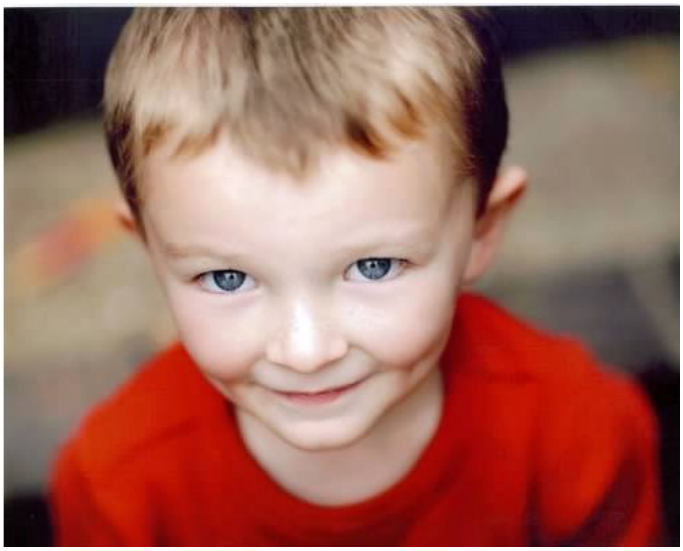
Office of the Child Advocate
Annual Report FY 2012

The Commonwealth of Massachusetts
One Ashburton Place, 5th Floor
Boston, MA 02108
Gail Garinger, The Child Advocate



The Office of the Child Advocate

Our Mission is to improve the safety, health and well-being of Massachusetts children by promoting positive change in public policy and practice.

Our Vision is that every child is safe and nurtured in a permanent home and that every family is supported and strengthened within the community.

Our Focus is on children who are served by the Commonwealth's child welfare and juvenile justice systems.

OCA STAFF

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Alexandra Rueckle, Harvard Law School	Summer 2012
Casey Schutte, Harvard John F. Kennedy School of Government	Summer 2012

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Glossary of Acronyms

CBHI	Children's Behavioral Health Initiative
CPCS	Committee for Public Counsel Services
DCF	Department of Children and Families
EEC	Department of Early Education and Care
ESE	Department of Elementary and Secondary Education
DMH	Department of Mental Health
DPH	Department of Public Health
DYS	Department of Youth Services
EOE	Executive Office of Education
EOHHS	Executive Office of Health and Human Services
EOPSS	Executive Office of Public Safety and Security
OCA	Office of the Child Advocate
OCME	Office of the Chief Medical Examiner

Letter from The Child Advocate

Dear Governor Patrick, Legislative Leaders, and Citizens of the Commonwealth:

I am pleased to submit the Office of the Child Advocate Annual Report for Fiscal Year 2012 covering the activities of our office and offering recommendations for your consideration. In light of recent United States Supreme Court decision, one of these recommendations must be addressed. On June 25, 2012, the Supreme Court published its decision in *Miller v. Alabama,* holding that children and adolescents can no longer receive mandatory criminal sentences of life in prison without the possibility of parole for crimes committed before they turned eighteen years of age.

Under current law in Massachusetts, adolescents as young as fourteen charged with murder bypass the juvenile justice system completely. The juvenile court has no jurisdiction over these cases, no transfer hearings are held, and the criminal cases are routed directly to criminal superior court, regardless of the circumstances. These youths are automatically tried as adults and, if convicted of first degree murder, receive mandatory sentences of life without the possibility of parole. A child's age, past conduct, level of participation in the crime, personal background, and potential for rehabilitation are irrelevant. All of these youths, regardless of their individual circumstances, grow up and grow old in prison, and will die while still incarcerated. But following the *Miller* decision, this sentencing scheme can no longer stand.

Our pledge to children in the Commonwealth should be that we will start early and never give up – particularly for children who have grown up in poverty and with difficulties imposed on them by their parents and communities. Abuse and neglect in the home and violence in the community create toxic stress in the developing brains of children. We should not be surprised when these same children find their way to trouble. They may be identified by their doctors after showing signs of depression or by their teachers after acting out in school. They may come to the attention of child protective services after their caretakers have been reported for neglect or abuse, or they may come through the court system on a CHINS petition or a delinquency charge. In many instances, the picture is the same – a child who has been living with the effects of trauma for years and has developed survival mechanisms for coping. We all are responsible for these children, whether they present as children abused by their parents in care and protection cases or as troubled adolescents accused of serious crimes.

Adolescents are different from adults. Their brains are still maturing, and their judgment reflects this. They act in the moment, are impulsive, and are unduly influenced by their peers

and by older adults. When adolescent thinking is layered on the effects of trauma, our kids can make some terrible mistakes. This is no excuse for violence, and public safety is paramount. But if we "lock them up and throw away the key," we are giving up on our kids, even though studies show that most youths outgrow criminal tendencies as they mature.

The Supreme Court has ruled that mandatory sentences of life in prison without the possibility of parole violate the Eighth Amendment's ban on cruel and unusual punishment when applied to youths under eighteen, and therefore Massachusetts must create a new sentencing statute. The Commonwealth has an opportunity to enact legislation that embraces the spirit of the *Miller* decision and ensures that each youth under eighteen receives an individualized sentencing hearing. This hearing would include evidence of circumstances of the offense, the background and characteristics of the youth, and, as stated by Justice Kagan, "how children are different, and how those differences mitigate against irrevocably sentencing them to a lifetime in prison."

Start early. Never give up.

Sincerely,

Gail Garinger

The Child Advocate

OCA Mission and Values

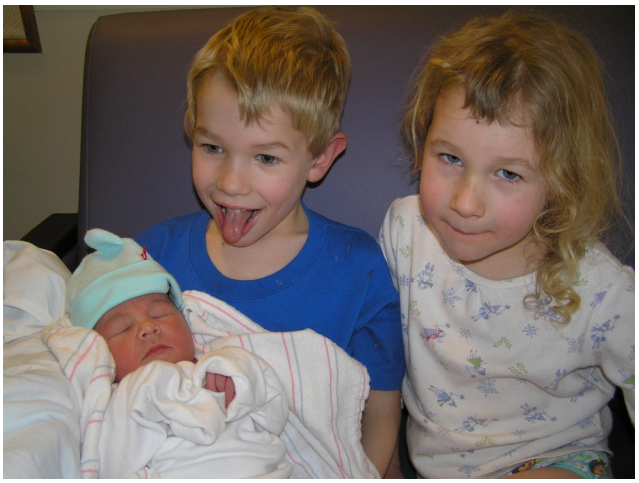
Our mission is to improve the safety, health and well-being of Massachusetts children by promoting positive change in public policy and practice. We further our mission by focusing on our core values: information, collaboration, and accountability.

Information: The Child Advocate and the OCA staff are always active, participating in meetings, forums, and events to learn more about services and initiatives for children and families in Massachusetts. We share this information with others through our policy work and our Helpline.

Collaboration: Collaboration is critical at every level. No single agency or system can provide all the resources needed to support and heal families. The OCA staff work to promote collaboration at every opportunity among initiatives, agencies, and systems.

Accountability: The OCA staff review critical incident reports and child abuse and neglect reports arising in out-of-home settings connected to state agencies. Through these reviews, we identify trends and look for opportunities for system improvements. We meet with agency commissioners and staff to learn from them and to share our perspective.

The role of the OCA is to connect the dots within and between the child welfare and juvenile justice systems. We work to promote system integration among agencies, courts, schools, and health service providers so that children and families can connect to resources in their communities.



Activities

Helpline

The OCA responds to calls on the Helpline from the public about state agencies that provide services to children and youth in Massachusetts. Anyone with concerns about the treatment of a child receiving services from a state agency may contact the OCA. Family members, foster parents, advocates, attorneys, and others have called or written the OCA on behalf of a child to express concerns and ask for advice. The OCA maintains the confidentiality of all information shared with our office. In 2011 the majority of contacts related to children involved with the Department of Children and Families (DCF). Callers asked questions and voiced concerns regarding placements for children, such as foster homes or residential programs, visits with parents, treatment plans, safety, and plans to return children to their parents' homes. Callers may be involved with the Probate and Family Court or Juvenile Court in addition to state agencies. Our clinical specialist and program assistant help individuals resolve their problems directly with the agency involved and identify resources related to a child's safety and well-being. In addition to helping with individual cases, the OCA maintains a database of the Helpline concerns and analyzes the information to better understand where there is room for improvement in the child welfare and juvenile justice systems. The Helpline informs our interagency and policy work and assists the OCA to identify priorities, including permanency and children and youth voice in court. Please see **Appendix A** for further information regarding the concerns we hear through the Helpline.

Reach our Helpline by phone, email, or mail.

Phone: 617-979-8360 or toll-free 866-790-3690

Email: childadvocate@state.ma.us

Mail: Office of the Child Advocate, One Ashburton Place, 5th Floor, Boston, MA 02108

How We Help

Karen called the OCA Helpline regarding Mark, her nine-year-old son. Mark was in the fourth grade and was being bullied by other students in his public school. One student in particular called Mark names in class and followed him through the halls taunting him. Karen had brought her concerns to the attention of the teachers and had met with the school principal and the superintendent of schools. Karen did not feel her concerns were taken seriously, as the bullying continued. Mark did not want to go to school, had become increasingly depressed, and had threatened to hurt himself. As a result, Mark was hospitalized. In thinking about Mark's return to home and school, Karen was worried about his mental health and safety. The OCA explored the specific resources available in Karen's local school district and provided her with information on accessing her school district's anti-bullying plan and filing a complaint with the harassment coordinator or on the anti-bullying hotline. The OCA encouraged Karen to develop a safety plan with the hospital team prior to Mark's discharge and to follow through on all the team's suggestions for care in the community, such as individual counseling and therapeutic mentoring. The OCA encouraged Karen to call back if she had additional concerns about Mark's transition back to school.*

*The names in this and all subsequent vignettes have been changed.

Reports of Abuse and Neglect in Out-of-Home Settings

The OCA receives reports that have been investigated and supported by DCF regarding abuse and neglect of children and youth in settings connected to certain state agencies[1]. These settings include licensed preschool and day care, foster care, group homes, residential treatment programs, elementary and secondary schools, and youth correctional facilities. OCA staff analyze and discuss every report, obtain more information from agencies when indicated, and provide feedback to the agencies about concerning issues and trends. Our reviews inform our participation in the Interagency Restraint and Seclusion Prevention Initiative[2] as well as our partnership with the Committee for Public Counsel Services[3] to examine the performance of child's counsel for children in state custody. Review of recurring scenarios in these reports has impressed upon The Child Advocate the importance of screening, training, and supervising our child-serving workforce and adopting a trauma-informed approach to care.

Critical Incident Reports

When a child receiving services from a state agency organized under the Executive Office of Health and Human Services (EOHHS) dies or is seriously injured, the agency involved is required to report the critical incident to the OCA. In practice, the agencies report critical incidents to EOHHS and the reports are then forwarded to the OCA. Over the past four years, the OCA has worked with EOHHS to improve this reporting process, and we continue to strive toward the goal of timely notification of critical incidents. Since the publication of the OCA FY 2011 Annual Report, which reported on calendar year 2010 critical incidents, the OCA received 19 critical incident reports from DCF concerning children who were injured or died during 2010. A revised account of critical incident reports, fatalities, and injuries from 2010 is included in Appendix B.

