OFFICE OF THE CHILD ADVOCATE

CELEBRATING 30 YEARS

Because every child deserves to be safe and cared for, and every child deserves the opportunity to succeed, OCA has dedicated the last 30 years to shining a light on deficiencies in state systems serving children and advocating for policies that improve those systems.

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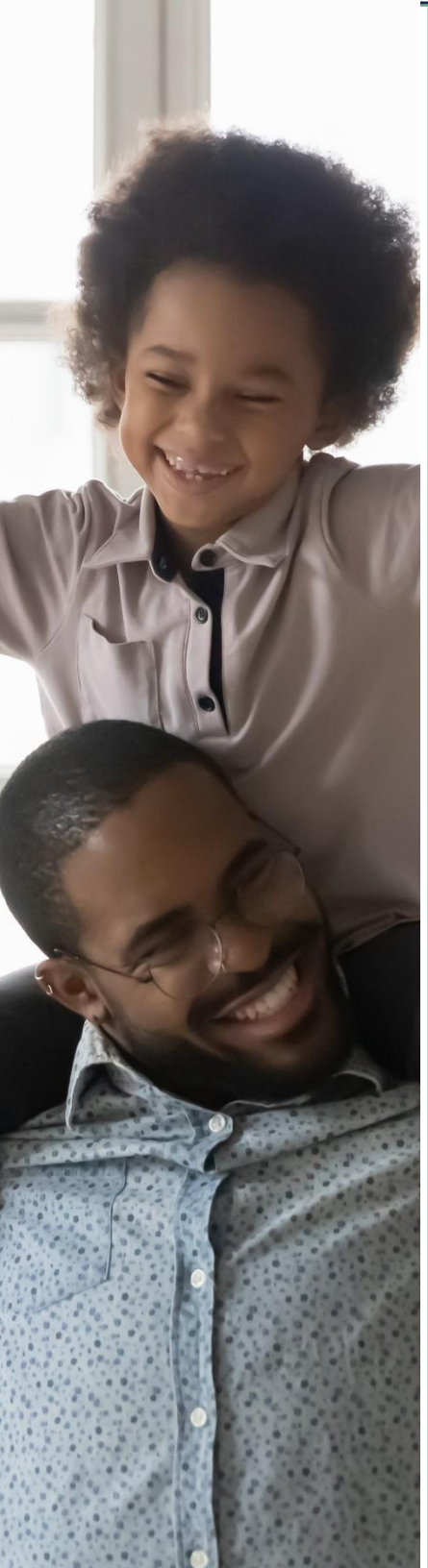

CHILD ADVOCATES:

1995 to 1997: Kristine Ragaglia, J.D.,

1997 to 2000: Linda Pearce Prestley, M.Ed., J.D.

2000 to 2012: Jeanne Milstein

2012 to 2013: Jamey Bell, J.D.

2013 to 2024: Sarah Eagan, J.D.

Current: Christina D. Ghio, J.D., CWLS

(pending confirmation)

ADVISORY COMMITTEE

Edwin Colon, J.D. (House Majority Leader)

Danielle Cooper, Ph.D. (Speaker of the House)

Shelley Geballe, JD, MPH (Senate President Pro Tempore)

Jeanne Milstein, B.S. (Office of the Governor)

Terry Nowakowski, LCSW (Majority Leader of the Senate)

Lisa Seminara, LCSW (Senate Minority Leader)

Zakkyya Williams, M.A. (House Minority Leader)

OCA STAFF

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Virginia Brown, J.D., Staff Attorney

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Brendan Burke, MSW., Assistant Child Advocate

Elizabeth Sitler, LPC Assistant Child Advocate

Julie McKenna, Human Services Advocate

Lucinda Orellano, Human Services Advocate

The Office of the Child Advocate in Connecticut is commemorating its 30th anniversary, marking three decades of dedicated advocacy for the state's most vulnerable children. Since its establishment, the OCA has played a pivotal role in investigating systemic issues, ensuring the safety and well-being of children, and influencing crucial legislative and policy changes. OCA's investigations have uncovered critical shortcomings across the state's child-serving systems, including child protection, education, and juvenile and adult justice systems.

FROM VISION TO VOICE

The Office of the Child Advocate was created in 1995, largely in response to the tragic death of nine-month-old Baby Emily. Baby Emily was sexually abused and killed by her mother's boyfriend. Though the Department of Children and Families (DCF) had investigated the family, Baby Emily was not removed from their care. With the increased focus on the welfare of Connecticut's children and the public outrage following Baby Emily's death, legislators recognized the need for an independent office to oversee, evaluate, and make recommendations regarding the various state-run and state-funded entities that are responsible for the care and protection of children in Connecticut.[1]

A bipartisan group of legislators, including Senator Donald Williams, the late Senator Adela Eads, and former Representative Ann Dandrow, spearheaded the movement to establish the office even before the tragic death of Baby Emily.[2] The three legislators were committed to creating an Office of the Child Advocate and their vision and leadership was indispensable to its creation. Senator Donald Williams acknowledged the troubles within the agencies that are entrusted with the care of children and said he recognized that there must be an independent entity empowered with real authority, to obtain information and to evaluate programs and policies.[3] Former Representative Ann Dandrow felt that the agencies involved with the care of children were not well connected and that an autonomous agency would be able to recognize potential pitfalls in a preventative way.[4] Together Williams and Dandrow co-sponsored the bill that created the Office of the Child Advocate.[5]

