Cause and Age Group, 2018-2022

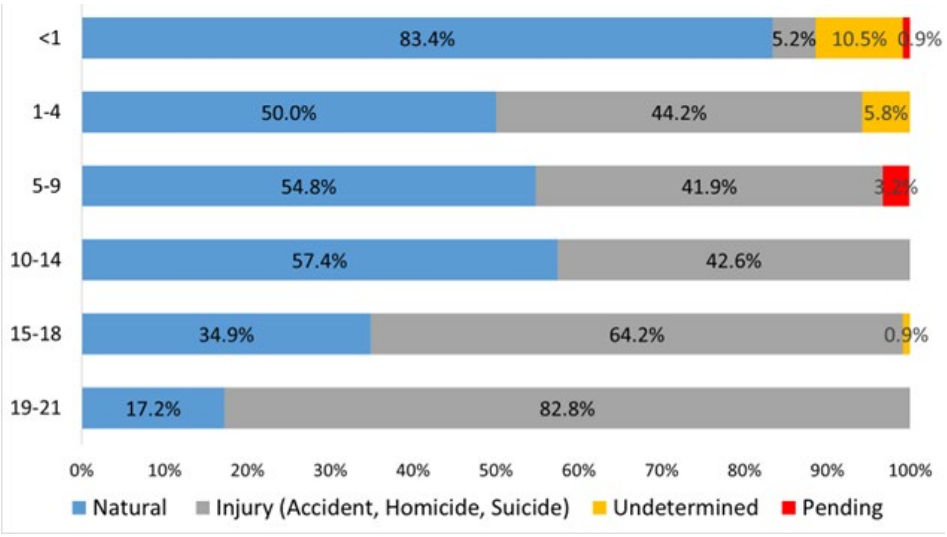
	Manner of Death										
		Injury									
	Natural	Accidental	Homicide	Suicide	Undetermined (Injury)	Undetermined (Not Injury)	Pending	Grand Total	% by Age	Estimated Population	Rate per 100,000
<1	191	8	*	0	3	24	*	229	36.8	59,209	386.8
1-4	26	17	4	0	2	3	0	52	8.4	258,350	20.1
5-9	17	9	4	0	0	0	*	31	5	347,564	8.9
10-14	27	5	0	14	*	0	0	47	7.6	380,124	12.4
15-18	37	38	*	29	0	*	0	106	17	329,160	32.2
19-21	27	80	5	41	4	0	0	157	25.2	276,690	56.7
Total	325	157	15	84	10	28	*	622	100	1,651,098	37.7

Data Source: New Hampshire Department of Health and Human Services, Health Statistics and Data Management Death Certificate data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2018-2022 Estimated Population are the New Hampshire Department of Health and Human Services, Department of Public Health Services population estimates, and are person-years (total estimated population for the 5 years combined)

*Data is suppressed due to small numbers

The majority of deaths in New Hampshire among infants under age one were due to natural causes (83.4%, Figure 1). Conversely, the majority of deaths in New Hampshire among young adults between 19 and 21 years of age were due to injury (82.8%, Figure 1).

Figure 1: Manner of New Hampshire's Children Deaths, % by Age Group (2018-2022)

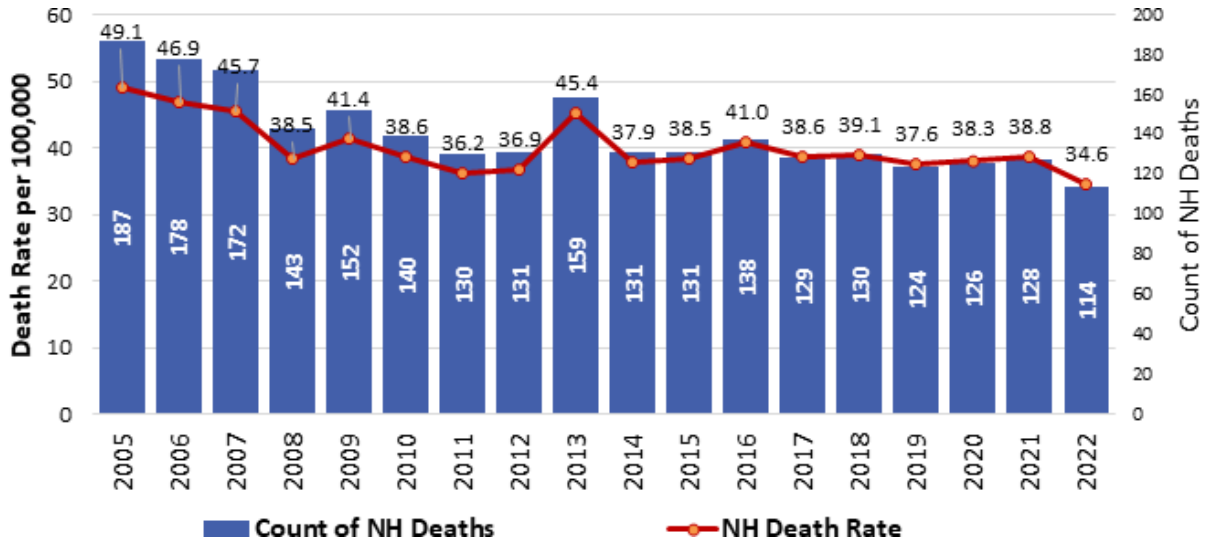


Data Source: New Hampshire Department of Health and Human Services, Health Statistics and Data Management Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2018-2022

The rate of child deaths in New Hampshire has remained relatively stable.

