State of New Hampshire

Office of the Child Advocate

Moira O'Neill
Director

Contact: Moira O'Neill, Director, 603-271-7773, 603-848-0413, Moira.ONeill@nh.gov

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Child Advocate Releases Critical Incident Review Emphasizing Culture of Safety

Concord NH: Calling for a shift from blame and shame to system accountability, the Office of the Child Advocate (OCA) released its first report on critical incident review this morning. The report summarizes learning from six critical incidents involving families who had contact with the Division for Children, Youth and Families (DCYF). Child Advocate Moira O'Neill described the summary report as the culmination of collaboration with DCYF frontline staff and administrators who carefully examined systemic influences on case outcomes of the six cases.

"We used the same science now common in safety-critical industries like aviation and nuclear power," O'Neill explained, "to examine the influences on case decision-making so we can understand when and how we can prevent tragedies. Child safety is equally as important as that of airplane passengers." Safety science is an integrated science of evaluation that cultivates a safe environment for honest, open problem solving.

Pursuant to RSA 170-G:18, DCYF must report all incidents to the OCA. This first report covers the period from February 2018 when the Office first began receiving notice of incidents. In that period, DCYF alerted the OCA to twenty-six child deaths. Only fifteen of those children had some contact with New Hampshire DCYF. Nine children had no child protection history, but died unexpectedly, prompting, under new DCYF policy, an assessment of the safety of surviving children and support for grieving parents. Two children had experience with child protection in another state or through distant family contact.

The OCA applied a uniquely designed System Learning Review process to six of the cases. The process identified ten themes in the system that affected casework decision making and agency action, including relationships and communication with other agencies, resource constraints, insufficient technology, and knowledge gaps. While none of these had direct impact on the children's deaths, there are opportunities, such as cross communication, including within the Department of Health and Human Services for consideration. For example, a child had lost health insurance coverage upon discharge from a hospitalization for suicidality. Lack of health insurance was an obstacle to follow-up care, placing the child at considerable risk but there was no way a caseworker would be alerted to the change.

The OCA's System Learning Review process was developed in collaboration with consultants from Collaborative Safety, LLC. For information about the application of safety science in child welfare critical incident review, contact: **Noel Hengelbrok, Collaborative Safety, LLC, nh@collaborative-safety.com**

Pursuant to NH RSA 170-G:18, the Office of the Child Advocate provides independent oversight of the Department for Children, Youth and Families to assure that the best interests of children are being protected.

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