

Office of the Child Advocate Annual Report Fiscal Year 2014



The Commonwealth of Massachusetts

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.

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The Child Advocate

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Fall 2013
Fall 2012 - Summer 2014
Summer 2014

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Our Partners in the Executive Agencies

CBHI	Children's Behavioral Health Initiative
DCF	Department of Children and Families
DDS	Department of Developmental Services
DEEC	Department of Early Education and Care
DESE	Department of Elementary and Secondary Education
DMH	Department of Mental Health
DPH	Department of Public Health
DYS	Department of Youth Services
EOHHS	Executive Office of Health and Human Services

Letter from The Child Advocate



December 2014

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

I am pleased to submit the Annual Report of the Office of the Child Advocate (OCA) for Fiscal Year 2014, the sixth annual report from the OCA, covering the activities of our office and offering recommendations for your consideration. Since the OCA's establishment by Governor Patrick in December 2007 and statutory authorization in July 2008, the OCA has worked diligently to improve services for children and families served by the Commonwealth's child welfare and juvenile justice agencies.

The events of the last year have focused public attention on the Department of Children and Families (DCF) and the need for additional resources to strengthen our child welfare system. The OCA played a central role in the Commonwealth's response to two critical incidents involving children receiving services from DCF during the last year. While the OCA reports publicly on a small number of tragedies, each year the OCA investigates many more critical incidents concerning children receiving services from the Commonwealth. The OCA works with DCF and other child-serving agencies to learn from these critical incidents and to promote accountability and improve policies and practices to reduce risk to other children.

The OCA is an independent office charged with encouraging collaboration among agencies and systems and providing a high level of government oversight and accountability for the state's child-serving agencies. The OCA has grown in size and stature over the last six years. I had just begun my tenure as The Child Advocate when the economic recession began. As the OCA established its mission and values, we did so with a staff of four and a long list of statutory obligations. This year the Legislature significantly increased our funding and tasked the OCA with two projects relating to DCF administration and management. The OCA is responsible for

conducting an emergency review of the management of DCF and evaluating DCF's Fair Hearing process. Our Fiscal Year 2015 budget will enable us to enlarge our staff from four to six persons, to develop new initiatives, and to carry out these important projects mandated by the Legislature.

I am honored to serve as The Child Advocate and I am grateful for my dedicated staff. I look forward to continuing to work together with the Governor, the Legislature, and all of you in the coming year to improve the lives of children and families in the Commonwealth.

Sincerely,

A handwritten signature in black ink, reading "Gail Garinger". The signature is fluid and cursive, with the first name "Gail" and last name "Garinger" clearly distinguishable.

Gail Garinger

The Child Advocate

"The future we hold in trust for our own children will be shaped by our fairness to other people's children." Marian Wright Edelman

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 strengthen 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.



Helpline

The OCA responds to calls on the Helpline about services provided to children and youth in Massachusetts by state agencies. 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 can call or write 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 2013 the majority of contacts were related to children involved with DCF. Many callers were also involved with the probate and family court or juvenile court. 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. To improve our services, OCA staff met with [Parent/Professional Advocacy League \(PPAL\)](#)¹ and [Federation for Children with Special Needs \(FCSN\)](#)² to collaborate and share information. PPAL is a statewide organization that advocates for improved access to mental health services for children and their families. FCSN is a resource that provides information, assistance and support to parents of children with disabilities.

The OCA maintains a confidential database of concerns from the Helpline and analyzes the information to improve our understanding of child welfare and juvenile justice systems. The Helpline informs our interagency and policy work and assists the OCA to identify priorities. The following page provides further detail regarding the concerns we hear through the Helpline.

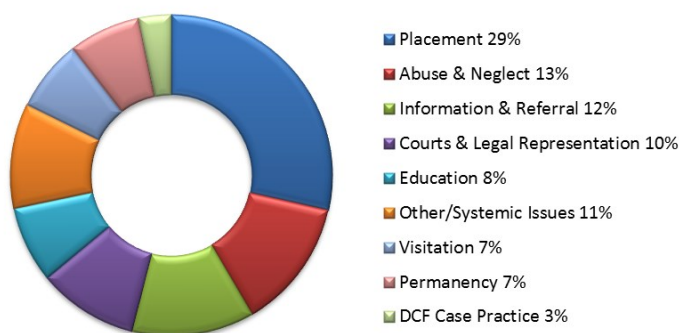
Reach our Helpline by phone, email, or mail.

Phone: 617-979-8360 or toll-free 1-866-790-3690

Email: childadvocate@state.ma.us

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

Helpline Concerns



Helpline Concerns

Placement

- Multiple placements
- Kinship placement rights
- Appropriateness of placement

Abuse & Neglect

- Filing a report (51A)
- DCF's response to a report (51A)
- Restraints in residential and group home facilities
- Maltreatment in schools
- Mandated reporters failing to report

Information & Referral

- Where to direct questions and concerns
- Registering a complaint with DCF
- Eligibility criteria to receive state services
- Becoming a kinship placement

Courts & Legal Representation

- Probate & Family
- Rolling trials
- Contested custody issues
- Grandparent and kin custody and visitation rights
- Court rulings
- Infrequent contact between attorney and client
- Ineffective legal representation
- Role of attorney and GAL
- Obtaining an attorney or GAL

Education

- Advocacy for special education services
- Bullying
- Restraints and discipline policies in schools
- IEP questions and process

Other/Systemic Issues

- Denial of services
- Coordinating multi-agency involvement
- Confidentiality and information sharing
- Cost shares for out-of-home placements
- Difficulty accessing services for children with complex needs
- Roger's Process
- Lack of professionalism
- Insurance limitations
- Overuse of psychoactive medication in foster care and treatment facilities

Visitation

- Grandparent visitation rights
- Appropriateness of visitation plan
- DCF caseworker not meeting home visiting requirements

Permanency

- Length of time in out-of-home placement
- Premature reunification
- DCF goal changes
- Delay of achieving permanency
- Adoption and guardianship
- Legal risk situation
- Transition plan for youth aging out of care

DCF Case Practice

- Decisions made by caseworker and agency staff
- Client/DCF communication and expectations
- Lack of agency responsiveness

How We Help

Sarah, a licensed foster parent, contacted the OCA regarding her three-year-old foster child Emma. DCF placed Emma with Sarah and her husband Kent when Emma was a newborn. Emma was born addicted to opiates and removed from her parents' care due to their long history of substance abuse and instability. DCF offered Emma's birth parents services to treat their substance abuse and parenting issues, but they relapsed several times and had not engaged with their DCF caseworker or the services offered in the last six months. After the most recent foster care review, Emma's goal for a permanent home was changed from reunification with her parents to adoption. As part of the process, the DCF attorney filed notification with the juvenile court seeking to terminate parental rights.

Sarah and Kent wish to adopt Emma and up until now believed they would be able to do so if the court freed Emma for adoption. However, two weeks ago Emma's Aunt Rosemary contacted DCF to express interest in adopting Emma. Rosemary told the ongoing DCF caseworker that she was estranged from Emma's mother and only recently learned about Emma's birth and placement in foster care. The DCF caseworker and supervisor have decided to assess Rosemary as a possible home for Emma and to begin supervised visits. The DCF caseworker told Sarah that relatives must be considered for placement by law. Sarah reports feeling fearful that Emma may be removed from her home -- the only home Emma has ever known --and placed with Rosemary.

OCA staff first listened to Sarah's concerns then helped her understand that The Child Advocate cannot interfere in juvenile court cases, nor can OCA staff substitute their judgment for that of a judge or a DCF caseworker. We then identified with Sarah the best people to contact regarding her concerns, such as Emma's court-appointed attorney. The OCA cannot provide legal advice, and we suggested to Sarah that she might want to consult an attorney regarding her legal rights. We talked Sarah through the process of bringing her concerns up the chain of command within DCF and provided Sarah with contact information for the DCF Ombudsman's office. The Ombudsman staff assist people involved with DCF, have access to DCF case records, and talk directly with DCF staff. The DCF Ombudsman's Office can be reached at (617) 748-2444. We invited Sarah to keep in touch with the OCA and let us know how things were unfolding for her family and for Emma.

Federal child welfare policy requires state child protective agencies like DCF to try to find family members and place children with kin when possible. Situations like Emma's are difficult for everyone involved. DCF should improve their efforts to locate family members and place children with kin as soon as possible, so that DCF pre-adoptive parents are reserved for situations where no relatives can care for a child.