The 2022 child mortality rate for New Hampshire was 34.6 child deaths per 100,000 children (0-21 years of age). The rate did not change significantly compared to the 2021 rate of 38.8 per 100,000 children. **New Hampshire's child mortality rate remains below the national rate** of 55.2, 53.1, 52.1 and 55.2 per 100,000 children reported for 2017, 2018, 2019, and 2020, respectively. Nationwide rates from 2021-2022 are not available. **Figure 2** shows the number and rate of child deaths in New Hampshire between 2005 and 2022.

Figure 2: Number and Rate of Child Deaths for Ages 0 to 21 Years in New Hampshire, 2005-2022



Data source: New Hampshire Department of Health And Human Services, Health Statistics and data management Death certificate data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2018-2022

Deaths of Infants in New Hampshire

Infants less than one year of age died primarily from natural causes. The leading cause of natural death in the aggregated five-year time period (Table 3) was congenital malformations, deformations, and chromosomal abnormalities. This category made up 20.9% of all natural deaths between 2018 and 2022.

Table 3: New Hampshire Resident Top Five Leading Causes of Natural Deaths, Infants (under 1 year of age), 2018-2022

Leading Natural Causes of Infant Death	2018-2022	% of Total
Congenital malformations, deformations, and chromosomal abnormalities	40	20.9%
Disorders related to short gestation and low birth weight, not elsewhere classified	32	16.8%
Newborn affected by complications of placenta, cord and membranes	21	11.0%
Newborn affected by maternal complications of pregnancy	13	6.8%
Respiratory distress of newborn	10	5.2%
Other Medical Causes	41	21.5%
Unranked (Unknown/Other)	34	17.8%
Grand Total	**191**	**100%**

Data Source: New Hampshire Department of Health and Human Services, Health Statistics and Data Management Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2018-2022 Deaths are categorized CDC' "ICD-10 Cause-of-Death Lists for Tabulating Mortality Statistics" rankable causes from the List of 130 Selected Causes of Infant Death (Table C), available at https://www cdc gov/nchs/data/dvs/Part9InstructionManual2020-508 pdf

According to the CDC, Sudden Unexpected Infant Death (SUID) is a term used to describe the sudden and unexpected death of a baby less than 1 year old in which the cause was not obvious before investigation. These deaths often happen during sleep or in the baby's sleep area.

Table 4: New Hampshire Resident Sudden Unexpected Infant Death (SUID) Counts by Year, 2017-2022

Cause of Death	2017	2018	2019	2020	2021	2022	Total
SUID (ICD10 Code: R95, R99,W75, and Other)	7	8	5	9	8	10	47

Data Source: New Hampshire Department of Health and Human Services, Maternal and Child Health and SUID review committee Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2017-2021 (Counts reflect the result of the reviewed and confirmed SUID cases)

Deaths of Children, Adolescents, and Young Adults (Ages 1 to 21 Years) in New Hampshire

For children between one and 21 years of age, data is presented by manner of death. In this age group, the two leading manners of death in 2022 were natural and accidental, both at 38.0%. Suicide was the next leading manner of death at 18.3% (Table 5).

Table 5: New Hampshire Resident Leading Manner of Death, Ages 1-21

Manner of Death	2013-2022		2018-2022		2022	
	Number	Percent	Number	Percent	Number	Percent
Natural	282	34.7%	134	34.1%	27	38.0%
Accidental	301	37.1%	149	37.9%	27	38.0%
Homicide	26	3.2%	14	3.6%	*	4.2%
Suicide	168	20.7%	84	21.4%	13	18.3%
Undetermined (Injury)	16	2.0%	7	1.8%	0	0.0%
Undetermined (Not Injury)	8	1.0%	4	1.0%	*	1.4%
Pending	11	1.4%	*	0.3%	0	0.0%
Grand Total	812	100%	393	100%	71	100%

Data Source: New Hampshire Department of Health and Human Services, Health Statistics and Data Management Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2013-2022

*Data is suppressed due to small numbers

Intentional Injury Deaths

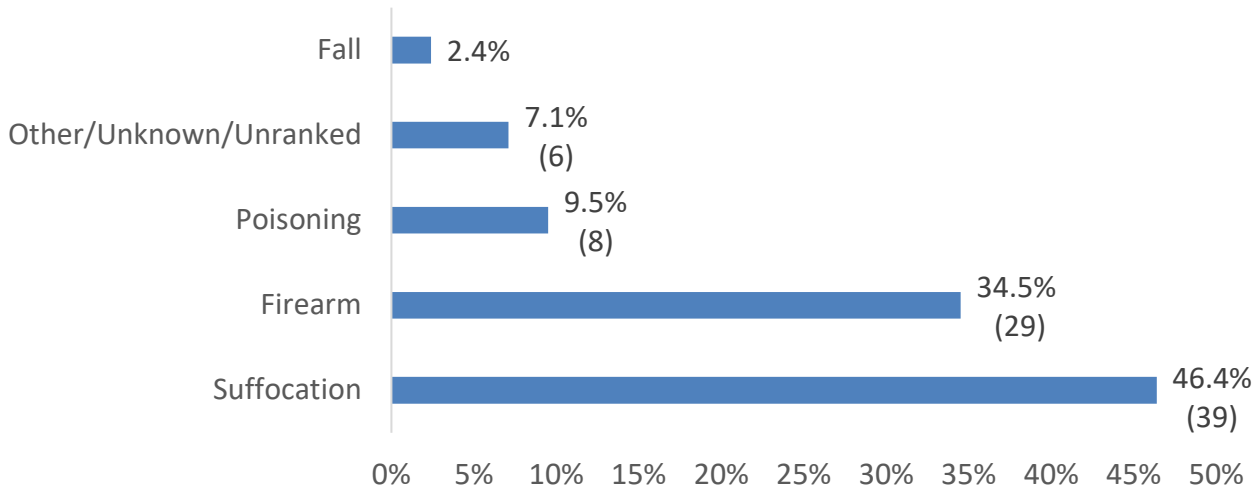
Suicide (85.7%) was the leading cause of intentional injury death in children ages 10 to 21, and the incidence of suicide deaths is highest among youth ages 19 to 21 (Table 6). The method of death in half of the suicides was suffocation (46.4%), followed by firearms (34.5%), and poisoning (9.5%, Figure 3).