In creating the office, legislators looked to Rhode Island, which had already established an Office of the Child Advocate. The independence of the office was the subject of much debate and became a foundational principle for the office. Before the Select Committee on Children, in February 1995, Senator Williams stressed that there was a "need for independent advocacy and investigation."[6] When discussing this issue, the Rhode Island Office of the Child Advocate, Laureen D'Ambra stated, "[t]he Office is independent and is bipartisan. And I think it's essential that any Child Advocate's Office have that independence and be maintained as a separate office."[7] Later in the February 1995 hearing, Representative Tercyak asked D'Ambra,

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[1] OCA acknowledges the contribution of Sarah Eilers, an intern with OCA during 2005, in collecting this history.
[2] The creation of the office had been discussed in 1994 by the legislature; however, there was not enough support to pass the necessary legislation. Legislation was again raised and a public hearing held in February 1995, approximately one month prior to Emily's death.
[3] Informal Interview with Senator Donald Williams. January 24, 2005, conducted by OCA Intern Sarah Eilers.
[4] Informal Interview with former Representative Ann Dandrow. January 25, 2005, conducted by OCA Intern Sarah Eilers.
[5] Other legislators who were key to the effort that established the office include Representative Nancy Beals, Representative Melody Curry, Representative Christopher DePino, Senator Judith Freedman, Senator Fred Lovegrove, Representative Jack Thompson and Representative Mary Mushinsky.
[6] Select Committee on Children Hearing. Pt. 2. 1995 Sess., 2/14/1995. pp. 000349-000408.
[7] Select Committee on Children Hearing. Pt. 2. 1995 Sess., 2/14/1995. pp. 000349-000408.

"Wouldn't it be or would it be advisable to incorporate the functions of a Child Advocacy Office into an existing DCYS office or DCYF?"[8] Rhode Island Child Advocate D'Ambra replied, "I would not recommend it at all. I think that without the office being independent and being able to be in a position for strongly advocating for children and the needs for children, then you might as well not have an office at all. I think it's absolutely crucial that there be a separate, independent office to be able to carry out the role and function."[9] Ultimately, the Office of the Child Advocate (OCA) was created to be independent. To maintain independence, the office was placed outside of the Governor's office and outside of DCF.[10] In addition, while the appointment of the Child Advocate would be made by the Governor, the Governor would select from a list of candidates submitted by a statutorily created Advisory Committee.[11] Over the years, the independence of the office has been closely guarded.

OCA was vested with broad and deep responsibilities and authority, including the responsibility to evaluate the delivery of services to children by state agencies and other state funded entities, investigate complaints regarding state funded services, periodically review facilities and procedures where children are placed by any agency or department, recommend changes to state policy, and take all possible action to secure the legal, civil, and special rights of children who reside in the state. OCA's authority includes access to any records necessary to carry out its responsibilities and the authority to subpoena such records if they are not timely produced.

OCA's unique combination of independence and access authority enables it to look across state funded entities – including, for example, state agencies, public schools, courts, hospitals, and medical providers – to understand the gaps in our child protective and child serving systems, inform the public about deficiencies, and identify remedies. This is the work that the office has carried out for the last 30 years.

CHILD FATALITY REVIEW AND PREVENTION

Along with the creation of the Office of the Child Advocate, the state created the Child Fatality Review Panel (CFRP). The CFRP 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 members of the panel include: the Child Advocate; the Commissioner of Children and Families, the Commissioner of Public Health, the Commissioner of Public Safety; the Chief Medical Examiner; the Chief State's Attorney; a pediatrician, an attorney; a social work professional; a representative of a community service group; a psychologist; and an injury prevention representative.

In partnership with the OCA and other state agencies, the Panel has reviewed hundreds of preventable child deaths since its inception, lending its knowledge and experience to the production of multiple Public Health Alerts focused on fatality awareness and prevention, including Safe Sleep Awareness, Suicide Prevention, Graduated Licensure, Drowning Prevention, the Safe Use of Benadryl for Children, and Safe Storage of Opioids.

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[8] Select Committee on Children Hearing. Pt. 2. 1995 Sess., 2/14/1995. pp. 000349-000408.
[9] Select Committee on Children Hearing. Pt. 2. 1995 Sess., 2/14/1995. pp. 000349-000408.
[10] The office has been placed for administrative purposes under several different offices over time, including the Office of Protection and Advocacy for Persons with Disabilities, the Freedom of Information Commission, the Department of Administrative Services, and most recently the Office of Government Accountability.
[11] While the number of candidates and process have changed over the years, the requirement that the Governor appoint from a list prepared by the Advisory Committee has remained constant.

Current Members of the Child Fatality Review Panel	
Ex Officio Members	
Office of the Chief State's Attorney:	*Brett Salfia, Esq.*
Office of the Child Advocate:	*Christina D. Ghio, J.D., C.W.L.S. (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.*

One of the first fatality investigations by OCA/CFRP was of the death of Andrew M. in 1998. Andrew died from traumatic asphyxia resulting from compression of the chest due to the weight of an adult individual during a so-called "therapeutic restraint hold" in a psychiatric facility. The facility was not licensed by DCF, but DCF placed children under their care in the facility regularly for psychiatric treatment. OCA found that the facility had an inadequate behavior management program and outdated physical restraint training program that did not conform to currently accepted standards established by contemporary training programs. In addition, OCA found that, despite the fact that DCF placed children in the facility regularly, it had not evaluated the facility's behavior management policies or training practices. Further, DCF had not promulgated regulations regarding permissible parameters of the use of physical restraints on children despite its statutory mandate to do so. Similarly, the Department of Public Health had not promulgated regulations or otherwise promoted the development of a statewide uniform policy of behavior management and physical restraint that was reflective of the best practices research. OCA made extensive recommendations related to behavior management, restraint, the quality of legal

representation, case documentation, and ongoing case assessment. OCA also recommended that DCF promulgate regulations and policies to address the development of appropriate physical restraint policies for use in the facilities that they licensed and in the facilities in which children who were under the care and custody of DCF were placed. In response to the report, DCF issued immediate directives to the facility that it licensed and promulgated regulations regarding the use of restraint and seclusion; changed policies to require all direct care staff in facilities used by DCF to be trained in CPR. The Judicial Department, then responsible for court appointed attorneys, instituted required training for all contract attorneys.