Website

The OCA website provides consumers and professionals with access to timely information and updates on the OCA's activities. The website includes a page dedicated to the OCA's Helpline, tips for summertime safety, safe sleep for infants, and child welfare and juvenile justice information. <http://www.mass.gov/childadvocate/>.

Mass.Gov

State Offices & Courts | State A-Z Topics | State Forms

No Active Alerts

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Office of the Child Advocate

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About the OCA

Responsibilities

Helpline

Reports

OCA Advisory Board

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Initiatives

Examination of the Rogers Process

Restraints and Seclusion

Child Fatality Review Program

Key Resources

Children's Trust

Department of Children and Families

Department of Youth Services

Department of Mental Health

Juvenile Court

Department of Developmental Services

Department of Public Health

Department of Transitional Assistance

Executive Office of Education

Probate and Family Court



Children's Behavioral Health Initiative

Welcome to the Office of the Child Advocate (OCA)

The goal of the OCA is to ensure that every child involved with state agencies in Massachusetts is protected from harm and receives quality services. We are here to listen to the problems you encounter and identify resources and strategies that can help. We also work with legislators, social workers, doctors, administrators, and other professionals to improve services to children and families.

We invite you to explore this website to learn more about the [responsibilities of the OCA](#). You can [contact us](#) to share your concerns or to give us feedback about your experience.



Make Your Home a SAFE HOME for Your Child

Parents can prevent injuries to their children by carrying out a home safety evaluation and putting child safety measures into place.

1 2 3 4

Learn More »

OCA Releases Statement Concerning the Death of Chase Gideika

The Office of the Child Advocate (OCA) received a Critical Incident Report on July 8, 2013, regarding the death of three-month-old Chase Gideika. Secretary John Polanowicz of the Executive Office of Health and Human Services (EOHHS) requested that the OCA conduct an independent investigation into DCF's work with Chase Gideika's family. This investigation included extensive document review and interviews with agency, union, and law enforcement personnel. The OCA has completed its investigation and has discussed its findings and recommendations with Secretary Polanowicz. A statement summarizing the OCA's observations and recommendations is available below.

GideikaStatement

Gail Garinger

The Child Advocate

Meet The Child Advocate

News & Updates

Pool Safely Releases New Infographic on Child Drowning

Summertime Safety Tips Reminder Issued

New Models for Transition Planning in Massachusetts

CPSC Calls for All Children to Learn to Swim in 2014

Report Concerning Jeremiah Oliver

See All

Hot Topics

OCA Releases Annual Report FY 2013

DPH Report: Infant & Early Childhood Injury

Supports in Response to Traumatic Community Events

A Guide on Psychotropic Meds for Youth in Foster Care

Trauma Experienced by Children: Implications for...

See All

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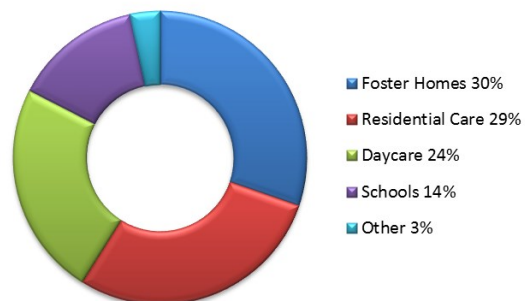
Reports of Abuse and Neglect in Out-of-Home Settings

The OCA receives reports that have been investigated and supported by DCF regarding abuse and neglect (51A reports) of children and youth in out-of-home settings. These settings include foster homes, residential treatment programs, licensed and unlicensed preschool and day care, elementary and secondary schools, and transportation services. OCA staff analyze and discuss each report and obtain more information in selected cases. We provide feedback to the agencies about concerning issues and trends. On the basis of our reviews, in CY 2013 OCA staff connected with:

- DCF concerning trends within foster homes and decisions regarding specific foster homes.
- DCF concerning staffing and programmatic issues in residential treatment programs.
- DCF and DEEC regarding issues that arise with families who provide both foster care and family day care.
- DEEC to review relevant licensing reports of licensed preschool and day care programs.
- DESE to establish communication concerning serious injuries and fatalities of children in public schools.
- DPH to learn about their substance abuse programs and policies for youth.
- Provider agencies to learn about improvements in their services to children.

Our reviews of these 51A reports inform our participation in the [Interagency Restraint and Seclusion Prevention Initiative](#)³ as well as our partnership with the [Committee for Public Counsel Services](#)⁴ to examine the performance of counsel for children in state custody. Review of these reports has impressed upon The Child Advocate and the OCA staff the importance of screening, training, and supervising our child-serving workforce and adopting a trauma-informed approach to care. In the fall of 2011, Massachusetts was awarded a five-year federal grant resulting in the [Massachusetts Child Trauma Project](#)⁵ (MCTP). MCTP is a statewide initiative to enhance the capacity of child welfare workers and child mental health providers to identify, respond, and intervene early and effectively with children traumatized by chronic loss, abuse, neglect, and violence. In June 2014 the Children and Youth Services Review published an [update](#)⁶ on Massachusetts efforts to implement this project.

Settings of Reports Reviewed in 2013



CY 2012 Supported Allegations

■ Neglect (348) ■ Physical Abuse (71) ■ Sexual Abuse (46)

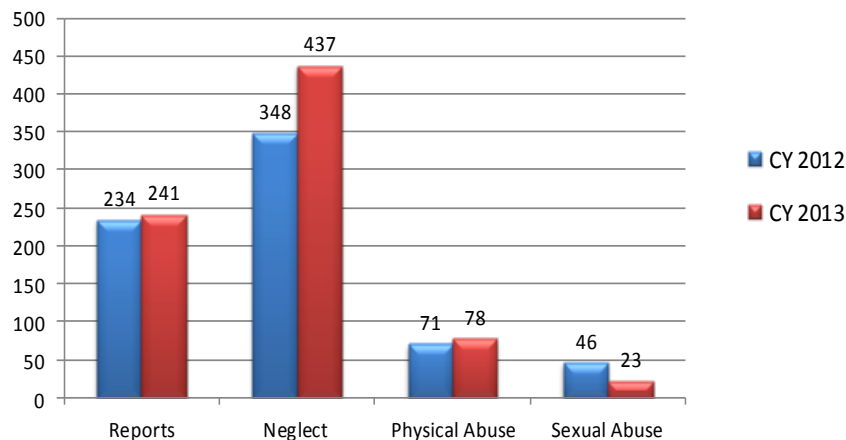


CY 2013 Supported Allegations

■ Neglect (437) ■ Physical Abuse (78) ■ Sexual Abuse (23)



Reports of Supported Allegations for CY 2012 & 2013



Depending on the circumstances, one 51A report may involve multiple allegations of abuse or neglect, multiple alleged perpetrators, or multiple children named as victims. Therefore, there can be multiple supported allegations in one DCF investigation of abuse or neglect. The OCA continues to modify our database to better analyze information and identify trends. In CY 2013, the OCA expanded our data analysis and examined the type and frequency of individually supported allegations. In CY 2013 the OCA reviewed 241 reports of abuse or neglect supporting 538 individual allegations of maltreatment. The OCA reexamined our CY 2012 data to compare information on the type and frequency of individually supported allegations. In CY 2012 the OCA reviewed 234 reports of abuse or neglect supporting 465 individual allegations of maltreatment.