Table 6: New Hampshire Resident Intentional Injury Deaths (Ages 1 to 21) by Age Group, 2018-2022

	1 to 4	5 to 9	10 to 14	15 to 18	19 to 21	Total (count)	Total (%)
Homicide	4	4	0	*	5	14	14.3%
Suicide	*	*	14	29	41	84	85.7%
Total	4	4	14	30	46	98	100%

Data Source: New Hampshire Department of Health and Human Services, Injury Prevention Program Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2018-2022 *Data is suppressed due to small numbers

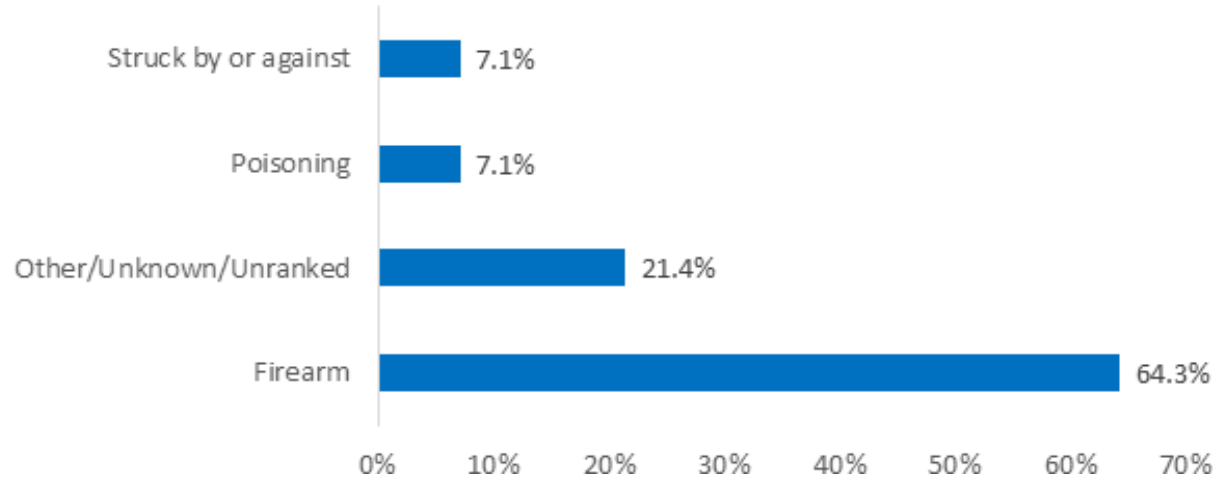
Figure 3: Percentages and Count of NH Resident Suicide Deaths by Method, Ages 10-21, 2018 to 2022



Data Source: New Hampshire Department of Health and Human Services, Health Statistics and Data Management Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 20187-20221 Deaths are categorized using the Centers for Disease Control/National Center for Health Statistics "ICD-10 Cause-of-Death Lists for Tabulating Mortality Statistics" rankable causes from the External Cause of Injury Mortality Matrix (Table H), available at https://www cdc gov/nchs/data/dvs/Part9InstructionManual2020-508 pdf pdf, with the addition of breaking poisoning into overdose (defined as underlying cause of death of X40-X44, X60-X64, X85 or Y10-Y14) and other *(Count) is suppressed due to small number

Among homicide deaths of New Hampshire children, 64.3% were caused by firearms (Figure 4).

Figure 4: New Hampshire Resident Homicide Deaths by Method, Ages 1 to 21, 2018-2022, N=14