OCA staff carefully review each critical incident report and, in many instances, follow up with the agency to learn more information. When a matter warrants closer investigation, the OCA may request investigation reports from the agency, speak with agency staff, and review case records to learn of a family's history and involvement with the agency. The OCA works with the reporting agency to review and learn from the reported situation and promote accountability. The OCA continues to work with EOHHS and the child-serving agencies to improve the process of learning from critical incident reviews. Please see **Appendix B** for further information regarding Critical Incident Reports.

Access to Agency Electronic Records

In order to respond to our Helpline callers and questions that arise from reviewing critical incident reports, the OCA requires access to information held by executive agencies. The majority of OCA Helpline calls and critical incident reports concern children receiving services from DCF, so prompt access to DCF records is particularly important. DCF provides a staff member to act as liaison to the OCA and to assist with information and communication. In addition, the Legislature amended Massachusetts General Law Chapter 18C, the law that describes the OCA's responsibilities, to clarify that OCA access to agency records includes electronic information systems. This law[4] became effective July 1, 2011. During FY 2012, the OCA worked with DCF to implement this provision with respect to FamilyNet, the DCF electronic records system. DCF provided the OCA with a laptop computer for remote access to FamilyNet, and DCF and the OCA entered into a Memorandum of Understanding to clarify protocols for OCA staff's read-only access and to affirm our commitment to confidentiality for children and families. OCA staff received training in both FamilyNet and iFamilyNet, DCF's web-based system, and are now able to obtain information directly from these systems.

Reviews of Agency Policies

Review of DYS Pass Policy: Following a homicide allegedly committed by a DYS client while on a pass in the community, the former Commissioner of the Department of Youth Services (DYS) requested that The Child Advocate conduct an objective and external review of the policy and practice of DYS regarding client passes. The OCA completed its review and recommended continued use of client passes to transition youth into the community with positive supports in place. As youth near their discharge dates from DYS commitment, passes are used to foster connections to family, school, work, and positive recreational activities. Public safety is of paramount importance, however, and improvements should be made to strengthen pass policy and practice within DYS. The OCA recommended changes to DYS client pass policy and practice to improve communication, training, and safeguards. For additional information visit: www.mass.gov/childadvocate/news/oca-reviews-dys-client-pass-policy.html.

Review of EEC Transportation Policy: Following the death of a child left unattended in a van used to transport children to day care, the Department of Early Education and Care (EEC) Board Chairperson and the Commissioner of EEC requested that The Child Advocate participate in a special commission to review and revise EEC regulations and policies concerning transportation. The commission was chaired by the Board Chairperson and included the Secretary of Education as well as representatives from the Board, EEC, EOHHS, and the Executive Office of Public Safety and Security (EOPSS). The commission conducted meetings and heard testimony from child care and transportation providers. The commission's work resulted in a revised transportation policy that requires attendance tracking for children and post-trip inspections, as mandated by EEC's licensing regulations and contracts. The new policy addresses program and parent notification to reflect best practices and to ensure that children are accounted for at all times during the day, particularly after transport. This new transportation policy took effect on December 12, 2011. Visit EEC's website[5] for additional information.

Outreach

Since our last Annual Report, The Child Advocate and staff have attended meetings and conferences across the state and have given presentations relating to child welfare, juvenile justice, and the OCA. Some examples of the venues at which The Child Advocate presented are:

- John Jay College: Keynote address at Juvenile Justice Symposium[6]
- State House: Child Fatality Review Team Briefing
- The Children's League and the Providers' Council
- Massachusetts Advocates for Children
- Citizens for Juvenile Justice
- Adolescent Consultation Services
- Harvard Law School
- The Wiener Center at the Kennedy School of Government
- Massachusetts Psychological Association and Massachusetts Psychiatric Society
- New England Medical Center and Tufts Medical Center
- Middlesex County Bar Association

The Child Advocate engages in ongoing discussions with two DCF foster care alumni associations. The OCA continued to reach out to agency-involved youth by distributing our Youth in Care Outreach Cards and OCA staff participated in a reading program with youths at a DYS facility.

The Child Advocate (second from left) moderated the Adolescent Consultation Services' Annual Event, "Kids in Crisis: Psychiatric Emergencies in the Juvenile Court". Also pictured (from left to right) are: Dr. Debra Pinals, DMH Medical Director; Dr. Michael Jellinek, Chief of Child Psychiatry at MGH; Dr. Jill Durand, ACS Staff Psychologist; and Lia Poorvu, ACS Board President.

How We Help

Lynn called the OCA regarding her 16-year-old adopted daughter, Christina. As a young child, Christina had been severely neglected and witnessed many episodes of violence between her biological parents. When Lynn adopted Christina at age eight, Christina was developmentally delayed and aggressive. She hit her teachers and peers, threatened to hurt herself, threw objects, and ran away from home. She needed help and supervision at all times, especially with eating, bathing, and dressing. By the time Christina turned 16, she had a mix of mental health, behavioral health, and educational needs. She was on an Individualized Education Plan (IEP) and was involved with DCF, DMH, and MassHealth.

At age 15, Christina had spent a year in a residential program, paid for by the school district and DCF. Her behaviors improved while in the program and at the end of the year she returned home with community and home-based services in place. Now Lynn was struggling to handle Christina's difficult and often violent behaviors and was frightened for Christina's safety and the safety of Lynn's two younger children. Lynn felt that the services in the home and community were not meeting Christina's needs and that she should return to the residential program. The professionals from the school and DCF disagreed with Lynn. Lynn called the OCA looking for advice and additional resources.

OCA staff suggested that Lynn request a case review by a Unified Planning Team (UPT)[7]. A UPT review is a process to improve the coordination of services for children with complex needs who are involved with three or more state agencies. A request for a UPT review can be made by a youth, parent, guardian, state agency personnel, or a juvenile court judge. OCA staff sent Lynn the necessary forms and contact information to request a UPT review, as well as additional information on the UPT process.

OCA staff often hear from parents of children who, like Christina, have a history of early childhood trauma that affects their ability to learn and to regulate their emotions. The Child Advocate is interested in the services provided to children with complex needs and the processes for coordination of those services. The Child Advocate receives an annual report from EOHHS summarizing the cases reviewed by the UPTs and the outcomes of those reviews.

Child Fatality Review Program

The statewide child fatality review program was created in 2000 with the goal of decreasing the incidence of preventable childhood deaths and injuries. The state team is chaired by the Chief Medical Examiner and co-chaired by the Medical Director of the Department of Public Health (DPH). Eleven local teams meet under the leadership of the elected District Attorneys' Offices to conduct multi-disciplinary reviews of individual deaths. The local teams take action in their communities and formulate recommendations for the state team to consider, including changes to policy, practice, or regulation. The OCA participates in the state team as an *ex officio* member. OCA staff take an active role on the state team and attended a regional New England child fatality review conference on behalf of the state team, along with the local team coordinator from the Worcester District Attorney's Office.

Certain child fatalities reviewed by the OCA as critical incidents are also reviewed by local child fatality review teams. OCA staff attend as many local team meetings as possible and attempt to attend whenever a death being reviewed was the subject of a critical incident report. During the last year OCA staff attended local team meetings in Bristol, Cape & Islands, Essex, Middlesex, and Suffolk County District Attorney offices. In February, the statewide child fatality review program conducted a legislative briefing in the State House to highlight the work of the program. The Child Advocate, the Attorney General, the Medical Director of DPH, and two District Attorneys spoke about the importance of the program.

The OCA commends the Office of the Chief Medical Examiner (OCME), DPH, and the District Attorneys for their leadership roles in this important multi-disciplinary work. Since its inception a decade ago, the child fatality review program has relied on resources allocated by its contributing members. As the budgets of the member offices and agencies have decreased over the last several years, these resources have been taxed. Agencies and other team members are not always able to send representatives to local team reviews, and the program has not implemented systemic review of near fatalities. The Commonwealth will benefit if it can assure sufficient resources are available to maximize the program's full capabilities.

Recommendation: The Child Fatality Review Program is a critical component of the state's efforts to decrease the incidence of preventable childhood deaths and injuries and requires sustainable funding at both the state and local levels. The agencies involved in this important multi-disciplinary work should formulate a plan to identify funding requirements and strategies for the Massachusetts Child Fatality Review Program.

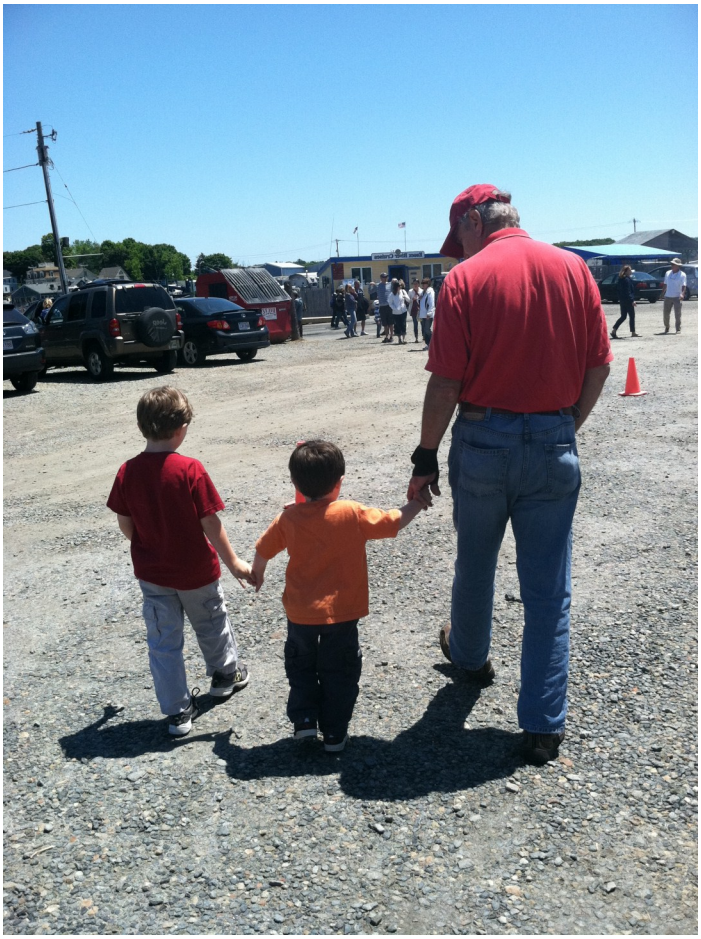
Sudden Unexpected Infant Deaths

Between 40 and 60 infants die suddenly and unexpectedly in Massachusetts each year. One of the focuses of the Child Fatality Review Program, along with reducing injury-related fatalities, has been to reduce sudden and unexpected deaths of infants, called "SUID" or "SIDS" deaths[8]. The national SIDS rate declined by more than 50% in the 1990s after the Back to Sleep Campaign taught the public that the safest sleep position for infants is on their backs. Despite this encouraging reduction in mortality, infants continue to die while sleeping in unsafe positions and environments. SUID is the leading cause of death for infants between the first month and first year of life, and the third leading cause of death for infants of any age. Understanding why infants die unexpectedly requires careful death scene investigation and data collection by law enforcement agencies, medical examiners, and public health officials. The Massachusetts Center for Sudden Infant Death Syndrome and the Child Fatality Review Program are important resources for this work. Members of the Child Fatality Review Program developed a standardized death scene investigation form for SUID deaths. Consistent use of this form by law enforcement is necessary to advance our understanding of the circumstances in which SUID occurs.

