OCA ADVISORY COMMITTEE'S
ANNUAL EVALUATION OF THE OFFICE OF THE CHILD ADVOCATE (JULY 1, 2024-JUNE 30, 2025)

January 27, 2026

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The OCA Advisory Committee Evaluation of the Child Advocate on OCA's 30th Anniversary

Section 46a-13r of the Connecticut General Statutes defines the role and responsibilities of the Advisory Committee to the Office of the Child Advocate ("the Committee"), whose members are appointed by the Governor and Senate and House leadership. A key responsibility of this Committee is to evaluate, each year, the effectiveness of the Office of the Child Advocate (OCA) and prepare this written evaluation.

In addition, this year the Committee fulfilled a second critical responsiblity – to assist the Governor in appointing a new Child Advocate when the position becomes vacant. State law requires that we provide the Governor a ranked list of the three to five strongest candidates for the position. After Child Advocate Sarah Eagan resigned in September 2024, the Committee launched a many months-long national search and vetting process, then provided the Governor its ranked list of the top three candidates. The Governor appointed Acting Child Advocate Christina Ghio to be the new Child Advocate, subject to her confirmation by the General Assembly.

Part 1 of our Annual Evaluation sets out OCA's critical and unique responsibilities, and the role of this Advisory Committee. Part 2 summarizes OCA's activities from July 1, 2024 to June 30, 2025 (and with regard to child fatalities, for the 2024 calendar year). Part 3 sets out our Committee's evaluation of the OCA's work and the Committee's recommendations for enhancing OCA's effectiveness. We begin this evaluation with brief summary of our conclusions and recommendations.

Advisory Committee's Annual Evaluation of the Child Advocate
A Summary

The Advisory Committee unanimously concludes that the Acting Child Advocate, Christina Ghio, did a superb job managing the work of the Office of the Child Advocate, particularly given that – for much of the reporting period – she was concurrently filling *two* critical roles in the Office: as the

Acting Child Advocate as well as her original position as Associate Child Advocate. She led and supervised the Office's work conducting its many important investigation, reporting on their findings and OCA's recommendations, and then advocating for the necessary changes in law, policy and procedure they identified. The acting Child Advocate also advocated for, and accomplished, the two tasks this Committee recommended in last year's evaluation report:

1. **Securing funding to increase OCA's staff.** Last year, the Committee recommended that the Child Advocate work to secure state funding for two additional positions deemed critical by the Office of the Child Advocate and this Committee: an Assistant Child Advocate and a Children's Services Consultant. Through her advocacy and with the support of the Governor and General Assembly, funding was, in fact, secured. These positions can bolster the Office's capacity: a) in child protection intake; b) in reviewing the conditions of confinement for (and services being provided to) all youth up to age 22 placed by agencies or departments in public and private institutions or residences; and c) reviewing, as well, as the operation of facilities licensed and/or operated by the Departments of Children and Families (DCF), Corrections (DOC) and Developmental Services (DDS), as well as the Judicial Branch's Court Support Services Division (CSSD)

2. **Protecting OCA's independence.** Last year our Committee recommended amending the OCA's enabling statute to better protect its independence from political influences on its work. Public Act 25-68 amended state law to extend the Child Advocate's term of office from four to five years, renewable for another term. It also altered the re-appointment process to provide for greater Advisory Committee input into the Governor' decision whether or not to re-appoint a Child Advocate.[1] It also now requires that this Committee's annual evaluation of the Child Advocate be provided to the Governor and to the Judiciary, Children's and Human Services Committees, as well as posted on the website of the Office of the Child Advocate.

The Advisory Committee's Recommendations
A Summary

1. **Secure OCA's increased capacity for data analysis.** Given the critical importance of data gathering and analysis to so much of OCA's investigatory and evaluation work (and particularly given the March 2022 end of federal Court Monitoring in the *Juan F.* case regarding the performance of the CT Department of Children and Families), we urge the Child Advocate to identify ways to enhance and assure its capacity for high quality, proactive data analyses (particularly in child protection). OCA could potentially build on its existing contract with the CT Data Collaborative and secure state funding for this work since the current contract relies on donated funds.

