ELDERLY AND INCAPACITATED ADULT FATALITY REVIEW COMMITTEE

"Wrinkles should merely indicate where smiles have been." ~Mark Twain

Annual Report
April 2015

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ACKNOWLEDGMENTS

Sincere appreciation goes to the members of the Elderly and Incapacitated Adult Fatality Review Committee (EIAFRC), who have continued to work diligently and respectfully to study New Hampshire's elder and incapacitated fatalities, in an effort to prevent future deaths.

These deaths are difficult and painful to review. The EIAFRC has worked to honor the lives that have been lost and to examine ways to help prevent future fatalities. The EIAFRC would like to recognize and thank all of the individuals who have made presentations at EIAFRC meetings and who have participated as guests in reviewing the cases. We are indebted to these individuals for assisting us in better understanding the complexities of the issues surrounding these fatalities.

Special thanks goes to **Alexandra Miller** of the Attorney General's Office who throughout the year provides support and information to the EIAFRC members and coordinates the work of the committee. Also, this is the first year that the EIAFRC has functioned without the support of **Sandra Matheson**, former Director of the Office of Victim/Witness Assistance at the Attorney General's Office, who provided guidance and support to the EIAFRC until her retirement this past year.

ELDERLY AND INCAPACITATED ADULT FATALITY REVIEW COMMITTEE

MISSION STATEMENT

To reduce elderly and incapacitated adult fatalities through systemic multidisciplinary review of fatalities, evaluation of practices, policies, relevant data and trends and through recommendations for changes in law, policy and practice.

We recognize the responsibility for responding to, and preventing, elder and incapacitated adult abuse and neglect fatalities, lies within the community and not with any single agency or entity. We further recognize that a careful examination of the fatalities provides the opportunity to develop education, prevention, service delivery, management, quality assurance strategies and, if necessary, prosecution strategies that will lead to improved coordination of services for elder and incapacitated adults and their families.

OBJECTIVES

1. Determine and report on trends and patterns of elderly and incapacitated adult deaths in New Hampshire.

2. Recommend policies, practices, and services that will promote collaboration among service providers for, and reduce preventable fatalities among, incapacitated adults.

3. Evaluate policies, practices, intervention and responses to fatalities among incapacitated adults and offer recommendations for any improvements in those interventions and responses.

4. Evaluate and report on high risk factors, current practices, gaps in systematic responses, and barriers to safety and well being for incapacitated adults in New Hampshire.

5. Recommend improvements in the sources of data relative to preventing fatalities among incapacitated adults.

6. Educate the public, policy makers, and budget authorities about fatalities involving covered incapacitated adults.

7. Identify and evaluate the prevalence of risk factors for preventable deaths in the population of incapacitated adults.

8. Development and dissemination of an annual report to state officials describing any trends and patterns of deaths or serious injuries or risk factors, together with any recommendations for changes in law, policy, and practice that will prevent deaths and related serious occurrences and special reports when doing so is necessary to alert authorities or the public to the need for prompt corrective action

ELDERLY AND INCAPACITATED ADULT FATALITY REVIEW COMMITEE
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I. INTRODUCTION

The abuse of elderly and incapacitated adults is a serious and growing problem, both locally and nationally. However, the responses of the justice, health, and social services systems to incapacitated adult abuse lag far behind their responses to the similar problems of child abuse or domestic violence. Fatality review teams for child abuse and domestic violence have had an impact in improving systems' responses to the victims of those similar forms of abuse. Yet, Incapacitated Adult fatality review teams are only just starting to develop.[1]

The Elderly and Incapacitated Adult Fatality Review Committee (EIAFRC) or "Committee" is a group of professionals from many different organizations, agencies and branches of government that convenes regularly to review cases where an elderly or incapacitated adult has died. The theory underlying the fatality review process is that if we are able to better understand why and how a death occurred, we can learn important lessons to help prevent future deaths. The review process affords the Committee with the opportunity to develop recommendations that are intended to improve the statewide provision and coordination of services for elderly and incapacitated adults and their families. By statute the primary emphasis is on reviewing selected deaths of elderly or incapacitated adults who are receiving or were recently receiving services or potentially should have been receiving services from the mental health system (including NH Hospital), the Area Agency system (which services individuals with developmental disabilities or acquired brain injuries), the elderly service system, licensed care and treatment facilities or were reported to the Bureau of Adult and Elderly Services as victims of abuse, neglect or exploitation. RSA 21-M (IV).

The theory underlying the fatality review process is that if we are able to better understand why and how a death occurred, we can learn important lessons to help prevent future deaths. The review process affords the Committee with the opportunity to develop recommendations that are intended to improve the statewide provision and coordination of services for elderly and incapacitated adults and their families.

II. HISTORICAL BACKGROUND

In 2007, House Bill 862-FN, sponsored by State Representatives Schulze, MacKay, Donovan, Emerson, French and Senator Fuller Clark was introduced to establish a committee to study the incidence and causes of deaths of incapacitated adults. (See Appendix A) The purpose of the proposed committee was, among other things, to recommend policies, practices, and services that will promote collaboration and reduce preventable fatalities among incapacitated adults.

