CONNECTICUT
Child Advocate

OFFICE OF THE CHILD ADVOCATE

2024-2025 ANNUAL REPORT

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A MESSAGE FROM THE ACTING CHILD ADVOCATE – CHRISTINA D. GHIO, JD, CWLS

The mission of the Office of the Child Advocate (OCA) is to ensure that publicly funded agencies that serve children are accountable to the citizens and families of Connecticut and effectively care for the most vulnerable children. During the last fiscal year, OCA responded to individual complaints and requests for advocacy from individuals and families across the state. OCA investigated complaints that raised systemic concerns regarding the state-funded provision of care to children. OCA reviewed preventable child fatalities and issued public reports with recommendations to prevent child injury and death. OCA testified on dozens of legislative proposals seeking to advance the legal and human rights of children. OCA talked with families, advocates, and service providers throughout the state to better understand and respond to the needs of young children at risk for maltreatment, the educational needs of children with disabilities, and solutions to support children's mental health.

OCA Statutory Responsibilities

- Investigate complaints regarding services provided to children.
- Evaluate the delivery of services provided to children.
- Advocate on behalf of children in Connecticut.
- Review the circumstances of the unexpected or unexplained death of any child.
- Take all possible action necessary to secure the legal and civil rights of children.
- Review the needs of children in foster care.
- Periodically review facilities in which juveniles are placed.
- Publish biennially a comprehensive report regarding conditions of confinement for incarcerated youth under age 22.
- Publish an annual report regarding the activities of the OCA.
- Recommend changes in state policies concerning children including changes in the system of providing juvenile justice, child care, foster care and treatment.

Current OCA Director and Staff

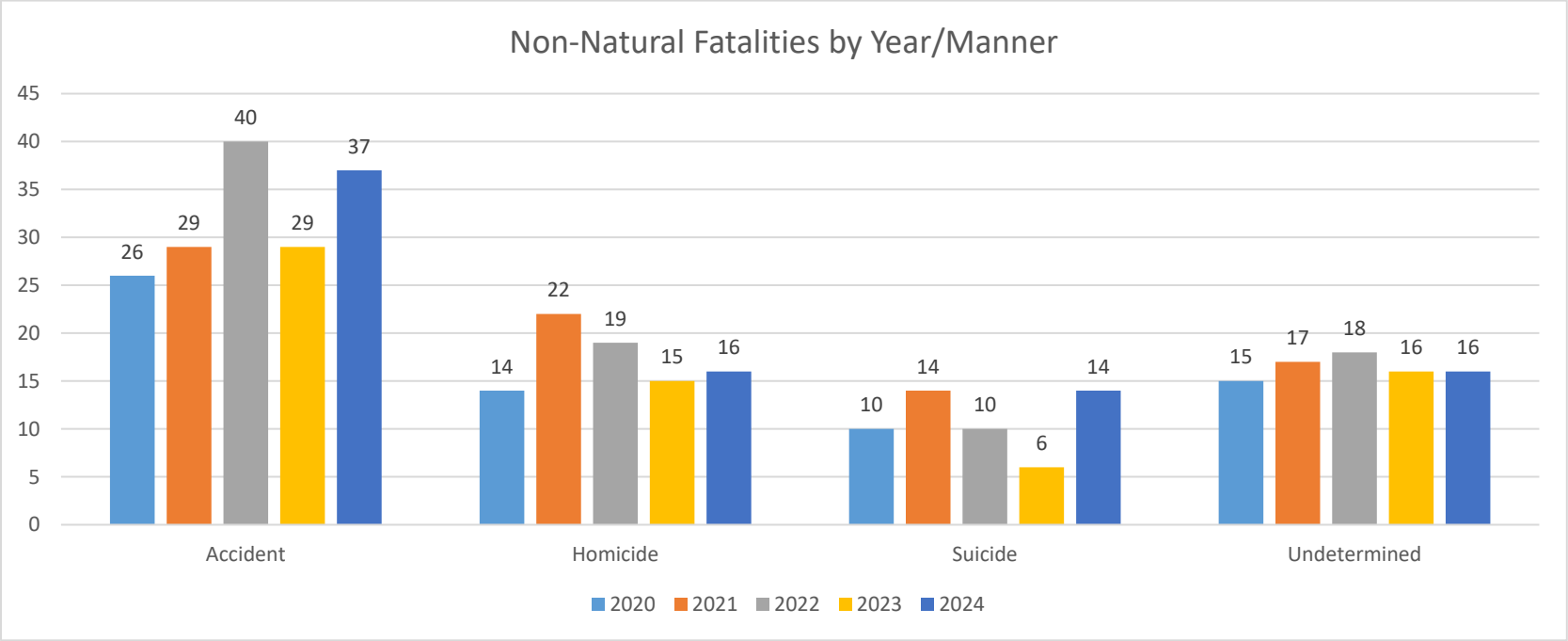
Christina D. Ghio, JD, CWLS, Associate Child Advocate, Acting Child Advocate
Virginia Brown, JD, Staff Attorney
Brendan Burke, MSW, Assistant Child Advocate
Heather Panciera, Assistant Child Advocate
Liz Stitler, LPC, Assistant Child Advocate
Julie McKenna, Human Services Advocate
Lucinda Orellano, Human Services Advocate

CHILD FATALITY REVIEW, JANUARY 1, 2024, TO DECEMBER 31, 2024

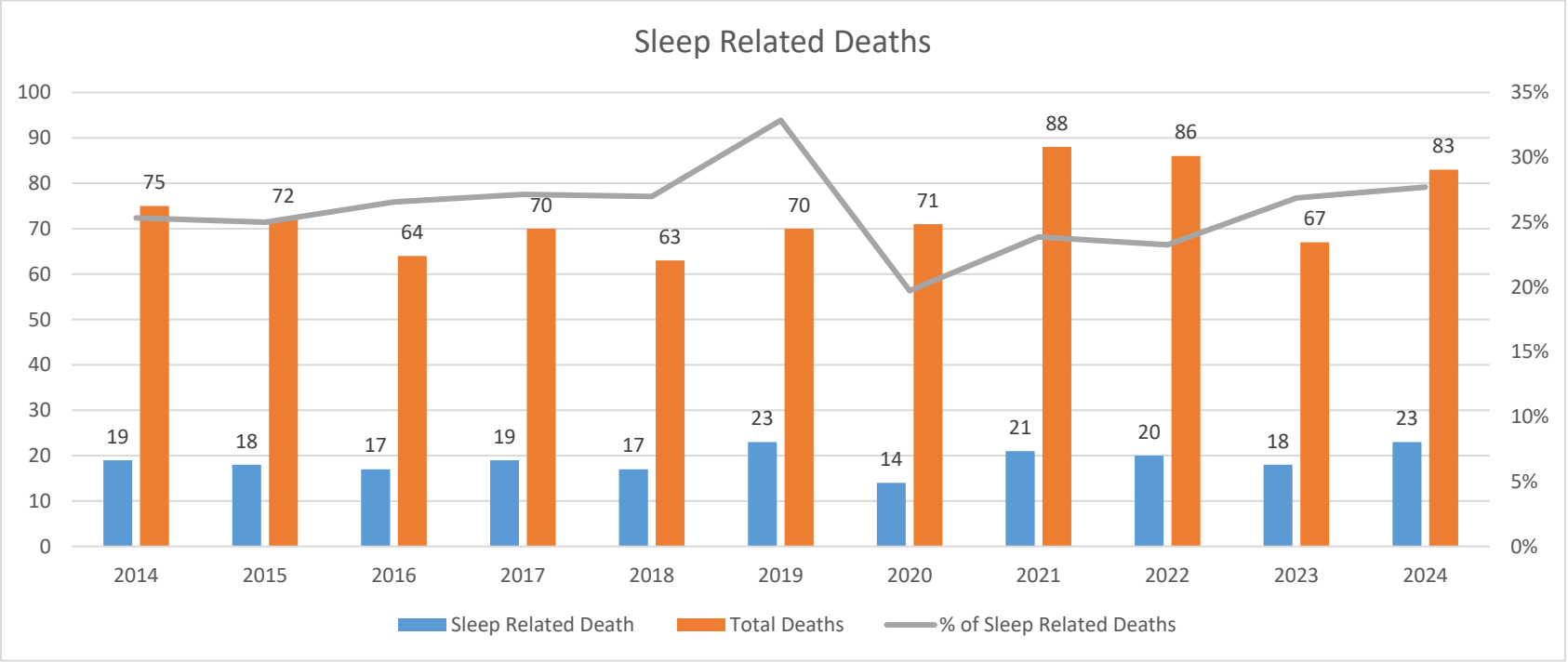
The Child Fatality Review Panel (CFRP) is statutorily tasked with reviewing the circumstances of the death of any child from unexpected or unexplained causes. The purpose of the state's fatality review process is to identify and report on patterns of risk to children and inform fatality prevention strategies. The CFRP is composed of state and community agencies from multiple disciplines (medical, mental health, law enforcement, legal). The CFRP is currently co-chaired by Acting State Child Advocate Christina D. Ghio and Dr. Kirsten Bechtel, an emergency-room pediatrician at Yale New Haven Hospital. The CFRP is staffed by OCA with support from the Office of the Chief Medical Examiner (OCME).