[1] The Advisory Committee is directed, not later than 12 months prior to the end of the Child Advocate's term, to submit a preliminary evaluation of the Child Advocate's tenure to date. Then, not later than 6 months prior to the end of the Child Advocate's term, the Committee must submit a final evaluation of the Child Advocate's tenure, as well as a recommendation whether the Child Advocate should be reappointed, or a new Child Advocate appointed. The Committee is to submit both evaluations when due to the Governor, the Child Advocate, and the Judiciary, Children's, and Human Services Committees. No later than 90 days after the final evaluation, the Governor must notify the Advisory Committee of the Governor's acceptance or rejection of the Advisory Committee's recommendation regarding reappointment. If the Governor fails to provide such notice, the Committee's recommendation is deemed accepted. If the Governor's decision is to reappoint, the Child Advocate is to be referred to the General Assembly for confirmation, If not, a new Child Advocate is to be appointed following the process in existing law [Section 46a-13k(a)(2)]

2. **Specify and harmonize reporting deadlines.** Amend OCA's enabling statutes to: a) require the OCA to publish its Annual Report by September 1 each year and specify that it report on work it completed during the state fiscal year ending June 30 of that year (consistent with Section 4-60 of the Connecticut General Statutes); and b) require the Advisory Committee to publish its evaluation of the Child Advocate no later than December 15 of that same year (since state law is silent on its due date).

PART 1 - RESPONSIBILITIES OF THE OFFICE OF THE CHILD ADVOCATE AND ITS ADVISORY COMMITTEE

OCA's Mission and Activities. The General Assembly created the Office of the Child Advocate (OCA) in 1995 (P.A. 95-242) to serve as an independent voice for children rather than an administrator of programs. In 2005, it was placed within the Office of Governmental Accountability (OGA)[P.A. 05-287). In 2016, its administrative functions were transitioned to the Department of Administrative Services' SMART units.

OCA's mission is to ensure that the many publicly-funded agencies and entities that serve Connecticut children are effectively caring for the state's most vulnerable children and are accountable to the residents and families of Connecticut.

OCA monitors and evaluates public and private agencies that are charged with the protection of children, and also reviews state agencies' policies and procedures to ensure they protect children's rights and promote their best interests. OCA's reviews of individual cases and its investigations assist it in identifying systemic issues. Its investigations often shape OCA's public policy and legislative advocacy. Committed to ensuring that *all* children receive the care and supports that they need, through these tools OCA continues to shine light on the diverse needs and circumstances of Connecticut's children, working constantly to identify necessary changes in policy, practice and funding for children and families and assure that these changes are made.

OCA shares its public investigative reports, public health alerts, issue briefs and other relevant educational information through a listserv, distribution to relevant legislative committees, and through the OCA website (www.ct.gov/oca/).

The OCA's Statutory Responsibilities. Over these past thirty years, the General Assembly has tasked OCA with an increasing number of duties and responsibilities as set out in Section 46a-13*l* of the General Statutes. OCA's duties are expansive. They include investigation and advocacy on behalf of individual children and providing training and technical assistance to attorneys who represent individual children. Through such work and other monitoring, OCA identifies broader systemic problems in Connecticut's child-serving state agencies and state-funded entities, and then recommends necessary changes to address identified deficiencies and improve child welfare policy and child well-being.

Because this Committee is charged with evaluating OCA's effectiveness, we set out its key duties, responsibilities, and reporting obligations, as set out in the General Statutes [§46a-13*l* (a)(1-13)]:

"The Child Advocate shall:

(1) Evaluate the delivery of services to children by state agencies and those entities that provide services to children through funds provided by the state;

(2) Review periodically the procedures established by any state agency providing services to children to carry out the provisions of sections 46a-13k to 46a-13p, inclusive, with a view toward the rights of the children and recommend revisions to such procedures;

(3) Review complaints of persons concerning the actions of any state or municipal agency providing services to children and of any entity that provides services to children through funds provided by the state, make appropriate referrals and investigate those where the Child Advocate determines that a child or family may be in need of assistance from the Child Advocate or that a systemic issue in the state's provision of services to children is raised by the complaint;

(4) Pursuant to an investigation, provide assistance to a child or family who the Child Advocate determines is in need of such assistance including, but not limited to, advocating with an agency, provider or others on behalf of the best interests of the child;

(5) Periodically review the facilities and procedures of any and all institutions or residences, public or private, where a juvenile has been placed by any agency or department;

(6) Recommend changes in state policies concerning children including changes in the system of providing juvenile justice, child care, foster care and treatment;