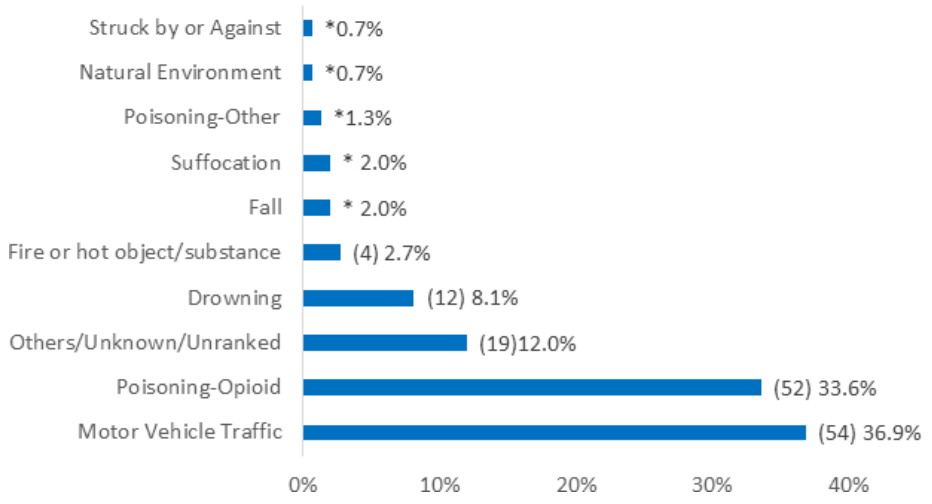
Data Source: New Hampshire Department of Health and Human Services, Injury Prevention Program Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2018-2022

Unintentional Injury Deaths

The top six mechanisms of unintentional injury death among children between the ages of 1 to 21 (Figure 4) between 2018 and 2022 were:

- Motor vehicle traffic (36.9%)
- Poisoning-overdose (33.6%)
- Drowning (8.1%)
- Fire or hot object/substance (2.7%)
- Falls (2%)
- Suffocation (2%)

Figure 5: New Hampshire Resident Unintentional Injury Deaths by Cause, Ages 1-21, 2018-2022



Data Source: New Hampshire Department of Health and Human Services, Health Statistics and Data Management Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2018-2022 Deaths are categorized using the Centers for Disease Control/National Center for Health Statistics "ICD-10 Cause-of-Death Lists for Tabulating Mortality Statistics" rankable causes from the External Cause of Injury Mortality Matrix (Table H), available at https://www cdc gov/nchs/data/dvs/Part9InstructionManual2020-508 pdf, with the addition of breaking poisoning into overdose (defined as underlying cause of death of X40-X44, X60-X64, X85 or Y10-Y14) and other *(Count) is suppressed due to small numbers

Undetermined Manner of Death

Undetermined manner of death is a category in which the Medical Examiner cannot discern a manner of death. These deaths should not be included when discussing injury deaths. Table 7 shows counts for child deaths that were categorized as undetermined manner of death by age group.

Table 7: New Hampshire Resident Undetermined Manner of Death, Ages 1 to 21, 2018-2022

	1 to 4	5 to 9	10 to 14	15 to 18	19 to 21	Total
Pending	0	1	0	0	0	1
Undetermined	5	0	1	1	4	11
Total	**5**	**1**	**1**	**1**	**4**	**12**

Data Source: New Hampshire Department of Health and Human Services, Health Statistics and Data Management Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2013-2022

Context and Recommendations

Each of the data points above represents an unimaginable tragedy experienced by families and loved ones across the state of New Hampshire. CRFC makes recommendations each year in the hopes of reducing – and one day eliminating – these tragedies.

The SFY 23 recommendations focus on motor vehicle deaths, which were the leading cause of death, opioid poisoning-overdose deaths, the second leading cause of death, and fire or hot object/substance deaths. The CFRC prioritized unintentional injury deaths because of the availability of existing resources and the opportunity to design preventative measures to reduce future deaths.

Fatalities Related to Motor Vehicles & Other Land Transport Vehicles

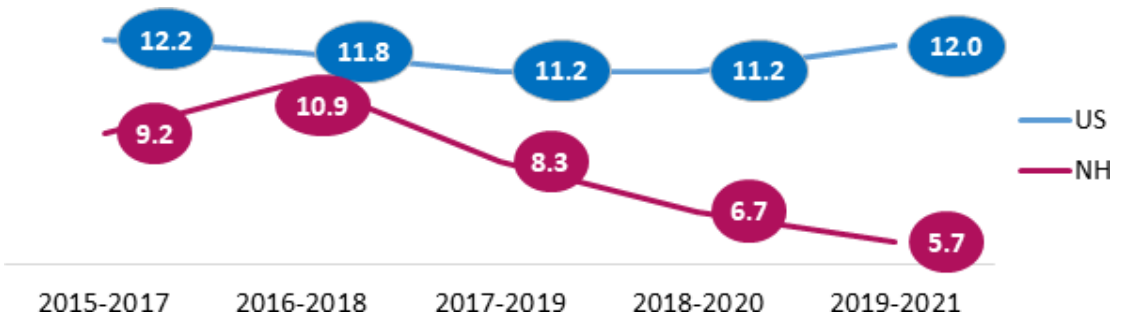
Motor vehicle crashes were the leading cause of death for children and youth ages 1-21 between 2018 and 2022. Though teens' seatbelt use has increased, they are still engaging in unsafe behaviors while behind the wheel, including texting and driving.

Although the rate of adolescent motor vehicle mortality has decreased in NH over the past five years (Figure 5), it remains one of the top three leading causes of death, along with fatalities involving other land transport vehicles.

In 2021, significantly more (42 9%) NH youth reported that they texted or emailed while driving a car or other vehicle as compared to the United States overall (36 1%)

Source: Youth Risk Behavior Surveillance System (YRBSS). 2021 Youth Risk Behavior Surveillance. https://www.cdc.gov/healthyyouth/data/yrbs/results.htm

Figure 5: Adolescent (15-19 years) Motor Vehicle Mortality Rates (per 100,000) in the United States and New Hampshire, 2015-2021



Data Source: National Center for Health Statistics Center for Disease Control and Prevention (n d) http://www cdc gov/nchs/data_access/vitalstatsonline thm

The CFRC reviewed two motor vehicle fatalities and three deaths related to other land transport vehicles, which involved a young child on a bicycle, a school-aged child on a tractor, and a young adult on a motor bike. The motor vehicle fatalities shared common risk factors such as distracted and impaired driving, as well as lack of seatbelt use.