On January 1, 2008, RSA 21-M: 16 took effect, creating the Elderly and Incapacitated Adult Fatality Review Committee. The Committee, which is administratively attached to the Attorney General's office, exemplifies New Hampshire's strong tradition of multi-disciplinary

[1] Reprinted with the permission of the American Bar Association Commission on Law and Aging publication entitled *Elder Abuse Fatality Review Teams: A Replication Manual*.

cooperation and its commitment to improving the State's ability to protect its most vulnerable citizens. The statute authorized the Attorney General to appoint members to the Committee from the health care field, organizations with expertise in services provided to incapacitated adults, law enforcement, organizations or individuals who advocate for or provide legal representation for incapacitated adults, and other members as the Attorney General determines will assist the committee in fulfilling its objectives.

The authority and objectives of the Committee are defined by statute and incorporated into the Committee's mission statement. The meetings and records of the Committee are exempt from the provisions of RSA 91-A (Right-to-Know Law). The Committee adheres to strict confidentiality standards and does not identify what cases have been reviewed. Additionally, Committee members sign a confidentiality agreement that prohibits any unauthorized dissemination of information beyond the purpose of the review process as a condition of membership.

The Committee strives to review certain deaths that pose unique or systemic questions with the ultimate question being posed, "What could have been done to prevent this death?"

III. FATALITY REVIEW

MEMBERSHIP

The Committee's membership is comprised of individuals representing the health care field, organizations with expertise in services provided to elderly and incapacitated adults, law enforcement, organizations or individuals who advocate for or provide legal representation for elderly and incapacitated adults, and such other members as the Attorney General determines will assist the committee in fulfilling its objectives.

A review of the membership list, included at the beginning of this report, reflects representation from the following: Probate Court, law enforcement, victim services (through both the Attorney General's Office and the New Hampshire Coalition Against Domestic and Sexual Violence), health care (medical and mental health), Department of Health and Human Services, Bureau of Elderly and Adult Services and Long Term Care Ombudsman, attorneys, disability rights advocates, emergency management services, home care providers, public guardians, and members of public and private organizations that advocate for, and serve the needs of, elderly and incapacitated adults.

The unique make-up of the committee members is the key to the committee's success. Committee members are volunteers and do not get paid for their time or mileage to participate. Their presence on the committee exemplifies their compassion, their professionalism, and their professional and personal commitment to improving the lives of our elderly and incapacitated adult population as well as the system that serves them.

These members come together every other month to review deaths with the hope of improving the State's ability to meet the needs of its most vulnerable citizens.

CONFIDENTIALITY AGREEMENT

Pursuant to RSA 21-M: 16, VIII, the meetings and records of the Committee are exempt from the provisions of RSA 91-A ("Right-To-Know-Law"). Because certain information that is shared at committee meetings is confidential, all members of the committee must sign a confidentiality agreement that prohibits any unauthorized dissemination of information beyond the purpose of the review process as a condition of membership. (See Appendix B).

In addition to individual confidentiality agreements, an Interagency Agreement has been signed by the heads of the New Hampshire Attorney General's Office, the New Hampshire Department of Health and Human Services, and the New Hampshire Department of Safety. (See Appendix C).

CASE REVIEW PROTOCOL

1. The EIAFRC will review data regarding certain deaths of New Hampshire elderly and incapacitated adults as defined in NH RSA 21-M:16, IV.

2. The Committee's review of a case shall not be initiated until such time as any related civil and criminal actions have finally been resolved.

3. Comprehensive, multi-disciplinary review of specific cases may be initiated by the Attorney General's Office, the Department of Health and Human Services, the Department of Safety, or by any member of the Elderly Incapacitated Adult Fatality Review Committee (EIAFRC).

4. Once the EIAFRC Executive Committee identifies a case for review, the EIAFRC Chairperson or Staff Assistant will send case information to EIAFRC members in a sealed envelope marked "Confidential" prior to the scheduling of the case for review at an EIAFRC meeting. The envelope may contain, among other things, the following information: name of victim and perpetrator (if applicable), name of facility or address of residence where death occurred, name of caregiver, deceased's date of birth, driver's license number and social security number.

5. The EIAFRC members should gather necessary information pertaining to the specific case and report this information and their organization's involvement or non-involvement during the EIAFRC meeting.

6. At the EIAFRC meeting, members will review the facts and information gathered for each case, and identify any policies and procedures that could be strengthened or implemented, or measures that could have been taken to prevent the death from occurring.

7. The Committee shall make an annual report, on or before the first day of November each year to the speaker of the House of Representatives, the President of the Senate, and the Governor describing any trends and patterns of deaths or serious injury or risk factors, together with any recommendations for changes in law, policy, and practice that will prevent deaths and related serious occurrences. The Committee may also issue special reports when

doing so is necessary to alert authorities or the public to the need for prompt corrective action.

8. Each Committee member representing a discipline or agency will designate an alternate member from their discipline or agency and will ensure that one member will be present at every meeting.

9. Confidentiality agreements are required of any individual participating in any EIAFRC meeting.

10. Written materials generated from the meeting such as case summaries or notes pertaining to the case will be collected by the Staff Assistant or the Chairperson and destroyed. Use of recording equipment is not allowed.

11. The EIAFRC Executive Committee, comprised of members of the EIAFRC, assesses case information to be reviewed by the EIAFRC and performs other business as needed.