Brain Building: Early experiences affect the development of brain architecture, which provides the foundation for all future learning, behavior, and health. A major ingredient in this developmental process is the "serve and return" interaction between children and their caregivers. In the absence of responsive caregiving, or if responses are unreliable or inappropriate, the brain's architecture does not form as expected, which can lead to disparities in learning and behavior. The emotional and physical health, social skills, and cognitive capacities that emerge in the early years are all important for success in school, the workplace, and in the larger community. Just as a weak foundation compromises the quality and strength of a house, adverse experiences early in life can impair brain architecture with negative effects lasting into adulthood. www.developingchild.harvard.edu

Effects of Child Maltreatment: All types of maltreatment can affect a child's emotional and psychological well-being and lead to behavior problems. While there is no single set of behaviors that is characteristic of all children who have been abused, the presence of emotional and psychological problems can include: low self-esteem, depression, anxiety, post-traumatic stress disorder (PTSD), attachment difficulties, eating disorders, poor peer relations, and self-injurious behaviors. Maltreated children may experience difficulties in understanding the emotions of others, regulating their own emotions, and in forming and maintaining relationships. www.childwelfare.gov

Children Are Resilient: Children are resilient, and being able to discuss and guide our children through a recovery process is crucial to their success. It is often the first step toward healing. Once safety is assured, children can overcome the effects of trauma through professional counseling and other supportive interventions. <http://www.joyfulheartfoundation.org/>

Importance of Caring Adults: Children who have experienced abuse need caring adults in their lives to help them recognize it's not their fault, to provide support, and to help them grow into healthy adults. www.ovc.gov



Critical Incident Reports

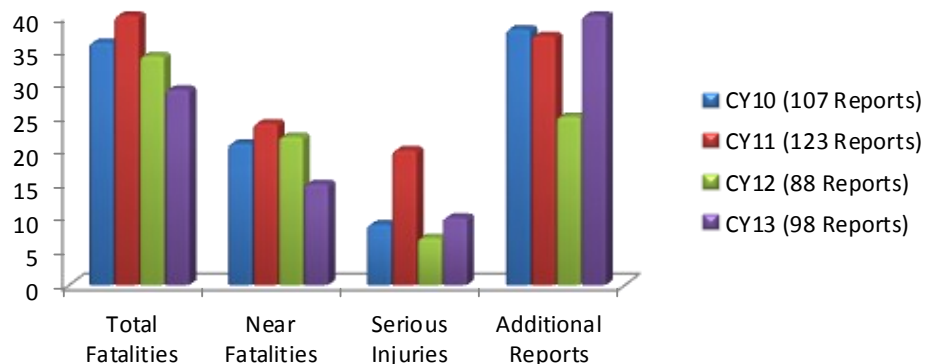
When a child receiving services from an agency organized under EOHHS dies or is seriously injured, the agency reports the death or injury to the OCA. These are called critical incident reports. The child may have been receiving family-based support services in the community or out-of-home services such as foster, group, or residential care. The agencies report on the different populations they serve:

- DCF reports critical incidents involving children in DCF care or custody as well as children whose families have had DCF involvement within the last six months.
- DDS reports critical incidents involving children and youth receiving services in the community.
- DMH report critical incidents involving children who are receiving services in the community and in acute care, residential programs, and hospital settings.
- DPH reports critical incidents involving children receiving DPH-funded services in the community and in residential treatment programs licensed and funded by DPH.
- DYS reports critical incidents involving youth committed by the juvenile court to DYS who are receiving services in the community and in group or foster care, residential treatment programs, and secure treatment centers.

In each of these settings, the death or serious injury of a child is a sentinel event that prompts the OCA to review the circumstances and the reporting agency's involvement.

OCA staff carefully review each critical incident report and follow up with the agency to learn more information as needed. When a matter warrants closer investigation, OCA staff 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 agency to review and learn from the reported situation and promote accountability. We continue to work with the agencies to improve the reporting process and move toward the goal of timely notification of all critical incidents followed by appropriate review by the agency and the OCA.

Numbers of Critical Incident Reports CY 2010-13



The OCA received 98 critical incident reports concerning 92 incidents that occurred in calendar year 2013. In six instances, two agencies submitted a report concerning the same critical incident. The number of reports filed varies from year to year. The OCA received 88 reports concerning critical incidents in 2012, 123 reports in 2011, and 107 reports in 2010. The following agencies filed the corresponding number of reports for incidents in 2013:

Department of Children and Families:	59 (9 reports regarding 10 children in DCF custody)
Department of Developmental Services:	2
Department of Mental Health:	2
Department of Public Health:	10
Department of Youth Services:	<u>25</u> (23 regarding youths committed to DYS)
	98

As discussed above, critical incident reports concern children receiving services from state agencies as well as children in state custody or care. State custody means that a judge has given legal custody of a child to DCF, along with the right to determine the placement of the child. DCF is the only agency that can be awarded legal custody of children through a Care and Protection proceeding, through a petition for a Child Requiring Assistance, or by the order of a probate and family court judge. Children in DCF custody may be placed with their parents, in licensed foster homes (including kin or extended family), in group homes, or in residential treatment programs. DCF care is different from DCF custody in that a child in care receives services under a voluntary placement agreement between the child's parent or guardian and DCF.

When a youth is committed by a judge to DYS, the parent or guardian remains the youth's legal custodian even though DYS determines services and placement for the youth. DMH, DPH, and DDS provide services on a voluntary basis to child clients and custody remains with the parent or guardian, even when the child is placed in a hospital or acute treatment setting.

OCA Reporting, Confidentiality, and CAPTA

The OCA 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 (CAPTA) 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 staff seek to balance the confidentiality of the information received with the duty of annual reporting and the duty to disclose the deaths and near deaths of children from abuse and neglect.

Fatalities

Reviewing the deaths of children is difficult but important work. Through our involvement with the statewide Child Fatality Review Program, OCA staff are well-grounded in principles of child death review and knowledgeable about Massachusetts child mortality data.

Thirty-two critical incident reports documented 29 deaths of children and youth involved with EOHHS agencies that occurred in 2013. In three instances, two agencies submitted a report concerning the same death. After reviewing each critical incident report, the OCA staff met to discuss the fatality and the agency response. If the agency conducted an investigation, OCA staff reviewed the resulting report. When both the OCA and law enforcement conducted an investigation into a child's death, OCA staff coordinated their work with the District Attorney's Office. Whenever possible, OCA staff attended 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. The Child Advocate and OCA staff met quarterly with DCF management to discuss our observations concerning fatalities and injuries to children.

Injury-related deaths occurred in nine children and youth aged two months to 17 years. None of these children were in DCF custody. The most common causes of injury-related death were drowning, motor vehicle crashes, and homicides. These were also leading injury-related causes of death for children across Massachusetts during 2007 through 2011, the period for which the most recent statewide data is available.

- Two infants died from homicide at the hands of their caretakers. A two-month-old boy and a three-month-old boy died from abusive head trauma.
- A two-year-old female died after strangling in the straps of her car seat, which had been fastened incompletely.
- Three children drowned in swimming pools or freshwater ponds -- a 12-year-old male, a 10-year-old male, and a two-year-old female.
- A 15-year-old female died by suicide by hanging.
- Two 17-year-old youths died in motor vehicle crashes, one male and one female.

Drowning: Children and youth are drawn to water, and while the Massachusetts rate of unintentional drowning among children is significantly lower than the national rate, drowning remains one of the leading causes of injury-related death in Massachusetts. Drowning can occur in bathtubs, water features, swimming pools, and fresh or salt water. Between August 2012 and April 2013, three Massachusetts youths drowned in swimming pools located in public schools. The OCA worked with the Child Fatality Review Program, DPH, and DESE to advocate for safety guidelines for swimming pools located in schools. A joint advisory addressing these concerns will be distributed to school superintendents, charter school leaders, and members of local boards of health. Look for the joint advisory on the DESE website at: <http://www.doe.mass.edu/>.

Deaths due to natural causes or medical conditions occurred in five infants, children, and youth. Two infants were in DCF custody at the time of their deaths, none of the other children were in DCF custody.

- Two two-month-old female infants died from complications of prematurity, congenital anomalies, and infection. Both infants were placed in DCF custody after their births and died without leaving the hospital.
- An 11-year-old male died from cardiac arrest following an episode of asthma.
- A 12-year-old male died from complications of leukemia.
- A 17-year-old male died from complications of sickle cell disease.

Sudden and unexpected infant and toddler death (SUID) is a category that includes Sudden Infant Death Syndrome (SIDS), accidental suffocation in bed, and undetermined causes of death in the infant and toddler population. A death cannot be definitively categorized as SUID until a medical examiner has determined the cause and manner of death. In 2013, the OCA received ten critical incident reports concerning deaths in circumstances that appear to be SUID. Of these ten deaths, the Office of the Chief Medical Examiner has established the cause and manner of death for five infants. These five SUID deaths are described below. The remaining five deaths, for which cause and manner of death have not been established, will be described in the next section. All of the five SUID deaths occurred in the setting of an unsafe sleep environment, such as bed-sharing or the prone position. Additional risk factors, such as parental substance use, were present in most of the deaths. All of these infants lived with their families in the community, none were in DCF custody.

- A seven-week-old male died while sleeping in the prone position on an adult bed.
- A three-month-old female died while sleeping in the prone position in a crib.
- A three-month-old male died while sleeping in the prone position on a sofa.
- A four-month-old female died while sleeping in an adult bed between her parents.
- A six-month-old male died while sleeping in an adult bed with his parent and siblings.

The OCA continues to work with the Child Fatality Review Program, DCF, and DPH to examine the deaths of infants who die suddenly and unexpectedly. OCA staff participate in the DPH Safe Sleep Task Force and the EOHHS Safe Sleep Working Group. See page 21 for a further discussion of issues related to sudden and unexpected infant deaths.