Through the case review process and discussion among expert committee members, the CFRC has recognized that there is a significant opportunity to promote and share underutilized resources and programs and bolster messaging on the persistent issue of distracted driving among New Hampshire children. The following are CFRC recommendations, along with examples of related resources, initiatives, and programs currently underway in New Hampshire, to better prevent future motor vehicle and other land transport vehicle fatalities.

CFRC Recommendations related to motor vehicle fatalities:

1. **Promote affordable driver education.**
   - Current initiatives: Scholarship opportunities for driver education are available through the AAA Drivers Education and Traffic School.

2. **Increase prevention efforts regarding unsafe driving practices by teen drivers.**
   - Current initiatives: A CFRC member sits on the Injury Prevention center (IPC) Teen Driving Committee to assist with joint initiatives involving teen drivers.

3. **Increase messaging and public awareness efforts by CFRC members and community partners to inform parents and adolescents about impaired driving.**
   - Current initiatives:
     - The NH Teen Driver website and program is managed by Youth Operator Program Coordinator of IPC, Alexis Bly. She is available to work directly with schools on implementing educational teen highway safety programs.
     - The NH DHHS Division for Children, Youth and Families (DCYF) discusses safe driving and distracted driving with families if there is an alleged substance misuse issue.
     - Anticipatory guidance is provided at adolescent well visits regarding unsafe driving practices (not using seatbelt, driving under the influence of substances, etc.).
     - The teen driver committee is working to bring AAA's Shifting Gears: the blunt truth about marijuana and driving program to NH.

4. **Increase the number of social media posts encouraging prevention of unsafe driving practices by CFRC/DPHS and community partners.**
   - Current initiatives: DPHS social media posts.

Fatalities Related to Poisoning and Overdose

Fatalities related to poisoning and overdose are the second-leading cause of death for children and youth between 2018 and 2022 (Figure 4). Although NH has been dedicated to reducing poisoning and overdose deaths, as evidenced in the State Opioid Response Plan and 10 Year Mental health Plan, poisonings and overdose remain a critical issue in NH.

The CFRC reviewed four fatalities related to poisonings/overdose in the state fiscal year 2023. The fatalities included both accidental unintentional and intentional overdoses with varying substances including morphine, cocaine, alcohol, and fentanyl. Common risk factors identified with such cases include the loss of a parent, previous suicide attempts, limited community connections and support, as well as parental substance use. Identification of risk factors helps the committee formulate appropriate and actionable recommendations.

CFRC Recommendations related to poisoning and overdose fatalities:

The following are CFRC recommendations, along with examples of related resources, initiatives, and programs currently underway in New Hampshire, to better prevent future poisoning and overdose fatalities:

1. **Increase the number of social media posts encouraging prevention of overdose fatalities by CFRC/DPHS and community partners.**
   - Current initiatives: DPHS social media posts.
2. **Increase awareness of supports for mental health and substance misuse for young adults by promoting resources of community partners.**
   - Current initiatives: When working with a family either through an investigation or an open child abuse/neglect case, DCYF assesses mental health needs and makes referrals and recommendations for services.
3. **Promote increased availability, distribution and utilization of lock boxes and other measures for families to limit exposure to medications by children and youth.**
   - Current initiatives: DCYF distributes medication lock boxes to families when the need arises.

Fatalities Related to Fires

The CFRC reviewed four fatalities related to fires. Common risk factors included nonfunctioning smoke alarms, the presence of smokers in the home, and possible lack of education related to fire safety, including escape routes and best practices in unfamiliar surroundings.

Though fatalities related to fires represent just 2.7% of unintentional injuries, fire has been in the top five causes of death from 2018-2022 (Figure 3). Through the case review process and discussion among expert committee members, the CFRC has recognized that there is a continued opportunity to educate the public about fire safety and the community services available for fire prevention.

CFRC Recommendations related to fire fatalities:

The following are CFRC recommendations, along with examples of related resources, initiatives, and programs currently underway in New Hampshire, to better prevent future fatalities related to fires.

1. **Promote fire safety education to children and families via the NH Fire Marshal's Office and Red Cross Program.**
   - Current initiatives:
     - The NH Fire Marshal's Office hosts a fire safety month in October and provides educational resources on its website.
     - The American Red Cross Home Fire Campaign helps families install free smoke alarms in their homes and educates families about fire safety.
2. **Include specific fire safety education and assessment for families involved with DCYF.**
   - Current initiatives:
     - DCYF includes fire safety education in their discussions with families.
     - DCYF holds regular practice discussions at their Intake & Assessment workgroup about the importance of staff asking if they have working fire alarms.
     - DCYF incorporates fire safety information into new hire training.
3. **Increase the number of social media posts encouraging fire safety prevention by CFRC/ DPHS and community partners.**
   - Current initiatives: DPHS and DHHS social media posts.