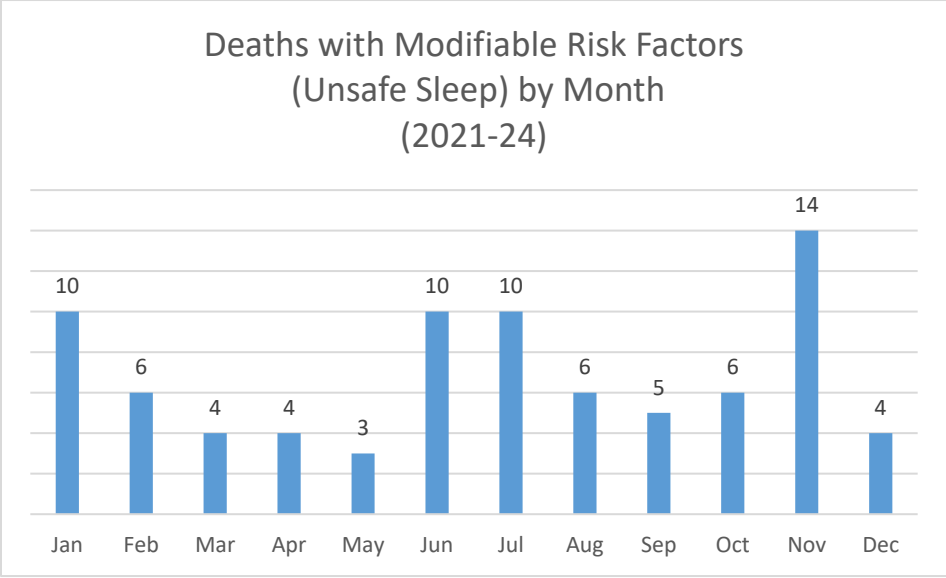
In Connecticut, all deaths reviewed by the CFRP are entered by OCA staff into the National Fatality Review–Case Reporting System, a secure, web-based, standardized case reporting tool. Connecticut is one of 47 states that participates in the national electronic child death review case reporting system. This centralized data collection system helps identify trends and patterns of child fatality in Connecticut and across the country, informing prevention efforts in Connecticut and throughout the United States. The National CFRP has developed a Child Dynamic Analysis and Statistics Hub (Child DASH), which supports Connecticut's child fatality prevention efforts, and facilitates greater data-sharing amongst prevention stakeholders.

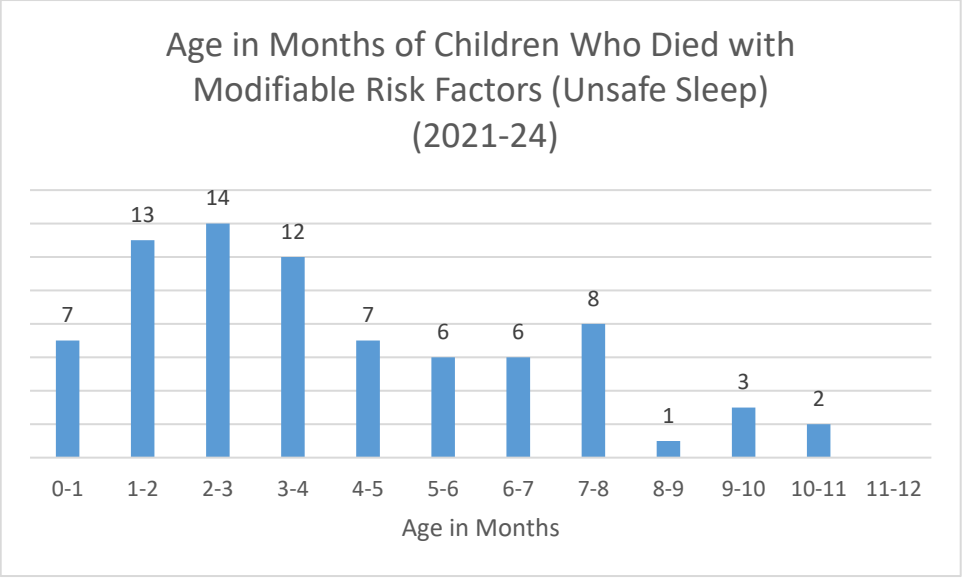
OCME reports unexpected and untimely deaths of children to the OCA. From January 1, 2024 to December 31, 2024, 83 child fatalities were determined to be Accidents, Homicides, Suicides, or Undetermined. 2024 marked an increase in preventable deaths of children, about 26% more than the total in 2023.



Although there is variance year to year in total child deaths, Connecticut persistently continues to see infants die from unsafe and modifiable sleep related causes, with numbers fluctuating from 17 to 23 infant deaths each year (a future kindergarten class of children). Over the last decade, more than a quarter (25.8%) of the children that have died in Connecticut from non-natural or unexpected causes had a sleep environment that was not consistent with safe sleep recommendations published by the American Academy of Pediatrics. These deaths are classified by the Medical Examiner as either Undetermined or Accidental manners of death. The CFRP will continue efforts to curb these deaths through partnership with the newly created Infant Mortality Review Committee, which will investigate and provide system level recommendations for deaths of children under age 1.


Sleep Related Deaths
100
90
80
70
60
50
40
30
20
10
0
35%
30%
25%
20%
15%
10%
5%
0%
19
75
18
72
17
64
19
70
17
63
23
70
14
71
21
88
20
86
18
67
23
83
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
Sleep Related Death
Total Deaths
% of Sleep Related Deaths


Deaths with Modifiable Risk Factors (Unsafe Sleep) by Month (2021-24)
10
6
4
4
3
10
10
6
5
6
14
4
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec

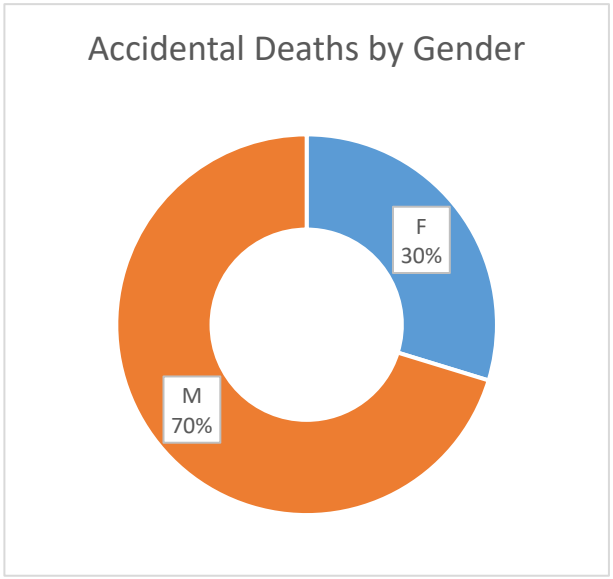

Age in Months of Children Who Died with Modifiable Risk Factors (Unsafe Sleep) (2021-24)
7
13
14
12
7
6
6
8
1
3
2
0-1
1-2
2-3
3-4
4-5
5-6
6-7
7-8
8-9
9-10
10-11
11-12
Age in Months