The medical examiner has not determined the cause and manner of death of 10 infants and children who were the subject of critical incident reports. One child was in DCF custody at the time of death.

- A three-week-old female died while sleeping in a crib.
- A four-week-old male died while sleeping in an adult bed with a parent.
- A five-week-old female died while sleeping on a sofa with a parent.
- An eleven-week-old female died while sleeping in an adult bed with her parents.

- A five-month-old male died after an illness.
- A seven-month-old male died while sleeping with his mother and sibling in an adult bed.
- A two-year-old female died suddenly and unexpectedly.
- A five-year-old male died after an illness.
- An 11-year-old male died following abdominal trauma.
- A 14-month-old female died after a brief illness.

In the Critical Incident Report section of the FY 2013 Annual Report, we listed five deaths reported in 2012 for which the medical examiner had not determined the cause and manner of death. Of those five deaths, the medical examiner has since determined that the 3-year-old male died a natural death from severe swelling of his tonsils. The cause of these other four deaths has not been determined:

- A 5-month-old male died while sleeping in an unsafe environment.
- A 6-month-old male died while sleeping in an unsafe environment.
- A nine-month-old male died after his caretaker fell on him.
- A 21-month-old female died after suffering seizures.

One of the infants was in DCF custody at the time of death.

Near Fatalities

The OCA received 16 critical incident reports concerning 15 incidents of near fatalities of children and youth involved with EOHHS agencies that occurred in 2013. 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. For youth receiving services from DYS, OCA staff request additional information in selected cases to review case management. Twelve of the incidents related to youths committed to DYS and receiving services in the community; one of these youths was a victim of violence on two separate occasions. The most common causes of the near fatalities reported to the OCA were gunshot and knife wounds in adolescents, which accounted for 11 reports. Physical abuse of three young children leading to near fatalities accounted for four reports. None of the children or youth were in DCF custody at the time of these incidents.

- Four reports documented that three infants suffered abuse at the hands of their caretakers resulting in life-threatening injuries. Two of these infants were four-month-old males and one was a three-month-old female.
- A 16-year-old male accidentally shot himself in the abdomen with a gun.

- A 17-year-old male sustained an injury to his neck during a sports game which later caused a disabling stroke.
- A 19-year-old male attempted suicide by gun.
- On five occasions males ages 15 through 20 years were injured in their communities by assailants with knives.
- On four occasions males ages 17 through 20 years were injured in their communities by assailants with guns.

Injuries

The OCA received ten critical incident reports concerning injuries to ten children and youth involved with EOHHS agencies that occurred in 2013. Four reports involved youth in DCF custody; one report concerned a youth committed to DYS and living in the community while injured. OCA staff followed up with agencies and reviewed relevant investigation reports.

- A seven-month-old male suffered bruising and a bite mark.
- An 11-month-old male and a seven-year-old female suffered burns from hot water.
- A two-year-old female suffered bruises and a broken rib after falling from a window.
- A 14-year-old male suffered a head injury in a motor vehicle crash.
- A 16-year-old male suffered a broken leg and a head injury in a motor vehicle crash.
- A 17-year-old male received a superficial wound not requiring stitches during an attempted robbery.
- Three youth were sexually assaulted or abused while residing at state-funded and licensed programs: a 14-year-old female, a 17-year-old female, and 17-year-old male.

Additional Reports

The OCA received an additional 40 reports concerning 38 incidents that occurred in 2013. Two reports involved three children in DCF custody. Ten reports involved youths committed to DYS. Twelve reports documented violent behavior in community settings allegedly caused by youths involved with EOHHS agencies. Ten reports described injuries or deaths of nine children and youth **not** involved with EOHHS agencies. Six reports described injuries or deaths of five youths over age 18 receiving services on a voluntary basis from EOHHS agencies. Other reports documented the following circumstances:

- A missing child whose family was receiving services from an EOHHS agency. This child was later found deceased; the cause and manner of his death is pending with the Office of the Chief Medical Examiner.
- Children and youths involved with EOHHS agencies who witnessed violence in their homes.
- The kidnapping of children from a foster home by a relative.
- Criminal charges stemming from a critical incident previously reported in 2012.
- Media alerts regarding children and families not involved with EOHHS agencies.
- A personnel matter.
- Threats by one adolescent client against another.

OCA Investigations

The Death of Chase Gideika

Chase died at age three months from abusive head trauma on July 8, 2013. When Chase was born, his family was involved with DCF due to neglect of an older child. At the request of EOHHS Secretary John Polanowicz, the OCA [investigated](#)⁷ the death of Chase and issued observations and recommendations concerning DCF case policy and practice.

Chase was one of three infants whose families were involved with DCF and who were allegedly killed or injured by their fathers or male caretakers between May and July 2013. Two infants died and another infant received life-threatening and permanent disabling injuries due to abusive head trauma. Two of these infants were exposed to substances while their mothers were pregnant. These tragedies highlight the importance for DCF caseworkers to recognize the vulnerability of substance exposed newborns and to thoroughly assess the capacity of all caretakers to respond to these vulnerable infants. The OCA report discussed the Commissioner's actions to address the safety of young children and recommended that DCF receive the resources necessary to implement new policies in screening, casework, and training.

The Disappearance of Jeremiah Oliver

In December 2013 the OCA learned that Jeremiah Oliver, a four-year-old child whose family was involved with DCF, was missing and had not been seen outside his home since September. At the request of Governor Deval Patrick, the OCA conducted an [investigation](#)⁸ and issued recommendations concerning DCF case policy and practice.

OCA observations included another state's failure to respond to DCF requests for the family's child protective history from that state; the caseworker and supervisor's failure to conduct a transfer meeting or conference call when the DCF case was transferred from one area office to another; and the lack of basic case practice, including the caseworker's failure to visit Jeremiah and his brother and sister. Neither the supervisor nor the manager effectively addressed the caseworker's failure to visit the Oliver children. The report discussed the context in which these lapses occurred, including the caseloads and climate in the area office and the statewide problem of insufficient resources for DCF during the economic recession.

Reflections

The ultimate responsibility for violence always rests with the individual who uses force against another, and this is true for the adults who harmed Chase, Jeremiah, and the other children not named in the investigations. When we ask DCF caseworkers to go into homes and make judgments about the future behavior of parents, we must give them tools to do this difficult work. Assessing safety and risk for children can be done but it requires time and resources. DCF has not received the resources it needs in recent years to keep caseloads at desirable levels and to provide supervision and support to its workers. DCF received an emergency appropriation in 2014 and its funding increased in the FY 2015 budget. While DCF has made progress, the rebuilding of the workforce and necessary supports is not complete.

A good child welfare system needs it all – a skilled workforce with manageable caseloads, staff committed to meeting their professional obligations, knowledgeable and supportive supervisors, seasoned managers, plus support, training, and quality assurance. There is no shortcut to creating this system. A steady and ongoing commitment is required by the public, the Legislature, and the administration to providing the resources that would be required by any system that delivers complex services every day of the year to families in crisis. And of course, to their children.

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 co-chaired by the Chief Medical Examiner and the DPH Director of the Bureau of Community Health and Prevention. Eleven local teams meet under the leadership of the District Attorneys' Offices to conduct multidisciplinary reviews of individual deaths. The local teams take local action and formulate recommendations for the state team to consider, including changes to statewide policy, practice, or regulation. The Child Advocate is an ex officio member and OCA staff take an active role on the state team.

The death of a child is a community responsibility. It is a sentinel event that should urge communities to identify other children at risk for illness and injury. Reviewing the deaths of children requires comprehensive case information and multidisciplinary participation from the community. Each review should lead to an understanding of risk factors and result in recommendations and actions to prevent deaths and to keep children healthy, safe and protected. – from The National Child Death Review Center for Policy and Practice

Certain child fatalities reviewed by the OCA as critical incidents are also reviewed by local child fatality review teams. OCA staff members attend as many local team meetings as possible and attempt to attend whenever the death being reviewed was the subject of a critical incident report. During the last year OCA staff attended local team meetings in Essex, Hampden, Middlesex, Norfolk, and Suffolk counties. Attending local team meetings helps OCA staff to learn about the circumstances in which all Massachusetts children are at risk for fatal injuries and other preventable deaths. It is important to understand the deaths of agency-involved children within this context. A sense of perspective is vital to child fatality review, because while difficult things sometimes happen to children involved with agencies, difficult things happen to other children, as well. At the OCA we continually examine whether agency-involved children are at increased risk of injury or illness and whether interventions aimed at prevention can be tailored to decrease this risk.