Appendix A: Child Fatality Review Committee Members July 2022-June 2023

Honorable Susan Ashley
NH Circuit Court- Family Division

Joy Barrett
Granite State Children's Alliance

Skip Berrien
Member of the Public

Vicki Blanchard
NH DOS,Bureau of Emergency Medical Services

Christine Brennan
NH Department of Education

Dianne Chase
NH DHHS, Bureau of Child Development

Marc Clement
Colby-Sawyer College

Jennie Duval
NH DOJ, Chief Medical Examiner

Adam Fanjoy
NH DOS, Fire Marshal's Office

Robyn Guarino
NH DOJ, Office of the Attorney General

Morissa Henn
NH DHHS, Office of the Commissioner of Health & Human Services

Kris Hering
New Hampshire Hospital Association

Angie Raymond Leduc
Injury Prevention Center- Dartmouth Health

Fran McLaughlin
NH DHHS, Women, Infants, and Children Program, Nutrition Services

Evan Nadeau
NH DOS, State Police

Resmiye Oral
Child Advocacy & Protection Program-Dartmouth Health

David Parenteau
Statewide Law Enforcement Officers' Advisory Council

Sylvia Pelletier
NH Family Voices

Josephine Porter
NH Center of Justice and Equity

Joseph Ribsam
NH DHHS, Division for Children, Youth, and Families

Schelley Rondeau
Home Visiting Program

Rebecca Ross
NH DHHS, Division of Behavioral Health

Cassandra Sanchez
Office of the Child Advocate for the State of NH

Rhonda Siegel
NH DHHS, Maternal and Child Health

Marcia Sink
CASA of NH

Joi Smith
NH Coalition Against Domestic & Sexual Violence

Catrina Watson
New Hampshire Pediatric Society

Lisa Fontaine-Storez
NH DHHS, Maternal and Child Health, Administrative Support

Jessica Bates
NH DHHS, Maternal and Child Health, Administrative Support

Appendix B: Additional CFRC Activities in SFY 2023

In January 2023, Abby Collier, Director of the National Center for Fatality Review and Prevention (National Center) came to New Hampshire to provide guidance on best practices for fatality committee reviews, recommendations, and reports. She observed a CFRC meeting and provided positive feedback regarding its opening educational component and how it can lead to a more effective fatality review and enhanced prevention recommendations by the committee.

Additionally, The National Center invited the CFRC to participate in a Diversity, Equity, and Inclusion (DEI) learning collaborative with the goal of integrating DEI into the CFRC's daily practices and policies. The CFRC met with consultant Dr. Terry Wright and the National Center to discuss best practices for incorporating DEI into child death reviews. The Health Equity: Diversity, Equity and Inclusion Assessment Guide for Multidisciplinary Teams will be used to assess and implement DEI practices in future CFRC reviews and recommendation development.

In Fiscal Year 2023, the CFRC created a monthly Recommendations Workgroup that is revising the policy and procedures of how recommendations are created, documented, and achieved. The CFRC Recommendations Workgroup meets monthly to ensure CFRC recommendations are specific, measurable, actionable, reasonable, and time-bound. The workgroup also discusses next steps and documents ongoing progress on implementing CFRC recommendations.

Appendix C: Additional SFY 2023 CFRC Recommendations

Below are two additional recommendations from the committee that represent successes and achievements in state fiscal year 2023. These recommendations are not necessarily directly related to CFRC cases reviewed in this current state fiscal year, and include recommendations from past case reviews.

1. **The CFRC recommended the promotion of the Know and Tell Program, which is a statewide initiative of the Granite State Children's Alliance that helps people recognize and report child abuse and neglect in NH:**
   - DCYF, within the DHHS' Constituent Relations Program, works closely with the Know and Tell Program. DCYF reviewed and provided feedback regarding the curriculum to ensure the message is accurate relative to DCYF practices, expectations, and limitations.
   - DCYF also engaged specific offices or DCYF program areas as appropriate, such as the Central Intake Department.
   - In addition, DCYF ensured that there was always a Division representative participating in the Know & Tell trainings delivered to schools and the community.

2. **The CFRC recommended increased awareness of community resources for youth with mental health concerns, including resources for post-discharge from psychiatric units. Community partners currently do the following to support the needs of youth:**
   - When DCYF is working with a family, either through an investigation or an open child abuse or neglect case, they assess the mental health needs of the family and make referrals and recommendations for services.
   - Hampstead Hospital, a specialty hospital that serves children and youth with psychiatric and substance related needs, contracts with Youth Villages, an intensive in-home program, so that they can participate in discharge planning better support the family when the child returns home.
   - If a child or youth is involved with DCYF, the discharge from the psychiatric unit is discussed during regular meetings between Hampstead Hospital, the Bureau for Children's Behavioral Health (BCBH) and the DCYF Constituent Relations Program.
   - The National Alliance on Mental Illness (NAMI) NH, has reached out to DCYF to provide CALM (Counseling on Access to Lethal Means) trainings to DCYF case workers.

Appendix D: 2020-2023 Child Fatality Review Committee Recommendations

Below is the document that tracks CFRC committee recommendations created by the newly formed Recommendations Workgroup. It includes the next steps related to each recommendation discussed during case reviews so that all CFRC committee members can track the progress. The next steps are carried out by various committee members that possess experience in the particular subject area. The table also includes related programs and efforts in NH by our community partners so that committee members can be aware of other agency efforts and programs in the state.