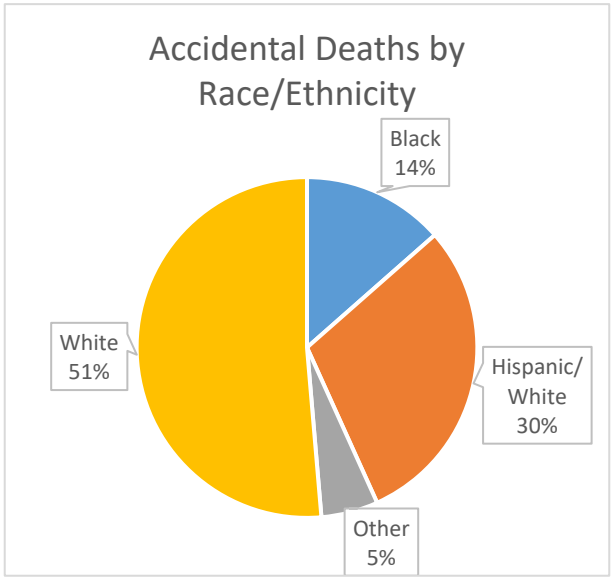
ACCIDENTAL DEATHS OF CHILDREN (37 TOTAL)

A death is ruled Accidental when there is little or no evidence that the injury occurred from intent to harm. The accidental death rate for children in 2024 increased 28% from the year prior. In 2024 accidental deaths of younger children were more prominent than typical, with more than half of the accidental deaths occurring before their 6th birthday.

In 2024, there were 9 deaths of children under age 1 classified as Accidents due to positional asphyxia, which is the insufficient intake of oxygen when breathing, most frequently the result of a compromised airway due to co-sleeping in an adult sleep space.

Four children died due to accidental drowning in 2024, six died from smoke inhalation from residential fires, and two young children died from dog attacks. Motor vehicle related accidents resulted in 13 fatalities in 2024. OCA regularly shares and discusses data and trends regarding the accidental deaths of children with injury prevention partners around the state and country to help inform public health prevention strategies. The OCA/CFRP is also engaged in a pilot program with the National Center for Fatality Review and Prevention (NCFRP) to support enhanced surveillance of drowning, which will inform future data collection efforts specific to drowning deaths.





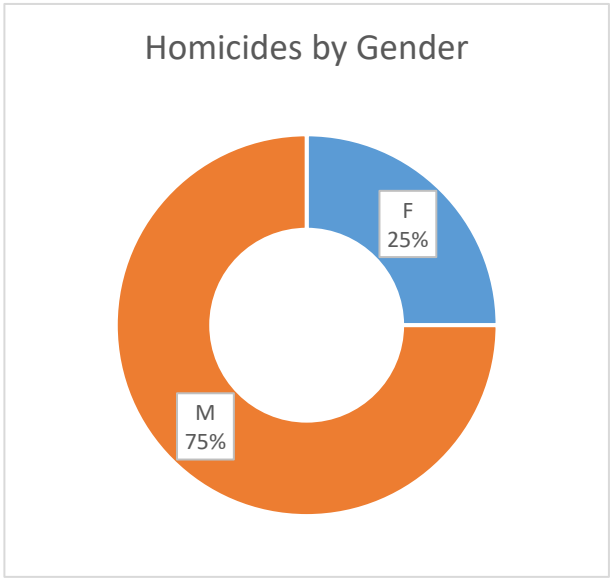
Accidental Deaths
Average Age: 7.2
Median Age: 5.1

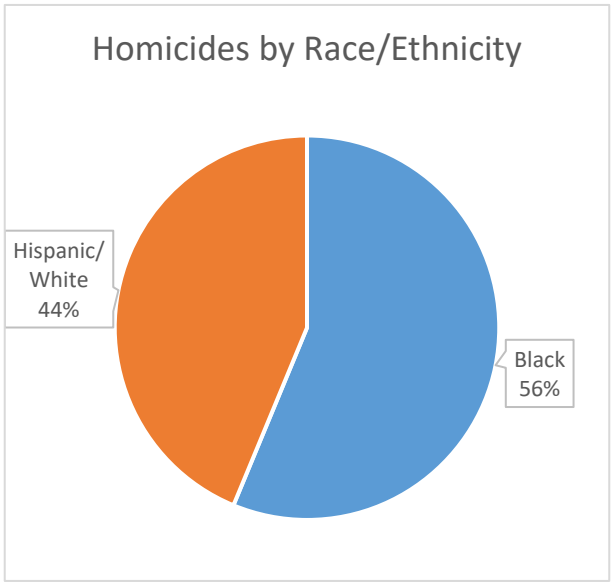
Cause
Motor Vehicle (Driver): 4
Motor Vehicle (Passenger): 8
Motor Vehicle (Pedestrian): 1
Drowning: 4
Positional Asphyxia/Overlay: 9
Acute Intoxication: 2
Smoke Inhalation: 6
Choking: 1
Dog attack: 2

HOMICIDES (16 TOTAL)

A death ruled a Homicide is a death that was caused by the act of another, typically an intentional act. Most homicides of Connecticut children in 2024 were the result of violence, either by firearm (6), child abuse (6) or drowning (2). In 69% of the homicide deaths, the perpetrator was identified as the caregiver of the child that died. Children of color were overrepresented in cases ruled to be homicides, with all of the victims being either Hispanic or Black. There was a noted decrease in firearm-related fatalities by non-caregivers, with 5 such incidents occurring in 2024 (7 in 2023), with all the victims aged 16 or 17.

- **UPDATE: Fentanyl intoxication continues to pose a risk for young children.** In 2024, one child died of Fentanyl intoxication, bringing the total number of very young children in Connecticut who have died from Fentanyl intoxication to 12 since 2020. Additionally, in 2024 there were 9 incidents reported to the Department of Children and Families due to suspicion of a young child having ingested opioids due to abuse/neglect by a caregiver. First responders and/or health care professionals administered Naloxone to these children and they survived the ingestions. Even a trace amount of Fentanyl can be fatal to a young child if ingested. The OCA is co-chairing the Accidental Ingestion Workgroup to ensure effective and easily accessible treatment options for caregivers with young children, expand naloxone distribution/training efforts, and build on safe storage messaging and intervention efforts. One outcome of these discussions is that the Judicial Branch now provides information regarding access to Narcan in its Pretrail Services office, with literature regarding access to community resources provided by the Department of Children and Families and the Department of Mental Health and Addiction Services.



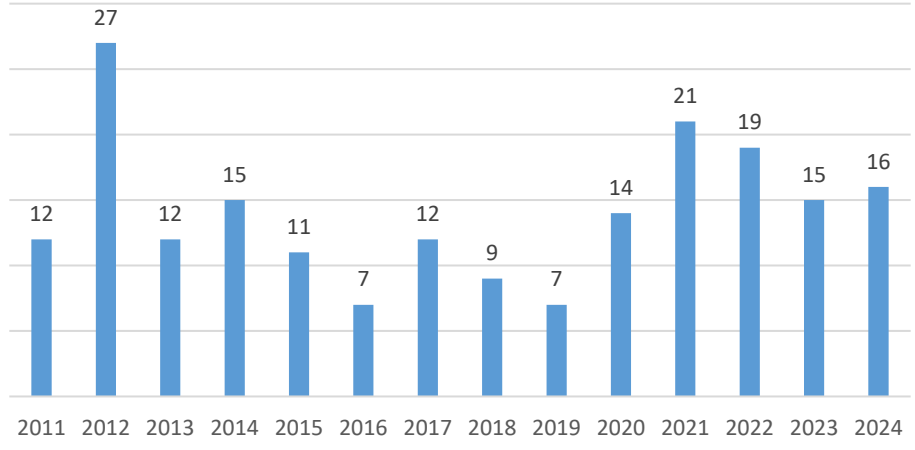


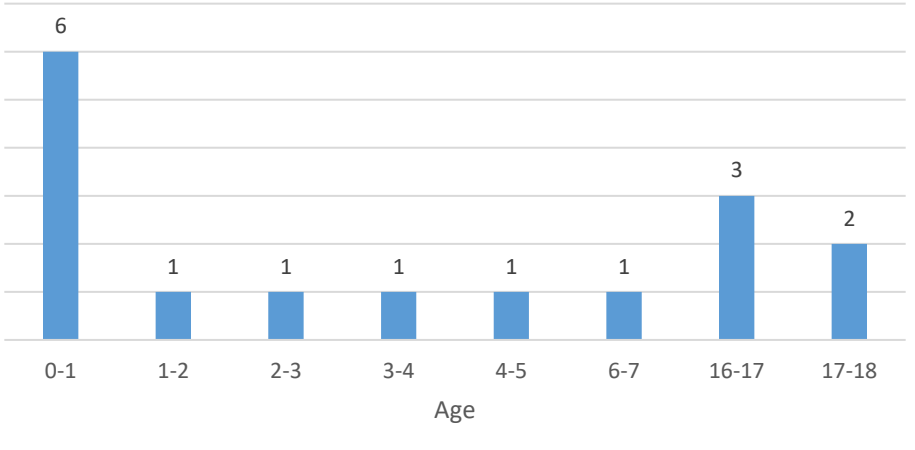
Homicide Deaths

Average Age: 6.6
Median Age: 2.4

Cause
Gun violence: 6
Fentanyl Intoxication: 1
Other child abuse: 7
Drowning: 2

Caregiver perpetrator: 11





SUICIDES (14 TOTAL)

