State of New Hampshire

Office of the Child Advocate

Moira O'Neill
Director

Mr. Jeffrey A. Meyers
Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

January 16, 2019

In re: Response to the DHHS response to the 2018 Annual Report of the Office of the Child Advocate

Dear Commissioner Meyers:

Thank you for your letter dated January 14, 2019 in response to the 2018 Annual Report of the Office of the Child Advocate. Our responses to concerns expressed in your letter are listed below by topic.

Shared Mission (Page 1, paragraphs 1 and 2)
We appreciate your recognition of our agencies' shared missions to ensure the protection of children. We agree that the safety and well-being of children is indeed, a shared, collective responsibility. That is clearly demonstrated in RSA 169-C:29 designating all of us as mandated reporters of suspected abuse and neglect of a child. The basic premise of community is a sense of responsibility to all, especially the young and vulnerable.

Agency Responsibility (Page 1, paragraph 3)
While we agree we all share responsibility for the protection of children, we assert that in New Hampshire, the Department of Health and Human Services (Department) is designated as the lead in ensuring the safety of children. RSA 161:2, II mandates that the Department develop and administer state responsibilities for child welfare. This includes providing the "[p]rotection and care of homeless, dependent and neglected children, and children in danger of becoming delinquent." Significantly, RSA 161:2, III gives the Department "general supervision of all neglected or dependent children" to ensure all of their needs are met and to "assist in the enforcement of all laws for the protection of children and investigate charges that may be brought to their attention." It is further the Department's mandate to supervise and license foster homes and child placing agencies pursuant to RSA 161:2,IV. These provisions dispel any ambiguity about the Department's mandate, and make clear that, although DCYF is part of a collective system, the agency has a responsibility specific to child well-being. Law enforcement and the courts do not have a similar, specific mandate towards children, although DCYF would hardly function effectively without them fulfilling their roles. Ultimately, while you take issue with the OCA's

focus on the roles of DCYF in the system of child well-being, it is only DCYF over which the OCA has jurisdiction of oversight pursuant to RSA 170-G:18, III(a). We agree it would be helpful to expand the jurisdiction of the OCA so that it can more deeply examine the roles and performance of other agencies that contribute or should contribute to child well-being.

Overdue Assessments (Page 1, paragraph 5 to page 2 paragraphs 1-3)
The OCA acknowledges that the advance copy of the annual report suggested that families were not being seen. Although you declined to provide comment or corrections to that copy, the OCA received other feedback regarding the report and was able to correct that inaccurate implication in the final report. We further acknowledge a lack of context to the overdue assessments section, as you point out. Our intent was to underscore the impact on workload. The number of overdue assessments is reflective of the need for more staff. The weight of so much unfinished work also has significant impact on morale. We are reassured that DCYF is taking steps with a vendor to continue processing assessments. We look forward to the outcome of that action.

Staffing Needs (Page 2, paragraph 4)
Thank you for pointing out the inaccurate number of staff that we recommended. The Office of the Child Advocate supports all of the prioritized needs in the DCYF budget. We regret not receiving feedback on that error earlier.

Entity Confusion (Page 2, paragraph 5)
Thank you also for pointing out possible confusion about which entities are referenced. That was not our intent. Without specific examples, however, we are not able to provide explanation or make correction.

DCYF – A Crisis Response System (Page 3, paragraph 1)
Again, we share your belief in a collective effort to care for and protect children. However, to disavow the leading role that DCYF holds and to further suggest the DCYF is solely a crisis response system belies the experience of children who are in DCYF custody or guardianship for years – some for an entire childhood. Aiming for DCYF to become solely a crisis response agency once a comprehensive system of care is in place is a shared goal. But it is not yet a reality. Within the collective efforts of the community to support children, the Department, as the entity mandated by statute to protect and supervise them, is held to the highest standard of care.

Enhanced Assessments (Page 3, paragraph 2)
You wrote that the OCA suggested two deaths were caused by abuse or neglect while in DCYF care, while also stating that it appears their deaths were the result of unexplained sudden infant death syndrome (SIUD) and natural causes, an inconsistency you assert that threatens to erode public trust in DCYF. The first paragraph on page 19 of the OCA report states, "*Reporting on critical incidents to the OCA is too recent to determine definitive patterns. However, there are concerns in New Hampshire and*

the surrounding region of children involved in critical incidents (serious injury or death) following multiple unfounded referrals or the closure of what is referred to as an enhanced assessment." As noted further in that paragraph, the OCA will continue to monitor this risk group.