Category	Recommendation	Year(s)	Related programs and efforts in NH	Next Steps
Child Abuse and Neglect	Promote programs that raise awareness of ways to report suspected cases of abuse or neglect	2020, 2022, 2023	**Know & Tell Program** **NH Children's Trust Strengthening Families Program**	Promote Know and Tell Program Promote Strengthening Families Program
	Facilitate referrals for suspected abuse and neglect	2020	Online tools for referrals Dartmouth Ken & Vickie French Child Advocacy and Protection Program (CAPP) program	Promote CAPP program Raise awareness of online referral mechanism
Drowning	Raise awareness of drowning prevention actions to child care, home visiting, and medical providers	2020	American Academy of Pediatrics Drowning Prevention Toolkit for Pool Safety	Work with NH AAP Chapter, home visiting program, other medical societies to share toolkit
	Creation of life jacket loaner stations	2020	Marine Patrol can assist with getting child-sized life jackets – but does not have jackets to provide for donation Injury Prevention Center at DHMC/Dartmouth Health provides 10+ NH Communities each year since 2022 12 + lifejackets of varying size and educational materials to set up a life jacket loaner program	IPC has grant application for life jacket loaner stations on annual basis contact James.E.Esdon@hitchcock.org

Category	Recommendation	Year(s)	Related programs and efforts in NH	Next Steps
Drowning (continued)	Identify hazardous sites and mark them as such	2020	Resource document has been generated for where swimming emergencies have happened multiple times	Identify the control points and ability to add signage IPC is available to provide support to communities that have high risk water ways and bring different stakeholders together to plan targeted strategies where life jacket loaner station may not be best strategy or only strategy needed
Fire Safety	Include fire safety to Division Children, Youth, and Families (DCYF) checklist and/ or processes	2023		DCYF to review Fire Safety, including the presence of working fire alarms during intake & assessment process Additionally, working to ensure fire safety information is incorporated in all new hire training as well as offered to more experienced staff
	Promote Fire Safety education to children and families	2023	**Red Cross Home Fire Campaign: Northern New England** Fire Marshal's Office education efforts Fire Safety Month (October)	Promote Red Cross home visits & program to provide smoke and CO_2 detectors Promote at NH Medical Society, Social Media, Newsletters **Promote NH DOS Fire Marshall's website for education.**
Suicide	Emphasize importance of consistent adolescent well care visits	2020, 2022	Medicaid MCOs incentives are in place for quality initiatives focused on follow up care and not missing appointments MCH primary integrated care grant requires FQHC's /CHC's to have work plans around increasing and following up on adolescent visits	Work with provider community to identify ways to improve follow up and missed adolescent well visits Track MCH data about follow-up care rates

Category	Recommendation	Year(s)	Related programs and efforts in NH	Next Steps
Suicide (continued)	Increase awareness of supports for mental health for young adults	2023	HI-fidelity wrap around NH National Alliance for Mental Illness (NAMI) YEAH -NH (youth for education advocacy & healthcare) Youth groups: Boys & Girls clubs, Big Brothers & Big Sisters The 13 Regional Public Health Networks (RPHN's) in the state have substance misuse prevention coordinators who may also work on suicide prevention and continuum of care facilitators – each of whom may be leading community coalitions or are technical support for community coalitions AND connected to many resources and supports in individual communities Community Mental Health Agencies Mental Health Resources on DHHS website DCYF assesses mental health needs of families they work with and provide referrals/ recommendations for services	Promote resources of community partners **NAMI NH Support Groups** **Promote RHPN's** **Promote NH Behavioral Health Association Website** **Promote DHHS Mental Health Resources website page.** **Promote the NH Children's System of Care (CSoC)**

Category	Recommendation	Year(s)	Related programs and efforts in NH	Next Steps
Suicide (continued)	Increase level of care and resources as part of follow-up after child/ adolescent psychiatric discharge	2022	Bureau of Children's Behavioral Health Residential treatment facilities (e g , Hampstead Hospital programs) Youth Villages - an intensive in-home program at discharge when leaving with complex needs Contracted with HH so they can participate in discharge planning then support family when child returns home If a child/youth is involved with DCYF the discharge is discussed during regular huddle meetings between Hampstead Hospital, BCBH and DCYF Constituent Relations Program DCYF (caseworkers) and Hampstead are also in contact if they have a legal relationship with a youth	Review processes in place for post-discharge planning
	Increase awareness and training regarding suicide prevention resources	2022	988 program **State and community suicide prevention resources including NAMI NH Connect Program** Katherine Cox, Suicide Prevention Coordinator for the State of NH: Katherine.M.Cox@ dhhs.nh.gov	Coordinate with Suicide Prevention Council, Youth Suicide Prevention Assembly, and combine efforts Promote information on Social Media and health fairs
Poisoning	Explore FDA reporting when death results from use of meds that includes black box warning	2020	Office of Chief Medical Examiner	Ask OCME about feasibility of this reporting