A death is ruled a Suicide when the injury to oneself is done with the intent to die. In recent years across the country, suicide has been the second leading cause of death in children aged 10-18.[1] Data presented by the Connecticut Department of Public Health consistently reflects that **more than 16 children per day in Connecticut seek treatment from a hospital emergency department for suicidal ideation or a suicide attempt.** The OCA participates in several working groups and stakeholder meetings aimed at suicide prevention and improving the children's mental health system.

Spike in Youth Suicide and Response- Summer of 2024

During the summer of 2024, the state of Connecticut lost 10 children to suicide within 3 months, an unprecented stretch of loss. These children died from a variety of means, lived in all corners of the state, had varied genders and racial/ethnic makeups, and ranged in age from 13-17. Some of these children had previous documented struggles with mental health and suicidal ideation, while others had no history of treatment. They came from suburban, urban, and rural communities, and from varying income levels. Some were high academic achievers, while others appeared to struggle. The shared constant is that these were lives lost too early.

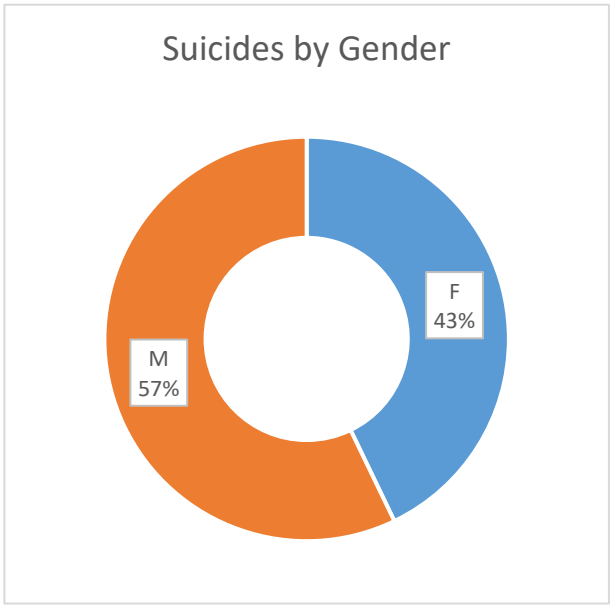
Given the efficiency and collaboration of the Child Fatality Review system in Connecticut, this trend was identified in real time. The state was able to mobilize a cross-system response, including a roundtable discussion, which highlighted the services available to youth and families in Connecticut while shining a bright light on the need for further attention, education, and support for this very vulnerable population. Commissioners from the Depatment of Children and Families (DCF), Department of Public Health (DPH), Department of Mental Health and Addiction Services (DMHAS), State Department of Education (CSDE); the Office of the Child Advocate (OCA); United Way (211); private non-profit providers; Connecticut Children's Medical Center; and individuals with lived experience discussed multi-system level interventions, the challenges for this generation of youth with technology, and their specific vulnerabilities and risks. Services highlighted included Urgent Crisis Centers (UCCs) and 988, the National Hotline Suicide and Crisis Lifeline.

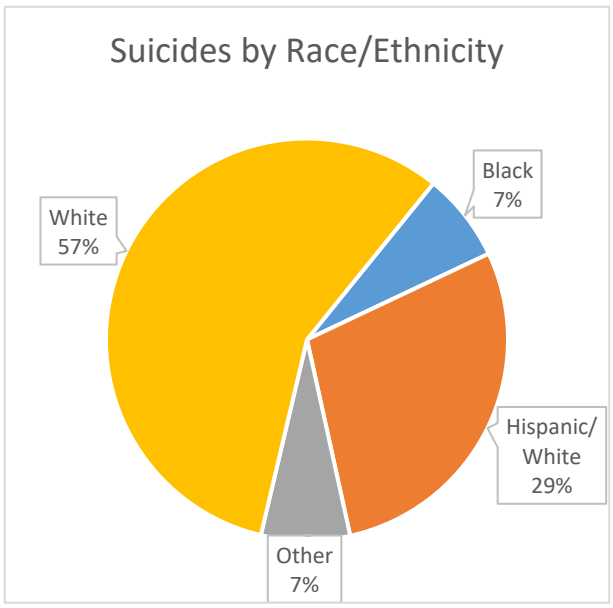
Consistent messaging from the panel of experts stressed the need for engagement and communication with our youth about the critical importance of recognizing mental health warning signs and ensuring that youth have an appropriate outlet to share those feelings. Normalizing conversations regarding mental health and feelings of self harm has proven to be a productive and effective means of minimizing risk.

[1] CDC, WISQARS Leading Causes of Death Visualization Tool.

"Our schools have taught our students the dangers of drugs, alcohol, teen sex. Suicide and mental health are no different. We have to talk about it. We didn't know the warning signs and in hindsight there were some warning signs. Our parents have a right to know. I often say, 'If I knew then what I know now maybe he would be here today."
Ann Dagle, President and Exec. Dir. of the Brian Dagle Foundation.

OCA and CFRP continue to work with statewide and national partners in identifying risk factors and strategies to keep our youth safe and our systems informed. Continued support for the access to emergency mental health services, including the UCCs, and suicide prevention training, such as Question.Persuade.Refer.(QPR), will be critical in strengthening the support network for addressing children's mental health needs.