In the OCA FY 2011 Annual Report, the OCA recommended collaboration among state agencies, offices, and programs to investigate and review all sudden unexpected infant deaths and to offer clear and consistent information to the public about safe sleep practices for infants. In October of 2011 the American Academy of Pediatrics (AAP) released a policy statement[9] and a technical report[10], expanding its recommendations from focusing only on SIDS to focusing on a safe sleep environment that can reduce the risk of all sleep-related infant deaths. In May 2012 DPH issued "Policy Recommendations for Safe Infant Sleep Practices," based on the AAP recommendations. These policy recommendations have been endorsed by the State Child Fatality Review Team and by the OCA, and are attached as **Appendix C**. DPH has identified infant safe sleep as a priority area in its Injury Prevention Strategic Plan and has developed a three-pronged initiative to address sleep-related deaths in infancy. The components of the initiative include updating policy among state agencies and entities, working with the federal program Women, Infants, and Children (WIC) to get the message out, and partnering with hospitals to examine the information that new mothers receive about safe sleep for their babies. OCA staff participate in the DPH Safe Sleep Task Force. DCF has included a Strategic Innovation Initiative specifically to address sudden unexpected infant deaths in its strategic plan for 2012-2015. DCF will strengthen its existing parental education and outreach on safe sleeping environments and convene a series of continuous quality improvement round tables. These round tables will be used to develop additional strategies to strengthen case practices that may help to increase parental attention to safe sleep environments. DCF will continue its collaboration with DPH to support broader public health efforts to reduce the number of sudden unexpected infant deaths.

In October of 2012, the National Institute of Child Health and Human Development launched the Safe to Sleep Campaign[11]—an expansion of the original Back to Sleep Campaign that was so successful in reducing infant death in the 1990s. This national campaign will present Massachusetts with an opportunity to join in the message and educate its citizens about the importance of putting infants to sleep on their backs, in their own sleep spaces, for every sleep time.

Recommendation: The Child Advocate urges continued collaboration among state agencies, offices, and programs to investigate and review all sudden unexpected infant deaths, and to collect and analyze data so that we advance our understanding of how to prevent these deaths. The Child Advocate encourages all state organizations to offer clear and consistent information to the public about safe sleep practices for infants, and to join forces with the national Safe to Sleep Campaign.



Substance Exposed Newborns

Substance use among pregnant women presents a significant public health challenge that impacts an estimated 10% of newborns in the United States. Prenatal substance exposure to both legal and illegal substances can affect a newborn's health and development and increases the newborn's risk for abuse and neglect. Through the OCA's review of critical incident reports and Helpline calls from concerned professionals, the OCA identified agency responses to substance exposed newborns as an area of concern.

In September of 2011, DPH presented data at a forum on substance exposed newborns held in Boston. The data came from a 2010 survey of all Massachusetts birthing hospitals regarding their newborn substance exposure screening protocols, including reporting to DCF. In this context, screening refers to verbal questioning designed to determine whether the mother has a substance abuse disorder. While most hospitals had screening protocols in place, 92% did **not** have universal screening for the mother. Lack of universal screening fails to protect all newborns and leaves health care providers to decide whether an individual mother should be screened. This decision may lead to bias, as research shows that women of color and living in poverty may be screened in situations when others wouldn't be.

The survey asked whether hospital workers filed an abuse or neglect report (a "51A") with DCF for a mother who was actively using substances. Ninety-six percent of hospitals file a 51A if a mother was actively using, unless she was in medically assisted substance abuse treatment, such as methadone maintenance. In that instance, the hospitals did not always file a report with DCF, but instead might contact the mother's treatment provider or their own hospital social service department. In response to the survey results, the DPH Perinatal Advisory Committee partnered with DPH, DCF, hospitals, and other stakeholders to develop universal screening guidelines for Massachusetts. These guidelines will be used at birthing hospitals with women prior to conception and in all stages of pregnancy.

Collaboration among birthing hospitals and DCF to assure proper intervention and response to these vulnerable families is critical. Health care providers in MA are required to file a 51A when a baby is born physically dependent on an addictive substance. After a 51A is filed, DCF must decide whether to "screen in" the report for further action. Screening decisions differ from case to case and between area offices. Doctors and other health care providers have expressed concern to the OCA and in other forums about inconsistent screening decisions. DCF recognizes the increased vulnerability of substance exposed newborns, and as part of its Integrated Casework Practice Model, is developing a practice guidance for DCF personnel on screening 51A reports related to substance exposed newborns.

The OCA supports DPH's work to develop universal screening guidelines for substances at birthing hospitals and DCF's development of guidelines for personnel making screening decisions relating to substance exposed newborns. The OCA recognizes the ongoing efforts of hospitals, DPH, DCF and other stakeholders to create these guidelines and policies and looks forward to learning more as they are completed and implemented.

Psychotropic Medications for Children in State Custody

Deciding whether a child should take psychotropic medication can be difficult for parents. When a child is in the custody of DCF, someone other than the child's parents must make that decision. A DCF social worker can consent to the administration of most psychotropic medications, such as stimulant medication or antidepressants, but DCF regulations require that a judge decide whether a child in DCF custody should be treated with antipsychotic medication. The practice of going to court to determine a treatment plan for antipsychotic medication is called the Rogers process. This practice has been in place for almost 25 years and has not been evaluated to determine its efficacy. In 2009, The Child Advocate began meeting with interested professionals to discuss whether the Rogers process serves its intended purpose for children in Massachusetts. These discussions evolved into the Rogers Working Group, an informal collaboration among researchers and policymakers to examine the Rogers process.

During the 2010-2011 academic year, the OCA partnered with the Northeastern University School of Law's (NUSL) Legal Skills in Social Context (LSSC) Social Justice Program[12] to conduct legal research and field interviews to examine the effectiveness and efficiency of the Rogers process. Details regarding the students' findings and recommendations can be found in the final report, "*Court-Ordered Consent: Revisiting the Rogers Process for Children in State Custody*." [13] Following the completion of the NUSL project in April 2011 and with support from the Court Improvement Program, the OCA commissioned a team of researchers based at Tufts Medical Center to build on the research and findings of the NUSL students. The Tufts research team presented their findings and recommendations to the Rogers Working Group and submitted a final report to the OCA in late August 2011. For additional information and to view the reports visit http://www.mass.gov/childadvocate/examination-of-the-rogers-process.html.

At the request of the Secretary of EOHHS, The Child Advocate submitted recommendations for reform of the Rogers process. The recommendations were:

- DCF regulations should be changed so that judges are no longer required to authorize the administration of antipsychotic medications for children in state custody.
- A tiered system of oversight by a team with expertise in child and adolescent behavioral health should be established for the behavioral health treatment of children in state custody.
- Data analysis and a continuous quality improvement model should be used to monitor behavioral health treatment and outcomes for children in state custody.

At the same time the work in Massachusetts advanced, national attention increased on the issue of foster children and psychotropic medication, resulting in new federal direction and oversight. The federal Fostering Connections to Success and Increasing Adoptions Act of 2008[14] requires state child welfare agencies to partner with other youth-serving organizations

to develop plans for the oversight of health and mental health services, including psychotropic medication. The federal Child and Family Services Improvement and Innovations Act of 2011[15] requires states to develop protocols for the appropriate use and monitoring of psychotropic medications for children in state custody. The federal Administration for Children and Families (ACF) issued a letter of guidance[16] and an information memorandum[17] to state agencies and held a two-day summit in late August 2012 with teams from all fifty states to collaborate around the development of state plans. The conference was co-sponsored by the Substance Abuse and Mental Health Services Administration and the Centers for Medicare and Medicaid Services.

The Child Advocate has been active in advancing this issue in Massachusetts by convening the Rogers Working Group, making recommendations to the Secretary of EOHHS, and co-chairing with the Commissioner of DCF the newly-formed steering committee that will develop the Massachusetts plan for authorization and oversight of psychotropic medications for children in state custody. The Child Advocate attended the August 2012 summit as part of the Massachusetts team.

Recommendation: The Child Advocate urges DCF to develop a process for authorizing and overseeing psychotropic medication use for children in DCF custody that places medication in the context of individualized behavioral health treatment plans and incorporates evidence-based practices.

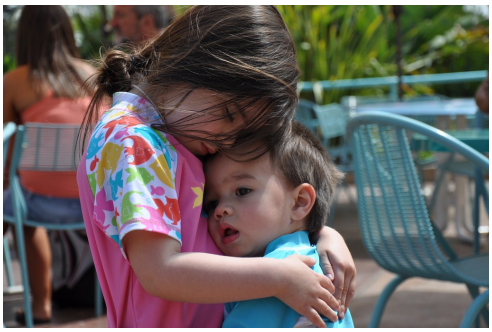
How We Help

Beth contacted the OCA with concerns about her grandson Zack, who was 11 years old and in the permanent custody of DCF. Beth explained that Zack had been moved from a residential school to a hospital after he assaulted two staff members and talked about committing suicide. At the hospital Zack's aggressive behaviors persisted and the doctors increased the dosage of his psychotropic medication and added another medication. By the time Zack was transferred to a community-based acute treatment (CBAT) placement, he was sluggish and slurred his words. At the CBAT, his medication dosage was decreased and he participated in therapy and treatment. His behaviors improved, he became alert, and his speech was clear. Although Zack was now better, Beth wanted to relay her concerns about medication to the OCA. She acknowledged that psychotropic medication helped Zack, but felt that he had received too much medication in the hospital. In responding to Beth's concerns, OCA staff gathered information from professionals and reviewed an investigation report concerning the hospital. We learned that hospital staff may have focused on medication treatment alone rather than connecting with the residential school to learn what kind of therapeutic interventions had worked for Zack in the past. OCA staff consulted DCF, DMH, and hospital personnel to learn about Zack's care and to determine what steps had been taken to address the issue of overmedication going forward. OCA staff explained to Beth that hearing about Zack's experience would help inform the OCA's work regarding the use of psychotropic medication among children in state custody. When children receive psychotropic medications, it is important that the medications are part of an overall behavioral health treatment plan. The Child Advocate has led the state's efforts to advance this issue and co-chairs a newly-formed steering committee to develop a Massachusetts plan for authorization and oversight of psychotropic medications for children in state custody.