(7) Take all possible action including, but not limited to, conducting programs of public education, undertaking legislative advocacy and making proposals for systemic reform and formal legal action, in order to secure and ensure the legal, civil and special rights of children who reside in this state;

(8) Provide training and technical assistance to attorneys representing children and guardians ad litem appointed by the Superior Court;

(9) Periodically review the number of special needs children in any foster care or permanent care facility and recommend changes in the policies and procedures for the placement of such children;

(10) Serve or designate a person to serve as a member of the child fatality review panel established in subsection (b) of this section;

(11) Take appropriate steps to advise the public of the services of the Office of the Child Advocate, the purpose of the office and procedures to contact the office;

(12) Prepare an in-depth report on conditions of confinement, including, but not limited to, compliance with section 46a-152, regarding children twenty-one years of age or younger who are held in secure detention or correctional confinement in any facility operated by a state

agency. Such report shall be submitted, in accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to children not later than March 1, 2017, and every two years thereafter; and

(13) Present to the advisory committee, established pursuant to section 46a-13r at least three times each year, a report on the goals of and projects undertaken by the Office of the Child Advocate, within available appropriations, that are consistent with the responsibilities of the Child Advocate."

The Child Advocate's Additional Responsibilities Regarding Child Fatalities. As noted above, the Child Advocate is a member (and co-chair) of the Child Fatality Review Panel, established by Sections 46a-13*l* (b)-(h) of the General Statutes and staffed by OCA. This Panel is charged with reviewing "the circumstances of the death of a child placed in out-of-home care or whose death was due to unexpected or unexplained causes to facilitate development of prevention strategies to address identified trends and patterns of risk and to improve coordination of services for children and families in the state."

The Child Advocate also is required, pursuant to Section 46a-13s of the General Statutes, to prepare an annual report regarding the causes and rates of child fatalities in the state. This report must be submitted no later than July 1 each year to the General Assembly's Committees on Children and Education. No later than 60 days after receiving this annual report, these Committees are required to hold a joint public forum regarding the causes and rates of child fatalities in Connecticut.

OCA's Legal Tools. Recognizing OCA's unique and critical role in our state government, the General Assembly granted the Office, through Sections 46a-13m through 46a-13o of the General Statutes, the legal tools it needs to gain access to all the information it requires to investigate and monitor the work of our child-serving state agencies and state-funded entities. These tools include: a) the right to inspect and copy otherwise confidential documents and records; b) the right to issue subpoenas and seek judicial enforcement of them when needed, and c) the right to intervene in or commence legal action on behalf of any child in any proceeding in any forum. Further, in Section 46a-13n(b) of the General Statutes, the General Assembly affords whistleblower protection to any employee of any state or municipal agency or publicly-funded entity "who in good faith makes a complaint to the Child Advocate or cooperates with the Office of the Child Advocate in an investigation"

The Role of the OCA Advisory Committee. Section 46a-13r of the General Statutes establishes the Advisory Committee to the Office of the Child Advocate and defines its membership and responsibilities. State law requires that no member of the Advisory Committee be a volunteer/board member/employee of, or a lobbyist for, any entity subject to OCA review.

The Committee must meet with the Child Advocate at least three times each year to review the goals and activities undertaken by OCA, as reported by the Child Advocate to Committee members. It also must, each year, evaluate and report on the effectiveness of the Office of the Child Advocate.

Section 46a-13k of the General Statutes directs that should the Child Advocate's position become vacant, the Committee must conduct a search and prepare a list of the three to five most

outstanding candidates, ranked in the order of Committee preference, for the Governor to use in making an appointment of the Child Advocate.

Current OCA Advisory Committee Members (and their appointing authorities) are:

Edwin Colon, JD (House Majority Leader)
Danielle Cooper, PhD (Speaker of the House)
Shelley Geballe, JD, MPH (Senate President Pro Tempore)
Jeanne Milstein, BS (Office of the Governor)
Terry Nowakowski, LCSW (Majority Leader of the Senate)
Lisa Seminara, LCSW (Senate Minority Leader)
Zakkyya Williams, MA (House Minority Leader)

Over the past year, members of the our Advisory Committee met at total of seven times, first with the Child Advocate Sarah Eagan and then with Acting Child Advocate Christina D. Ghio (when Child Advocate Egan resigned in September 2024). We learned about OCA's activities, administration, and investigations and shared our thoughts and guidance. The Committee also was provided and reviewed copies of OCA's multiple reports and alerts.