12. The EIAFRC will convene every other month at times published by the Executive Committee.

13. The Committee may invite non-member guests to observe and participate in a review. Invited guests shall be required to sign a confidentiality agreement.

IV. REVIEW AND ANALYSIS OF DATA

The need for the EIAFRC to focus on the prevention of deaths is underscored by the fact that many of the individuals who are the subject of the reviews already have many biopsychosocial stressors in their lives that can put them at a higher risk of injury and/or death. For example, while the Bureau of Behavioral Health is only one of many agencies serving the individuals, research has shown that individuals with severe mental illness die, on average, over twenty years sooner than an individual without a mental illness. It is factors such as this that drives the work of the committee.

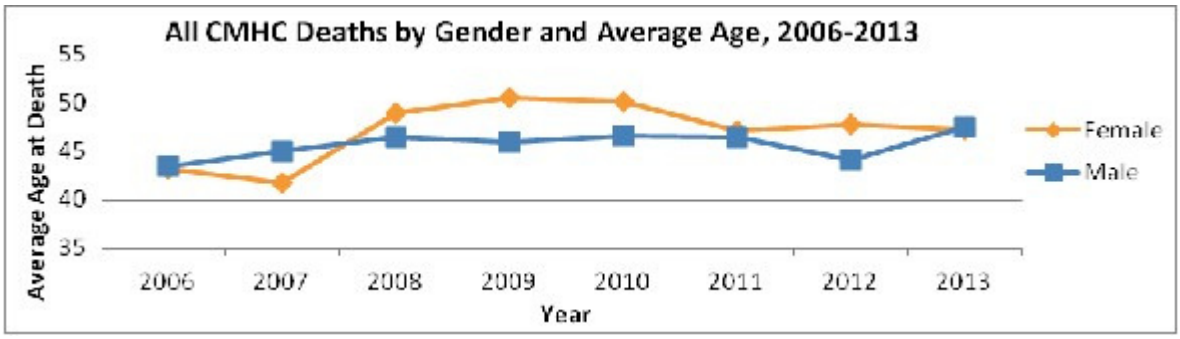
CENTER FOR DISEASE CONTROL DATA

The discrepancy of life spans for individuals with mental illness compared to those without has been documented in numerous studies, including the 2006 report issued by the National Association of State Mental Health Program Directors (NASMHPD) "*Morbidity and Mortality in People with Serious Mental Illness",* which highlighted this. Early morbidity and mortality can be attributed, in part, to poor health behaviors (inactivity, smoking, poor diet, and lack of health care). A more recent study comparing premature mortality in the Severely Mentally Ill population and the general population was published in the July 2010 issue of *Psychiatric Services*. The study concluded the following: "Suicide, cancer, accidents, liver disease, and septicemia increased premature mortality among persons, with serious and

persistent mental illness. Along with on-going suicide prevention programs, efforts to integrate primary and psychiatric care should focus on these preventable causes of early death."
It is recommendations such as this that the EIAFRC strives to encourage and follow.

The Centers for Disease Control (CDC) estimate for 2012 gives a life expectancy at birth of 76.2 years for males and 81 years for females. However, the most frequent age range of 45 to 64 years for New Hampshire Bureau of Behavioral Health consumers' deaths reflects the aforementioned reports' findings.

The chart on the next page depicts the annual average age of deaths of Community Mental Health Center (CMHC) consumers (overseen by the Bureau of Behavioral Health) over an eight-year span. The average age is between 40 and 50, which is much younger than the current life expectancy of 76 to 81 years.



DRUG DEATHS

The Elderly and Incapacitated Adult Fatality Review Committee focused on drug related deaths for two of the six meetings held in 2014.

Drug deaths are increasing in the state of New Hampshire for all individuals, not just the individuals covered under the statutory authority of this committee. An "issue brief" released by the New Hampshire Department of Health and Human Services noted that "in 2011, drug-related deaths peaked at 200, more than ever before and four times as many deaths as in 2000, with 80% of drug deaths involving prescription medication, primarily opioid pain relievers". *www.dhhs.nh.gov/dcbcs/bdas/.../issue-brief-rxdrug.pdf* June 2014.

The majority of drug deaths in New Hampshire are determined to be "Accidental" in nature; although some Suicide and Undetermined deaths are due to drugs.

In 2014, one meeting focused on drug related deaths. This meeting featured a presentation by a committee member, New Hampshire's Chief Medical Examiner, Dr. Thomas Andrew. Dr. Andrew presented material that showed an increase in drug deaths in New Hampshire. This presentation highlighted deaths due to opiates and specifically, heroin. The slide on the next page highlights the prevalence of opiate deaths in New Hampshire.

A second meeting featured a representative from the New Hampshire Bureau of Drug and Alcohol Services covering some of the "Best Practices" regarding substance misuse treatment and points to be mindful of regarding treatment and programming. There was also discussion about the need to cross-train staff in all agencies given the prevalence of substance misuse.

Subsequently, six of the thirteen recommendations from 2014 involve substance misuse training, public awareness and policy. A seventh recommendation indirectly involves substance misuse policy as it related to a suicide.