Permanency

Children need permanent homes where they can be safe, stable, and nurtured as they grow. The connection of a permanent home and a caring adult supports healthy growth and development as youth transition into adulthood. When children and youth wait in foster or congregate care for years without a permanent home, the child welfare system has failed to provide permanency. Youth who reach adulthood while still in foster care face financial obstacles as well as challenges to their health and wellbeing. The OCA works with the executive agencies to understand barriers to permanency and to foster collaborations to move past these barriers, such as the Task Force on Youth Aging out of DCF Care (described in "Committees, Boards, and Councils"). Several recent initiatives in Massachusetts have attempted to address the goal of finding permanent homes for all children before they reach adulthood.

- **Elimination of rolling trials:** The Juvenile Court Department issued Standing Order 1-10 in 2010 to attempt to eliminate lengthy "rolling trials" and to ensure that care and protection and termination of parental rights trials are completed within a reasonable time. The Juvenile Court monitors cases that go beyond 30 days, though no data is available comparing trial schedules before and after the Standing Order was issued. OCA staff hear from stakeholders that trial schedules are improving but still hear of protracted trials. With the implementation of the MassCourts information technology system in FY 2013, better data collection and evaluation of Standing Order 1-10 should be possible.
- **Permanency hearings:** A hearing to determine a permanent plan for a child must take place within one year after DCF takes custody of a child and annually thereafter. Last year the Administrative Office of the Juvenile Court and DCF received Court Improvement Program funds to coordinate a pilot project in Suffolk County to increase participation of older youth in permanency hearings. Two coordinators from the Juvenile Court funded by the Court Improvement Program are now working in other counties to increase attendance of youth and to provide the court and youth with tools to make the hearings more meaningful. The implementation of MassCourts may help the juvenile court to schedule permanency hearings and to collect data for evaluation.



- **Extended DCF services:** In 2010 the Legislature extended to youth in state custody the right to continue receiving supportive services from DCF after they have turned 18, if they remain involved with DCF.
- **Juvenile court supervision through age 22:** In 2010 the Legislature extended juvenile court oversight of youth receiving services from DCF up to age 22. This law extends the responsibility of the court to monitor through permanency hearings those youth who remain involved with DCF after they turn 18.

The OCA will continue to track Juvenile Court and DCF initiatives to monitor the effectiveness of state efforts to find permanent homes for children and youth in state custody.

Transition Planning

Transition planning programs and services support older youths' transition from foster care to self-sufficiency. This process can be an opportunity for young people to take ownership of their futures and determine their own paths with the guidance of adults. New legislation requires that DCF provide all foster youth with support to develop a written transition plan before they exit care.[18] In response to this legislation, the OCA partnered with DCF and our first OCA Fellow to investigate promising transition planning models from across the country and to gauge the interest in bringing one of these models to Massachusetts. The project will encompass a literature review and interviews with experts and practitioners. At least two well-regarded models that incorporate recommended practices will be selected; these models will be discussed with a broad-based group of individuals from across Massachusetts concerned with the well-being of youth in foster care. These interviews will focus on which model would best support foster youth in Massachusetts, while also ensuring compliance with the new statutory transition planning requirements. Finally, the OCA will seek perspectives on what it would take to bring one or more of the models to Massachusetts.

How We Help

Attorney Jones contacted the OCA on behalf of her 17-year-old client, Alicia. Alicia had been in foster care and group homes since she was 10 years old and had never been adopted or placed in a guardianship. Alicia had long-standing issues related to the trauma of her childhood. She had trouble trusting people and forming relationships and had run away from several foster homes. When she turned 16, DCF created a transition plan to help Alicia prepare for independent living. She worked a part-time job while going to school and living in a group home. Although a good student when she was younger, Alicia was now struggling in school and nearly failing several of her classes. She was no longer engaged in individual therapy, declaring herself "tired of talking." Attorney Jones was concerned that Alicia would not be ready to assume responsibility for herself when she left DCF custody at age 18, just four months away. Attorney Jones wanted information on how recent developments in state and federal law were being implemented by DCF. OCA staff discussed with the attorney changes in the law that gave Alicia the right to receive supportive services from DCF from age 18 until her 22nd birthday, so long as she remained in school or had a job. DCF would help Alicia plan for her transition to independence. Alicia would continue to have a court-appointed attorney to represent her and a juvenile court judge would review her transition plan. By the time Alicia turned 22, she should have a plan in place to address her needs for housing, health insurance, education, employment, and mentoring or continuing support services. The OCA continues to work with DCF, providers, and advocates to ensure ongoing support for transition-aged youth, and has been working with DCF to examine other states' models for transition planning for older youth.

Child and Youth Voice in Court

Children and youth involved with courts rely on their attorneys to advocate for them. Representing children is a public trust that must be honored by the advocates who accept these court appointments. The OCA collaborates with the Committee for Public Counsel Services (CPCS) and the juvenile court to improve the quality of advocacy for children, whether in care and protection, child in need of services (CHINS), or delinquency or youthful offender proceedings. OCA staff refer Helpline callers and website visitors to the CPCS Performance Standards for court-appointed counsel in delinquency or youthful offender proceedings[19] and child welfare matters.[20]

Two divisions of CPCS oversee appointment of counsel for children. The Youth Advocacy Division (YAD) provides attorneys to represent children in delinquency and youthful offender cases. The Children and Family Law (CAFL) Division provides legal representation to children and indigent parents in state intervention cases including:

- care and protection and termination of parental rights proceedings
- other child custody cases involving DCF
- child in need of services (CHINS) cases
- guardianship-of -minor cases

In response to Governor Patrick's initiative and the FY 2012 budget, YAD and CAFL increased the number of attorneys employed full-time to carry out this work. Both YAD and CAFL have significantly enhanced trainings for all attorneys. CPCS is in the process of recertifying private attorneys who accept appointments through the CAFL or YAD panels.

In care and protection cases in the juvenile court, reports are submitted by court-appointed investigators and, in some cases, guardians *ad litem*. The quality of the reports submitted by the investigators and guardians *ad litem* varies considerably, as there have been no uniform requirements for becoming an investigator or guardian *ad litem*, and no standardized program of training or standardized format for submitting reports. In May 2012, the Juvenile Court Department issued a new directive[21] requiring recertification for all juvenile court investigators. This directive sets forth the qualifications and continuing legal education requirements for investigators as well as the application process. This new policy requires that court investigators comply with the Juvenile Court Guidelines on Court Investigator Reports.

A good lawyer can be a godsend to a child in a tough situation. The OCA appreciates the dedication of the many attorneys who go the extra mile for their child clients, and recognizes the work of CPCS in increasing training and accountability for child's counsel.

Legislation and Regulations

During the last legislative session, The Child Advocate and OCA staff reviewed and commented on proposed legislation relating to child welfare and juvenile justice issues. Governor Patrick signed three important pieces of new legislation creating additional responsibilities for schools, courts, and agencies to provide services for children and families.

- Senate Bill 2410, "An Act Regarding Families and Children Engaged in Services" (FACES), transforms the 38-year-old CHINS system to offer services to families before beginning court proceedings for youths who are truants, runaways, or persistently noncompliant with school or household rules.
- House Bill 4332, "An Act Relative to Student Access to Educational Services and Exclusion from School," reforms procedures for school expulsion and requires schools to provide educational services for children who have been expelled.
- House Bill 3808, "An Act Relative to the Commercial Exploitation of People," contained Safe Harbor provisions to redefine commercially sexually exploited youth as children requiring assistance rather than criminals. Massachusetts is one of only 11 states with Safe Harbor legislation and one of only eight whose legislation meets the Polaris Project's criteria for effectiveness.

The Child Advocate testified in support of legislation that would raise the age of youth falling within juvenile court jurisdiction to 18 for delinquency matters. The Child Advocate supported the exclusion of youthful offender adjudications from those convictions that increase criminal sentences for habitual offenders under House Bill 3818, the "three strikes" legislation passed at the end of the session. The OCA reviewed and offered comment on the following topics addressed by proposed legislation and regulations:

- Educational stability for foster children
- Life sentences without the possibility of parole for juvenile offenders
- Sexual offender registry board provisions and federal Adam Walsh Act requirements
- Treatment of youthful offender records within Criminal Offender Records Information (CORI) regulations.

Evidenced-Based Juvenile Justice

Research in adolescent brain development has changed our understanding of how youth process information and make decisions. This understanding should translate into a reconsideration of several juvenile justice laws and policies.

- **Raise the Age**
  The Child Advocate strongly supports raising the age of juvenile court jurisdiction to 18 for delinquency cases. The Child Advocate testified[22] before the Joint Committee on the Judiciary in support of this position.
- **Competency Issues in Delinquency Cases**
  The OCA 2009 Annual Report[23] discussed the issue of competency of youths in delinquency cases. A statute limiting the indefinite detention of youths found incompetent to stand trial is needed to satisfy constitutional due process requirements. The Child Advocate urges policymakers to ensure the constitutional rights of these youths are guaranteed, and their needs for assessment, education, and treatment are met.
- **Mandatory Life Sentences Without the Possibility of Parole for Juveniles**
  The Child Advocate advocated for fair sentencing for juveniles[24] by testifying before the state legislature's Joint Committee on the Judiciary, signing an amicus brief on behalf of former juvenile court judges, and publishing an op-ed in the New York Times regarding abolishing juvenile life sentences without the possibility of parole. On June 25, 2012, the United States Supreme Court issued its opinion in *Miller v. Alabama*,[25] ruling that mandatory life without parole sentences for those under the age of 18 at the time of their offenses violate the Eighth Amendment's ban on cruel and unusual punishment. The Commonwealth has an opportunity to enact legislation that embraces the spirit of the *Miller* decision and ensures that each youth under eighteen receives an individualized sentencing hearing. This hearing would include evidence of the circumstances of the offense, the background and characteristics of the youth, and, as stated by Justice Kagan, "how children are different, and how those differences mitigate against irrevocably sentencing them to a lifetime in prison."

Juvenile Court Record Expungement

Young people with records of juvenile court involvement face barriers to educational and employment opportunities. In Massachusetts a juvenile record can be sealed under some circumstances, but not wholly erased or expunged. During the 2011-2012 academic year, the OCA partnered with students from the NUSL LSSC Social Justice Program to examine sealing and expungement of juvenile court records. Fifteen NUSL students under faculty supervision researched Massachusetts and other states' laws and conducted interviews. As the OCA learned more about this issue through the students' research, we were left to wonder whether

expungement of a record is possible now that records are stored electronically and companies that mine and store data have access to court records. The OCA is interested in partnering with advocates concerned with issues of justice and poverty to develop recommendations and an action plan to address barriers for young adults with juvenile records. The students' final report and recommendations can be found at the OCA website at: www.mass.gov/childadvocate/expungement-of-juvenile-court-records.html.