Upon Child Advocate Sarah Eagan's resignation in fall 2024, our Advisory Committee (with the assistance of the Department of Administrative Services) launched a many months' long national search for a new Child Advocate. After a lengthy and comprehensive search, the Committee voted, unanimously, to send the ranked list of its top three candidates to Governor Lamont on August 22, 2024. The Governor's office acknowledged receiving our list on August 25, 2024.

On October 27, 2025, Governor Lamont announced his nomination of Acting Child Advocate, Christina Ghio, to serve as the next Child Advocate, subject to confirmation by the Connecticut General Assembly when it convenes in February 2026.

PART 2: SUMMARY OF OCA's ACTIVITIES JULY 1, 2024 TO JUNE 30, 2025

A full recounting of OCA's many activities and accomplishments over this period can be found in its 2024-2025 Annual Report. What follows is a brief summary that illustrates the breadth of the work OCA's small staff[2] accomplished and highlights the ways OCA's recommendations to address identified shortcomings in our child-serving agencies were embraced by the General Assembly and Governor, and incorporated into state law through OCA's effective advocacy.

A. Ombudsman Activities

Between July 1, 2024 through June 30, 2025, the OCA responded to nearly 400 individual and systemic complaints regarding the provision of state-funded services to vulnerable children. These

[2] For nearly all the time this evaluation covers, OCA had seven staff working. For just one month, there were eight (with a new hire starting just before Child Advocate Eagan resigned, returning the roster to seven). This Committee is most grateful that its recommendation in last year's evaluation to increase OCA's staff was fulfilled by the General Assembly and Governor through funding for two new positions added in the July 1, 2025 to June 30, 2026 budget. OCA is in the process of filling these positions,

inquiries and concerns came from family members, health and mental health care providers, school personnel, foster parents, attorneys, legislators, employees of public agencies, and youth seeking assistance for themselves.

In most case intakes, OCA provided information and guidance on how to effectively navigate our state's commonly complex service systems. When the cases presented more complex concerns about the unmet needs of vulnerable children, OCA's investigation and advocacy efforts included reviews of case records and direct communications with state and community-based agencies to assess whether the needs of children were being appropriately assessed and addressed.

Over this period, issues OCA frequently addressed and/or investigated included:

- For children who experienced abuse and/or neglect, concerns about permanency or safety
- For children with mental health needs, the lack of timely, available mental health treatment services across the care continuum: from outpatient, to in-home, to residential treatment.
- For children in hospital emergency departments or hospitals whose discharge is delayed, the inability to access recommended levels of care (including in-patient treatment, psychiatric residential treatment facilities, foster care, and/or community-based services).
- For children awaiting appropriate mental health services and/or foster care, concerns that arise when they become justice-involved while waiting.
- For children living with disabilities, the lack of access to appropriate special education and related services in the least restrictive environment.
- For children with intellectual and developmental disabilities, the lack of timely, available and appropriate services
- For children experiencing bullying and harassment, inadequate efforts to reduce exposure and mitigate harm.

B. Child Fatality Prevention & Child Safety

Child Fatality Review Panel. OCA co-chaired and staffed the state's Child Fatality Review Panel (CFRP). This multi-disciplinary panel met monthly to review the unexpected and unexplained deaths of Connecticut children as reported to the Office of the Chief Medical Examiner (OCME). During calendar year 2024, 83 child fatalities were determined by CFRP to be Accidents, Homicides, Suicides, or Undetermined. 2024 marked an increase in preventable deaths of children, about 26% more than the total in 2023.

Two disturbing patterns emerged.

Fentanyl in young children. Even a trace amount of fentanyl can be fatal to a young child if ingested. In 2024, one child died of fentanyl intoxication, bringing to twelve the total number of very young children in Connecticut who have died from fentanyl intoxication since 2020. Also in 2024, nine incidents were reported to the Department of Children and Families related to suspicion that a young child had ingested opioids and that this was associated with caregiver abuse/neglect. Fortunately, first responders and/or health care professionals administered Naloxone to these children and they survived their ingestions.

In response, the OCA co-chairs 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 Pretrial Services office and the Departments of Children and Families and Mental Health and Addiction Services provide literature regarding access to community resources. .