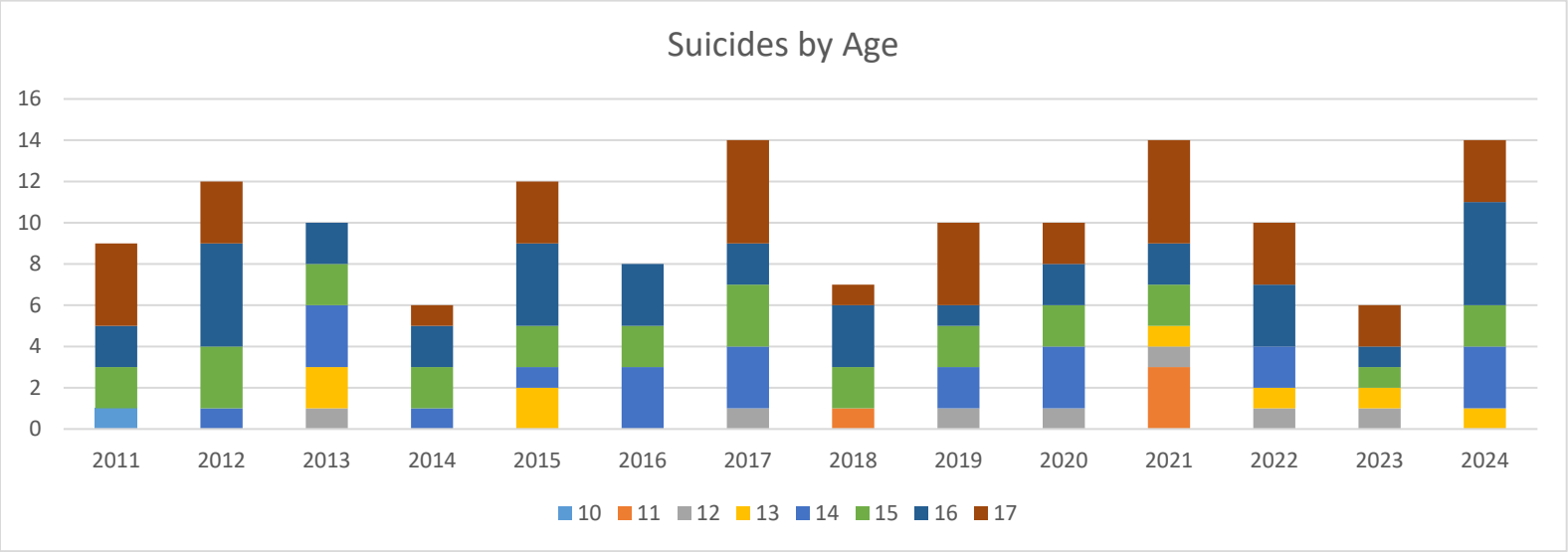


Suicide Deaths

Average Age: 16
Median Age: 15.8

Cause
Hanging/Asphyxia: 7
Gun shot wound: 3
Blunt Force Trauma: 3
Poisoning: 1

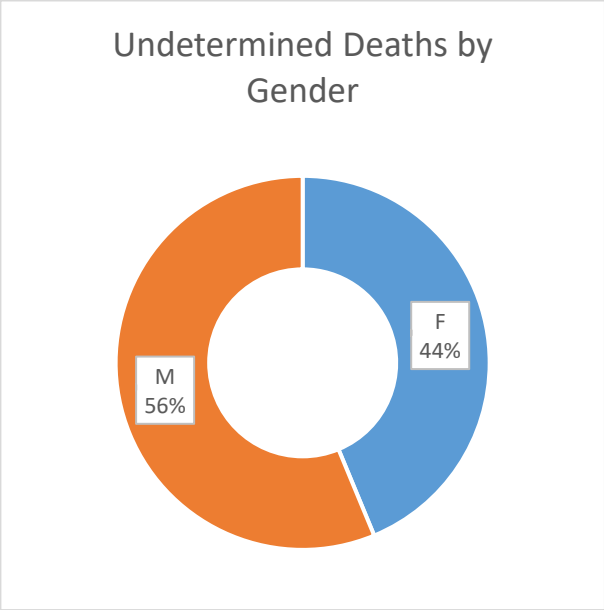
By season
Winter: 1
Spring: 2
Summer: 9
Winter: 2

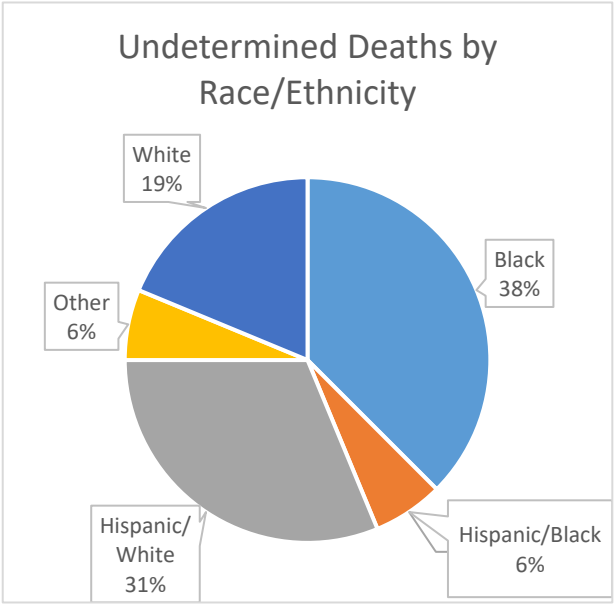


UNDETERMINED (16 TOTAL)

A death is ruled Undetermined when there is no sufficient degree of medical certainty to determine the cause of death. With Undetermined deaths, there is no sign of natural disease and there is no obvious injury, such as would be found in a Homicide, Suicide, or Accident. These cases, which *typically involve infants*, have been rigorously examined by the OCME. Most often case review identifies modifiable risk factors in the infant's sleep environment, such as the baby being in an adult-sized bed, in an adult-sized bed with other children, or in their own sleep environment but with blankets, pillows, etc. These risk factors are typically referred to collectively as an "unsafe sleep environment." "Unsafe sleep environment" also includes the position of the infant, i.e. an infant is placed prone (on their stomach) or on their side. Unlike Accidental deaths where unsafe sleep conditions are definitively established, autopsy and scene investigation may identify unsafe sleep risk factors such as those listed above, but positional asphyxia or lay-over is not conclusively determined.

In 2024, 93.8% of the infants that died in their sleep environments had documented modifiable risk factor(s), inconsistent with recommendations of the American Academy of Pediatrics (AAP).





Undetermined Deaths

Average Age: 7.2 months
Median Age: 4.7 months

Modifiable Sleep Environment Factor
Co-sleeping: 7
Adult sized mattress: 8

Child Fatality Review and Panel (CFRP) Membership (current as of July 2025)

Ex Officio Members	
Office of the Chief State's Attorney:	*Brett Salfia, Esq.*
Office of the Child Advocate:	*Christina D. Ghio, JD, CWLS (Co-Chair)*
Office of the Chief Medical Examiner:	*Gregory Vincent, M.D.*
Emergency Services and Public Protection**:**	*Samantha Haynes*
Department of Children and Families:	*Ken Mysogland, MSW*
Department of Public Health:	*Adelita Orefice, J.D., M.P.M*
Statutorily Appointed Members	
Pediatrician (by Governor):	*Kirsten Bechtel, M.D. (Co-Chair)*

Community Service Representative (by Speaker of the House):	*Pina Violano, Ph.D*
Social Work Professional (by Senate Minority Leader):	*Thomas C. Michalski, Jr. LCSW*
Injury Prevention (by House Minority Leader):	*Steven Rogers, M.D.*
Attorney (by Senate Majority Leader):	*Andrea Barton-Reeves, J.D.*
Psychologist (by Majority Leader of the House of Representatives):	*Elizabeth Corley, Psy D.*
Law Enforcement (by President Pro Tempore of the Senate):	*Sgt. Ivys Arroyo*
Appointed by CFRP Membership	
Neonatologist:	*Ted Rosenkrantz, M.D.*
Intimate Partner Violence Professional:	*Megan Scanlon*
Pediatrician**:**	*Ada Booth, M.D.*

FACILITY OVERSIGHT – July 1, 2024 to June 30, 2025

The OCA staff, within available resources, may visit with children and youth in publicly operated or regulated settings including, but not limited to, hospitals, residential treatment programs, juvenile detention, correctional institutions, and schools. OCA's facility oversight priorities are determined by a) concerns reported to OCA, b) the vulnerability of children and youth served by the program, and c) legislative mandates.

OCA MONITORING OF CONDITIONS OF CONFINEMENT FOR DETAINED AND INCARCERATED YOUTH

OCA published a report examining the conditions of confinement for youth aged 15-17 in the custody of the Department of Correction (DOC), at Manson Youth Institution (boys) and York Correctional (girls). OCA participated in the state's Juvenile Justice Policy and Oversight Committee (JJPOC) to present the findings of this report in September 2024. The report focused on youth aged 15 to 17 in the custody of the DOC, at Manson Youth Institution (MYI) and York Correctional Institution (YCI), and examined: (1) availability and utilization of mental health treatment and rehabilitative programming; (2) use of physical isolation; (3) use of mechanical and chemical restraint; (4) access to educational programming for youth; and (5) access to family visits and family therapy. OCA found that incarcerated youth at MYI received minimal individual mental health treatment and inconsistent clinical programming, inadequate educational and special educational services, and persistently low visitation rates. OCA also found continued reliance on isolation and restriction to address youth behavior. OCA made several recommendations to improve mental health treatment, reduce reliance on cell confinement to address youth behaviors, reduce strip searches, improve educational service delivery, and address the special education needs of youth. In addition, OCA recommended that youth held in custody for adult charges should be held in smaller, community based, rehabilitative, secure environments that support developmentally appropriate work with minors. OCA continues to monitor conditions of confinement for youth in the custody of DOC at MYI and YCI and to advocate for individual youth when appropriate.