Over the years, OCA has conducted numerous fatality investigations, applying its unique ability to look across state systems, to identify gaps, ensure transparency and accountability, prevent future fatalities, and improve services to children and families.

OMBUDSMAN

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. Over three decades, OCA has received over 20,000 calls and has opened thousands of cases involving child welfare, special education, concerns about children in facilities, children with mental health needs, and children with special health care needs. OCA has helped countless families across the state to obtain the services their children need. Every case that comes through OCA is understood within the context of our state serving systems. OCA's ombudsman work often leads to comprehensive investigations and public reports of findings and recommendations. OCA has published over 60 Reports, Letters of Findings, and Letters of Concern.

CHILD PROTECTION

From the beginning, OCA's child fatality investigations have been critical to identifying needed system reforms to protect children and prevent child fatalities. OCA's investigations have resulted in significant changes in state law and policy, especially in the area of child protection.

Alex B. was a three-year-old victim of homicide while in the custody of DCF. On September 8, 2000, DCF placed Alex in the care of a Florida couple. Less than three weeks later, Alex died and the prospective adoptive father was arrested and charged with first-degree felony murder. The fatality review investigation revealed that DCF made errors throughout the course of Alex's life. The most significant mistakes, which led to Alex's death, included that (a) DCF failed to obtain even basic information about Alex's prospective adoptive parents before sending him to live with them; (b) DCF violated the requirements of the Interstate Compact of the Placement of Children, which would have protected Alex from harm, in order to expedite his placement in Florida; (c) DCF provided inadequate supervision of the caseworker's decisions and (d) DCF failed to ensure that Alex had health insurance or providers in Florida to meet his special needs. OCA made numerous recommendations regarding case practice, case supervision, and communication within DCF and with external entities, including, for example, recommendations that DCF visit the home of any proposed out of state placement, conduct monthly visits of children placed out of state, and ensure that searches of child protective history and criminal history are completed.

In 2010, the OCA issued a report regarding the circumstances surrounding the death of Baby Michael, a seven-month-old child who died in foster care under the custody of the DCF. OCA conducted a comprehensive review to identify systemic failures and recommend improvements in child welfare practices. The report highlights deficiencies in foster care licensing, training, placement processes, risk assessment, and the management of allegations against DCF employees. It also addresses the organizational response to critical incidents, the role of the Special Investigations Unit (SIU), and the use of the LINK case management system. The findings emphasized the need for better oversight, training, and systemic reforms to prevent similar tragedies. OCA's extensive recommendations included incorporating Shaken Baby Syndrome prevention into foster parent training, reviewing foster parent qualifications and improving the home study process, and strengthening DCF policies for licensing DCF employees as foster parents to avoid conflicts of interest. Perhaps most notably, at the time of Michael's death, abuse and neglect allegations against DCF employees were not regularly entered into the LINK system, as were all other reports, and were instead maintained in hard copy form. DCF changed this practice to ensure that allegations involving DCF employees would be entered into DCF's LINK system going forward.

The child fatality investigation regarding the tragic death of Londyn S., a 2-year-old girl from Connecticut, who died on October 19, 2014 due to Suboxone toxicity, underscored the need to focus on the safety of young children. Suboxone is a drug used to treat opioid addiction. Londyn's death was ruled a homicide, and her mother was charged with manslaughter. OCA found that DCF failed to gather critical information about Londyn's mother's mental health, substance abuse, and child welfare history; that despite multiple reports of abuse and neglect, Londyn's family was repeatedly assigned to the lower-risk Family Assessment Response (FAR) track, which did not provide adequate supervision or intervention; that DCF did not gather complete information from community providers, and supervisory oversight failed to identify and correct deficiencies in case management; and that DCF lacked a robust quality assurance framework to ensure reliable risk and safety assessments. OCA recommended, among other things, that DCF ensure that caseworkers gather all relevant information (medical, mental health, education records) before closing cases or assigning families to FAR; develop protocols for handling moderate-risk families who fail to engage with services; create specialized guidelines for cases involving young children, including heightened supervision and mandatory legal consults for high-risk families; revise protocols to ensure allegations involving children under age 2 or impaired caregivers are screened in for investigation; and develop a robust quality assurance framework to support effective safety and risk assessment practices for families and ensure that the needs and risks facing children, particular infants and toddlers, are thoroughly identified and addressed.

Similar themes were again found when OCA investigated the deaths of Marcello M., who died in June of 2023 from Fentanyl, Xylazine, and cocaine intoxication, and Liam R., who died by homicide in December 2023. While the circumstances of the deaths of these two children differed, certain themes were consistent. In particular, OCA found that DCF had relevant policies and guidance regarding assessment, safety planning, and supervision, but agency records did not support that those expectations were consistently followed. In both reports, OCA recommended implementation of a strong quality assurance framework, revised safety protocols regarding young children, data-driven assessment of the available service array, and improved external oversight. DCF later modified case screening to exclude cases involving children aged 0-5 from diversion to the Family Assessment Response process. In addition, DCF made several changes related to quality assurance and case supervision including:

- DCF created a new position, the Director of Child Safety Practice and Performance, to bring heightened attention to safety practice across the agency. DCF continues to conduct real-time critical incident reviews. Special Qualitative Reviews (more in depth reviews) are completed for certain child fatalities and near-fatalities.

