The Digest of Administrative Reports to the Governor

Fiscal Year 2024-2025

Agency:	Office of the Child Advocate/Office of Governmental Accountability
Agency Head:	Christina D. Ghio, JD, CWLS, Acting Child Advocate
Deputy Head:	Christina D. Ghio, JD, CWLS, Associate Child Advocate
Established:	1995
Statutory Authority:	C.G.S.§ 46a-13K, et seq.
Central Office:	165 Capitol Avenue, Hartford, CT 06105
Number of Employees:	7 (and 1 vacancy)
Recurring Operating Expenses:	$ 860,755.75 (OCA/CHILD FATALITY)

Designated as a division of the OGA, the OCA maintains its independence and statutory authority/responsibilities. The office's administrative functions were transitioned to the Department of Administrative Services' SMART unit in 2016.

Mission

The Office of the Child Advocate (OCA) was created in 1995 to serve as an independent voice for children rather than an administrator of programs. OCA's mission is to oversee the care and protection of Connecticut's children and to advocate for their well-being. OCA is committed to ensuring that all children receive the care and supports that they need.

Statutory Responsibilities

The OCA's statutory responsibilities include: evaluating the procedures for and the delivery of state-funded services to children; investigating inquiries or complaints about services for children; recommending changes in state policy; conducting programs of public education, legislative advocacy and proposing systemic reform; reviewing conditions and procedures of all public and private facilities where children are placed; investigating conditions of confinement for incarcerated youth under the age of 22; providing training and technical assistance to children's attorneys; serving on the Child Fatality Review Panel (CFRP); and conducting a fatality review when a child dies due to unexpected or unexplained causes, in order to identify trends and patterns of risk, facilitate development of prevention strategies, and improve coordination of services for children and families in the state.

Public Service

OCA continues to shine the light on the needs and circumstances of children in Connecticut, and works to bring about necessary change for children and families. Specific reviews and investigations assist the OCA in identifying systemic issues and such investigations often shape OCA's public policy and legislative advocacy. 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 on the OCA website (www.ct.gov/oca/).

ACHIEVEMENTS/IMPROVEMENTS FOR FISCAL YEAR 2024-2025

Child Fatality Prevention/Child Safety

OCA continues to co-chair and staff the state Child Fatality Review Panel (CFRP), meeting monthly with a multi-disciplinary panel to review unexpected and unexplained deaths of CT's children reported to the Office of the Chief Medical Examiner (OCME) and develop strategies for fatality prevention.

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

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

- During the summer of 2024, the state of Connecticut lost 10 children to suicide within 3 months, an unprecented stretch of loss. These children died from a variety of means, lived in all corners of the state, had varied genders and racial/ethnic makeups, and ranged in age from 13-17. Given the efficiency and collaboration of the Child Fatality Review system in Connecticut, this trend was identified in real time. The state was able to mobilize a cross-system response, including a roundtable discussion, which highlighted the services available to youth and families in Connecticut while shining a bright light on the need for further attention, education, and support for this very vulnerable population. Commissioners from the Depatment of Children and Families (DCF), Department of Public Health (DPH), Department of Mental Health and Addiction Services (DMHAS), State Department of Education (CSDE); the Office of the Child Advocate (OCA); United Way (211); private non-profit providers; Connecticut Children's Medical Center; and individuals with lived experience discussed multi-system level interventions, the challenges for this generation of youth with technology, and their specific vulnerabilities and risks. Services highlighted included Urgent Crisis Centers (UCCs) and 988, the National Hotline Suicide and Crisis Lifeline. Consistent messaging from the panel of experts stressed the need for engagement and communication with our youth about the critical importance of recognizing mental health warning signs and ensuring that youth have an appropriate outlet to share those feelings. Normalizing conversations regarding mental health and feelings of self harm has proven to be a productive and effective means of minimizing risk.

- OCA actively participates on several committees, taskforces, and working groups, local and national, focused on prevention efforts for children at risk of intentional and unintentional injuries/fatalities.

Facility Oversight and Investigation

The OCA staff visit children and youth in both public and privately operated settings including, but not limited to, hospitals, residential treatment programs, detention, correctional facilities and both public and private school classrooms. OCA's authority allows our staff to meet with children and youth, assess their environment of care, observe care and treatment in vivo, interview program staff and administration and review both program and child-specific records, thus allowing appreciation of the true experience of the children and families served.

- During the last year, OCA participated in the state's Juvenile Justice Police and Oversight Committee (JJPOC) and worked with members of the JJPOC's Incarceration Subcommittee to improve re-entry services for children returning to their communities.

- OCA staff continue to monitor conditions of confinement for incarcerated youth under the age of 22, meeting with youth, staff, and agency administrators at the DOC and JB-CSSD. In September 2024, OCA published a report examining the conditions of confinement for youth aged 15-17 in the custody of the Department of Correction (DOC), at Manson Youth Institution (boys) and York Correctional (girls). The report focused on: (1) availability and utilization of mental health treatment and rehabilitative programming; (2) use of physical isolation; (3) use of mechanical and chemical restraint; (4) access to educational programming for youth; and (5) access to family visits and family therapy. OCA found that incarcerated youth at MYI received minimal individual mental health treatment and inconsistent clinical programming, inadequate educational and special educational services, and persistently low visitation rates. OCA also found continued reliance on isolation and restriction to address youth behavior. OCA made several recommendations to improve mental health treatment, reduce reliance on cell confinement to address youth behaviors, reduce strip searches, improve educational service delivery, and address the special education needs of youth.