Youth suicides. Within three months in the summer of 2024, Connecticut lost ten youth aged 13-17 to suicide, an unprecented stretch of loss. These youth died by a variety of means, lived in all corners of the state, had varied genders, and were of diverse races and ethnicities. Some of these youth had previously-documented struggles with their mental health and suicidal ideation. Others had no history of treatment. The youth lived in suburban, urban, and rural communities. Their income levels varied. Some were high academic achievers, while others appeared to struggle. The shared constant is that these were lives lost too early.

Given the efficient collaboration in Connecticut's Child Fatality Review system, this disturbing trend was identified in real time. Connecticut was able to mobilize a cross-system response, which included a roundtable discussion that 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. State agencies, United Way, private non-profit providers, Connecticut Children's Medical Center; and individuals with lived experience discussed multi-system level interventions, the technology-related challenges for this generation of youth, and their specific vulnerabilities and risks. Services highlighted included Urgent Crisis Centers (UCCs) and 988, the National Hotline Suicide and Crisis Lifeline.

Youth overdose deaths. In September 2024, the OCA, in consultation with Child Fatality Review Panel (CFRP), published an Ad-Hoc review of 409 young adults, ages 18-21, who died unexpectedly in Connecticut between January 1, 2018 and September 30, 2022. A key finding in the study was that the leading cause of death for this age group was overdose, with 27% dying from this cause and a majority had fentanyl in their systems upon autopsy. Notably, forty-three percent of these youth (43%) had prior involvement with DCF, with approximately one-third committed to DCF guardianship at some point during their childhood. Twenty-seven of these young adults had open individual or family DCF cases at the time of their deaths. For the other 143 with previous DCF involvement, that involvement with DCF ended an average of 5.3 years (median of 3.5 years) prior to their death. These findings were shared with colleagues and may have policy/practice implications for those working with this population.

As discussed more fully in the section of this evaluation about OCA's child welfare work, OCA published an addendum (with an executive summary) to two of its Fatality Investigation Findings reports: 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): Addendum To Fatality Investigation Findings & Recommendations Reports Regarding the Deaths of LR & MM (December 17,2024). This addendum provided additional information about how well the various local and state agencies and individuals involved in these cases were addressing the indiviual and systemic issues identified in the earlier Findings reports. It also included a summary of a more recent critical incident involving Baby John who also had ingested fentanyl, and identified the responsible agencies' "strengths and areas for attention movimg ahead."

In addition to this investigatory work and related legislative advocacy, OCA staff participated on multiple committees, taskforces, and working groups – national as well as local - focused on prevention efforts for children at risk of intentional and unintentional injuries/fatalities.

C. Investigation and Oversight of Facilities in Which Children and Youth are Placed

Sections 46a-13*l* (5),(12) of the General Statutes require the Child Advocate to: "Periodically review the facilities and procedures of any and all institutions or residences, public or private, where a juvenile has been placed by any agency or government" and also "Prepare an in-depth report on conditions of confinement, including, but not limited to, compliance with section 46a-152, regarding children twenty-one years of age or younger who are held in secure detention or correctional confinement in any facility operated by a state agency."

During this past year, OCA staff visited children and youth in facilities operated by the Department of Correction (DOC) and the Judicial Bureau-Court Support Services Division (JB-CSSD), monitoring conditions of confinement for incarcerated youth aged 15 to 22 and meeting with youth, staff, and agency administrators at DOC and CSSD.

In November 2024, OCA released An Examination of Conditions of Confinement – Incarcerated/Detained Youth in the Custody of the Department of Corrections. It focused on youth incarcerated in Manson Youth Institution (MYI). This was OCA's fifth report regarding conditions of confinement for incarcerated youth in the last nine years, with four of the audits focused on youth at MYI. OCA found that while there were some improvements, MYI continues to rely heavily on cell confinement and movement restrictions as its response to youth misbehavior. MYI staff also underestimated youths' significant clinical and behavioral health treatment needs, and were not providing a therapeutic setting that delivers consistent rehabilitative programming in a developmentally-appropriate context. OCA's recommendations included that Connecticut should work to relocate adolescent boys to smaller, community-based, rehabilitative, secure environments that support developmentally-appropriate work and also that it should relocate the girls to a juvenile setting, given their small numbers.