In addition, OCA staff continue to monitor conditions of confinement for incarcerated youth up to the age of 22 by reviewing data, conducting facility visits, and meeting with youth, staff, and agency administrators at the DOC and JB-CSSD. OCA will publish a report in the fall of 2025 regarding late adolescents (aged 18-21) held in DOC facilities. This report will include information regarding conditions for 18- to 21-year-olds held in restrictive housing settings.

> *During the course of OCA's investigative activities, OCA met a 21-year-old late adolescent who presented with significant unmet mental health treatment needs. Upon review of his records, OCA learned that he had been incarcerated since the age of 16, was identified as Security Risk Group (SRG) when he turned 18, and had remained on SRG for 3.5 years. SRG is described in policy as a one-year program with five phases. For the calendar year 2022, this late adolescent spent 214 days in SRG1, which is the most restrictive phase and constitutes isolated confinement. By late 2022, his mental health had deteriorated to the point where he was*

in a repetitious cycle of seeking mental health treatment, engaging in attention seeking behaviors (flooding his cell, covering his window), being sprayed with a chemical agent, and receiving disciplinary tickets for these behaviors. After OCA advocated with DOC administrators for mental health intervention and support, he was transferred to Garner, where there is a mental health unit. He later met with OCA representatives and reported improved conditions.

OCA anticipates releasing a separate report on the conditions for youth in the custody of JB-CSSD this year. OCA continues to work with members of the JJPOC to improve re-entry services for incarcerated youth, increase access to gender responsive programming, and ensure oversight and accountability for state agencies serving incarcerated children.

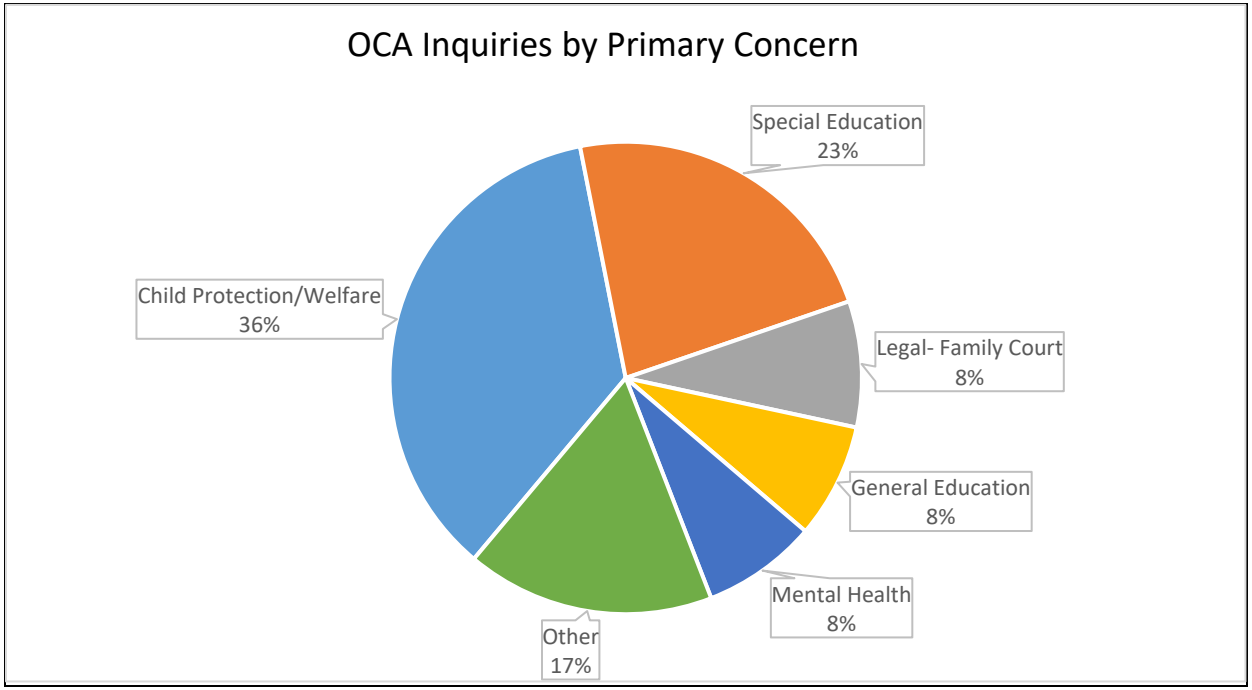
OCA OMBUDSMAN & SYSTEMIC ADVOCACY – July 1, 2024 to June 30, 2025

The OCA is contacted by family members, providers of health/mental health services, school personnel, foster parents, attorneys, legislators, and employees of public agencies, as well as youth who are seeking assistance. The OCA provides all callers with guidance on how to navigate the state's service systems. In the most urgent cases or where the individual complaint raises a systemic concern, OCA undertakes additional investigation and advocacy efforts, which may include record reviews, program visits, and advocacy with both state and local agencies to ensure the needs of children are appropriately met.

Between July 1, 2024 and June 30, 2025, the OCA responded to **nearly 400** individual and systemic complaints regarding the provision of state-funded services to children. The vast majority of calls to the OCA involved concerns related to child protection/child welfare or special education.

Issues addressed and/or investigated by the OCA this year included:

- Safety or permanency concerns for children who have experienced abuse/neglect.
- Lack of access to appropriate special education and related services for children with disabilities in the least restrictive environment.
- Lack of timely and available mental health treatment services across the continuum, from outpatient to in-home to residential treatment.
- Children on discharge delay in hospital emergency departments or hospitals who could not access recommended levels of care, including in-patient, psychiatric residential treatment facilities, foster care, or community-based services.
- Children awaiting appropriate mental health services and/or foster care, who become justice-involved while waiting.
- Lack of timely and available services for children with intellectual and developmental disabilities.
- Children experiencing bullying and harassment.



In its efforts to address systems issues arising from these concerns, OCA meets regularly with the staff and executive administrations of several state agencies and government officials, including DCF, DMHAS, DPH, the Department of Developmental Services (DDS), the Department of Social Services (DSS), the Office of Early Childhood (OEC), DOC, CSDE, the Office of Policy and Management (OPM), the Office of the Chief Public Defender (OCPD), OCME, the Judicial Branch Court Support Services Division (JB-CSSD), and the Connecticut General Assembly.

EDUCATIONAL ADVOCACY

Many of the community complaints received by the OCA involve educational concerns. All complaints received by the OCA are kept confidential and are reviewed by OCA staff regularly. The OCA is authorized to investigate individual complaints that raise concerns about a systemic problem. Some of OCA's investigation activities result in the OCA issuing an Investigatory Report, an Issue/Policy Brief, or a Letter of Concern, which are also provided to the CSDE for further investigation and corrective action, where applicable. OCA encourages local school districts to develop remedial action plans wherever possible to address system concerns uncovered during the review. Where a local district provides a remedial action plan, OCA includes this plan on its website.

INDIVIDUAL EDUCATIONAL PROGRAMMING REVIEWS

During the 2024-2025 fiscal year, the OCA assisted families in accessing disability support services, summer programming, early intervention services, and delivery of services in the least restrictive environment. During its reviews, the OCA participated in Planning and Placement Team (PPT) meetings as advocates for students in cases in which a public-school district's policies, procedures and/or practices were not in conformance with state and/or federal law or best practices. In matters concerning children who were denied a free appropriate public education (FAPE) that could not be resolved, the OCA filed administrative complaints with the CSDE.

> *The OCA received a complaint about a young boy with a history of trauma, Post Traumatic Stress Disorder (PSTD), and severe anxiety who was unable to access his educational programming. Despite educational records over several years showing a student who was chronically absent from school, struggling to pass his core classes, and unable to focus in class, he never received any evaluations, formal assessments, interventions, or appropriate educational testing. Comments from his teachers included "inconsistent effort" and "uncompleted work" and "does not use class time wisely." When the student's parent asked for him to be evaluated for special education and related services, the school district declined to conduct a single evaluation to make such a determination. Rather, it provided homework assistance and encouraged the student to meet with his school social worker. When those limited interventions failed to provide the student with the support he needed to access his educational programming, the school district recommended retaining him and offered a 504 Plan for the upcoming school year. Still, there were no planned evaluations, formal assessments, or appropriate educational testing. The OCA filed a complaint on the child's behalf with the CSDE, on the basis of a Child Find violation under the Individuals with Disabilities Education Act (IDEA). CSDE resolved the matter in the child's favor and ordered corrective action.*

SYSTEMIC EDUCATIONAL REVIEWS/INVESTIGATIONS AND ADVOCACY

During this reporting year, the OCA conducted systemic reviews/investigations of multiple public school districts and privately run, publicly funded programs that provide special education instruction. Investigations addressed issues concerning educational administration and programming, Title IX compliance, and Title VI language-based discrimination. All of the OCA's systemic educational reviews/investigations resulting in the issuance of a formal OCA Report, Letter of Findings, and/or Program Concern are available on the OCA website. The OCA, in partnership with DRCT, continued its investigation into certain private special education facilities located outside of Connecticut where Connecticut students are receiving special education and related services. Its investigation is primarily focused on oversight and monitoring by local educational agencies (LEAs) and CSDE and educational programming and service delivery. This investigation is expected to conclude in late 2025.