Violence in the Community

As The Child Advocate and the OCA staff learn of fatalities and serious injuries through reviewing critical incidents and by participating in child fatality review team meetings, we are confronted with the question of how to protect our young from the violence that claims so many of their lives. In 2011 the OCA received critical incident reports of four children and youths receiving EOHHS services killed by guns, reports of seven nonfatal gunshot wounds, and reports of six nonfatal knife wounds. Critical incident reports document the trajectories of nine youths who have returned to the community after successful stays in programs or facilities, only to be caught up again in violence. Vulnerable communities need strategies and support to give their children and youth a better chance for a bright future. Governor Patrick has identified youth violence as one of his top priorities during his second administration. The Massachusetts Safe and Successful Youth Initiative[26] was launched in May 2011 to address youth violence and promote peaceful communities. During the Initiative's first year, 11 cities across the state were awarded a total of ten million dollars to identify and provide case management to at-risk male youth, and connect them with activities and services, including ongoing monitoring and supervision. EOHHS and EOPSS developed an award-winning public service announcement entitled, "Stop. Think. Let It Go,"[27] designed to encourage youth to consider the consequences of their actions before engaging in violent activity. The Child Advocate shares the Governor's sense of urgency about this issue and is a member of the Governor's Advisory Committee to the Massachusetts Safe and Successful Youth Initiative.

Governor Patrick meets Youth Violence Prevention Committee to discuss the "Massachusetts Safe and Successful You Initiative", Monday, June 20, 2011. Pictured left to right: Michael Coelho, Jane Tewksbury, Gail Garinger, William Rodriquez, Swaonil Maniar, John Auerbach, Marilyn Chase, Bob Gittens, Sandra McCroom, Tito Jackson, Governor Deval Patrick, Mary Beth Heffernan, and Mayor Tom Menino

Restraints and Seclusion

As OCA staff review reports of abuse and neglect in out-of-home settings, we learn of restraints that are employed as punishment or to manage behavior rather than to protect children or staff from harm. We also hear from family members and advocates through our Helpline about their concerns related to restraints. OCA staff collaborate with agencies to review investigations and provide feedback in selected instances about concerning restraints. OCA staff sit on the Steering Committee for the Interagency Restraint and Seclusion Prevention Initiative (IRSPI)[28] and participate in the data analysis and reporting subcommittee. This initiative presents opportunities to advocate for trauma-informed care and workforce development, issues that are priorities within the OCA. Every restraint is a nonconsensual traumatic incident to the child and is potentially physically and emotionally harmful to the child, other children and staff. The behaviors of some youth in residential treatment programs can be challenging and aggressive, and staff members need training and supervision to learn to de-escalate situations, redirect behaviors, and prevent harm to all present. The IRSPI provides a forum for leadership from state agencies, providers, advocates from schools and the community, youth and family members to focus on preventing and reducing the use of behavior restrictions that can be re-traumatizing.

Online Mandated Reporter Training

The Child Welfare Law of 2008 requires that all mandated reporters who are professionally licensed by the Commonwealth complete training to recognize and report suspected child abuse and neglect. This requirement became effective January 1, 2010. Since the passage of the legislation in 2008, the OCA has advocated for the development and implementation of an online mandated reporter training (OMRT) program that would provide a standardized curriculum and consistent message to mandated reporters regarding their reporting obligations. Unified training is critical to ensure that all mandated reporters in Massachusetts properly recognize, report, and respond to suspected abuse and neglect of children. The OCA envisions an OMRT program that would be developed by EOHHS in conjunction with other stakeholders and would:

- Outline the obligations of mandated reporters
- Set the tone for trauma-informed intervention
- Offer a user-friendly format at minimal or no cost
- Satisfy the requirement that a licensed mandated reporter receive training

EOHHS developed and launched in June 2012 a pilot OMRT program for EOHHS staff. After the pilot period, the training will be made available statewide to state employees. The EOHHS pilot program provides basic information about reporting child abuse and neglect. The OCA urges EOHHS to view the pilot program as a first step and to work with the OCA and other stakeholders to develop a more robust OMRT program available to all mandated reporters.

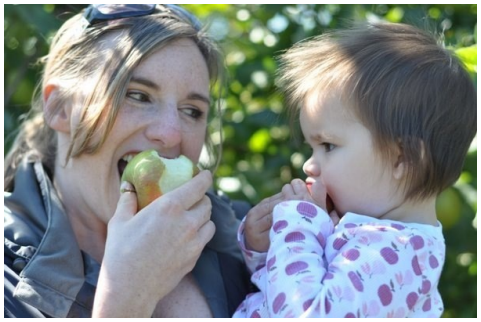
Recommendation: An online training that meets the legislative requirement should be available to all mandated reporters. The training should be built upon a standardized, state-approved curriculum that educates mandated reporters about their duties to report suspected child abuse and neglect and introduces the principles of trauma-informed care.

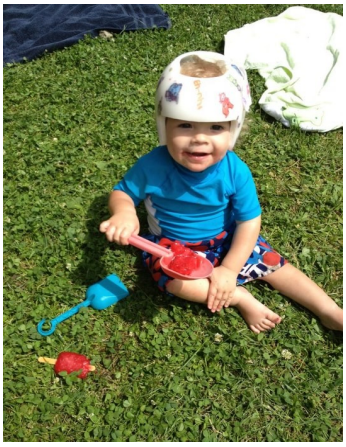
Children, Youth and Families (CYF) Advisory Committee

In July 2011 EOHHS convened the Children, Youth and Families (CYF) Advisory Committee. Nearly 70 stakeholders from the child welfare and juvenile justice community met monthly for six months to identify key issues for reform, share experiences, gather input from other states, and discuss the changes needed to strengthen the Massachusetts system. Stakeholders included legislators, providers, advocates, parents and families, educators, academics, practitioners, state executives and staff. The CYF Advisory Committee was charged with developing a plan for strengthening children's services and improving service delivery for children, youth and families. Four working groups focused on the issues of access, behavioral health, education and human services, and interagency coordination. The Child Advocate was a member of the CYF Advisory Committee and participated in the Behavioral Health and Interagency Coordination working groups. EOHHS and its partners also conducted six public listening sessions in locations across the Commonwealth. These efforts culminated in a January 2012 report to the Governor, "It's All About the Children: Recommendations for Strengthening Children, Youth and Family Services in Massachusetts."[29]

One issue not resolved during the CYF Advisory Committee or working group meetings was the need identified by many stakeholders for improved access to information and data sharing. Data sharing enables measurement of outcomes across agencies and secretariats and can enhance safety and case management for children and families. Many parents and advocates raised legitimate concerns about privacy, particularly with respect to sharing individually identifiable data. In February 2012, a steering committee of state executives and staff and a broader advisory committee of internal and external stakeholders were formed to explore developing regulations to facilitate data sharing and strengthen communications between EOHHS and EOE entities.

The CYF Advisory Committee has continued to meet to follow up on recommendations in the January 2012 report. Specific topics include family resource centers, integrated eligibility, CHINS/ FACES pilot development and data sharing. The OCA encourages the CYF Advisory Committee to identify data sharing as a priority and to build on the work of the EOHHS-EOE committee. The CYF Advisory Committee has the potential to serve as an ongoing broad-based forum for discussing and advancing child welfare and juvenile justice initiatives.





Office for Children Project

The Massachusetts Office for Children (OFC) was established in 1972 with a broad mandate to improve services for the Commonwealth's children and families. The OFC's roles included advocacy, licensing and monitoring, ensuring parental involvement and oversight of children's programs, and coordinating services to children. Over time, the functions of the OFC were moved to other entities and the OFC was officially dissolved in 2008, the same year The Child Advocate was appointed. To preserve the history and lessons of the OFC, the OCA initiated a research project in collaboration with a faculty member at the John F. Kennedy School of Government at Harvard University. The purpose of the research is to understand the history of the OFC and learn its accomplishments and challenges, why it was dissolved, and what lessons can be drawn for the OCA. Research methods will include interviews and review of legislative records and published accounts of the office. The interviews will include individuals who worked for or interacted with the OFC and will include parents whose children received services. A blog was also created to encourage the exchange of memories and insights about the OFC's history. By highlighting valuable lessons from the work of the OCA's predecessors, this project will help the OCA fulfill its mission of improving the well-being of Massachusetts youth.

Recommendations

Child Fatality Review Program: The Child Fatality Review Program is a critical component of the state's efforts to decrease the incidence of preventable childhood deaths and injuries and requires sustainable funding at both the state and local levels. The agencies involved in this important multi-disciplinary work should formulate a plan to identify funding requirements and strategies for the Massachusetts Child Fatality Review Program.

Sudden Unexpected Infant Deaths: The Child Advocate urges continued collaboration among state agencies, offices, and programs to investigate and review all sudden unexpected infant deaths, and to collect and analyze data so that we advance our understanding of how to prevent these deaths. The Child Advocate encourages all state organizations to offer clear and consistent information to the public about safe sleep practices for infants, and to join forces with the national Safe to Sleep Campaign.

Psychotropic Medications for Children in State Custody: The Child Advocate urges DCF to develop a process for authorizing and overseeing psychotropic medication use for children in DCF custody that places medication in the context of individualized behavioral health treatment plans and incorporates evidence-based practices.

Evidence-Based Juvenile Justice

- **Raise the Age:** The Child Advocate strongly supports raising the age of juvenile court jurisdiction to 18 for delinquency cases.
- **Competency Issues in Delinquency Cases:** The Child Advocate urges policymakers to ensure the constitutional rights of youths found incompetent to stand trial are guaranteed, and to ensure their needs for assessment, education, and treatment are met.
- **Mandatory Life Sentences Without the Possibility of Parole for Juveniles:** For youths under age eighteen at the time of their offenses, these mandatory sentences violate the Eighth Amendment's ban on cruel and unusual punishment. The Child Advocate urges the Commonwealth to create a sentencing statute that provides fair and individualized sentences for youth under eighteen.

Online Mandated Reporter Training: An online training that meets the legislative requirement should be available to all mandated reporters. The training should be built upon a standardized, state-approved curriculum that educates mandated reporters about their duties to report suspected child abuse and neglect and introduces the principles of trauma-informed care.

Committees, Boards, and Councils

The Child Advocate participates as an *ex officio* member on many boards and councils and OCA staff attend meetings of various groups and initiatives. Involvement with these groups helps to inform and educate staff, so that the OCA can share information and synchronize policy for child welfare and juvenile justice.

Children's Behavioral Health Initiative Advisory Council: The Children's Behavioral Health Initiative (CBHI) is an integrated system of state-funded behavioral health services for children and youth insured by MassHealth. CBHI provides for early periodic screenings, diagnosis and community-based treatment of behavioral, emotional and mental health disturbances. The Child Advocate is a member of the CBHI Advisory Council and of the Child Systems Integration Committee. For information visit: www.mass.gov/masshealth/cbhi.

Children's Trust Fund Board of Directors: The Massachusetts Children's Trust Fund (CTF), a public-private partnership, is a leader in efforts to prevent child abuse and neglect by supporting parents and strengthening families. CTF funds over 100 family support and parenting education programs throughout Massachusetts and offers training and technical assistance to professionals who work with children and families. The Child Advocate is a member of the CTF Board of Directors and serves as Vice Chair of the Governance Committee. For information visit: www.mctf.org.