Ombudsman Activities

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

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

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

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

<u>Educational Advocacy</u>

- During the 2024-2025 fiscal year, the OCA assisted families in accessing disability support services, summer programming, early intervention services, and delivery of services in the least restrictive environment. During its reviews, the OCA participated in Planning and Placement Team (PPT) meetings as advocates for students in cases in which a public-school district's policies, procedures and/or practices were not in conformance with state and/or federal law or best practices. In matters concerning children who were denied a free appropriate public education (FAPE) that could not be resolved, the OCA filed administrative complaints with the CSDE.
- 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. The OCA, in partnership with DRCT, continued its investigation into certain private special education facilities located outside of Connecticut where Connecticut students are receiving special education and related services. Its investigation is primarily focused on oversight and monitoring by local educational agencies (LEAs) and CSDE and educational programming and service delivery. This investigation is expected to conclude in late 2025.
- OCA participates in several committees and working groups to address systemic educational concerns affecting children throughout Connecticut.

<u>Advocacy For Children With Unmet Mental Health Treatment and Disability Support Needs</u>

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

- OCA is frequently contacted regarding children with intellectual disability and/or Autism. OCA has identified children with Autism Spectrum Disorder, Intellectual Disability, and

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

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

Child Welfare Advocacy

- The OCA meets regularly with the DCF Executive Team to review child fatality/critical incidents involving children recently involved with or under the care/supervision of DCF, quality assurance data regarding OCA's child protection activities, foster care, and other systemic issues affecting children and youth. OCA reviews DCF systems data regarding core practice areas: safety, permanency, and wellbeing.

- The OCA responds to individual complaints about children involved with DCF. Complaints come from parents, foster parents, relatives, service providers, schools, attorneys, guardians ad litem, and others. Where appropriate, OCA provides information to the caller to enable them to use existing administrative or judicial procedures for resolving their issues.

- In December 2024, OCA issued an *Addendum to Fatality Investigation Findings & Recommendations Regarding The Deaths Of Liam Rivera/Marcello Meadows--Follow Up On Individual And System Improvement Efforts*. This report was an addendum to OCA's reports regarding the 2022 death by homicide of 2-year-old Liam Rivera (child abuse) and the 2023 death by homicide of 10-month-old Marcello Polino (Fentanyl intoxication). Both children and/or their caregivers were involved with state and local agencies, including DCF and the JB-CSSD. In Liam's case, the OCPD was also involved, as it is the agency through which legal counsel was assigned to represent Liam in the child protection proceeding. OCA's investigations found assigned staff at DCF and JB-CSSD had not complied with several agency policies regarding case assessment and supervision, and that the assigned counsel for Liam did not follow statutory and contractual obligations pertaining to the legal representation of children. OCA's reports identified certain systemic issues across agencies and made several recommendations. The

purpose of this Addendum was to provide additional information regarding how the state agencies addressed or are addressing individual and systemic issues referenced in the reports. In Liam, Marcello, and Baby John's[1] cases, DCF made critical decisions based on the information that they had available at the time. In all three cases, however, because policies were not followed, critical decisions were made with incomplete or inaccurate information. In all three cases, DCF was unable to produce any documentation or disclose any counseling to address the lack of adherence to agency policies or practice of the respective assigned staff. The lack of individual accountability in the face of significant lapses in adherence to agency policies and practices raised concerns regarding how such lapses are remedied, how lessons can be learned, how progressive discipline can be implemented, and the culture of accountability to the agency's expectations. OCA made several recommendations to ensure accountability, improve the reliability of information provided to courts, and improve oversight by the DCF Statewide Advisory Committee. The report also included information regarding system changes implemented by JB-CSSD and OCPD and recommendations for additional system changes to improve the safety and well-being of children.

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

- In March 2025, news media reported on a man's rescue, after allegedly being held captive for approximately 20 years following his withdrawal from school in or around 5th grade. The man's story prompted renewed discussions about homeschooling in Connecticut. OCA previously issued a report on homeschooling following the death of Matthew Tirado in 2017. OCA's prior report, *Examining Connecticut's Safety Net for Children Withdrawn from School for the Purpose of*

[1] 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.

Homeschooling—Supplemental Investigation to OCA's December 12 2017 Report Regarding the Death of Matthew Tirado, reviewed data regarding six districts and identified significant concerns for the state's lack of regulation of homeschooling. OCA immediately began an investigation to better understand the state of homeschooling and identify systemic recommendations. In May 2025, OCA released a report regarding the state's ongoing lack of regulation of homeschooling. The report, entitled *A Review Of Children Withdrawn From School For Equivalent Instruction Elsewhere*, included a review of statewide homeschooling data and recommendations for regulation to ensure the safety and education of children. 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.

Respectfully submitted,

Christina D. Ghio, JD, CWLS

Acting Child Advocate