NH Top 5 2005-2012

2005	2006	2007	2008
Methadone	Methadone	Methadone	Methadone
Cocaine	Cocaine	Cocaine	Oxycodone
Oxycodone	Oxycodone	Oxycodone	Cocaine
Diazepam	Diazepam	Diazepam	"Heroin"
"Heroin"	Fentanyl	Morphine	Diazepam

2009	2010	2011	2012
Methadone	Methadone	Oxycodone	Heroin
Oxycodone	Oxycodone	Heroin	Oxycodone
Cocaine	Cocaine	Methadone	Methadone
"Heroin"	Morphine	Cocaine	Cocaine
Citalopram	Fentanyl	Alprazolam	Morphine

V. RECOMMENDATIONS

This report contains the recommendations made by the EIAFRC the corresponding, responses and what has been accomplished through the recommendation.

TRAINING

1. **Recommendation**: Explore the need to enhance existing educational and outreach plans to ensure all potentially eligible beneficiaries have access to health insurance under the Affordable Care Act or expanded Medicaid coverage.

   Response: Bi- State Primary Care Association was contacted and reported that there is no need for enhancing existing educational and outreach plans in public forums. It was further advised that there are representatives in all areas of New Hampshire to assist individuals in applying for New Hampshire Medicaid to ensure access to health care.

2. **Recommendation**: To replicate statewide the Laconia Police Department's model of contacting and notifying prescribers of reported controlled medication loss or theft.

   Response: The Laconia Police Department was contacted and a request was made to have a representative of the department make a presentation to the New Hampshire Association of Chiefs of Police.

3. **Recommendation**: To encourage the New Hampshire Association of Chiefs of Police to survey how many of their departments have a similar procedure to that of the Laconia Police Department of contacting or notifying prescribers of reported controlled medication loss or theft.

   Response: This recommendation was pursued with the Laconia Police Department.

4. **Recommendation**: To explore with the Department of Education what, if any, type of education is available regarding recognizing and responding to overdose signs and symptoms.

   Response: The Department of Education was contacted to determine what is currently available for educational materials and presentations related to recognizing and responding to overdose signs and symptoms. The Department of Education representative advised that every school is required to address substance abuse as part of their health curriculum. However, the curriculum is not standardized throughout school systems.

5. **Recommendation**: Explore the feasibility of a master of social work or a law student research project to determine the current practice and the effectiveness of drug courts nationwide and in New Hampshire.

   Response: The University of New Hampshire was contacted and a representative determined that it was not feasible to develop such a research project at the time. However, UNH officials will again reconsider this recommendation in the spring of 2015.

PUBLIC AWARENESS

1. **Recommendation:** Explore whether or not the Suicide Prevention Council has a suicide prevention campaign. If so, does the format include print and electronic media, billboards, PSAs and newsletters. Among the concerns raised is whether or not the New Hampshire liquor stores would make this information available.

   Response: The Media/Communications subcommittee of the Suicide Prevention Council was contacted. The subcommittee conducted research and found that the posting of helplines does lead to an increase in the use of the hotline. The

Suicide Prevention Council has endorsed the efforts to advertise the National Suicide Prevention Lifeline number, in collaboration with some of the Public Health Networks in the state. The Suicide Prevention Council is working with the Liquor Commission representatives regarding suicide and substance misuse. The suggestion of having suicide prevention materials, including the Suicide Prevention Lifeline number, be made available in the liquor stores will be brought forward.

2. **Recommendation**: Explore the feasibility of preprogramming the national suicide prevention lifeline number into all cell phones.

   Response: The local NAMI (National Alliance for Mental Illness) chapter and national suicide prevention organizations were contacted to explore the feasibility of having all cell phones preprogrammed with the suicide prevention hot line emergency telephone number. Suicide prevention advocates are awaiting the decisions of the nation's cell phone carriers.

3. **Recommendation**: Create an on-line resource directory for substance abuse treatment programs that are available in New Hampshire that is continually updated and then is shared with case managers and others.

   Response: The Bureau of Alcohol and Drug Services (BDAS) advised that the BDAS already has an on-line resource directory of substance abuse counselors. The BDAS regularly updates and makes their alcohol and drug provider resource guide available on their web site.

   BDAS plans to release a much more comprehensive on-line treatment locator with geo mapping that includes providers beyond those under contract with BDAS.

4. **Recommendation**: Explore possible funding for home health aides to visit recently discharged patients from hospital emergency departments as an alternative to law enforcement conducting "well person checks."

   Response: The Home Health Association (HHA) was contacted. It was discovered that at least one visiting nurse association is already performing this task. However, there is currently no reimbursement for this service. The HHA was asked to consider polling the thirty-nine visiting nurse associations to both determine how many agencies provide this service and how many agencies would consider this as a service, if they could be reimbursed. In addition it was discussed with the HHA whether or not there was any potential grant funding for this service.

POLICY

1. **Recommendation**: That more Crisis Intervention Teams (CIT) be created, that the model be expanded state wide and to request that the Association of Chiefs of Police to consider discussing this during an upcoming meeting.

   Response: The committee is currently attempting to determine statewide commitment to CITs. They are looking to bring together key stakeholders to explore if it is fiscally possible to train and maintain certifications statewide.