Though released after the date this annual evaluation covers, it bears noting that on December 2025, OCA released an updated investigative report (with an executive summary) regarding conditions of confinement for late adolescents (aged 18 to 21) who are being placed in long-erm highly restrictive settings other than MYI. It identifies multiple problems and systems issues, including prolonged cell time with accompanying restrictions, minimal mental health treatment, limited educational services, a lack of rehabilitative programming, and many youth languishing in these restrictive settings. The report concludes with nine recommendations to address these problems. This report will be discussed in greater detail in the Committee's 2025-26 evaluation.

OCA also participated in the state's Juvenile Justice Policy and Oversight Committee (JJPOC) and worked with members of its Gender Responsive and Incarceration Workgroups to improve re-entry services for incarcerated youth, increase access to gender-responsive programming, and provide oversight and ensure accountability for state agencies serving incarcerated children.

D. Educational 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.[3]

The OCA, in partnership with Disability Rights Connecticut (DRCT), continued its investigation into certain private out-of state special education facilities where Connecticut students are placed for their special education and related services. This investigation primarily focused on the level of oversight and monitoring being done by local educational agencies (LEAs) and the Connecticut's Department of Education, as well as on the quality of the schools' educational programming and services. This investigation has been completed and OCA anticipates publishing a report, in conjunction with DRCT, in early 2026.

OCA participated in multiple committees and working groups to address systemic educational concerns affecting Connecticut children, including: the U.S. Attorneys' Disability/Education Working Group; JJPOC's Working Groups on Education and on Suspension and Expulsion; the CSDE Special Populations Roundtable and its Title IX Compliance Toolkit Working Group; the CT Language Access & Equity Strategic Partnership Workgroup; the CT School Climate Standards and Bullying Complaint Form Subcommittee, and the Gender/Transgender in Education Working Group.

E. Child Welfare Advocacy

The OCA responded to individual complaints about care being provided to children who are DCF-involved by providing advice to callers and following up with DCF regarding the alleged unmet needs of these children for services, permanency, and/or protection. OCA also met regularly with the DCF Executive Team to review issues of mutual concern including: child fatalities and critical incidents involving children recently involved with DCF or under the care/supervision of DCF; DCF's quality assurance data; and other systemic issues affecting children and youth.

OCA continues to advocate for systems-level changes to improve the safety and well-being of children involved with our child welfare system. OCA reviews DCF's systems data regarding its core practice areas: safety, permanency, and well-being. It meets regularly with DCF's Executive Team to review child fatalities and critical incidents involving children recently involved with DCF or under its care/supervision as well as quality assurance data about DCF's child protection activities and foster care. OCA also raised with DCF other systems issues about which OCA is concerned, including 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 them; and the need for an appropriate continuum of services for all children.

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[3] OCA publications in the time frame of this Committee's evaluation include a Complaint filed with the United States Department of Education alleging significant deficiency in the level of oversight being provide to Connecticut students living with disabilities (September 19, 2024) and an investigative report (with executive summary) regarding Probate Court guardianship proceedings and, pursuant to Public Act 24-118 (section 12), a one-time review of (February 2025) and report on the Probate Court's practice and procedures in guardianship matters, with recommendations for improvement (March 2025)

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 Judicial Branch's Court Support Services (JB-CSSD). In Liam's case, the Office of the Public Defender also was involved, as it is the agency that assigned legal counsel to represent Liam in the child protection proceeding.

OCA's investigations found the 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.

Since OCA's reports identify certain systemic issues across agencies and make recommendations for improvement, 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 these earlier reports. The Addendum found that in Liam, Marcello, and Baby John's[4] cases, DCF made critical decisions based on the information that they had available at the time. However, because policies were not followed in these cases, 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 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 March 2025, OCA issued a report, entitled *Connecticut Probate Court Guardianship Proceedings*. It reported on OCA's investigatory review of the circumstances of a particularly harmful guardianship of a minor as well as OCA's required review (pursuant to Public Act 24-118) of Probate Court procedures related to the guardianship of minors.

OCA found that DCF missed multiple opportunities to intervene to protect the minor. In addition, OCA found that assessments done 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 assessments done 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.

[4] 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.

OCA recommended in its report 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 framework to inform the agency about future training needs and caseload weighting.