- The Department established the Quality Improvement Leadership Team (QuILT) as a governing body to review data and determine recommendations and further strategy development for statewide implementation. This team is responsible for determining how best to improve performance and key outcomes.
- DCF developed a new safety practice supervisory tool to be used during case supervision sessions to emphasize review of child safety, quality visitation, and needed action steps.

In response to the report regarding Liam, the legislature enacted Public Act 24-126 to improve oversight of DCF, improve the quality of information provided by DCF to courts and attorneys representing parents and children, establish a legal procedure with court oversight for trial home visits, ensure that foster parents receive proper notice of court proceedings regarding children in their care, and require the court to confirm that certain actions have been taken by the attorney and/or guardian ad litem for the minor child.

In October 2023, amid public concerns about escalating and serious incidents at the Harwinton-based STAR (Short-Term Assessment and Respite) home resulting in calls for assistance from first responders, OCA began an investigation into the circumstances of girls' placement in this and other DCF-licensed youth shelters. OCA found that the girls in DCF shelters often had significant trauma histories, behavioral health treatment needs, and histories of child abuse. In reviewing a cohort of 22 girls placed in three different STAR homes, 17 had a history of sexual abuse (including sex trafficking concerns), and 20 of the 22 girls had a history of suicidal ideation, suicide attempts, or self-injurious behavior. The median age of first contact with DCF was four years old. The shelter-care model was neither designed nor resourced to meet the needs of children being placed there. Most significantly, DCF oversight was not adequate and, to the extent that incident and program review was conducted, it did not adequately inform strategic system design. OCA recommended swift action to supplement care and resources in the STAR programs, inject funding into home and community-based services, and strengthen oversight. Shortly after OCA's report, DCF announced modifications including enhanced staffing, training and supervision, reduction in census, enhancing therapeutic recreation, development of two Intensive Transitional Treatment Centers, and timely access to psychiatric residential treatment facilities for youth struggling in the shelter. With these changes, DCF changed the name of these facilities to Specialized Traum-Informed Treatment Assessment and Reunification (STTAR), though the facilities remain licensed as shelters. Concerns regarding children in the STTAR homes involve not only DCF's child protective services work, but also their role as the state's children's mental health agency. They are a reflection of the state's dearth of mental health services for children with significant histories of trauma, mental health needs, and behavioral health needs. OCA continues to monitor implementation of these changes, review conditions for children in these programs, and advocate for implementation of a continuum for mental health treatment.

JUVENILE JUSTICE

From its inception, OCA was charged with reviewing facilities in which children are placed. OCA's facility investigations have exposed abuse, neglect, systemic deficiencies, and a persistent lack of necessary oversight and quality assurance to ensure that children receive safe and timely treatment services appropriate to their needs. Much of OCA's work in this area has focused on facilities in which children involved with the juvenile and adult justice systems are housed.

On September 28, 1998, fifteen-year-old Tabatha, a child dually committed to DCF as a neglected child and as a delinquent child, died after a suicide attempt while she was incarcerated at Long Lane School.[12] Tabatha experienced years of abuse and neglect and a long series of placements in foster homes, shelters, and a residential facility before being placed in the state's juvenile correctional facility. Tabatha's stay at Long Lane School was fraught with minor behavioral infractions. She experienced a series of setbacks and disappointments over events that occurred during that period and over relationships with family and former caretakers. She made statements about suicide and, on one occasion, unsuccessfully attempted suicide. She was placed on safety/suicide watches on numerous occasions during this period. On September 26, 1998, a series of events occurred that led to administrative charges of assault, disciplinary action against her, and a planned suicide attempt on that day. She was found hanging in her room, was transported to a local hospital and placed on life support. Those supports were terminated two days later, by agreement of medical personnel, DCF, and Tabatha's biological family. OCA found that Long Lane School was grossly inadequate to meet the needs of its diverse population. Staff at Long Lane failed to recognize the significance of Tabatha's multiple suicidal behaviors and failed to conduct a comprehensive assessment of her mental health issues. OCA also found that children in the facility were routinely mechanically and physically restrained, often under circumstances that violated DCF's own policies. OCA made extensive recommendations. In response, DCF began the process of developing a quality management system to achieve accreditation of the facility, established a 30-day diagnostic intake unit to conduct assessments of the educational and treatment needs for each child, increased staffing, added clinical staff, and refined its suicide intervention policy. In the aftermath of Tabatha's death, OCA placed a monitor at Long Lane School to monitor promises for improvement.

At the time of Tabatha's death, Long Lane School was the state's only secure facility for children adjudicated delinquent in Connecticut. It housed upwards of 240 children, both boys and girls, though the facility capacity was 176. When children were adjudicated as delinquent and the court determined that the child should be removed from the community, the court committed children to the custody of DCF. Many of these children were placed in Long Lane School. OCA's report on Tabatha included findings regarding Long Lane School, including numerous systemic deficiencies, not the least of which was the fact that Long Lane was a correctional facility operating without independent oversight, without accreditation, and without licensing. The report stated that "Long Lane School has suffered as a result of its position in DCF, because the child welfare bureau receives the lion's share of resources and attention. This factor, coupled with the failure of DCF to promulgate regulations and policy, as well as its insulated position from third party oversight, has resulted in the substandard facility that exists today."[13] In 2002, the state decided to close Long Lane School with plans to build a new facility, eventually the Connecticut Juvenile Training School (CJTS). Sadly, many of the deficiencies that resulted in poor conditions for children at Long Lane School persisted at CJTS and other facilities.