EXPLANATION OF CRISIS INTERVENTION TEAM

"The Crisis Intervention Team (CIT) is an innovative first-responder model of police-based crisis intervention with community, health care, and advocacy partnerships. The CIT Model was first developed in Memphis and has spread throughout the country. It is known as the "Memphis Model." CIT provides law enforcement-based crisis intervention training for assisting those individuals with a mental illness, and improves the safety of patrol officers, consumers, family members, and citizens within the community. CIT is a program that provides the foundation necessary to promote community and statewide solutions to assist individuals with a mental illness. The CIT Model reduces both stigma and the need for further involvement with the criminal justice system. CIT provides a forum for effective problem solving regarding the interaction between the criminal justice and mental health care system and creates the context for sustainable change. " [2]

2. **Recommendation**: Explore with the Division for Children, Youth and Families (DCYF) whether there is a policy to educate foster parents about suicide prevention.

   Response: The Division for Children Youth and Families was contacted to explore this question and recommend the inclusion of suicide prevention criteria in foster parent training.

   It was discovered that all applicants for a foster care license must participate in a twenty-one hour initial training program called FACES (Foster and Adoptive Care EssentialS). There is not a dedicated module regarding suicidal risk, however, the topic is discussed in two of the seven modules. Both modules include suicidal behavior as a possible indicator of early abuse and as a potential feeling or behavior associated with despair.

3. **Recommendation**: Contact the New Hampshire Hospital Association regarding recently reviewed cases of potential medication overdose.

[2] Crisis Intervention Team Core Elements; University of Memphis School of Urban Affairs and Public Policy; Department of Criminology and Criminal Justice CIT Center (2007) pg.3 et all

Response: A letter was drafted to the New Hampshire Hospital Association. This letter is currently under review.

4. **Recommendation**: To encourage long term funding of the Prescription Monitoring Program (PMP).

   Response: The Board of Pharmacy was contacted to ascertain the current funding plan. The board advised that they are actively working to secure more grants for the future, but as of now they will run out after May 16th . The EIAFRC recommends to the legislature that the Prescription Monitoring Program (PMP) be fully funded in the future.

Some meetings were held where no specific recommendations were felt to be necessary by the EIAFRC, due to no apparent systems issues being found leading to an adverse event. In other instances, the case reviewed represented a recommendation that had already been made.

GENERAL EIAFRC POLICY STATEMENTS

The following recommendations were also generated from case reviews conducted during the reporting period of this report. Some were immediately tabled due to lack of resources and the inability to implement. Others are policy statements the Committee wanted to issue.

1. The EIAFRC supports the efforts of the New Hampshire Suicide Prevention Council, and acknowledges the need for funding for public awareness and training for key service providers.

2. The EIAFRC supports NAMI's efforts to expand The National Alliance on Mental Illness Connect Suicide Prevention Program.

3. The EIAFRC supports the Public Education Committee of the Governor's Commission on Domestic Violence and Sexual Assault to develop a statewide bystander responsibility campaign.

4. The EIAFRC supports the recommendations made by the Disability Right's Center's White Paper entitled "Examining Preventable Deaths in the Developmental Services System—A Call to Action- Keeping Vulnerable Citizens Safe from Harm"

5. The EIAFRC supports having an Assertive Community Treatment (ACT) teams in each of the Community Mental Health Center's catchment area.

6. The EIAFRC supports studies that consider the long-term effects of psychiatric drugs prescribed to elderly individuals who are at a heightened risk of adverse side effects and drug interactions and make recommendations as necessary at additional reviews.

7. The EIAFRC supports full and prompt implementation of the prescription drug-monitoring program, including, if authorized and feasible, real-time access to information about other authorized prescriptions.

CROSS-FATALITY RECOMENDATION

The Domestic Violence Fatality Review Committee proposed a "Cross-Fatality Recommendation" regarding "access to lethal means" be created and shared with the other Fatality Review Committees.

Firearms are the most commonly used method in completed suicides. The 2013 Annual Suicide report noted that firearms are used 46% of the time. The 2013 Domestic Violence Fatality Review Committee annual report noted that firearms were used 42% of the time for fatalities related to domestic violence. Reducing access to lethal means may reduce suicide deaths and deaths from other circumstances.

Firearm safety is important to stress, given the aforementioned statistics and the fact that roughly one-third of residences in New Hampshire have one or more firearms at any given time. The following statement was part of the Domestic Violence Annual Report for 2014 and is included in this report with their permission and support.

ACCESS TO LETHAL MEANS: CROSS-FATALITY BOARD RECOMMENDATION

The expression, "Reducing Access to Lethal Means", is commonly associated with suicide prevention activities. Research has demonstrated that restricting access to lethal means (or method) decreases the incidence of suicide death. (Mann JJ, Apter A, Bertolote J, et al. (2005). Suicide prevention strategies: A systematic review. JAMA, 294, 2064-2074)

Limiting access to lethal means is a recommendation of the National Strategy for Suicide Prevention (Goal 6) and the New Hampshire Suicide Prevention Plan. As a result, it is being recommended for all of the State of New Hampshire's Fatality Boards. The goal of this recommendation is not only to reduce the incidence of suicide deaths, but also to reduce suicide/homicide, homicide and unintentional deaths and injuries.