Children's League of Massachusetts: The Children's League of Massachusetts is a statewide nonprofit association of private and public child and family service organizations. Through public education and advocacy, the Children's League promotes access to quality services for children, youth, and families. Though not a member of the League, The Child Advocate regularly attends meetings and collaborates with League members. For information visit: www.childrensleague.org.

Governor's Child and Youth Readiness Cabinet: In 2008 Governor Patrick signed an executive order establishing the Child and Youth Readiness Cabinet (Readiness Cabinet). The purpose of the Readiness Cabinet is to enhance collaboration across state departments and agencies that serve Massachusetts children, youth and families. The Readiness Cabinet recognizes the many environments in which children develop and is committed to improving the delivery and coordination of state services in all of these environments. The Child Advocate is a designated member of the Readiness Cabinet and supports its efforts to synchronize state policies regarding youth and families. For more information visit: http://www.mass.gov/edu/child-youth-readiness-cabinet.html.

Governor's Council to Address Sexual and Domestic Violence: In 2007 Governor Patrick signed an executive order creating the Governor's Council to Address Sexual and Domestic Violence (GCSDV). Chaired by Lieutenant Governor Timothy Murray, the GCSDV explores strategies for Massachusetts to address sexual and domestic violence, provide services and legal protections for survivors, and ensure that perpetrators are held accountable for their actions. OCA staff regularly attend GCSDV meetings, collaborate with GCSDV members on issues related to children exposed to sexual and domestic violence, and participate as a member of the GCSDV's Children's Committee. For more information visit: http://www.mass.gov/governor/administration/ltgov/lgcommittee/sexualassault/.

Governor's Interagency Council on Housing and Homelessness Advisory Board: In 2007 Governor Patrick signed an executive order reinstating the Governor's Interagency Council on Housing and Homelessness (ICHH). Chaired by Lieutenant Governor Timothy Murray, the ICHH works to implement the recommendations from the Massachusetts Commission to End Homelessness and leads a five year strategic plan to end homelessness in the Commonwealth by 2013. The Child Advocate participates as a member of the ICHH Advisory Board and provides policy recommendations to the ICHH regarding the impact of homelessness on children and families. For more information visit: http://www.mass.gov/governor/administration/ltgov/lgcommittee/housingcouncil/.

Governor's Interagency Council on Substance Abuse and Prevention: In 2008 Governor Patrick signed an executive order reestablishing the Governor's Interagency Council on Substance Abuse and Prevention (ICSAP). Chaired by Lieutenant Governor Timothy Murray, ICSAP works to maximize coordination between DPH and other state agencies regarding substance abuse and prevention. In July 2010 ICSAP submitted an update of the Commonwealth's 2005 Substance Abuse Strategic Plan. Through its participation in ICSAP meetings, OCA staff highlight the impact on children when substance abuse is present in the home, as well as the need for additional substance abuse services for youth. For more information visit: http://www.mass.gov/governor/administration/ltgov/lgcommittee/subabuseprevent/.

Juvenile Detention Alternatives Initiative: The Juvenile Detention Alternatives Initiative (JDAI) is an Annie E. Casey Foundation initiative spearheaded by DYS under the leadership of the Commissioner and the JDAI Statewide Steering Committee. JDAI focuses on safely reducing the numbers of youth charged with delinquency offenses who are held in secure detention prior to adjudication or while awaiting a violation of probation hearing, and on developing a multi-tiered system of detention alternatives and diversion programs that better serve the needs of court-involved youth. The Child Advocate supports this initiative and has spoken at various conferences about the negative consequences of unwarranted detention and the need to develop additional programs as alternatives to secure detention. For more information visit: http://www.mass.gov/eohhs/gov/commissions-and-initiatives/juvenile-detention-alternatives-initiative-jdai.html.

Professional Advisory Committee for Child and Adolescent Mental Health (PAC): PAC was founded in 1978 as a statewide group with representatives from professional, advocacy, trade, and family organizations. PAC's goal is to ensure universal access to quality mental health services for all children and adolescents in Massachusetts. PAC makes recommendations to the Department of Mental Health (DMH) and other child-serving agencies and to the Legislature regarding service quality, best practices, access, system change and design, and public policies that will promote quality behavioral health services for children and adolescents. The Child Advocate and staff attend meetings to discuss the concerns and ideas of this group of advisors.

Special Commission to Study the Commonwealth's Criminal Justice System: The Special Commission to Study the Commonwealth's Criminal Justice System was created by Outside Section 189[30] in the 2012 budget. The commission is tasked with exploring the feasibility of developing an application for technical assistance that would use a data driven approach to reduce corrections spending and utilize the savings to reduce crime, strengthen public safety and fund other budget priorities. The Child Advocate was appointed to the Commission's position reserved for a member with experience in juvenile justice.

Support to End Exploitation Now Coalition: The Support to End Exploitation Now (SEEN) Coalition, an initiative of the Children's Advocacy Center of Suffolk County and the Suffolk County District Attorney's Office, is a collaboration of government and community-based agencies that has developed a multidisciplinary team approach to intervention when children and teens are victims of commercial sexual exploitation. SEEN forges partnerships between stakeholders to provide services to child and teen victims and to support the prosecution of offenders. OCA staff members sit on the SEEN Coalition Steering Committee. The SEEN Coalition was instrumental in drafting and advocating for the Safe Harbor provisions passed as part of House Bill 3808, "An Act Relative to the Commercial Exploitation of People." Safe Harbor provisions redefine commercially sexually exploited youth as children requiring assistance rather than criminals. Massachusetts is one of only 11 states with Safe Harbor legislation and one of only eight whose legislation meets the Polaris Project's criteria for effectiveness. For information visit: www.suffolkcac.org/programs/seen.

Task Force on Youth Aging Out of DCF Care: The Task Force on Youth Aging Out of DCF Care (The Task Force) is a group of private and public representatives working to improve the outcomes of youth transitioning from DCF care. The Task Force's goals are to ensure that these youth have lifelong connections with one or more adults, are fully prepared for education, work and life, and are contributing members of their communities. The Child Advocate is a member of the Legal Working Group, which focuses on improving the quality of juvenile court permanency hearings for transition-aged youth. The Task Force was instrumental in developing and advocating for 2010 legislation that provides youth in state care with legal

rights to continued supportive services after they turn 18. For more information on this legislation visit the OCA's website.[31] For more information on The Task Force visit: www.thehome.org/site/PageServer?pagename=about_advocacy_about.

Task Force on Behavioral Health and the Public Schools: This task force was established in 2008 as part of the Children's Mental Health Legislation. Chaired by the Commissioner of the Department of Elementary and Secondary Education (ESE), the task force developed a behavioral health services framework to improve educational outcomes for students with behavioral health challenges and a tool for statewide assessment of the capacity of schools to collaborate with behavioral health services and provide supportive school environments. The goal of the task force was to create linkages between schools and behavioral health systems in order to reduce suspensions, expulsions, dropout and truancy. As a member of the task force, The Child Advocate and staff attended meetings and contributed to the development of the framework and assessment tool. On June 30, 2011, the final report of the task force was submitted to the Governor, the Child Advocate, and the General Court. This final report detailed the findings of the statewide assessment and recommended a plan for statewide utilization of the framework in order to build the essential state infrastructure to create safe, healthy, and supportive learning environments. The final report is available at: http://www.doe.mass.edu/research/reports/0811behavioralhealth.pdf.

Young Children's Council: The Young Children's Council (YCC) was formed in March 2010 to advise EOHHS, DPH, and the Boston Public Health Commission as they implement two federal grants, MYCHILD and Project LAUNCH. The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration funded the grants to expand early childhood mental health services in Boston, with an emphasis on youth and families who have experienced toxic stress related to child abuse, neglect, domestic violence and homelessness. The Child Advocate is a member of the YCC and values the opportunity to share information pertaining to mental health intervention for children younger than five years of age. For information on these grants visit: www.ecmhmatters.org/Pages/ECMHMatters.aspx.

OCA Administration and Advisory Board

Gail Garinger was appointed by Governor Deval Patrick as the first Child Advocate for the Commonwealth in April 2008. Before her appointment, she served as a juvenile court judge for thirteen years, including eight years as First Justice of the Juvenile Court in Middlesex County. She also served as General Counsel at Children's Hospital Boston. Garinger is assisted in her duties by a staff of three employees with collective experience in social work, nursing, law, and early childhood education. In the spring of 2012 the OCA's part-time clinical specialist left the office and a full-time licensed certified social worker joined our staff. During the last year the OCA has hosted a fellow and interns from universities, law schools, and public policy school. Our appropriation for FY 2012 was $243,564 in a dedicated line-item and has increased to $300,000 for FY 2013. This increase conveys an important acknowledgement of the OCA's work. The amount does not fully support the salaries and benefits for our four full-time employees, and additional expenses for the OCA have been absorbed by the Governor's Office.

The OCA's website underwent several content and layout changes in an effort to provide consumers and professionals with access to timely information and updates on the OCA's activities. The new website includes a page dedicated to the OCA's Helpline, tips for summer-time safety and safe sleep for infants, as well as child welfare and juvenile justice information.

Twenty-three *ex officio* members, including secretaries and commissioners from child-serving agencies and offices, and three governor's appointees sit on the Child Advocate Advisory Board. The appointees include an advocate, a grandparent raising a grandchild, and a former foster youth. The Child Advocate chairs the semi-annual meetings, during which the OCA staff update the Board and elicit their input on OCA activities. Information concerning our Advisory Board and past meetings is available on our website http://www.mass.gov/childadvocate/advisory-board/.

Endnotes

1 See M.G.L. Chapter 119, Section 51B(1).

2 http://www.mass.gov/eohhs/consumer/family-services/child-care-support/interagency-restraint-and-seclusion-prevention.html

3 http://www.publiccounsel.net/Practice_Areas/cafl_pages/civil_cafl_index.html

4 See M.G.L. Chapter 18C, Section 6

5 http://www.mass.gov/edu/birth-grade-12/early-education-and-care/provider-and-program-administration/transportation-policy.html

6 http://jjie.org/juvenile-justice-system-flux-updates-from-john-jay-symposium/82966

7 http://www.lawlib.state.ma.us/source/mass/cmr/cmrtext/101CMR17.pdf

8 Sudden Infant Death Syndrome (SIDS) is a diagnosis that can be made only be a medical examiner after postmortem examination and death scene investigation have ruled out all other causes of death. Sudden Unexpected Infant Death (SUID) is a broader label used to describe the circumstances of infant deaths that are sudden and unexpected.