In part, due to the need to move children out of Long Lane School, DCF approved the opening of Haddam Hills Academy in 1998. Prior to Haddam Hills Academy opening at the end of May 1998, DCF was aware that Haddam Hills Academy did not have an adequate program description (written plan describing in detail how youth are to be served at the facility) or clinical staff to provide necessary services for the residents.[14] Nonetheless a provisional license was issued. Once opened, "Haddam Hills Academy demonstrated an early and significant inability to properly care for the children placed there by DCF. Despite the numerous, serious and well-documented problems occurring there, DCF did nothing to protect the children under its care . . ."[15] An investigation by OCA and the Office of the Attorney General (OAG) exposed to the public the reality of "hit squads," consisting of

[12] Investigation into the Death of Tabatha B. (November 30, 1998)
[13] Investigation into the Death of Tabatha B. (November 30, 1998), at 26
[14] Report of the Attorney General and the Child Advocate Department of Children and Families Oversight of Haddam Hills Academy (May 30, 2002), at 4.
[15] Id., at 5.

young people who were used by certain staff members as enforcers against other youth. In May 1999, DCF's own investigation substantiated abuse and neglect and stated that "[t]he reality at Haddam Hills of adult sanctioned youth violence has created an environment of fear, secrecy, mistrust, and physical danger. Haddam Hills Academy cannot be considered a safe or viable placement for children or youth without immediate and credible corrective action and safety plans."[16] After several years of efforts to improve care at Haddam Hills Academy, DCF revoked its license in 2001.

On August 28, 2001, Connecticut Juvenile Training School ("CJTS") opened and DCF transferred boys who were committed to state custody to the new facility. OCA, in conjunction with the OAG, launched a joint investigation only three months after the facility opened "based on reports of supply shortages such as books and desks at the school; staffing shortages all around; and the total lack of a behavioral management plan for the facility, among other things."[17] OCA and the OAG found "an alarming delay in establishing a behavioral management program that is still not fully functioning; boys are not being treated for mental and behavioral health disorders; the educational program is severely weak and special educational needs are not being identified or addressed."[18] Most concerning was that, despite the lessons learned following the Tabatha's death, OCA and OAG found that "boys are still at imminent risk of suicide."[19] DCF committed to making improvements and OCA issued another report in 2004 identifying areas still in need of improvement. In 2015, OCA again received complaints regarding the care and treatment of children in CJTS and Pueblo (a secure facility for girls adjudicated as delinquent, located on the grounds of Riverview Hospital). OCA found "inadequate suicide prevention, lack of appropriate support and training for staff, inadequate and harmful crisis management, and an opaque system that, despite significant public funding, reports scant information regarding quality, public safety outcomes, and oversight."[20] OCA made extensive recommendations including a recommendation that the state should urgently consider "alternatives to the Connecticut Juvenile Training School and Pueblo."[21] In 2016, legislation was passed to require the closure of CJTS.

Following the closure of CJTS, OCA continued to expose deficiencies in the conditions of confinement for youth in the juvenile justice system, with a report in 2019 regarding conditions in juvenile detention facilities, operated by the Judicial Branch's Court Support Services Division (CSSD), Manson Youth Institution (MYI), and York Correctional Institution. OCA found that "[c]hildren/youth, particularly boys with the most complex needs, who are incarcerated in the adult criminal justice system, are the most likely to lose meaningful access to education, rehabilitative services, visits with family, even the ability to purchase hygiene products or extra food, if they are deemed a risk to the general youth prison population."[22] Following the OCA's 2019 report, the U.S. Department of Justice (DOJ) initiated a multi-year investigation into potential civil rights violations at MYI. In December 2021, the DOJ completed its investigation and released a report regarding conditions for minor boys, finding: [T]here is reasonable cause to believe that conditions for children at Manson Youth Institution violate the Eighth and Fourteenth Amendments of the United States Constitution and the Individuals with Disabilities Education Act, 20 U.S.C. §§ 1400-1482 . . . Manson's isolation practices and inadequate mental health services seriously harm children and place them at substantial risk of serious harm. In addition, Manson fails to provide adequate special education services to children

[16] Id., at 12.
[17] Report of the Child Advocate and Attorney General Regarding Connecticut Juvenile Training School (September 19, 2002), at 15.
[18] Id., at 16.
[19] Id.
[20] Office of the Child Advocate Investigative Facility Report Connecticut Juvenile Training School and Pueblo Unit (July 22, 2005), at 6.
[21] Id., at 8.
[22] Incarcerated/Detained Youth – An Examination of the Conditions of Confinement (January 16, 2019), at 5.

with disabilities."[23] In August 2024, the DOJ and Department of Correction entered into a settlement agreement addressing disciplinary isolation, mental health care, and special education. OCA continues to monitor conditions at MYI for youth aged 15 to 18 and late adolescents aged 18 to 21.

CHILDREN WITH COMPLEX NEEDS

OCA's responsibility to review facilities includes facilities where children with disabilities are placed and/or receive treatment. Over the years, OCA has conducted numerous investigations related to facilities that serve children with physical disabilities, mental health and behavioral health needs, and developmental disabilities (including intellectual disability and autism). OCA's investigations and resulting reports have been integral to reducing the state's reliance on large congregate care settings.