Category	Recommendation	Year(s)	Related programs and efforts in NH	Next Steps
Poisoning (continued)	Promote increased availability, distribution, & utilization of lock boxes and other measures to limit exposure to medications by children Promote safe use, safe storage & safe disposal of unwanted or unused medications Promote Northern New England Poison Center & education	2023	Drug take back days **Promotion of Twin State Safe Meds Website and drop box locator** DCYF is able to purchase lock boxes for families that they are working with if needed	Promote drug take-back days & Twin State Safe Meds (24/7 drop box available) **Promote Northern New England Poison Center & education**
Motor Vehicle	Explore additional restrictions on graduated driver's licenses for young people	2021	RSA for drivers education requirements	Identify the RSA for drivers and determine if there are possible ways to strengthen
	Expand driver's education curriculum: information for parents about car safety, impaired driving	2021	Drivers education programs **AAA Northern New England resources for parents of Teen Drivers.** **NH Teen Drivers website parent section.**	Identify how drivers education curriculum is set Promote parent resources from AAA NNE and NH Teen Drivers websites Contact Lexi Bly, YOPC of IPC to support parent education nights
	Increase completeness of records around fatalities in crashes, including requirements for crash reconstruction	2021	State Police crash reconstruction program	Identify criteria for crash reconstruction and when it can be used

Category	Recommendation	Year(s)	Related programs and efforts in NH	Next Steps
Motor Vehicle (continued)	Increase education for youth about what to do if you don't feel safe driving with someone else	2021	Drivers education programs High schools (see NH Teen Driver program) **NH Teen Drivers website managed by Youth Operator Program Coordinator of IPC, Alexis (Lexi) Bly. Lexi is available to work directly with schools (10 + new per year) on bringing them targeted educational programs.**	Identify programs that exist around the issue of what to do if you don't feel safe Promote Teen Driver website and contact Lexi Bly for specific educational needs: Alexis.R.Bly@hitchcock.org
	Reinforce the use of seatbelt use	2021	Drivers education programs High schools (see NH Teen Driver program) **NH Teen Driver Program – Lexi Bly at IPC.**	Work with community organizations to promote seat belt use Buckle Up NH/Teen Driver committee led by Lexi Bly at IPC
	Promote affordable driver education	2023	**DmvEdu.org**	Promote drivers education programs

Category	Recommendation	Year(s)	Related programs and efforts in NH	Next Steps
Motor Vehicle (continued)	Increased messaging and public awareness about what impaired driving	2023	**NH Teen Drivers website & program managed by Youth Operator Program Coordinator of IPC, Alexis (Lexi) Bly. Lexi is available to work directly with schools (10+ new per year) on bringing them targeted educational programs.** **Shifting Gears: The Blunt Truth about marijuana and driving. A program by AAA Automotive** If DCYF is involved with a family for alleged or confirmed substance misuse issue they discuss safe driving with the parent	Increase messaging through social media and health fairs
Other Land Transport	Promote bike safety education programs	2023	IPC at DHMC/Dartmouth Health provides Safe & Active grant opportunity annually to 20+ NH communities providing bike helmets and bike and pedestrian safety education. **Promote Transportation Safety for NH website managed by IPC.**	Collaborate with community organizations to promote bike safety – push IPC as resource. For annual Safe & Active grant program contact April.T.Simonds@hitchcock.org.
	Support YRBS question around helmet safety to understand use	2023	Department of Education	Identify mechanism to add the question
Process and Operations	Communicate PCP of deaths	2020	Office of Chief Medical Examiner	Discuss this as possibility with OCME

Category	Recommendation	Year(s)	Related programs and efforts in NH	Next Steps
Process and Operations (continued)	Identify best practices for communication between police, DCYF, and families	2020	Police operations DCYF protocols AG protocols in place for conducting joint investigations speaks to communication between professionals	Review process of communication upon child issues OCA working on legislation for 2024 recommending a study commission to look at the current process of sharing records/information, barriers in current laws, and make recommendations for future legislation to improve communication
Follow-up	Provide resources to referrals for children exposed to trauma (i.e. ACERT)	2020	Adverse Childhood Experiences Response Team (ACERT) DCYF will arrange for trauma informed services when they have a legal relationship with children/youth	Promote ACERT
	Training on Adverse Childhood Experiences (ACEs) for people interacting with children	2021, 2022	NH Family Voices DCYF has provided an ACEs training to field workers	Work with schools and daycares to promote ACEs
	Improve referral systems for home visiting and wrap-around	2021	CAPP **NH Family Voices** **Project Launch Upper Valley**	Propose CAPP and home visiting Promote the NH Children's System of Care (CSoC)

Category	Recommendation	Year(s)	Related programs and efforts in NH	Next Steps
Follow-up (continued)	Ensure grief supports available to families after a child death	2020, 2022, 2023	**Friends of Aine Center for grieving children & Bereavement Camps** **Grief packets given to families after the death of a child – Suicide death NH Survivor Resource Packet** **Survivors of Suicide Loss Newsletter via NAMI NH Connect Program** DCYF refers parents and surviving siblings to grief supports through the course of a child death investigation	Understand the process and materials provided after a child death

Appendix E: Resources

Poisoning and overdose prevention

- Unintentional Poisoning Deaths in U.S. Infants, Children, and Adolescents (Children's Safety Network)
- Northern New England Poison Center
- Teen Self-Poisoning Prevention Toolkit for Healthcare Providers (NNEPC)

Fire safety

- New Hampshire Division of Fire Safety
- Northern New England Home Fire Campaign (American Red Cross)
- Fire and Burn Prevention: 2021 Resource Guide (Children's Safety Network)

Teen driver safety

- New Hampshire Teen Driver Program (NH Teen Drivers)
- Teen Driving Safety: 2022 Resource Guide (Children's Safety Network)
- AAA Teen Driver Education Program

Suicide prevention

- NH Suicide Prevention Annual Report.