9 http://pediatrics.aappublications.org/content/128/5/1030.full.pdf+html

10 http://pediatrics.aappublications.org/content/128/5/e1341.full.pdf+html

11 https://www.nichd.nih.gov/sids/

12 http://www.northeastern.edu/law/academics/curriculum/lssc/social-justice.html

13 http://www.mass.gov/childadvocate/docs/nusl-full-report.pdf

14 http://www.gpo.gov/fdsys/pkg/BILLS-110hr6893enr/pdf/BILLS-110hr6893enr.pdf

15 Child and Family Services Improvement and Innovation Act of 2011 Sec. 101(b)(2): www.govtrack.us/congress/bills/112/hr2883/text

16 http://www.childwelfare.gov/systemwide/mentalhealth/effectiveness/jointlettermeds.pdf

17 http://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf

18 Mass. Gen. Laws. Ch. 119, Sec. 23(f).

19 http://www.publiccounsel.net/Practice_Areas/yap%20pdf/juvenile_delinquency_youthful_offender_(trial_level).pdf

20 http://www.publiccounsel.net/Practice_Areas/cafl_pages/performance_standards_for_cafl_attorney.html

21 http://www.mass.gov/courts/courtsandjudges/courts/juvenilecourt/uniform-practice-proc-appt-court-investigators.pdf

22 http://www.mass.gov/childadvocate/news/ca-position-on-age-of-juvenile-court-jurisdiction.html

23 http://www.mass.gov/childadvocate/docs/annual-report2009.pdf

24 http://www.mass.gov/childadvocate/news/the-child-advocates-position-on-juvenile-life-without-.html

25 *Miller v. Alabama,* 132 S. Ct. 2455 (2012). http://www.supremecourt.gov/opinions/11pdf/10-9646.pdf

26 http://www.mass.gov/governor/pressoffice/pressreleases/2011/safe-and-successful-youth-initiative-launched.html

27 http://hhs.blog.state.ma.us/blog/2012/02/commonwealths-safe-and-successful-youth-initiative-advances-with-powerful-public-service-message-by-assistant-secretary-f.html

28 http://www.mass.gov/eohhs/consumer/family-services/child-care-support/interagency-restraint-and-seclusion-prevention.html

29 http://www.mass.gov/eohhs/docs/eohhs/childservices/final-report-011012.doc

30 http://www.mass.gov/bb/gaa/fy2012/os_12/h189.htm

31 http://www.mass.gov/childadvocate/news/legislation-provides-additional-opportunities-and-servi.html

Appendix A: Helpline Issues

Helpline Category	Specific issue/concern
Accessing Services	• Denial of services • Voluntary services request • Eligibility criteria for state agencies • Coordinating multi-agency involvement • Difficulty accessing services for children with complex needs
Case Management	• Treatment/service plan • Caseworker not meeting visitation requirements • Decisions made by caseworker and agency staff
Placement & Permanency	• Placement of child (facility, foster home, or relative) • Rolling trials • Visitation • Multiple placements • Restraints in facilities • Length of time in foster care/placement • Premature reunification • Permanency plans • Kinship placement rights • Adoption and legal risk situation • Transition plan for youth aging out of care
Policies & Timeframes	• Becoming a placement resource • Where to direct questions and concerns • Client/DCF communication and expectations • Confidentiality and information sharing • DCF processes
Education	• Bullying • Advocacy for special education services • Cost shares for out-of-home placements • Restraints and discipline policies in school settings • Accessing Department of Education Problem Resolution System and Bureau of Special Education Appeals • Educational continuity for foster youth
Legal	• Role and responsibilities of child's attorney • Children, youth, and adults seeking an attorney • Custody issues • Probate & Family Court • Questioning fairness of court orders • Seeking an advocate (educational, mental health, medical) • Lack of criminal prosecution • Filing a grievance regarding a judge

Appendix B: Critical Incident Reports

The Child Advocate and the OCA staff are aware of the sensitive nature of the information they receive and their responsibility to maintain its confidentiality. The OCA also is responsible for reporting annually to the Governor, legislative leaders, and the public on the activities of our office. In addition, Massachusetts has a duty under the federal Child Abuse Prevention and Treatment Act to disclose to the public information about child abuse or neglect resulting in a child fatality or near fatality. By providing the information below, the OCA seeks to balance confidentiality with its duty of annual reporting and the duty to disclose the deaths and near deaths of children from abuse and neglect.

Since the publication of the OCA FY 2011 Annual Report, which reported on calendar year 2010 critical incidents, the OCA received 19 critical incident reports from DCF concerning children who were injured or killed during 2010. A revised account of critical incident reports, fatalities, and injuries from 2010 is included in this appendix.

2011 Data

The OCA received 123 critical incident reports concerning 117 incidents that occurred in calendar year 2011. The following agencies filed the corresponding number of reports:

Department of Children and Families:	75
Department of Developmental Services:	1
Department of Mental Health:	5
Department of Public Health:	5
Department of Transitional Assistance:	1
Department of Youth Services:	31
MassHealth:	1
Office of Behavioral Health:	3
Office of Long Term Services and Support:	1

The OCA received two additional critical incident reports in 2011 from DPH concerning incidents that occurred in 2008 and 2009, but were not disclosed and reported to the agency until 2011. These incidents are described under the “Additional Reports” paragraph below.

Fatalities

Forty-one critical incident reports documented 40 deaths that occurred in 2011 of children and youths involved with EOHHS agencies. After reviewing critical incident reports, the OCA gathers more information in selected fatalities. If the agency conducted an investigation, OCA staff reviewed the resulting report. When possible, OCA staff attended local child fatality review team meetings to learn more about the involvement of agencies, law enforcement, courts, schools, and health care providers in the lives of the children who died.

Injury-related deaths occurred in 17 children and youths aged 19 months to 20 years; 12 of the 17 were male and 5 were female. Causes of death include motor vehicle accidents, homicide, suicide, and drowning. When both the OCA and law enforcement conduct an investigation into a child's death, OCA staff coordinate their work with the local District Attorney's Office.

- Five youths died from gunshot wounds while in the community. These included 4 males, ages 17, 17, 19, and 20 years; and 1 female, age 16 years.
- Seven youths died from suicide: 4 from hanging, 1 from a fall from height, 1 from a gunshot wound, and 1 from prescription drug toxicity. These included 5 males, ages 11, 14, 16, 16, and 17 years; and 2 females, ages 15 and 19 years.
- A 16-year-old male driver died in an automobile wreck.
- A 16-year-old female passenger died in an automobile wreck.
- An 8-year-old male died from intentional carbon monoxide poisoning while in the care of his family.
- A 7-year-old male accidentally drowned in a bathtub while in the care of his family.
- A 19-month-old female died from abusive head trauma while in the care of her family.

A concerning number of agency-involved children and youth die from injuries. Between 2005 and 2008, the most recent years for which statewide data has been published, 14-18% of fatalities of children and youth in Massachusetts were caused by injuries each year.[i] In the deaths reported by agencies to the OCA, 42% of children and youth died from injuries in 2011, and 47% in 2010. Based on this observation, the OCA is partnering with DPH to further compare OCA data with statewide child fatality data for Massachusetts.

[i] Massachusetts Child Fatality Review Program, Fifth Annual Report on Program Activity 2005 (2009); Report of Program Activity 2006-2008 (2011).

Deaths due to medical conditions occurred in 11 infants, children, and youths.

- A 9-year-old female died from a chronic cardiac condition.
- A 9-year-old female died from a seizure disorder.
- An 8-year-old female died from complications of chronic medical conditions.
- A 7-year-old female died from a metabolic disorder.
- A 5-year-old female died from a cardiac arrhythmia.
- A 3-year-old female died from respiratory complications of a congenital disorder.
- A 10-month-old female died from complications of a congenital condition.
- A 5-month-old male died from complications of prematurity.
- A 4-month-old male died from complications of chronic medical conditions.
- A 4-month-old male died from complications of a dermatologic disease.
- A newborn male died at 6 days from complications of pregnancy and delivery.

Twelve sudden and unexpected infant and toddler deaths ("SUID") were reported in 2011. Ten of these deaths occurred in settings of unsafe sleep positions or environments.

- Four females died while sleeping in a bed with an adult. Their ages were 8 months, 5 months, 2 months, and 2 months.
- A 2-year-old male with a history of febrile seizures died while sleeping in an adult bed.
- An 8-month old male died while sleeping with an adult and a sibling in a recliner.
- A 6-month-old female died while sleeping with her siblings in an adult bed.
- A 6-month-old male died while sleeping in his crib.
- A 5-month-old female died while sleeping in an infant seat.
- A 3-month-old male died while sleeping in the prone position on a pillow in his crib.
- A 2-month-old male died while sleeping in the prone position in an adult bed.
- A 2-month-old male died while sleeping in the prone position in his bassinet.

A concerning number of agency-involved child fatalities are SUID deaths. Between 40 and 60 infants and toddlers die each year across the state of Massachusetts in circumstances described as sudden and unexpected. Yet 12 of these 40-60 SUID deaths occurred in agency-involved children in 2011 and 10 SUID deaths of agency-involved children occurred in 2010. Based on this observation, the OCA is partnering with DPH to further compare OCA data with statewide child fatality data for Massachusetts.

Near Fatalities

The OCA received 25 critical incident reports concerning 24 near fatalities of children and youths involved with EOHHS agencies. The OCA defines a near fatality as an event that places a child in critical or serious condition. Because of the imminent risk of death involved, we include all wounds from dangerous weapons and suicide attempts in this definition. The OCA is working with involved agencies to understand each agency's response to near fatalities, and to coordinate our work with that of the agency. For children receiving services from DCF, the OCA obtains and reviews relevant records and in selected cases, meets with DCF managers at area offices to review case practice. The causes of the near fatalities reported to the OCA were gunshot and knife wounds in adolescents, suicide attempts by youth, physical abuse of young children by caretakers, and other injuries as described below.

- Eight youths, ages 16 through 20 years, were victims of gunshot wounds while in their communities. These included 7 males and 1 female.
- Seven youths, ages 15 through 20 years, were victims of assaults with knives. These included 6 males and 1 female.
- Two youths attempted suicide. A 17- year-old male ingested poison and an 18-year-old male attempted to hang himself.
- A 16-year-old male pedestrian was intentionally struck by a motor vehicle.
- A 9-year-old male became entangled in a rope and suffered an accidental near-hanging.
- Three young children, ages 7 months through 5 years, suffered abusive head trauma and other injuries at the hands of their caretakers. Two of these children were male and 1 was female.
- A 20-month-old female suffered a fall from a second-story window.
- A 1-month-old male suffered a near-drowning in a bathtub with an adult.

Injuries

The OCA received 19 critical incident reports concerning injuries to 20 children and youths involved with EOHHS agencies. In these matters, OCA staff followed up with agencies and reviewed relevant investigation reports.

- Two male youths, both 18, were injured during a disturbance instigated by another resident at a treatment program.
- Two 17-year-old youths, 1 male and 1 female, were struck by motor vehicles while walking or while riding a bicycle.
- Two females, ages 15 and 17, disclosed sexual assaults by caretakers in residential settings.
- A 15-year-old female disclosed a sexual assault by another patient in a hospital setting.
- An 8-year-old male was bitten by a dog and suffered soft tissue injuries.
- Eleven infants and children up to 7 years of age suffered injuries at the hands of their caretakers. Seven were male and 4 were female.
- A 5-month-old male was injured after falling from a couch.