Since its inception a decade ago, the Child Fatality Review Program has relied on resources allocated by its contributing members. As discussed in prior OCA annual reports, dedicated resources are necessary for this important program to fulfill its mandate and achieve its potential for preventing child fatalities and injuries. The most recent report of the Massachusetts Child Fatality Review Program, *A Multi-Disciplinary Approach to the Prevention of Child Deaths*, presents data and program information for the years 2009-2012. It can be viewed at <http://www.mass.gov/eopss/docs/eops/publications/cfrrt-2009-2012-annual-report.pdf>.

Recommendation: The Child Fatality Review Program is a critical component of the state’s efforts to prevent child deaths and injuries and should receive adequate resources to enable the work of both the state and local teams.

Newborns are vulnerable to complications arising from pregnancy, fetal development, and the birth process, particularly during the first month of life. For infants ages one month to one year, Sudden Unexpected Infant Death (SUID) is the leading cause of death. The infant mortality rate measures how many infants under one year of age die per 1,000 live births and is considered to be an indicator of well-being in a society. The child mortality rate measures deaths of children ages 0-19 per 100,000. Massachusetts’ infant mortality and child mortality rates are among the lowest in the nation.

Massachusetts Infant Mortality Rate 2010	4.5 per 1,000 live births
National Infant Mortality Rate 2010	6.2 per 1,000 live births
Massachusetts Child Mortality Rate 2010	35.8 per 100,000
National Child Mortality Rate 2010	54.1 per 100,000

Source: National MCH Center for Child Death Review, CDC, National Center for Health Statistics.

Sudden Unexpected Infant Deaths

Sudden Unexpected Infant Death (SUID) is the leading cause of death of infants between the first month and first year of life. Between 30 and 50 infants die suddenly and unexpectedly in Massachusetts each year – the equivalent of the loss of two classrooms of kindergarten students. SUID impacts Hispanic and black infants at higher rates than white infants in the Commonwealth.⁹ Understanding why infants die unexpectedly requires careful scene investigation and data collection



by law enforcement agencies, medical examiners, and public health officials. In Massachusetts, the Center for Sudden Infant Death at Boston Medical Center and the Child Fatality Review Program are important resources for this work.

The relationship between SUID and unsafe sleep environments is well established. Multidisciplinary reviews of these deaths, conducted by local child fatality review teams, have found that many are associated with unsafe infant sleep positions and sleep environments, such as bed-sharing, couches, and prone or side-lying positions. The understanding of SUID is evolving on the national level as well as in Massachusetts. In 2011 the American Academy of Pediatrics (AAP) expanded its recommendations concerning safe sleep practices for infants. In 2012 DPH issued “Policy Recommendations for Safe Infant Sleep Practices,” based on the AAP recommendations. These policy recommendations were endorsed by the State Child Fatality Review Team and the OCA. DPH has identified safe sleep as a priority area in its Injury Prevention Strategic Plan and convenes the Safe Sleep Task Force.

In the summer of 2014 EOHHS convened an interagency Task Force on Infant Safe Sleep to educate the public, parents, and caregivers about infant safe sleep practices. The task force forged collaborations across state agencies and with medical associations and hospitals to reduce the risks associated with unsafe infant sleep practices. Governor Patrick proclaimed October 2014 to be Infant Sleep Awareness Month. Throughout the month of October, the Task Force on Infant Safe Sleep conducted a campaign to educate the public about the importance of infant safe sleep practices through its Mass.gov/SafeSleep¹⁰ website and awareness advertising. The Task Force provided a board book promoting safe sleep for every baby born in October. These board books will also be distributed through the Reach Out and Read program and by DCF in its Welcome Baby bags for parents with infants, along with other safe sleep materials. Information for physicians was shared through the Massachusetts Chapter of the AAP and the Massachusetts Hospital Association.

Recommendation: Our goal is for every parent of every newborn to hear the safe sleep message during pregnancy, at birth, and at doctor visits. The Child Advocate encourages all state organizations to offer clear and consistent information to the public about safe sleep practices for infants.

Safe Sleep Tips for Parents

- Always put babies on their back to sleep for naps and at night.
- Keep babies near, but in their own crib. New parents often want to be close to their babies at night, but sharing a bed puts your baby at risk for suffocation from someone rolling over on them, or from pillows and blankets. Taking medications, sleeping aids, or drinking alcohol can affect your sleep and put your baby at even higher risk.
- Don't let your baby sleep or nap in the same bed with anyone else – even a twin, sisters, brothers, or babysitters. Another person, no matter how small, could roll over and smother the baby. This includes pets.
- Put your baby in her own crib but keep the crib close enough to know when your baby needs you. If you are breastfeeding, sleeping near your baby's crib makes it easy for you to feed your baby when she's hungry and helps you build a good milk supply. Breastfeeding has been shown to reduce the risk of sudden infant death and has many health benefits for babies, but even breastfeeding moms should keep their babies in their own cribs.
- Use a firm mattress and a tight-fitting sheet in your baby's crib. Fluffy pillows, quilts, and toys are not safe for sleep. Blankets, pillows, or bumper pads in the crib could make it hard for your baby to breathe. Young babies can't move around enough to hurt themselves, and the slats on their cribs should be close enough together to prevent their heads from getting stuck.
- Keep babies cool. Don't overheat the room or overdress the baby. You can dress your baby in warm pajamas or a sleep sack and put your baby to sleep without a blanket.
- Never smoke around babies. Keep the sleeping area and the home smoke-free. Second and third-hand smoking are also risk factors for babies.
- Give your baby plenty of tummy time when he is awake and an adult is watching. This will help your baby's neck and shoulder muscles get stronger.
- If you have an older crib or a used crib, make sure it meets current safety standards. To find out if the crib is approved for infants, call the Consumer Product Safety Commission toll-free at 1-800-638-2772 or visit their Check Your Crib for Safety video.¹¹

Source: DPH Injury Prevention and Control Program

The Opioid Epidemic and Substance Exposed Newborns

In March 2014, Governor Patrick declared a statewide public health emergency in response to the opioid epidemic in Massachusetts. DPH reports a concurrent rise of infants experiencing withdrawal symptoms at birth, known as neonatal abstinence syndrome (NAS), as a result of the increase in opioid abuse. DPH has partnered with the Neonatal Quality Improvement Collaborative of Massachusetts (NeoQIC) to share data, review policies and guidelines in birthing hospitals, and set goals for improvement in care of newborns with NAS. For example, NeoQIC recommends that hospitals use universal screening of mothers and infants to identify NAS. NeoQIC also promotes the use of comfort measures for infants with NAS by placing them in dimly lit rooms, swaddling them snugly, and encouraging skin-to-skin contact and breastfeeding.

Substance use among pregnant women presents a significant public health challenge that impacts an estimated ten percent of newborns in the United States. Prenatal substance exposure to both legal and illegal substances can affect a newborn's health and development, increase the newborn's risk for abuse and neglect, and is a risk factor associated with Sudden Unexpected Infant Death (SUID).

Health care providers in Massachusetts are required to file a report of abuse or neglect (51A report) when a baby is born physically dependent on an addictive substance. In August 2013 DCF implemented new screening and response guidelines related to substance exposed newborns. Under these guidelines, all 51A reports of abuse or neglect involving a substance exposed newborn are screened in for investigation and DCF holds a clinical and legal conference to discuss whether DCF should assume custody of the newborn. If a determination is made not to assume custody, DCF coordinates with the hospital to assure in-home support services are in place before the newborn is discharged. DCF has also added capacity in their data management system to identify substance exposed newborns to follow their safety and well-being.

Newborns need safe and nurturing care 24 hours a day and parents need support to provide this care. When the demands of newborn care are compounded by substance exposure, the parents' need for support is also compounded. Collaboration among state agencies and birthing hospitals to assure proper intervention and response to these vulnerable infants and families is critical. The OCA supports these efforts by DPH and DCF to increase their responsiveness to the needs of substance exposed newborns and their caregivers.

Continuous Quality Improvement in the Children's Behavioral Health Initiative

The mission of the Children's Behavioral Health Initiative (CBHI) is to provide behavioral health services in a comprehensive, community-based system of care to ensure children and families receive the services necessary for success in the home, school, and community. CBHI services are child-and-family-centered and are designed to meet individual needs. CBHI was developed in response to a court order following a class action lawsuit filed on behalf of Massachusetts children with significant behavioral, emotional, or mental health needs enrolled in MassHealth.