OCA also recommended the creation of a working group to review the report's findings - including the specific reforms identified by OCA - and make recommendations for systemic reform. The legislature adopted this in 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.[5] OCA immediately began an investigation to better understand the current state of homeschooling and 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 their 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 per child 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 its review of these cases raised concerns about whether the children were, in fact, receiving appropriate educational instruction. In May 2025, OCA released the report about its investigation - *A Review Of Children Withdrawn From School For Equivalent Instruction Elsewhere*. The report ncluded a review of statewide homeschooling data and made recommendations for some regulation that would ensure the safety and education of children.

Notably, 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 also blocks DCF's capacity to respond to cases of child maltreatment. In the absence of some form of regulatory oversight of homeschooling, abusive parents can remove their children from school, isolate them, and thereby shield them from mandated reporters.

In its report, OCA recommended several specific amendments to state law that would balance parents' right to choose to educate their children outside of public schools with the rights of

[5] OCA had issued a earlier report on homeschooling following the death of Matthew Tirado in 2017, *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*. This report reviewed data about six districts and identified significant concerns about Connecticut's lack of regulation of homeschooling.

chidren who are withdraw from public school to receive an education and be safe from harm. 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.

F. Advocacy for Children with Unmet Mental Health Treatment and Disability Support 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. In September 2024, Child Advocate Sarah Eagan presented data to the Committee showing that suicide rates have increased in Connecticut and nationally. National data reveal that suicide is now the second leading cause of death in children aged 10-18.[6] 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 these numbers have 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, to ensure that children are able to access treatment at the appropriate level based on their clinicial needs, including outpatient treatment, intensive outpatient, partial hospitalization, inpatient, and residential treatment.

In February 2025, OCA 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 reports that these 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 such settings 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. In the 2025 Session, 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.

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

Children with autism, intellectual disability, and mental/behavioral health challenges are of particular concern to OCA, as Connecticut lacks 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.

In sum, OCA remains concerned about the paucity of services available for children with intellectual and developmental disabilities -from community-based services to group home levels of care. OCA has testified to the General Assembly 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. OCA continues to meet with DCF and DDS to advocate for Connecticut to develop a robust continuum of care that can meet the needs of children and young adults with intellectual and developmental disabilities.

G. Committees & Taskforces

Integral to OCA's systemic advocacy efforts is its staff's participation in multiple taskforces and working groups, including but not limited to:

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			

H. Training

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.

PART 3: FINDINGS AND RECOMMENDATIONS OF THE OCA ADVISORY COMMITTEE

The OCA Advisory Committee bases this evaluation on what its members have learned about OCA's activities through its seven meetings between July 1, 2024 and June 30, 2025 with the Child Advocate – first Child Advocate Sarah Eagan and then, upon her resignation in September 2024, the

Acting Child Advocate/Associate Child Advocate Christina Ghio. We also have considered the multiple published investigation and other reports that have been provided to us, OCA's 2024-2025 Annual Report, and our other communications with OCA staff and persons who work with OCA.

Based on this body of information, the Advisory Committee concludes as follows:

- The Office of the Child Advocate has accomplished far more than one could ever expect of this agency, given the mismatch between the breadth of OCA's *unique* statutory responsibilities and the resources Connecticut has provided for staff to accomplish OCA's work. Further, the Acting Child Advocate/Associate Child Advocate Christina Ghio seamlessly assumed her dual role upon the Child Advocate's September 2024 resignation. She has done a superlative job not only leading the Office's investigatory, policy, and advocacy work, she also has maintained the morale of OCA's dedicated staff as it uncovers and reports on harms occasioned on our state's most vulnerable children, and develops and advocates for systemic strategies to both mitigate the harms' impactsand avert such harm in the future.

- The Acting Child Advocate/Associate Child Advocate and others on the OCA staff are highly experienced and well respected among the child-serving community. Staff works extremely hard to prioritize its workloads and the foci of their work so the challenges posing the greatest danger to our state's most vulnerable children get the requisite, immediate attention.

However, now, with no federal court monitor tracking the quality of DCF's care for our state's most vulnerable children[7] and no Office of Program Review and Investigations[8] to provide the General Assembly with its independent professional assessment of the performance of our state's child-serving agencies, it is OCA *alone* that is tasked with independent monitoring of agencies, programs, and services serving our state's most vulnerable children and youth, and also granted the multiple legal tools needed to do this work, including access to individual children's records and aggregate data collected by the state.