Limiting access to lethal means involves efforts to securely store items that can be used for self harm and/or harm to others. Firearms are the primary focus as they are the most lethal method. Access to medications should also be included as the most frequently used method for suicide attempts. Knives, pesticides, and other potential items for harm should also be addressed when, and where, applicable.

Secure storage means the item(s) is/are consistently locked up and out of sight of the person at risk, the combination or the key is known to only those for whom there is no concern, and/or the item(s) are stored out of the residence. These efforts would include any residence the person of concern frequents.

An article on firearm safety was also included in the report and is shared in this report:

THE IMPORTANCE OF GUN SAFETY

New Hampshire, along with the rest of the nation, is engaged in dialogue about gun laws in the wake of the school shooting at Sandy Hook Elementary school in Newtown, Connecticut in December 2012. This article is not about any stance towards more, or less, restrictions on gun ownership. Research is mixed and inconclusive as to whether or not stricter gun laws on ownership result in less violence. New and/or existing gun laws apply only to guns legally obtained, not all guns. Instead, this article is about safety of guns in the home. The Domestic Violence Fatality Review Committee is concerned with gun safety and how best to achieve that goal.

The importance of gun safety should be obvious. Sadly, many times the expression "access to lethal means" comes into play for the cases reviewed.

Research (1) has found that guns are involved in more than 31,000 deaths, and an estimated 74,000 nonfatal injuries, among US residents each year. Increased gun safety by all who have guns, wherever they have guns, has the potential to affect over 100,000 individuals each year.

The risks (meaning deaths and injuries) involving guns are more often risks related to suicide and suicide attempts, as opposed to homicides and accidental shooting injuries and deaths. Statistics show that more people die by suicide with a gun each year than are murdered by someone using a gun. In 2010 in the U.S., 19,392 people died by gun suicide compared with 11,078 who were killed by others.

Guns can be lethal, and guns that are not "in use" may be accessible.

Gun owners and their families are much more likely to kill themselves than are non-gun-owners. A 2008 study by Matthew Miller and David Hemenway, both from the Harvard Injury Control Research Center, found that rates of gun suicides in states with the highest rates of gun ownership are 3.7 times higher for men and 7.9 times higher for women, compared with states with the lowest gun ownership— though the rates of non-gun suicides are about the same. For individuals in gun-owning households, compared to individuals in households without guns, there was no difference in rates of mental illness or in terms of serious consideration of suicide.2 this study suggests that the single factor of a gun is responsible for the difference.

One third of the households in the United States have at least one gun; be it for self-defense, hunting, target shooting, collections, re-enactments, their jobs, etc… The varied

purposes and benefits of gun ownership are important to the individuals and their lifestyles. This article is about gun safety for the guns in these households.

Research supports gun safety, regardless of the purpose of the gun(s). Restricting access to lethal means (or method) decreases the incidence of suicide death [3]. Suicide, as previously mentioned, is by far the most common occurrence in deaths involving guns. Gun safety, however, is important to prevent deaths and injuries from all events: suicide, murder-suicide, homicide, and unintentional shootings. Gun safety can occur by following the suggestions below for all guns in the residence:

1. Individuals should seek proper instruction before using a gun. This can be done by attending a reputable gun safety-handling course or by seeking private instruction before attempting to use a gun. Individuals are encouraged to learn how it operates before handling a new gun. The safety device can never replace safe gun handling. Knowing how to use each gun properly decreases accidental shootings.

2. Individuals need to be sure of their target—and what's beyond. One must be absolutely sure the target has been identified without any doubt. It is also equally important to be aware of the area beyond the target.

3. It is not advisable to mix alcohol or drugs with shooting.

4. Individuals should store guns safely and securely when not in use. "Secure storage" means the gun(s) is/are consistently locked up. It is suggested that if there is a concern about suicide and an individual, that the gun(s) also be kept out of sight of that individual. Lock all guns unloaded in a safe designed for guns or in a tamper-proof, locked storage place. Lock the ammunition separately. The combination, or the location of key to the lock, should be known only by those for whom there is no concern, and/or the gun(s) is/are stored away from the residence. "Secure storage" would need to occur for any residence a person of concern frequents. Hiding unlocked guns is not advised; children often know their parent's hiding places.

5. Individuals who own guns for self-defense own guns that are always "in use". The responsible gun owner needs to make prudent decisions as to how to balance easy access to the gun for self defense use if, and when, needed with sensible precautions against access to the gun by persons and/or situations that are of concern.

6. Other individuals who come into contact with someone for whom there is concern (e.g. family members, First Responders called for any reason, neighbors and/or co-workers) are encouraged to explore access to firearms and, if necessary, make arrangements for temporary storage away from the individual. Efforts are currently underway to address this issue for First Responders.

References:

1. Centers for disease control and Prevention. Web-based injury statistics query and reporting systems: fatal injury reports. Available at http:/www.cdc.gov/injury/wisquers/fatal-injury-reports.html. Accessed January 9, 2013.