In order to measure the success of services provided to children and families, it is critical that agencies and community providers engage in continuous quality improvement efforts to monitor the effectiveness of services and identify areas for improvement. CBHI uses a protocol called the System of Care Practice Review (SOCPR) to evaluate CBHI services. Consent is obtained from randomly chosen families, then trained reviewers use the SOCPR protocol to review a child's treatment record and to guide interviews with service providers, caregivers, and the child. Reviewers then rate their impressions of the child's care according to the core values of CBHI.¹² Findings from the Central Region review were published and are available at: <http://www.mass.gov/eohhs/docs/masshealth/cbhi/socpr-report-januar.pdf>.

In FY 2013 the OCA Clinical Specialist trained in the SOCPR protocol and began participating as a statewide reviewer. The OCA welcomes the opportunity to participate in this quality improvement process and to hear directly from children, family members, and providers about the quality of community-based services provided to children and families of the Commonwealth.

Psychotropic Medications for Children in DCF Custody



Deciding whether a child should take antipsychotic 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. In Massachusetts, DCF regulations require that a judge approve antipsychotic medication prescriptions for children in DCF custody. This is known as the Rogers process.

Since 2009 the OCA has spearheaded an effort to review the process for authorizing and overseeing not just antipsychotic, but all psychotropic medications for children in DCF custody. Previous OCA annual reports have documented the work involved in examining the Rogers process and coming to recommendations for a tiered system of oversight for psychotropic medications and behavioral health treatment of children in DCF custody. In 2012 the Psychopharmacology Steering Committee co-chaired by the DCF Commissioner and The Child Advocate was formed to develop a plan for implementing these recommendations.

In an effort to understand better the scope of the problem, in 2013 DCF established an internal monitoring system to review the treatment plans for children who fell into categories that caused the most concern: children under age five who are prescribed a psychotropic medication, children who are prescribed four or more medications, and children who are prescribed two or more medications in the same class. The Psychopharmacology Steering Committee then began exploring additional strategies, such as requiring prior authorization of medications that fall into "red flag" categories, as well as ongoing review and monitoring procedures for children in DCF custody.

In the summer of 2014 the MassHealth Pharmacy Program, in collaboration with DCF and DMH, developed the Pediatric Behavioral Health Medication (PBHMI) Initiative, which will be launched in November 2014. PBHMI builds on the work of the Psychopharmacology Steering Committee, described above, and the Working Group on Children's Psychoactive Medication, described on page 26. PBHMI eventually will cover all children and adolescents insured by MassHealth, not just those in DCF custody. PBHMI will use practice guidelines and a selective prior authorization process for psychoactive medications starting with the primary care clinician and fee-for-service plans.

Oversight of psychoactive medication in children is an important issue for everyone in Massachusetts, but when a child is removed from her family and taken into DCF custody, the Commonwealth becomes responsible for that child's health and well-being. This responsibility requires more than prior authorization for psychoactive medications – it requires that medication be part of an individualized behavioral health treatment plan that includes ongoing review and evaluation.

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

Improving Psychopharmacology for All MassHealth Kids: Efforts to improve behavioral health care for all children insured by MassHealth (Massachusetts' Medicaid agency), not just DCF foster children, was the focus of the Working Group on Children's Psychoactive Medication, first convened by DMH and MassHealth in 2007. The Working Group, with the managed care entities that manage behavioral health care for children insured by MassHealth, standardized methods for tracking the use of psychoactive medications for vulnerable children. The Working Group helped each managed care entity develop its own method for detailed clinical analysis of concerning cases as well as outreach to the responsible providers. Through these efforts, from 2009 to 2013, there was an 8% reduction in the rate at which children under six received antipsychotic medications, and a 67% reduction in the rate at which children under six received three or more psychoactive medications. These reductions occurred even while MassHealth enrollment was increasing.

Evidence-Based Juvenile Justice

Since 2009, The Child Advocate has worked tirelessly in the state and the nation in promoting fair sentences for youth. On September 18, 2013, Governor Patrick signed legislation that raised the age of juvenile court jurisdiction to 18 for delinquency matters. This change in the law validated our common understanding that teenagers are different from adults.

Adolescents' brains are still developing in ways that affect their judgment, and while youth must be held accountable for their actions, their lack of maturity and potential for rehabilitation should be considered at every step in the juvenile justice system, including sentencing.

The rationale for expanding juvenile court jurisdiction supported another necessary reform in Massachusetts, that of addressing fair sentencing for youth following the United States Supreme Court's decision in *Miller v. Alabama*. *Miller* rejected Alabama's mandatory sentence of life without the possibility of parole for a youth convicted of committing a first degree murder while under the age of 18, and held that such sentences violate the Eighth Amendment of the Constitution. Massachusetts, like Alabama, required mandatory sentences. In the absence of another sentencing statute following *Miller*, Massachusetts superior court judges instead imposed sentences for second degree murder, which require a life term with the possibility of parole after 15 years. On December 24, 2013, the Massachusetts Supreme Judicial Court released *Commonwealth v. Diatchenko*, which held that the Massachusetts Constitution afforded youth greater protection than the United States Constitution, and forbade a sentence of life without the possibility of parole for youth under any circumstances. *Diatchenko* secured for youth the right to a parole hearing at some future point to be determined. Absent action by the Legislature, the time to a parole hearing was 15 years.

The Legislature passed "An Act Relative to Juvenile Life Sentences for First Degree Murder" in July 2014, and Governor Patrick signed the bill on July 25, 2014. It is now the law in Massachusetts that youths between 14 and 18 years of age when they commit a first degree murder will receive life sentences with a parole hearing after 20-30 years. The time before the first parole hearing will be set by the court. If the murder was committed with deliberately premeditated malice, the time before parole may be set between 25 and 30 years. If the murder was committed with extreme atrocity or cruelty, the time before parole may be set after 30 years.

Like the United States Supreme Court's decision in *Miller*, this new Massachusetts sentencing law is based on the understanding that youth are different from adults and that their sentences should reflect these differences. This insight should not be limited to homicides. Fairness requires that the unique characteristics of youth be taken into account at every stage in the juvenile justice decision-making process.

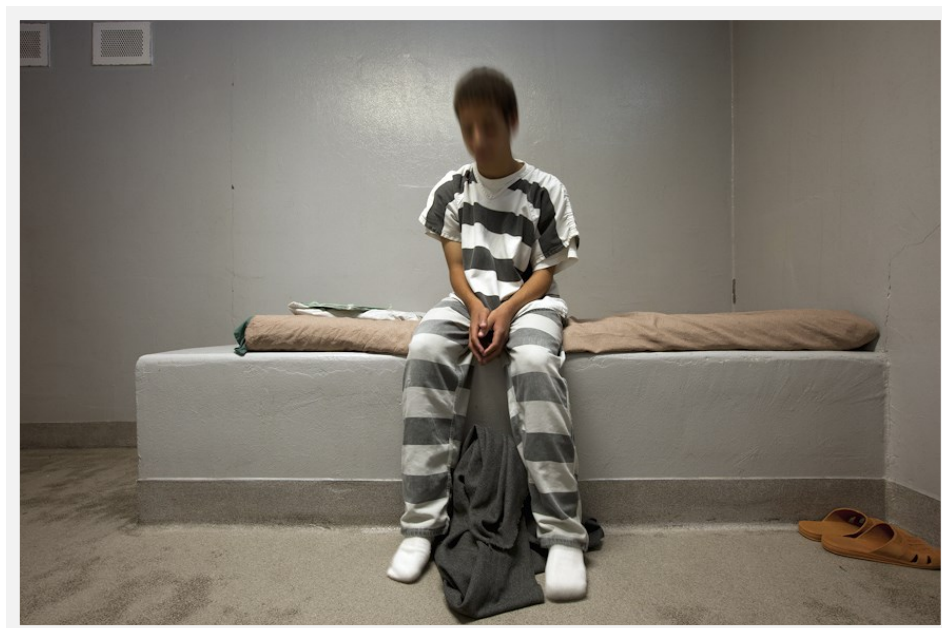
Recognition of the cognitive and developmental limitations of adolescents warrants two additional reforms. First, although the Legislature expanded juvenile court jurisdiction to age 18 for all non-homicide offenses, it left jurisdiction for 14- to 18-year-old youths charged with homicide in the superior court. But as the United States Supreme Court recognized in *Miller*, the developmental characteristics of adolescents must inform the handling of homicides as well. The juvenile court is particularly suited for taking these characteristics into account. The law should be changed to restore jurisdiction to the juvenile court for youths under age 18 charged with homicide.