Additional Reports

The OCA received an additional 38 critical incident reports concerning 37 incidents. These incidents occurred in 2011, with the exception of 2 reports described in the next paragraph. Many of these reports described fatalities, near fatalities, and injuries of children ***not*** involved with EOHHS agencies. Other reports documented injuries and violent behavior in community settings allegedly caused by youths involved with EOHHS agencies, a disturbance in a correctional setting for youth, fires in two residential programs, runaway youths, and incidents covered by the media which were later determined not to involve children receiving services from EOHHS agencies.

On two occasions, the OCA received information that youths formerly involved with EOHHS agencies had allegedly committed homicides in the community. The OCA reviewed available records and connected with agency personnel to learn about the services provided to these youths and their families and to identify areas for system improvement.

Two reports filed by DPH documented delayed disclosures in 2011 of sexual contact within hospital settings. One situation involved contact between a female patient and a male volunteer in 2008, and another involved a reportedly consensual sexual relationship between a male and female patient in 2009. Both incidents were investigated by law enforcement.

Revised 2010 Data

The OCA received 107 critical incident reports concerning 104 incidents that occurred in calendar year 2010. Eighty-eight of these critical incident reports were described in the FY 2011 OCA Annual Report.[ii] In 2012, the OCA received an additional 19 critical incident reports from DCF concerning children who were injured or died during 2010. The OCA is providing a revised account of critical incident reports, fatalities, and injuries from 2010. The following agencies filed the corresponding number of reports:

Commission for the Blind:	2
Department of Children and Families:	56
Department of Mental Health:	8
Department of Public Health:	2
Department of Transitional Assistance:	1
Department of Youth Services:	36
Office of Behavioral Health:	2

Fatalities

Thirty-six critical incident reports documented deaths that occurred in 2010 of children and youths involved with EOHHS agencies. After reviewing critical incident reports, the OCA gathers more information in selected fatalities. If the agency conducted an investigation, OCA staff review the resulting report. When possible, OCA staff attend local child fatality review team meetings to learn more about the involvement of agencies, courts, schools, and health care providers in the lives of the children who died.

Injury-related deaths accounted for 17 deaths of children and youths aged 6 weeks to 20 years; all were male. Causes of death include motor vehicle accidents, drowning, opioid poisoning, homicide, and suicide. When both the OCA and law enforcement conduct an investigation into a child's death, OCA staff coordinate their work through the District Attorney's Office.

- Three males died from suicide or apparent suicide. An 18-year-old and a 20-year-old died from hanging. An 18-year-old died after ingesting opiates.
- A 17-year-old male pedestrian died after he was struck by an automobile.
- A 16-year-old male passenger died in an automobile wreck.
- A 15-year-old male died while swimming in a pond.
- Two males, ages 15 years and 17 years, died from stab wounds.
- Five males, ages 1 year, 16 years, 17 years, 17 years, and 19 years, died from gunshot wounds.
- Four very young male children, ages 6 weeks to 2 years, died from abusive head trauma and other traumatic injuries while in the care of their families.

[ii] The FY 2011 Annual Report documents 89 critical incident reports in Appendix B; one of these reports concerned a child's death that occurred in December 2009 but was reported in 2010. That report is not included in the 88 reports describing incidents that occurred in 2010.

Nine deaths were due to medical conditions.

- A 15-year-old female died from complications of chronic and severe disabilities.
- A 15-year-old male died from complications of chronic and severe disabilities.
- A 13-year-old female died from complications of a seizure disorder.
- A 10-year-old boy died unexpectedly after collapsing while playing sports.
- A 7-year-old female with a chronic cardiac condition died after an invasive medical procedure.
- A 20-month-old female died after living in a minimally conscious state.
- A 9-day-old female infant died from a rare metabolic condition.
- A 6-day-old male infant died from complications related to a virus.
- A 4-day-old male infant died from a chromosomal disorder.

Ten sudden and unexplained infant deaths occurred in 2010.

- A 17-month-old female died while sleeping in the prone position in bed with an adult.
- A 7-month-old female died while sleeping in the prone position in her crib.
- A 4-month-old male died while sleeping in bed with an adult.
- A 3-month-old male died while sleeping in the prone position in his crib.
- A 3-month-old male died while sleeping in the prone position in his crib with his twin.
- A 3-month-old male died while sleeping in his crib.
- A 9-week-old female died while sleeping in the prone position in a bassinet.
- A 7-week-old male died while sleeping in bed with an adult.
- A 3-week-old male died while sleeping in an adult bed.
- A 3-week-old male died from oxygen deprivation to the brain after being found unconscious and unresponsive in a baby swing.

Near Fatalities

The OCA received 23 critical incident reports regarding near fatalities of 21 children and youths involved with EOHHS agencies. The OCA defines a near fatality as an event that places a child in critical or serious condition. Because of the imminent risk of death involved, we include all wounds from dangerous weapons and suicide attempts in this definition. The OCA is working with involved agencies to understand each agency's response to near fatalities, and to coordinate our work with that of the agency. For children receiving services from DCF, the OCA obtains and reviews relevant records and in selected cases, meets with DCF managers at area offices to review case practice. The causes of the near fatalities reported to the OCA were gunshot and knife wounds in adolescents, suicide attempts by youths, physical abuse of young children by caretakers, and other injuries as described below.

- Ten youths – 9 males, ages 14 through 20 years; and 1 female, age 15 years, were victims of gunshot wounds while in their communities.
- One male, age 18 years, was stabbed during a robbery.
- Two 16-year-old youths, a male and a female, attempted suicide while in treatment facilities.
- One male, age 13 years, was struck by a motor vehicle as a pedestrian.
- Seven young children, ages 8 months through 2 years, suffered inflicted injuries such as abusive head trauma or abdominal trauma at the hands of their caretakers. Three of these children were male and 4 were female.

Injuries

The OCA received 9 critical incident reports concerning injuries of youths involved with EOHHS agencies. In these matters, OCA staff followed up with agencies and reviewed relevant investigation reports.

- An 18-year-old male assaulted another 18-year-old male in an inpatient setting, causing a head wound.
- An 18-year-old female at a residential program injured herself by purposefully ingesting objects.
- An 18-year-old male received second-degree burns after another youth threw hot food on him in a facility.
- Two reports concerned allegations of sexual assaults committed by youths on other youths, ages 15 and 18 years, in residential or inpatient settings. These were investigated by agencies and law enforcement.
- A 16-year-old male sustained internal injuries while in a residential program after he was struck by another resident.
- A 7-year-old female was injured as a patient while being transferred by an attendant.
- Two reports concerned young male children injured at the hands of their parents or caretakers in their homes. A 2-year-old suffered burns and a 2-month-old suffered rib fractures.

Additional Reports

The OCA received an additional 39 critical incident reports regarding 38 incidents. These incidents include fatalities, near fatalities, and injuries of children ***not*** involved with EOHHS agencies; other reports documented violence in community settings caused by youths involved with EOHHS agencies, disturbances in treatment and transportation settings for youth, runaway youths, and concerns regarding staff and staff safety.

Appendix C: DPH Policy Recommendations for Safe Infant Sleep Practices

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

Policy Recommendation: Safe Infant Sleep Practices

May 2012

Each year, approximately 40-60 Massachusetts infants die due to sudden unexpected infant death. Reviews of these deaths by local Massachusetts child fatality review teams indicate that many of these deaths occurred in sleep positions and environments that are considered unsafe. The Massachusetts Department of Public Health (MDPH) makes the following recommendation related to sleep position, environment and practices, to help reduce the number of these preventable infant deaths. This policy recommendation is based on evidence-based best safe sleep practices for infants less than 12 months of age.

Safe Sleep Policy Recommendation

The safest place for an infant to sleep is on his or her back, in the same room with a parent or caregiver, and in a separate sleep space, such as a safety-approved crib or bassinet.

Recommended Sleep Position

The MDPH recommends that:

- Infants are placed on their backs to sleep for naps and at night. Substantial research demonstrates that this reduces the risks of Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death (SUID).
- Parents and caregivers tell relatives, friends, babysitters and childcare providers that the infant should be placed on his/her back to sleep at all times.
- Infants are given time on their tummies (tummy-time), while awake and supervised by a responsible adult, to promote the infant building head control as well as neck, shoulder and arm strength.

Recommended Sleep Environment

The MDPH recommends that:

- Infants are placed to sleep on their backs in safety approved cribs or bassinets with firm mattresses using well-fitting sheets made for the crib or bassinet.
- Infants are placed to sleep in the same room with a parent or caregiver but on a separate sleep surface. Being in the same room allows parents to check on and bond with their infant and supports breastfeeding. Placing infants on a separate sleep surface reduces the risk of suffocation or an adult or child rolling over on the infant while sleeping in the same space.
- Parents maintain the home and infant sleep environment free of tobacco smoke, including cigarettes and cigars.
- Infants are dressed in a sleeper or a sleep sack to avoid over-bundling and overheating.

- Infants' sleep environments are free of the following items to reduce the risk of suffocation or strangulation:
    1 soft mattresses or cushions;
    2 blankets or comforters, pillows or other soft bedding items;
    3 bumper pads;
    4 wedges or positioning devices;
    5 stuffed animals or toys;
    6 plastic sheets or plastic bags; and
    7 strings, cords, or ropes.

Additional Healthy Habits for Safe Sleep

The MDPH recommends that:

- Parents look for safety information on cribs, bassinets, and other related items found in an infant sleep environment such as bedding.
- Parents do not place an infant to sleep, or leave an infant sleeping unsupervised, in a car seat, stroller or baby swing.
- Parents do not place the infant's crib near the furnace, space heater, or any other heat source.

Bed Sharing Dangers

MDPH recommends that infants are put to sleep on their backs, in their own crib, bassinet or pack and play. **The adult bed is not a safe setting for an infant to sleep, with or without another person. There are circumstances in which bed sharing is particularly hazardous**. Bedsharing is especially dangerous when:

- The infant is younger than 3 months of age;
- One or both parents smoke;
- The infant is placed to sleep with soft bedding such as pillows, blankets, quilts, sheepskins and comforters;
- The infant is placed on soft surfaces, such as a sofa, futon, cushioned chair, recliner, or water bed;
- The parent is using medications that cause drowsiness;
- The parent is using any amount of alcohol or drugs (prescription or illicit);
- The parent is sick or unusually tired; or
- There are multiple bedsharers, including siblings or pets.

Note Regarding Breastfeeding

As part of a comprehensive SIDS/SUID prevention strategy, MDPH strongly supports breastfeeding and encourages mothers to sleep in close proximity to, but in a separate space from, their infants, regardless of feeding status. Breastfeeding is often cited as a reason mothers bedshare, and some data suggests that bedsharing is associated with longer duration of breastfeeding. However, bedsharing is not essential for successful breastfeeding. Mothers may breastfeed their infants in bed, but infants should be placed on their backs in their own crib, bassinet, or other separate sleep space after breastfeeding.

MDPH Safe Infant Sleep Policy Resources:

- American Academy of Pediatrics (AAP) Task Force on Sudden Infant Death Syndrome. SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment; *Pediatrics* 2011; 128: 1030-39.
- American Academy of Pediatrics (AAP) Task Force on Sudden Infant Death Syndrome. Technical Report: SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment; *Pediatrics* 2011; 128: e1-e27.
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