One of OCA's most significant investigations was that of Lake Grove at Durham, a 116-bed institution that was licensed, regulated, and utilized by DCF to serve children with intellectual disabilities, many of whom also suffered from mental health problems related to the trauma of abuse and neglect.[24] The DCF placed children at Lake Grove because Lake Grove was the only facility in Connecticut to serve children with intellectual disability. OCA's investigation identified serious deficiencies including that nursing care was grossly deficient, medical care and oversight were inadequate, a mental health therapeutic program was essentially non-existent, and administration and staff lacked the credentials, experience, training, and supervision to properly care for children with intellectual disabilities and complex mental health and behavioral conditions. OCA's investigation exposed a practice at Lake Grove of "banning children from residential cottages and sending them to the lobby of an old building at Lake Grove as a form of punishment. One banished child was required to live in a laundry room without air conditioning during extreme summer heat, slept on a mattress on the floor, did not attend school and was only allowed brief supervised walks outside."[25] The physical conditions at Lake Grove were dismal. The facility was finally closed in September 2007 when DCF stopped sending children there.

In 2006, following receipt of concerns about care at Riverview, the state's mental health hospital for children, OCA conducted a comprehensive review, in conjunction with DCF's Bureau of Continuous Quality Improvement and the Juan F. Court Monitor. Of note, in 2006, 38% of the children admitted to Riverview had identified intellectual disability or other cognitive and developmental disabilities.[26] The report identified serious deficiencies at the facility and, in response, DCF created a two-year strategic plan to improve conditions. To monitor implementation of the strategic plan, OCA placed a monitor at Riverview from June 2007 to June 2009. The monitor conducted site visits, reviewed medical documentation, met with staff, interviewed children, and reviewed data. Areas of focus included safety, restraint and seclusion, treatment planning, implementation of evidence-based treatment approaches, and holding staff accountable to clear expectations. OCA's final report in June 2009 discussed areas of progress, including a management reorganization that placed increased management resources on patient care units and sought to define and increase unit-based accountability for delivering effective, strengths-based patient care; and staff development to move its treatment culture to a more supportive, strengths-based and less restrictive array of interventions. At the same time, OCA highlighted areas of ongoing concern including the need for

[23] Letter to Lamont, December 21, 2021.
[24] This investigation was conducted in conjunction with the Office of the Attorney General.
[25] Report of the Investigation of Lake Grove at Durham and the Department of Children and Families (October 2008), at 3.
[26] Testimony of Jeanne Milstein, Child Advocate, before the Select Committee on Children, February 2006.

reduction in the use of restraint and seclusion, the lack of a sustained or comprehensive quality improvement program, and the ongoing need for staff training in approaches to treatment and care of children with significant developmental disabilities.

In October 2021, the OCA received a concern regarding an incident between a minor boy and a young adult woman in a Community Living Arrangement (CLA) licensed by the Department of Developmental Services (DDS) wherein the boy was found attempting sexual intercourse with the young woman. Both the boy and the young woman were developmentally disabled and were unsupervised at the time of the incident. The boy had a known history of sexually reactive behaviors. The DDS-licensed CLA, run by a community-based provider agency, served both minor and adult clients, male and female, with various developmental disabilities. Two of the CLA's residents, including the boy involved in the incident, and a young adult (not connected to the incident), were DCF-involved. DCF was the guardian for the minor boy. Although DCF was the guardian of the minor child in the CLA critical incident for several years, DCF records did not contain adequate information regarding the educational, treatment, and developmental needs and service delivery to the child. Review of this incident led to a broader investigation of the State's framework for ensuring the delivery of safe care to individuals with intellectual and developmental disabilities in state licensed CLAs, particularly in the wake of 2016 deficiency findings by the federal Inspector General. OCA conducted an investigation and, in 2023, issued a lengthy report detailing extensive findings regarding DDS oversight of CLAs, including ongoing deficiencies in reporting critical incidents, failure to visit facilities to confirm implementation of corrective actions, and insufficient resources to conduct independent investigations. OCA also made findings regarding DCF including an ongoing lack of training for DCF caseworkers on the needs of children with intellectual disability and lack of a system for following up on program concerns identified during DCF investigations of DDS-licensed facilities. OCA made recommendations to address these system deficiencies and ensure the safety and well-being of children and young adults placed in these facilities.

In addition to reviewing the conditions in facilities, OCA has conducted investigations that look across systems to identify gaps that leave children with complex disabilities at risk. In 2012, in the wake of the horrific tragedy at Sandy Hook, in which twenty first grade children and 6 adults were killed, the Child Fatality Review Panel directed OCA to conduct an investigation and prepare a report discussing the circumstances pre-dating the commission of this mass murder. The charge was to develop any recommendations for public health system improvement that emanated from the review. OCA partnered with numerous content experts including pediatricians, child psychiatrists with expertise in trauma and developmental disabilities, and experts in the education of children with disabilities. OCA made extensive recommendations for public health reform, focused on early intervention, treatment, and education for children with disabilities, and the development of a service array for families of children with mental health and developmental disabilities.

When Matthew Tirado died in 2017 from prolonged child abuse and neglect, OCA obtained records and conducted interviews with DCF personnel, Hartford Public Schools, the Judicial Branch, Oak Hill School, and the Office of the Public Defender. Matthew was 17, diagnosed with Autism and Intellectual Disability, and described by providers as a mild-mannered boy who enjoyed school, using the microwave to cook food, and looking at books. While Matthew had intellectual disability, there was no record of his family being referred to the Department of Developmental Services. The report highlighted the fact that children with disabilities are more likely than their non-disabled peers to experience abuse and neglect and more likely to be seriously harmed by abuse.[27] OCA's investigation found numerous deficiencies in state law and policy, case practice, and communication between systems. In its report, OCA made extensive recommendations for the child protection system (including DCF, the courts, and the Office of the Public

[27] Child Fatality Investigation Report: Matthew Tirado (December 2017), at i.