We did not intend to give the impression of DCYF involvement at time of death. Our intent was only to point out a pattern, even if that pattern is for a higher incidence of SIUD. If there is a heightened risk of SIUD with drug-exposed infants, then that is a public health concern that should be responded to. This was the reason for our recommendation that DCYF and DHHS public health services monitor as well and consider adjusting enhanced assessments to a longer period. Your comment pointed out one error of ours, however. Of the two children who died following enhanced assessments, one died from SIUD. We incorrectly reported the second child died from natural causes. We do not know that to be fact. At this time, the OCA has been unable to obtain information on cause of death per the Attorney General's office.

Visitation Centers (Page 3, paragraph 3)
We agree that visitation centers predominantly serve families with domestic violence, marital or custody disputes. We discussed visitation centers in our section on persistent psychological maltreatment, to highlight that children continue to suffer such maltreatment even while under the supervision of DCYF staff. Our recommendation to re-establish visitation centers was intended to create an opportunity for children to have a safe space with trained staff who could protect them while potentially guiding parents towards healthier interactions with children.

"No Eject-No Reject" Policy (Page 3, Paragraph 4)
You object to the OCA's suggestion that providers view pressure from DCYF to admit children to residential facilities as a "no eject-no reject" policy. It is true your advance copy of the report provided for comment and correction had misleading language regarding that phenomenon. Although you declined to comment prior to publication, we received feedback from other sources and were able to clarify the language in the final report. The phenomenon we describe does not exist in DCYF policy. However, some providers shared with the OCA this feeling of pressure to admit all children. "No eject-no reject" was their language. We point this out on page 25, paragraph 5, of the report. This concern underscores a possible need for increased and consistent communication with institutional providers.

Cost Comparisons of Juvenile Justice & SYSC (Page 3, paragraph 5)
Your concern about our cost comparisons of the juvenile justice system and SYSC addresses another section of the report for which we received feedback from other sources prior to issuance of the report. The first paragraph on page 29, carried over from page 28, notes that the DCYF budget is integrated and that the OCA was not able to extract costs such as residential treatment. While you describe the integration as an efficiency, and we believe that may be so, we noted that it somewhat lacks transparency. Therefore, as the system reforms, it will be difficult to determine savings in specific areas of care.

SYSC Training and Activities (Page 3, paragraph 6)
The OCA regrets that the 2018 Annual Report was completed late. That caused some confusion as to the OCA reporting period, which ran through September 30th as well as confusion regarding changes that may have occurred after the reporting period. We did, however, make note of the completion of Trust-Based Relational Intervention training in a footnote on Page 36. We stand by our reporting on the dearth of activities at SYSC. Our sources included both children and staff at all levels. In fact, you stated that activities have increased with decline in census, but staff have consistently reported fewer activities since the reduction in force by 30 positions that occurred in the spring of 2018.

DCYF Internal Reviews of Child Deaths (Page 4, paragraphs 1 and 2)
We agree that the advanced copy of the report the OCA shared with you did not accurately reflect why DCYF interrupted internal reviews of child deaths. Based upon feedback received by the OCA on that report, paragraph 3 of the final report contained an explanation similar to yours for the interruption of these reviews. The OCA also noted that the new policy was put in place after the OCA reporting period. Your comment on this section brought to our attention that we inadvertently edited out an explanation for why the Child Fatality Review Committee interrupted fatality reviews, which was the same explanation you provided in your response. There is legislation proposed to codify the Child Fatality Review Committee as a solution to this problem. The OCA supports that undertaking. The purpose of the OCA's comments on the interruption of review was to underscore the importance of establishing securely the infrastructure to continue that critical process for system improvement. Thank you for prompting this opportunity to note that error.

Looking Forward (Page 4, paragraph 3)
Thank you for taking the time to review the 2018 Annual Report of the Office of the Child Advocate. We too look forward to continuing to learn and discuss opportunities to improve the system in order to ease the experience of children and families who live it, and to further support increased prevention resources for New Hampshire families.

Sincerely,

Moira O'Neill, PhD
Director