ADVOCACY FOR CHILDREN WITH UNMET MENTAL HEALTH TREATMENT AND DISABILITY SUPPORT NEEDS

Many calls to the OCA involve the unmet needs of children with mental health disorders or developmental disabilities. Expressed concerns may be specific to child and family safety, lack of treatment options, the adequacy of special education services being provided, or lack of access to in-home or community-based services. OCA frequently advocates for children with unmet mental health needs to assist the family with obtaining mental health services at the appropriate level of care.

INDIVIDUAL ADVOCACY

This fiscal year, OCA opened numerous citizen complaint cases to advocate for appropriate services for children with unmet mental health needs and/or disability support needs. In this capacity, OCA convenes meetings that include community providers, state agencies, care coordination services, educational providers, and others to identify needed services, barriers to those services, and solutions that ensure the child's needs are met.

> *OCA received a call from a community provider regarding a 17-year-old girl with significant mental health concerns. The youth was adopted at the age of 5 after experiencing considerable trauma at a young age, including a traumatic brain injury due to abuse. The provider was concerned about the youth's adoptive parents' willingness and ability to care for her clinical needs, which consisted of frequent suicidal ideations, serious suicide attempts, and runaway behaviors. Over the years, there were numerous reports to DCF alleging abuse and/or neglect, but DCF never substantiated the allegations. DCF had previously had legal involvement with the family in relation to a sibling, who presented with similar concerns to this child. OCA's*

review of the DCF history, along with the information collected during our investigation, raised significant concerns for abuse and neglect and for the youth's well-being once she turned 18. OCA advocated for DCF to accept a recent report and investigate the allegations. While DCF did not substantiate the allegations, it agreed to keep the case open in ongoing services to ensure the child would be connected with Young Adult Services through the DMHAS upon her 18th birthday.

OCA is frequently contacted regarding children with intellectual disability and/or Autism. OCA has identified children with Autism Spectrum Disorder, Intellectual Disability, and behavioral health challenges as particularly vulnerable and in need of access to a continuum of care and treatment services. Throughout the year, OCA has advocated for multiple children who were unable to access services to meet their needs. These cases represent the most challenging individual cases in which OCA is involved, as the dearth of adequate services and placement leaves children in emergency room and/or hospital settings for extensive periods of time while they await appropriate treatment services. OCA continues to advocate for these individuals and has dedicated resources to addressing related systemic issues.

SYSTEMIC ADVOCACY FOR CHILDREN WITH MENTAL HEALTH NEEDS AND DISABILITY RELATED NEEDS

OCA participates in the Transforming Children's Behavioral Health Policy and Planning Committee (TCB) to advocate for the development of an adequate continuum of mental health services. Then Child Advocate Sarah Eagan presented suicide data to the TCB in September 2024. OCA shared with the Committee that suicide rates have increased in Connecticut and nationally. National data reveals that suicide is now the second leading cause of death in children aged 10-18.[2] OCA shared that, at the time of the presentation, 12 children aged 13 to 17 years old had died in Connecticut in 2024. OCA also shared that approximately 17 children present to the emergency department every day for self-harm and/or suicidal ideation, and the rates at which children present to the emergency department with these concerns has increased over time. OCA recommended that the TCB include periodic updates on the progress on implementation of the state's 5-year Suicide Prevention Plan. In particular, OCA emphasized the importance of training individuals on suicide prevention, such as training on Question.Persuade.Refer. (QPR), and the need to monitor data to ensure that such training is widespread. OCA continues to advocate for a continuum of mental health services in Connecticut, such that children can access treatment at the appropriate level based on clinicial needs, including outpatient treatment, intensive outpatient, partial hospitalization, inpatient, and residential treatment.

Children with Autism, Intellectual Disability, and mental/behavioral health challenges are of particular concern to OCA, as the state does not have an adequate service array to meet their needs. OCA has engaged DCF, DDS, DMHAS, and OPM in an effort to address the needs of children with these complex needs. OCA testified to the legislature regarding the unmet needs of children with intellectual and developmental disabilities, including children with Autism, and the efforts needed to ensure services are available to all children who need them across Connecticut. OCA continues to meet with DCF and DDS to advocate for the state to develop a continuum of care that

[2] CDC, WISQARS Leading Causes of Death Visualization Tool.

can meet the needs of children and young adults with intellectual and developmental disabilities. Addressing the dearth of services for children with these complex needs remains a priority area of advocacy for OCA.

OCA also released a report regarding the need for oversight of entities providing Applied Behavioral Analysis (ABA) treatment to children with Autism Spectrum Disorder. The report, entitled *Review of State Oversight of Entities Providing ABA Treatment to Children*, followed an investigation spurred by concerns that children were spending a great deal of time receiving services in environments similar to child care settings, where parents were not present, but to which childcare regulations did not apply. OCA found that, while there are laws, regulations, and policies that provide some oversight of aspects of entities providing ABA services to children, there is no overarching statutory or regulatory framework. The lack of a regulatory framework leaves significant gaps in oversight that may impact the safety and well-being of children receiving such services. For example, OCA found that there is no mechanism in law that allows DCF to notify ABA providers if an employee is placed on the DCF Child Abuse Registry. OCA recommended several specific statutory amendments, to be made as soon as possible, and a working group to develop recommendations for statutory and regulatory oversight. OCA advocated for the necessary legislation and a bill was raised to create the recommended working group. The bill passed the House but ultimately died in the Senate. OCA continues to work toward implementation of OCA's recommendations to ensure the safety and well-being of children in these settings.

CHILD WELFARE ADVOCACY AND ACTIVITIES

The OCA responds to individual complaints about children involved with DCF. Complaints come from parents, foster parents, relatives, service providers, schools, attorneys, guardians ad litem, and others. Where appropriate, OCA provides information to the caller to enable them to use existing administrative or judicial procedures for resolving their issues. Callers raise concerns regarding the safety of the child, DCF's plans for the child and/or family, unmet needs, and permanency planning.

INDIVIDUAL ADVOCACY

Where the complaint raises a systemic issue, an immediate safety concern for the child, or the child has no advocate, OCA follows up with DCF administrators to address the concerns for the child. In these cases, OCA may review DCF records, contact service providers, communicate with DCF, and convene meetings to address case concerns.

> *OCA was contacted regarding an 11-year-old girl who had been in the emergency department for 10 days, had been cleared for discharge, but remained stuck in the emergency department. The caller raised concerns about the lack of communication between DCF and the hospital and the fact that there was not a clear discharge plan for the child. Upon review of the DCF record, OCA learned that in just over 8 months, the child had been in multiple out-of-home placements and was never in one place longer than a few weeks.*

Shortly after OCA's first contact, the child was moved to another hospital facility due to concerns about medical issues and then remained there for several months. OCA was instrumental in pulling together a larger team meeting to plan for an appropriate placement. These meetings were held weekly until the child stepped down to a medical therapeutic group home while her team continues to work on an interstate compact to support placement with a relative who lives in another state.

SYSTEMIC ADVOCACY

OCA continues to advocate for changes at the system level to improve the safety and well-being for children involved with the child welfare system. OCA reviews DCF systems data regarding core practice areas: safety, permanency, and well-being. The OCA meets regularly with the DCF Executive Team to review child fatalities and critical incidents involving children recently involved with or under the care/supervision of DCF, quality assurance data regarding DCF child protection activities and foster care, and to address other systemic issues affecting children and youth. Current system issues of concern include the safety and well-being of children, particularly girls, in STTAR homes; the availability of foster homes and the adequacy of supports and services provided to foster homes; and an appropriate continuum of services for all children.