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[7] The federal Court Monitor in the *Juan F. v. O'Neill* class action litigation (filed in 1989) was tasked with monitoring compliance with the terms of a Consent Decree that DCF signed in 1991 and then with monitoring progress toward Exit Plan benchmarks. Its quarterly reports tracked DCF's performance on multiple child welfare outcome measures, based on its independent and thorough analyses of multiple sets of DCF data. These reports provided reliable and independent insight into, and accountability for, the care being provided to our state's abused and neglected children. (https://portal.ct.gov/DCF/Positive-Outcomes-for-Children/Outcome-Measures-for-Children).This oversight ended in 2022.

[8] The General Assembly's Office of Program Review and Investigations was established in 1972 to provide the General Assembly with the capacity to conduct "an examination of programs administered by state departments and agencies to ascertain whether such programs are effective, continue to serve their intended purposes, [and] are conducted in an efficient manner." Its full-time professional staff conducted "investigations to assist the General Assembly in the proper discharge of its duties," researched and analyzed agency practices and policies, and reviewed state programs for "efficiency, effectiveness, compliance, and recommended changes as needed." (https://www.cga.ct.gov/pri/index.asp)

Between 1977 and 2016, the PRI Office produced eighteen deeply researched reports about our state's children and youth. These included eight reports about the Department of Children and Families and the children and youth it serves (1978, 1990, 1995, 1999, 2007, 2009, 2013, 2016), as well as reports on child day care (1981, 1995), the Birth to Three Program (1995), educational services for blind and visually impaired children (2000), youth substance use (1996), psychiatric hospitalization services for children and adolescents (1986), juvenile justice (1977, 1988) and more. (www.cga.ct.gov/pri/studies.asp#children).

As pleased as we are with OCA's work, the Committee remains concerned that OCA–with its unique and expansive investigatory authority and advisory responsibility in our state–lacks sufficient capacity to analyze and report on data pertaining to child welfare, injury/fatality prevention and OCA's related systems investigations. Greater capacity would enable the Office to begin to address the void in independent oversight of DCF that was created when the *Juan F.* federal court Monitor's work ended in 2022 and the Office of Program Review and Investigations was eliminated.

Currently, OCA relies on *donated* funds for a contract with the CT Data Collaborative for the discrete tasks of helping OCA standardize its data requests to ensure consistency in the data sets and data formats DOC provides OCA, developing some tools to streamline OCA's analysis of the data produced, and training OCA staff on the use of the tools. While an important first step, current OCA staff are social workers and clinicians, and not trained data analysts. Given OCA's unique access to critical state data about children, OCA must have *secure* funding to enable its analysis of more complex data pertaining to condition of confinement reviews, as well as analysis of more complex data related to child welfare and its other areas of oversight.

Advisory Committee's Recommendations

- **Increase OCA's capacity for data analysis.** Given the importance of data analysis to so much of OCA's investigatory work (and particularly given the end of federal court monitoring of DCF in March, 2022), we urge the Child Advocate to identify ways to enhance and secure its capacity for high quality, proactive data analysis (particularly regarding child protection issues). Short term, OCA could potentially build on its existing contract with the CT Data Collaborative, secure some state funding for it (as the contract currently relies on donated funds), and expand the breadth of the contract ways that support OCA's work (e.g., gathering and analyzing data from former foster parents and youth who have aged out of care)

- **Specify reporting deadlines.** Amend OCA's enabling statutes to: a) explicitly require the OCA to publish its Annual Report by September 1 each year (and report on work it completed in the state fiscal year ending June 30 of that year); and b) require the OCA Advisory Committee to publish its evaluation of the Child Advocate on or before December 15.[9]

Respectfully submitted by the Members of the OCA Advisory Committee:

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January 28, 2026

[9] State statutes set several deadlines for OCA reports: a) the annual Child Fatality Review Report is due no later than January 1 [Conn. Gen. Stat. §46a-13*l* (d)]; b) the report on conditions of confinement is due no later than March 1, every two years [Conn. Gen. Stat. §46a-13*l* (a)(12)]; and c) an annual report regarding the causes and rates of child fatalities in the state is due no later than July 1 [Conn. Gen. Stat. §46a-13*s*]. No specific date is set for the OCA's own annual report (although Conn. Gen. Stat.§4-60 defines the deadline for the "annual reports of budgeted agencies" as "on or before September 1).