2. Drexler M. Guns and Suicide: the Hidden Toll, *Harvard School of Public Health* newsletter, Spring 2013, 24-35.
3. Mann JJ, Apter A, Bertolote J, et al. (2005). Suicide prevention strategies: A systematic review. *JAMA*, 294, 2064-2074)

VI. CONCLUSION

The work of the New Hampshire Elderly and Incapacitated Adult Fatality Review Committee represents an important and significant step forward in the State's effort to reduce preventable deaths of its most vulnerable citizens. We hope that our recommendations will be received and considered by those organizations and agencies that are dedicated to preserving the rights and general welfare of New Hampshire's elderly and incapacitated adult population.

The challenges that face our state are not unique. As our elderly and incapacitated adult populations increase, greater strains will be placed on a system that is already overburdened and under-funded. In such an environment, competent, professional, and caring service providers are our strongest weapon against abuse and neglect. These are the ones that we must retain while we filter out the incompetent and uncaring.

We must also provide support to the growing number of caregivers in our state. An increasing number of family members are finding themselves in situations where they are working full-time while also caring for an elderly or incapacitated parent, relative or child. We must recognize and appreciate the enormous physical and mental strains placed upon these caregivers and provide them with necessary support through counseling, respite care, in-home support services, and adult day services. If we do not improve the system today, it will not be available for future generations of individuals needing this important resource.

"It was once said that the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy and the handicapped."

- Hubert H. Humphrey

APPENDIX A:
STATUTORY AUTHORITY

TITLE I
THE STATE AND ITS GOVERNMENT
CHAPTER 21-M
DEPARTMENT OF JUSTICE

[RSA 21-M: 16 effective January 1, 2008.]

21-M: 16 Incapacitated Adult Fatality Review Committee Established. –

I. There is hereby established the incapacitated adult fatality review committee (committee) which shall be administratively attached, under RSA 21-G:10, to the department of justice.

II. The Attorney General shall appoint members and alternate members to the committee. The members of the committee shall include individuals representing the health care field, organizations with expertise in services provided to incapacitated adults, law enforcement, organizations or individuals who advocate for or provide legal representation for incapacitated adults, and such other members as the attorney general determines will assist the committee in fulfilling its objectives. The terms of the members shall be 3 years; provided that the initial members shall be appointed to staggered terms. Members shall serve at the pleasure of the attorney general.

III. The committee shall:

(a) Recommend policies, practices, and services that will promote collaboration among service providers for, and reduce preventable fatalities among, incapacitated adults.

(b) Evaluate policies, practices, interventions and responses to fatalities among incapacitated adults and offer recommendations for any improvements in those interventions and responses.

(c) Determine and report on trends and patterns of incapacitated adult deaths in New Hampshire.

(d) Evaluate and report on high risk factors, current practices, gaps in systematic responses, and barriers to safety and well-being for incapacitated adults in New Hampshire.

(e) Educate the public, policy makers, and budget authorities about fatalities involving covered incapacitated adults.

(f) Recommend improvements in the sources of data relative to preventing fatalities among incapacitated adults.

(g) Identify and evaluate the prevalence of risk factors for preventable deaths in the population of incapacitated adults.

IV. For the purposes of this section, ""incapacitated adult" means:

(a) Adults who are clients of the area agency system pursuant to RSA 171-A or RSA 137-K at the time of the person's death or within one year of the person's death.

(b) Adults who are patients at the New Hampshire hospital or any other designated receiving facility or whose death occurs within 90 days following discharge, who are on conditional discharge, or who are applicants for or clients of the community mental health center system under RSA 135-C: 13 and RSA 135-C:14 at the time of death or within one year of death.

(c) Adults who are receiving services pursuant to RSA 161-E and RSA 161-I.

(d) Adults who are participants in programs or residents of facilities specified in RSA 151:2, I(a), (b), (d), (e), or (f), or RSA 161-J, or within 90 days of discharge from such a facility.

(e) Adults who were the reported victims of abuse, neglect, self-neglect, or exploitation which was reported to the department of health and human services pursuant to RSA 161-F:46, where the report was determined to be unfounded and was filed within 6 months prior to death, where the report was determined to be founded and was filed within 3 years prior to death, or where the report was pending at the time of death.

(f) Adults who were in need of any of the services defined in subparagraph (a)-(e) at the time of their death.

V. The committee shall adopt a protocol defining which deaths shall be reported to the committee and subject to review, and which deaths may be screened out for review, such as deaths where the cause is natural, expected, and non-preventable. The committee shall also determine whether it is appropriate to have different types of review, such as comprehensive or more limited reviews depending on the incident under review or the purpose of the review. The protocol shall also define the character of the contents of the committee's annual report, required under paragraph VII.

VI. The committee's review of a case shall not be initiated until such time as any related criminal action has been finally adjudicated at the trial court level. Records of the committee, including testimony by persons participating in or appearing before the committee and deliberations by committee members relating to the review of any death, shall be confidential and privileged and shall be protected from direct or indirect means of discovery, subpoena, or admission into evidence in any judicial or administrative proceeding. However, information, documents, or records otherwise available from original sources shall not be construed as immune from discovery from the original sources or used in any such civil or administrative action merely because they were presented to the committee, and any person who appears before the committee or supplies information as part of a committee review, or who is a member of the committee, may not be prevented from testifying as to matters within his or her knowledge, but such witness may not be asked about his or her statements before the committee, participation as a member of the committee, or opinions formed by him or her or any other member of the committee, as a result of participation in a review conducted by the committee.