In December 2024, OCA issued an *Addendum to Fatality Investigation Findings & Recommendations Regarding The Deaths Of Liam Rivera/Marcello Meadows--Follow Up On Individual And System Improvement Efforts*. This report was an addendum to OCA's reports regarding the 2022 death by homicide of 2-year-old Liam Rivera (child abuse) and the 2023 death by homicide of 10-month-old Marcello Polino (Fentanyl intoxication). Both children and/or their caregivers were involved with state and local agencies, including DCF and the JB-CSSD. In Liam's case, the OCPD was also involved, as it is the agency through which legal counsel was assigned to represent Liam in the child protection proceeding. OCA's investigations found assigned staff at DCF and JB-CSSD had not complied with several agency policies regarding case assessment and supervision, and that the assigned counsel for Liam did not follow statutory and contractual obligations pertaining to the legal representation of children. OCA's reports identified certain systemic issues across agencies and made several recommendations. The purpose of this Addendum was to provide additional information regarding how the state agencies addressed or are addressing individual and systemic issues referenced in the reports. In Liam, Marcello, and Baby John's[3] cases, DCF made critical decisions based on the information that they had available at the time. In all three cases, however, because policies were not followed, critical decisions were made with incomplete or inaccurate information. In all three cases, DCF was unable to produce any documentation or disclose any counseling to address the lack of adherence to agency policies or practice of the respective assigned staff. The lack of individual accountability in the face of significant lapses in adherence to agency policies and practices raised concerns regarding how such lapses are remedied, how lessons can be learned, how progressive discipline can be implemented, and the culture of accountability to the agency's expectations. OCA made several recommendations to ensure accountability, improve the reliability of

[3] John is a pseudonym. Baby John's case was reviewed in the addendum. Baby John suffered a near-fatal ingestion of Fentanyl in 2024 and was saved by the administration of Naloxone by a first responder. Baby John's case raised substantially similar findings to Liam and Marcello's cases.

information provided to courts, and improve oversight by the DCF Statewide Advisory Committee. The report also included information regarding system changes implemented by JB-CSSD and OCPD and recommendations for additional system changes to improve the safety and well-being of children.

In February 2024, the OCA became aware of allegations that a young woman, "Jane," was repeatedly sexually assaulted throughout her childhood by her guardian, Roger Barriault, who was appointed by the Connecticut Probate Court. In March 2025, OCA issued a report, entitled *Connecticut Probate Court Guardianship Proceedings*, regarding OCA's investigatory review of the circumstances of the Barriault guardianship and OCA's review pursuant to Public Act 24-118, which required OCA to review Probate Court procedures related to guardianship of minors. OCA found that DCF missed opportunities to intervene to protect Jane. In addition, OCA found that assessments for the Probate Court are not treated as investigations by DCF, in the way that reports to the DCF Careline would be. As a result, the way information is recorded by DCF in relation to assessments for the Probate Court may result in a lack of complete and accurate information, impact the availability of complete and accurate information for future investigations or assessments, and create a lack of clarity on whether and when police reports are required. OCA recommended that DCF develop a quality assurance framework to monitor and ensure the quality of DCF assessments in matters in the Probate Court and utilize this quality assurance to inform the agency about future training needs and caseload weighting. OCA also recommended the creation of a working group to review the findings, including review of specific reforms identified by OCA, and make recommendations for systemic reform. This recommendation was adopted by the legislature through Special Act 25-18. OCA will participate in the working group and continue to work to ensure implementation of systemic reforms in this area.

In March 2025, news media reported on a man's rescue, after allegedly being held captive for approximately 20 years following his withdrawal from school in or around 5th grade. The man's story prompted renewed discussions about homeschooling in Connecticut. OCA previously issued a report on homeschooling following the death of Matthew Tirado in 2017. OCA's prior report, *Examining Connecticut's Safety Net for Children Withdrawn from School for the Purpose of Homeschooling—Supplemental Investigation to OCA's December 12 2017 Report Regarding the Death of Matthew Tirado*, reviewed data regarding six districts and identified significant concerns for the state's lack of regulation of homeschooling. OCA immediately began an investigation to better understand the state of homeschooling and identify systemic recommendations. In May 2025, OCA released a report regarding the state's ongoing lack of regulation of homeschooling. The report, entitled *A Review Of Children Withdrawn From School For Equivalent Instruction Elsewhere*, included a review of statewide homeschooling data and recommendations for regulation to ensure the safety and education of children. OCA found that over a three-year-period:

- 5,102 children under the age of 18 were withdrawn from school for homeschooling;
- 1,547 children aged 7 to 11 (inclusive) were withdrawn from school for the stated purpose of homeschooling; and
- Of the children aged 7 to 11, 31% were chronically absent and 19% were children identified as students with special education needs prior to their withdrawal from public school.

From the list of 1,547 children aged 7 to 11, OCA then randomly selected 50% of the children (774 children) to cross reference with DCF

records to understand the prevalence of contact with DCF. OCA found that of the 774 children, 22.9% (177) of the children lived in families with at least one accepted DCF report. The number of reports ranged from 1 to 23. 7.9% (61) lived in families with four or more accepted reports to DCF. OCA sampled cases in which there were four or more prior reports to DCF, and these samples raised concerns about whether the children were, in fact, receiving appropriate educational instruction.

While Connecticut has robust procedures for following up on children who are not attending school, once children are withdrawn for the purpose of enrolling in private school in Connecticut or to be homeschooled, nothing is in place to ensure those children are, in fact, receiving educational services. Connecticut's lack of statutory and regulatory oversight at times confounds the child welfare system and enables parents who wish to use this lack of regulation to remove their children from school, isolate them, and shield them from mandated reporters. OCA made recommendations for several specific statutory amendments to ensure that children who are withdrawn from school receive an education, while also ensuring that parents continue to have the right to choose to educate their children outside of public school. OCA advocated for legislative action during the 2025 legislative session and will continue to advocate for the state to address this issue. In addition, with regard to the man rescued in Waterbury, OCA continues to gather and review documentation and assess all of the system implications of this case. OCA anticipates issuing a public report in the future, which will include recommendations developed from that investigation.

COMMITTEES AND COUNCILS – July 1, 2024 to June 30, 2025

OCA participates in multiple taskforces and working groups as part of our systemic advocacy efforts.

PREVENTION	INFANT & TODDLER	EDUCATION	CHILDREN'S HEALTH & WELL-BEING	TEEN/ADOLESCENT SAFETY	JUVENILE JUSTICE
Accidental Ingestion Workgroup	Maternal Child Health Coalition	CT Language Access/Equity Strategic Partnership Workgroup	Transforming Children's Behavioral Health Planning and Policy Committee	Suicide Advisory Board	Juvenile Justice Policy and Oversight Committee (JJPOC)
National Child Fatality Review Case Reporting System	CT Perinatal Quality Collaborative	Title IX Compliance Toolkit Workgroup	Children's Behavioral Health Plan Implementation Advisory Board	Trafficking of Persons Council	Incarceration subcommittee (JJPOC)
Interagency Restraint Prevention Partnership	Substance Exposed Pregnancy Initiative of CT (SEPI-CT)	School Discipline Collaborative	Autism Spectrum Disorder Advisory Council	Regionalized Human Trafficking Recovery Taskforce	Education Workgroup (JJPOC)
Alcohol and Drug Policy Council		U.S. Attorneys' Disability/Educational Rights Coalition Meetings	Child Support Guidelines Commission		Suspension and Expulsion Workgroup (JJPOC)
Statewide Epidemiological Outcomes Workgroup		CT School Climate Standards and Bullying Complaint Form Subcommittee	Finding Words Trainer/Advisor		
		CSDE Special Populations Roundtable	Governor's Task Force on Justice for Abused Children		
		Gender/Transgender in Education Working Group			

TRAININGS – July 1, 2024 to June 30, 2025

This past year OCA provided several trainings to health care professionals, social service providers, parents, legal professionals, and educators and on topics ranging from child death prevention strategies, representation of vulnerable child populations, and cross-agency multidisciplinary advocacy.