Second, the law must also address the particular problems faced by juveniles found incompetent to stand trial. (Please refer to OCA Annual Report 2009.) Unlike many states, Massachusetts has no statutory scheme that limits the period of confinement for these youths or that provides the programs or services they need to achieve or be restored to competency. Other states have devised solutions that address the educational and behavioral health needs of juveniles while protecting their constitutional rights. Massachusetts must do the same.

Recommendations:

The Child Advocate strongly supports legislation that would restore jurisdiction to the juvenile court for youths under age 18 charged with homicide.

The Child Advocate urges policymakers to ensure the constitutional rights of juveniles who have been found incompetent to stand trial are guaranteed, and their needs for assessment, education, and treatment are met.



How We Help

Jenny called the Helpline regarding her 16-year-old son, Kyle. Kyle has a history of behavioral health problems dating back to third grade. He has received services from DCF, DMH, and MassHealth and has an Individualized Education Plan (IEP) at school. Kyle has been admitted to residential treatment facilities in the past but is now at home with his mother. A treatment team comes to the home to work with Jenny and Kyle, but Kyle is resistant to the in-home therapy and often refuses to take the medication his psychiatrist prescribed for him. Jenny thinks Kyle should go back to a residential placement but says she is getting different stories from the school, his therapist, and his caseworker about what level of care Kyle needs.

It is difficult for parents to cope with a complex system of care, and Jenny needed support as well as information. OCA staff talked with Jenny about requesting a meeting to bring the involved professionals together to talk about Kyle's needs, what services are appropriate for him, and who should be coordinating those services. In addition, OCA staff suggested Jenny contact [Parent Professionals Advocacy League](#)¹³ (PPAL), an organization of people who believe that no parent should have to struggle alone. PPAL helps individuals through one-on-one communication, support groups, and resource distribution. Families can visit PPAL's website to find factsheets, advocacy tools, and support group listings.



Outreach

The Child Advocate appeared often in public during FY 2014, lecturing and presenting information to interested groups, giving interviews, and participating in conferences and symposia related to child welfare and juvenile justice. The Child Advocate and the OCA staff presented at the following venues:

- Endicott College, Essex County “Youth at Risk” Conference, breakfast keynote and panelist
- Harvard University Schools of Law and Education and Kennedy School of Government
- Holyoke Community College, “Re-envisioning Foster Care in America” Conference
- Massachusetts Continuing Legal Education, Juvenile Delinquency and Child Welfare Law Conference
- Massachusetts Health Law Advocates Committee
- Massachusetts Medical Society, Mental Health Task Force
- Massachusetts School of Professional Psychology
- Middlesex County Bar Association
- New England School of Law
- Parent/Professional Advocacy League
- Providers’ Council, “Chat with the Commissioners”
- Statewide Child Fatality Review Program Conference
- Tufts Medical Center
- University of Pennsylvania Law School, Edward Sparer Symposium
- WBUR and WGBH interviews
- Worcester State University, Grandparents Raising Grandchildren Statewide Conference, keynote address



From left to right: Kathy Betts, Mary McGeown, Gail Garinger, Erin Deveney & Cheryl Tellier-Haddad at the 29th Annual Foster and Adoptive Parent Recognition Brunch

The Child Advocate and OCA staff attended conferences and meetings addressing a broad range of topics related to child welfare and juvenile justice, including early education, child protection and family strengthening, nurturing fathers, interdisciplinary approach to investigating child abuse, medical child abuse, psychotropic medications, improving delivery of justice in the probate and family court, justice and mental health collaboration, adoption, sex trafficking, juvenile detention alternatives initiative, juvenile life without parole, fair sentencing for youth, targeted interventions for unaccompanied youth, transition planning, permanency, and child fatality review. In addition, The Child Advocate and OCA staff engaged in youth outreach through meetings with Teens Leading the Way, staff and clients at More Than Words, and representatives from a DCF foster care alumni association. OCA staff also distributed OCA Youth in Care Outreach Cards to youth and their attorneys.

Recommendations

Child Fatality Review Program: The Child Fatality Review Program is a critical component of the state's efforts to prevent child deaths and injuries and should receive adequate resources to enable the work of both the state and local teams.

Sudden Unexpected Infant Deaths: Our goal is for every parent of every newborn to hear the safe sleep message during pregnancy, at birth, and at doctor visits. The Child Advocate encourages all state organizations to offer clear and consistent information to the public about safe sleep practices for infants and to continue to investigate and review all sudden unexpected infant deaths and to collect and analyze data to advance our understanding of how to prevent these deaths.

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

Restore Homicide Jurisdiction to the Juvenile Court: The Child Advocate strongly supports legislation that would restore jurisdiction to the juvenile court for youths under age 18 charged with homicide.

Rights for Youth Found Incompetent to Stand Trial: The Child Advocate urges policymakers to ensure the constitutional rights of juveniles who have been found incompetent to stand trial are guaranteed, and their needs for assessment, education, and treatment are met.



OCA Administration and Advisory Board

Governor Deval Patrick appointed Gail Garinger as the first Child Advocate for the Commonwealth in April 2008. Before her appointment, she served as a juvenile court judge for 13 years, including eight years as First Justice of the Middlesex County Juvenile Court. She also served as General Counsel at Children's Hospital Boston. Judge Garinger is assisted in her duties by a staff of three employees with collective experience in law, social work, nursing, and human services. During the last year the OCA has hosted two fellows and one intern from a law school. The OCA line item appropriation for FY 2015 is \$700,000, not less than \$200,000 to be used to conduct an emergency review of DCF management in consultation with the Inspector General. An additional \$200,000 was placed in reserve with the Executive Office for Administration and Finance for the OCA to select an independent evaluator to assess DCF's administrative Fair Hearing process. The net \$500,000 available for the administration of the OCA represents an increase over our budget of \$304,000 in FY 2014, \$300,000 in FY 2013, and \$243,564 in FY 2012. These DCF oversight projects and the increase in funding convey an important acknowledgement of the OCA's work over the last six years. With the additional funding, the OCA is adding two new staff and planning new initiatives.

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 meetings, during which OCA staff update the Board and elicit their input on OCA activities. Information concerning our Advisory Board and past meetings is available on the OCA website.



Office of the Child Advocate Staff

From left to right: Heather Porriello, Gail Garinger, Elizabeth Armstrong, & Christine Palladino-Downs

Issues and Initiatives from Previous Reports

This is the sixth annual report published since the OCA was created in 2008. Our 2008 and 2009 reports were based on the calendar year (CY); in 2010 we began reporting on our activities for the fiscal year (FY), though we continue to analyze data for the previous calendar year. Past reports have included discussions of the following issues and initiatives:

- Alternative Lock-up Programs – CY 2008, CY 2009
- Child Fatality Review Program – CY 2008, CY 2009, FY 2011, FY 2012, FY 2013
- Child's Counsel and Child's Voice – CY 2008, CY 2009, FY 2011, FY 2012, FY 2013
- Competency of Juveniles in Delinquency Cases – CY 2009, FY 2011, FY 2012
- Comprehensive Plan – CY 2008, CY 2009, FY 2011
- Disproportionate Minority Contact and Data Collection – CY 2009
- Expert Consultation in the Investigation of Child Abuse – CY 2009
- Expungement of Juvenile Court Records – FY 2011, FY 2012
- Fair Sentencing & Juvenile Life Without Parole – CY 2009, FY 2011, FY 2012, FY 2013
- Implementation of Child Requiring Assistance Law – FY 2013
- Juvenile Detention Alternative Initiative – CY 2008, CY 2009
- Kin Raising Kin– CY 2009
- Legislation and Regulation – CY 2009, FY 2011, FY 2012
- Online Mandated Reporter Training – CY 2008, CY 2009, FY 2012
- Permanency and Transition Planning – CY 2008, FY 2011, FY 2012, FY 2013
- Psychotropic Medication and the Rogers Process – CY 2009, FY 2011, FY 2012, FY 2013
- Raise the Age Legislation – FY 2011, FY 2012, FY 2013
- Restraints and Seclusion – CY 2008, CY 2009, FY 2011, FY 2012
- Review of Agency Investigations – CY 2008
- Review of Agency Policies – FY 2012
- Substance Exposed Newborns – FY 2012, FY 2013
- Sudden Unexpected Infant Deaths – FY 2012, FY 2013
- Use of Aversives at Judge Rotenberg Center – CY 2009
- Violence in the Community – FY 2011, FY 2012
- Zero Tolerance and Dropout Prevention – CY 2008, CY 2009

Please visit the [annual report page](#)¹⁴ of our website to review any of these discussions.