Defender, which is responsible for court-appointed attorneys) and the educational system. In response, the legislature passed Public Act 18-67 to ensure that DCF can interview children without the consent of the parent if the alleged perpetrator is the parent is the parent or guardian not only in cases where abuse is alleged but also where neglect is alleged. The legislature also passed Public Act 18-71 requiring DCF to analyze the efficacy of its risk and safety assessment practices; DCF to develop investigation, assessment and case-planning procedures that are responsive to the needs of children with intellectual and developmental disabilities; and DCF, DDS, the Department of Social Services (DSS), and the Office of Early Childhood (OEC) to develop investigation, assessment, and case planning procedures that are responsive to the needs of children with intellectual and developmental disabilities.

EDUCATION

In 2010, OCA, in partnership with the OAG, issued a report entitled "Protecting Our Children: Improving Protections for Children When Allegations are Made that School System Personnel Neglected and/or Abused Children." This report examined systemic failures in protecting children from abuse and neglect by school personnel. Investigators reviewed five school districts in depth, examined over 100 investigations conducted by DCF throughout the state and the corresponding records in in the possession of the Connecticut State Department of Education (CSDE), and reviewed relevant data from DCF and SDE for the period from 2001 to 2009. Investigators identified serious deficiencies in the state's system for protecting children from abuse and neglect, including but not limited to: the CSDE did not routinely check the DCF Child Abuse & Neglect Registry before certifying teachers, administrators, or coaches; school districts lacked access to the DCF registry and rarely conducted checks of the DCF Registry; training for mandated reporters was inadequate; schools did not consistently maintain records of allegations of abuse or neglect by school employees; DCF was not always able to obtain necessary records from schools in order to conduct its investigations; and the SDE was often not notified of substantiated allegations, especially in cases of neglect, limiting its ability to revoke certifications. In response to these findings, the Connecticut legislature enacted Public Act 11-93 to close these loopholes.

OCA, jointly with the Office of Protection and Advocacy (OPA),[28] published a report in 2013 regarding the use of seclusion rooms in Middletown's Farm Hill Elementary School. The school had two seclusion rooms. Children with special education needs, and children who were not identified as special education students, were held in these rooms in response to behavior that was inappropriate in the classroom. Parents visiting the school and children who attended the school witnessed children in these rooms kicking and screaming as school staff held the door shut. Despite multiple admissions to the seclusion rooms, most of the children were not referred to a PPT to recommend functional behavioral assessments and behavior intervention plans individually designed to meet their needs. Policies, procedures, and training were lacking. Several children who resisted being placed in seclusion were restrained. Children were, at times, placed in seclusion for behaviors that were a manifestation of their disability. For example, a child who was diagnosed with Autism was routinely removed from class to be isolated in the seclusion room based on her inability to get along with other children. OCA and OPA made a host of recommendations, including the need for the CSDE to promote a cultural change in the education of children with behavioral challenges and issuing a periodic "report card" documenting progress being made by districts in preventing the use of restraint and seclusion.

[28] The Office of Protection and Advocacy was abolished and replaced by Disability Rights Connecticut in 2017.

In 2014, OCA conducted a broader investigation of the use of restraint and seclusion in schools. OCA examined the data and reports produced by the CSDE, met with state agency officials and leadership, visited numerous educational programs around the state to review practices, and sampled student-specific education records from several schools, both public and state-approved private. OCA's review focused on the use of restraint and seclusion with elementary-school age children. OCA found that educational programs varied widely in their ability to provide trauma-informed, expert-driven educational plans for children identified as eligible for special education services due to a diagnosis of Emotional Disturbance. Likewise, school programs often struggled to identify and meet the multi-disciplinary needs of children identified as having an Autism Spectrum Disorder. Some children benefitted from carefully constructed Individual Educational Plans and the provision of related support services. However, educational plans for other children with either emotional or developmental disorders often lacked appropriate supports or services. OCA found that these deficits contributed to over-reliance on seclusion and restraint for many children with disabilities whose educational files were reviewed as part of this investigation. OCA recommended revision to the state's laws regarding restraint and seclusion to ensure consistency with current research and best practices for children regarding the potential harms of restraint and seclusion; increased monitoring and evaluation of restraint and seclusion; and offer more support, including training and capacity building, for schools to meet the varied and specialized learning needs of children with and without disabilities.

In follow up to these reports, the legislature enacted Public Act 15-141, which prohibited the use of life threating restraint, prohibited the use of physical restraint except as an emergency intervention to prevent immediate or imminent injury to the student or to others, and prohibited seclusion except as an emergency intervention to prevent immediate or imminent injury to the student or to others, provided the seclusion is not used for discipline or convenience and is not used as a substitute for a less restrictive alternative. The law also established requirements for conducting and revising behavioral assessments for children who experienced restraint or seclusion four or more times within twenty school days; training to school staff regarding restraint and seclusion; notification to parents; and the development of policies and procedures regarding restraint and seclusion.