VII. The committee shall make an annual report, on or before the first day of November each year, beginning on November 1, 2008, to the speaker of the house of representatives, the president of the senate, and the governor describing any trends and patterns of deaths or serious injuries or risk factors, together with any recommendations for changes in law, policy, and practice that will prevent deaths and related serious occurrences. The committee may also issue special reports when doing so is necessary to alert authorities or the public to the need for prompt corrective action.

VIII. The meetings and records of the committee shall be exempt from the provisions of RSA 91-A. The committee's reports shall not include any private or privileged information. Members of the committee may be required to sign a confidentiality agreement that prohibits any unauthorized dissemination of information beyond the purpose of the review process as a condition of membership.

Source. 2007, 256:1, eff. Jan. 1, 2008.

APPENDIX B:
CONFIDENTIALITY AGREEMENT
NEW HAMPSHIRE INCAPACITATED ADULT FATALITY REVIEW COMMITTEE

The purpose of the New Hampshire Incapacitated Adult Fatality Review Committee is to conduct a full examination of incapacitated adult fatalities. In order to assure a coordinated response that fully addresses all systemic concerns surrounding incapacitated adult fatality cases, the New Hampshire Incapacitated Adult Fatality Review Committee must have access to all existing records on each case. 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 incapacitated adult, family and perpetrator, if applicable.

Records of the committee, including testimony by persons participating in or appearing before the committee and deliberations by committee members relating to the review of any death, shall be confidential and privileged and shall be protected from direct or indirect means of discovery, subpoena, or admission into evidence in any judicial or administrative proceeding. However, information, documents, or records otherwise available from original sources shall not be construed as immune from discovery from the original sources or used in any such civil or administrative action merely because they were presented to the committee, and any person who appears before the committee or supplies information as part of a committee review, or who is a member of the committee, may not be prevented from testifying as to matters within his or her knowledge, but such witness may not be asked about his or her statements before the committee, participation as a member of the committee, or opinions formed by him or her or any other member of the committee, as a result of participation in a review conducted by the committee

The meetings and records of the committee shall be exempt from the provisions of RSA 91-A. The committee's reports shall not include any private or privileged information.

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

_____

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

Print Name: _____

Authorized Signature: _____

Witness: _____

Date: _____

APPENDIX C:
INTERAGENCY AGREEMENT

INTERAGENCY AGREEMENT TO ESTABLISH THE NEW HAMPSHIRE ELDERLY INCAPACITATED ADULT FATALITY REVIEW COMMITTEE

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

WHEREAS, the parties hereto are vested with the authority to promote and protect the public health and to provide services which improve the well-being of incapacitated adults; 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 161-F, the Department of Health and Human Services – Bureau of Elderly and Adult Services, has the responsibility to protect the well-being of elder and incapacitated adults; and

WHEREAS, the objectives of the New Hampshire Incapacitated Adult Fatality Review Committee are, as specified by the statute, agreed to be:

1. *Recommend policies, practices, and services that will promote collaboration among service providers for, and reduce preventable fatalities among, incapacitated adults.*
2. *Evaluate policies, practices, interventions and responses to fatalities among incapacitated adults and offer recommendations for any improvements in those interventions and responses.*
3. *Determine and report on trends and patterns of incapacitated adult deaths in New Hampshire.*
4. *Evaluate and report on high risk factors, current practices, gaps in systematic responses, and barriers to safety and well-being for incapacitated adults in New Hampshire.*
5. *Educate the public, policy makers, and budget authorities about fatalities involving covered incapacitated adults.*
6. *Recommend improvements in the sources of data relative to preventing fatalities among incapacitated adults.*
7. *Identify and evaluate the prevalence of risk factors for preventable deaths in the population of incapacitated adults.*
8. *Development and dissemination of an annual report to state officials describing any trends and patterns of deaths or serious injuries or risk factors, together with any recommendations for changes in law, policy, and practice that will prevent deaths and related serious occurrences and special reports when doing so is necessary to alert authorities or the public to the need for prompt corrective action.*

WHEREAS, all parties agree that the membership of the New Hampshire Incapacitated Fatality Review Committee needs to be comprehensive and to include at a minimum, representation from the following disciplines: law enforcement, judiciary, medical, mental health, public health, child protection services, consumer advocacy organizations, with specific membership from designated agencies to include, but not to be limited to: the Office of the Chief Medical Examiner, the New Hampshire Department of Justice,

the New Hampshire Department of Safety and the New Hampshire Department of Health and Human Services; and

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

NOW, THEREFORE, it is hereby agreed that the following agencies will cooperate with the New Hampshire Incapacitated Adult Fatality Review Committee under the official auspices of the New Hampshire Department of Justice, subject to the renewal of this Interagency Agreement. Records of the committee, including testimony by persons participating in or appearing before the committee and deliberations by committee members relating to the review of any death, shall be confidential and privileged and shall be protected from direct or indirect means of discovery, subpoena, or admission into evidence in any judicial or administrative proceeding.

The meetings and records of the committee shall be exempt from the provisions of RSA 91-A. The committee's reports shall not include any private or privileged information.

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

Attorney General	Date
Commissioner, Health and Human Services	Date
Commissioner, Department of Safety	Date