We welcome feedback and questions.

<http://www.mass.gov/childadvocate/contact/>



Committees, Boards, and Councils

In addition to the OCA's committee work discussed within this report, The Child Advocate participates as an ex officio member on many boards and councils. OCA staff also attend meetings of selected working groups and initiatives. Involvement with these groups helps to inform and educate staff, so that the OCA can share information and help 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. For information visit: www.mass.gov/masshealth/cbhi.

Children's Trust Board of Directors: Massachusetts Children's Trust, a public-private partnership, is a leader in efforts to prevent child abuse and neglect by supporting parents and strengthening families. Children's Trust 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 Board of Directors and serves as vice-chair of the Governance Committee. For information visit: <http://childrenstrustma.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: <http://www.childrensleague.org>.

Essentials for Childhood Leadership Action Team: Child maltreatment is a public health issue and is preventable. The Essentials for Childhood (EfC) framework uses evidence-based strategies to promote safe, stable and nurturing environments and relationships and prevent maltreatment. Massachusetts is one of five states funded by the Centers for Disease Control and Prevention to implement EfC's core strategies. The OCA's Deputy Director is a member of the EfC Leadership Action Team. For information visit: <http://www.cdc.gov/violenceprevention/childmaltreatment/essentials>.

Families and Children Requiring Assistance Advisory Board: An Act Relative to Families and Children Engaged in Services went into effect in November, 2012. This law overhauled the Child in Need of Services (CHINS) system serving children who are runaways, truants, have serious problems at home or in school, or who are the victims of commercial sexual exploitation. The new law encourages families to seek services prior to going to court, and requires EOHHS to develop a network of child and family service programs throughout the Commonwealth to assist these children and families. The law also created the Families and Children Requiring Assistance Advisory Board to advise EOHHS on the development and implementation of the community-based service network and to monitor the progress. The Child Advocate is a designated member of the Advisory Board.

Governor's Child and Youth Readiness Cabinet: In 2008 Governor Patrick signed Executive Order 505 establishing the Child and Youth 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 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). 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 and collaborate with GCSDV members on issues related to children exposed to sexual and domestic violence. For information visit: <http://www.mass.gov/governor/administration/councilscabinetsandcommissions/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). The ICHH is responsible for implementing the state's plan to prevent and end homelessness among youth, families, survivors of domestic and sexual assault, older adults, and veterans. OCA staff attend meetings of the ICHH Advisory Board and

provide policy recommendations to the ICHH regarding the impact of homelessness on children and families. For information visit: <http://www.mass.gov/governor/administration/councilscabinetsandcommissions/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). The ICSAP works to maximize coordination between DPH and other state agencies regarding substance abuse and prevention. In July 2010 the ICSAP submitted an update of the Commonwealth's 2005 Substance Abuse Strategic Plan. Through 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 information visit: <http://www.mass.gov/governor/administration/councilscabinetsandcommissions/subabuseprevent/>.

Interagency Restraint and Seclusion Prevention Initiative: In response to growing concern about restraint and seclusion in child-serving settings, the Commonwealth in 2009 organized a cross-secretariat effort to reduce and prevent their use. The Initiative brings together leaders from DCF, DDS, DMH, DYS, DEEC, and DESE to work in partnership with the OCA, parents, youth, providers, schools, and community advocates to focus on preventing and reducing the use of behavior restrictions that can be re-traumatizing. The vision for the multi-year effort is that all youth-serving educational and treatment settings will use trauma-informed, positive behavior support practices that respectfully engage families and youth. For information visit: <http://www.mass.gov/eohhs/gov/departments/dcf/interagency-restraint-and-seclusion-prevention.html>.

Juvenile Detention Alternatives Initiative: The Juvenile Detention Alternatives Initiative (JDAI) is an Annie E. Casey Foundation initiative under the leadership of the JDAI Statewide Steering Committee with support from DYS. The JDAI focuses on safely reducing the numbers of youth held in secure detention prior to adjudication of a delinquency offense or probation violation, and on developing a multi-tiered system of detention alternatives and diversion programs that better serve the needs of court-involved youth. For information visit: <http://www.mass.gov/eohhs/gov/commissions-and-initiatives/jdai/>.

Kitchen Cabinet Initiative: The DCF Kitchen Cabinet is a collaborative group of representatives of child welfare organizations, service providers, academia, and the family perspective. The Kitchen Cabinet was convened to provide insight and recommendations on the initiatives that DCF is undertaking as a result of the Child Welfare League of America report. The recommendations and input offered by the Kitchen Cabinet members provide the public with reassurance that the priorities DCF is undertaking will address areas that have the greatest positive impact on the services delivered to children and families of the Commonwealth. For information visit: <http://www.mass.gov/eohhs/gov/departments/dcf/>.

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 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 OCA 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 in the FY 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 serves on the Commission as the designated member with experience in juvenile justice and also co-chairs the subcommittee on incarcerated persons. For information visit: http://www.mass.gov/bb/gaa/fy2012/os_12/h189.htm.

Special Commission on Unaccompanied Homeless Youth: The Special Commission on Unaccompanied Homeless Youth was established through Outside Section 208 of the FY 2013 Budget. The Commission analyzed barriers to serving unaccompanied youth under age 18, including gay, lesbian, bisexual and transgender youth; assessed the impact of mandated reporting requirements on unaccompanied youths' access to services; reviewed the Commonwealth's ability to identify and connect with unaccompanied youth; and developed recommendations to reduce identified barriers to serving this population. Although not a member of the Commission, OCA staff attended Commission meetings to support

development of the recommendations to address the diverse needs of this unique population. The Commission released a final report in [June, 2013](#)¹⁵ and an update in [March, 2014](#).¹⁶

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. OCA staff sit on the SEEN Coalition Steering Committee. The SEEN Coalition was instrumental in drafting and advocating for Safe Harbor provisions that redefined commercially sexually exploited youth as children requiring assistance rather than criminals, passed as part of “An Act Relative to the Commercial Exploitation of People.” For information visit: <http://www.suffolkcac.org/programs/seen/>.

Task Force on Youth Aging Out of DCF Care: The Task Force on Youth Aging Out of DCF Care 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 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 information visit: http://www.thehome.org/site/PageServer?pagename=about_advocacy_about#taskforce.

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 implemented 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 children and families who have experienced toxic stress related to child abuse, neglect, domestic violence, or 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 visit: <http://www.ecmhatters.org/Pages/ECMHMatters.aspx>.

Endnotes

¹<http://ppal.net/>

²<http://fcsn.org/>

³<http://www.mass.gov/eohhs/gov/departments/dcf/intragency-restraint-and-seclusion-prevention.html>

⁴http://www.publiccounsel.net/Practice_Areas/cafl_pages/civil_cafl_index.html

⁵<http://machildtraumaproject.org/>

⁶Implementation of a workforce initiative to build trauma-informed child welfare practice and services: Findings from the Massachusetts Child Trauma Project. http://www.traumacenter.org/products/pdf_files/Trauma-informed_child_welfare_MA_G0001.pdf

⁷<http://www.mass.gov/childadvocate/docs/gideika-finalreport.pdf>

⁸<http://www.mass.gov/childadvocate/docs/140123-oca-final-report.pdf>

⁹Five year (2007-2011) average annual SUID rates among MA Black non-Hispanic and Hispanic infants are 2.6 and 1.6 times, respectively, that of White non-Hispanic infants. (Source: Registry of Vital Records and Statistics, Massachusetts Department of Public Health. Data prepared by the Massachusetts Department of Public Health.)

¹⁰<http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/dvip/injury-prevention/infant-safe-sleep.html>

¹¹<http://www.cpsc.gov/onsafety/2010/06/watch-and-share-check-your-crib-for-safety/>

¹²System of Care Practice Review Regional Reports of Findings: Central, Executive Summary at v. (June 2014). <http://www.mass.gov/eohhs/docs/masshealth/cbhi/socpr-report-januar.pdf>

¹³<http://ppal.net/contact>

¹⁴<http://www.mass.gov/childadvocate/reports/>

¹⁵http://www.mahomeless.org/files/Special_Commission_on_Unaccompanied_Homeless_Youth_Report.pdf

¹⁶http://www.mahomeless.org/files/Special_Commission_on_Unaccompanied_Homeless_Youth_FY14_Status_Report.pdf

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