Between 2007 and 2024, OCA conducted numerous investigations concerning Title IX compliance, including sexual harassment of students by school employees in the educational setting in multiple Connecticut public school districts, including Hartford Public Schools, Stonington Public Schools, New London Public Schools, and most recently Vernon Public Schools. The OCA's investigation into the policies and practices of these Districts in receiving, investigating, and resolving claims of sexual harassment showed deficiencies in all areas. Most notably, students were not provided with clear guidance and support when reporting sexual harassment, allegations were not properly investigated, and little was done to ensure that students were safe from future harassment. OCA's reports provided guidance on identifying, responding to, and preventing Adult Sexual Misconduct in the educational setting and recommendations for systemic reform. In response to OCA's reports, the legislature enacted Public Act 23-66, to require the formation of a Title IX Working Group tasked with developing a Title IX Compliance Toolkit for educators, students, and parent/guardians. The Toolkit has since been completed.

In 2020, the OCA received complaints about young students with disabilities being subjected to suspensions and school-based arrests in Waterbury Public Schools and opened an investigation. Its investigations included an extensive review of police records and education records, juvenile court records, data from the CSDE on school discipline, and reports maintained by DCF and the Child Health and Development Institute of Connecticut (CHDI). OCA found that young students with disabilities were disproportionately subjected to suspensions and school-based arrests at an alarming rate in the district. The suspensions and arrests were often in response to behavioral concerns related to the student's disability. The OCA made recommendations centered on incorporating better strategies for supporting children with behavioral concerns and providing resolution training and

support for staff. In response to the OCA's investigation, CSDE developed a corrective action plan and worked closely with the district to address the concerns. However, despite those corrective actions, the U.S. DOJ Civil Rights Division turned its attention to the District in June of 2022, specifically investigating school discipline and the number of school-based arrests of students with disabilities and whether the district was violating Title II of the ADA. The DOJ closed its investigation in 2025 but reminded the district in its closing letter that it "has an ongoing obligation not to discriminate against students based on disability, including in the district's policies and practices related to discipline, restraint, seclusion, or referrals to law enforcement."[29]

Following its Waterbury Report, the OCA continued to monitor school discipline practices and school-based arrests of young students in Connecticut public schools. Based on data reviewed by the OCA on a regular basis on school-based arrests, the OCA began an investigatory review of West Hartford Public Schools due to the high number of school-based arrests of young children reported to the Connecticut Judicial Branch Court Support Services Division. OCA findings included that during the period under review, there was a disproportionate impact of student discipline on students of color and students with disabilities. The district was classified by the CSDE as a "Tier 3 district," which is a district in need of greater support and technical assistance to address CSDE's determination of "consistently high disproportionality" in student discipline. OCA recommended, and the district later committed to, consultation with CHDI's School Based Diversion Initiative.

In 2024, OCA published a report, in partnership with Disability Rights of Connecticut (DRCT), regarding students with disabilities placed at High Road Schools[30] across Connecticut. OCA and DRCT investigation included data review, site observations and interviews, consultation with both educational and clinical experts, and a sample record review of students enrolled in High Road Schools. The OCA/DRCT investigation found that students were not being provided a free appropriate public education in the least restrictive environment in violation of the Individuals with Disabilities Education Act and American with Disabilities Act (ADA). Deficiencies included inadequate staffing at High Road Schools, including lack of qualified special education staff; lack of individualized educational programing for students; and failure of both the local educational agencies and CSDE to adequately monitor and provide the necessary oversight of these programs. Students were subjected to excessive restraint and undocumented seclusion, received very little academic instruction, and rarely returned to his/her home district. Recommendations from this report were incorporated into the legislature's omnibus bill on special education, Public Act 25-67. In particular, the legislation includes enhanced requirements for audits of private approved special education programs by CSDE and requirements that the results of such audits be available to the public on the Department's website.

CONCLUSION

For three decades, OCA's independence and access authority have enabled it to shine a light on the care and circumstances of the state's most vulnerable children. This work has contributed to sustained improvements in the systems designed to care for and protect children. Despite these improvements, it is clear that improving systems requires constant and ongoing care, attention, and oversight, not just by the agencies or entities providing services, but by an independent agency charged with ensuring transparency and accountability. In 2000, OCA published a report entitled *The Cost of Failure*. In it, OCA calculated the cost of care, focusing on one child, identified as Brittany, who was aging out of DCF care. Over 8 years

[29] Letter from DOJ to Waterbury Public Schools, May 16, 2025.
[30] High Road Schools are approved private providers of special education services.

in DCF care, Brittany spent 2765 days in a total of 24 mental health, juvenile justice, and correctional facilities. The total cost for her care amounted to over 1.8 million dollars. At age 18, following her release from York Correctional Institution, and on adult probation, she returned to her family home with few skills to prepare her for life as an adult. OCA's report described in detail the child's story and identified the many missed opportunities to provide meaningful, high-quality, sustained interventions in her home and in the community. Had those interventions been available and provided, perhaps Brittany's life would have taken a different path. The state has since closed or downsized our largest congregate care settings and reduced placements in out of home care. Nonetheless, in 2026, OCA continues to see children like Brittany, who are moved from placement to placement, struggling with the impact of early trauma, and not receiving the treatment they need. We see them in STTAR Homes, emergency rooms, hospitals, foster homes, and correctional settings. In-home and community-based services are structured to last a specified duration, rather than the duration needed by the child and family, and access to such programs is limited. Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS), which first contracted with DCF not long before the 2000 report, has extensive waitlists. Children are often recommended for the placement or service that is available, rather than for the treatment they need. Every day, OCA holds in awareness *The Cost of Failure* and continues to advocate for a continuum of high-quality treatment services that are available, based on the needs of the child, and of sufficient intensity and duration to meet that need. OCA is humbled by the awesome responsibility it holds and its staff remains dedicated to independent and objective oversight with a focus on improving services and supports to Connecticut's most vulnerable children.