Office of the Child Advocate
Annual Report
Fiscal Year 2017

The Commonwealth of Massachusetts
Maria Z. Mossaides
Child Advocate

The Office of the Child Advocate

The mission of the OCA is to ensure all children in the Commonwealth receive appropriate, timely and quality services with full respect for their human rights. Through collaboration with public and private stakeholders, the OCA examines services to children to identify gaps and trends, and makes recommendations to improve the quality of those services. The OCA also serves as a resource for families who are receiving, or eligible to receive, services from the Commonwealth.

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Letter from the Child Advocate

February 6, 2018

Dear Governor Baker, Acting Senate President Chandler, Speaker DeLeo, Legislative Leaders, and Citizens of the Commonwealth,

I am pleased to submit the Office of the Child Advocate (OCA) Annual Report for Fiscal Year 2017 (FY17)[1]. In keeping with the change introduced last year, the OCA now reports data on a fiscal year, rather than calendar year, basis. We detail the activities we have undertaken to fulfill our core statutory functions, as well as the initiatives we have launched to examine and make recommendations for improvements to state services for children and their families.

The OCA is unique because we are an independent agency responsible for overseeing that the children[2] of the Commonwealth receive timely, quality and appropriate services across the broad spectrum of state government. Although our enabling statute mandates the OCA to focus on those children who are served by our child welfare and juvenile justice systems, we are concerned with the needs of all our children, especially children with disabilities and those who identify as LGBTQ. The OCA oversees both the individual agencies that provide services to children and the systems that connect those agencies. The OCA frequently serves as a neutral convener, bringing state agencies, advocates, and service providers together to address issues of common concern. We want to ensure that our policies and programs support the healthy transition of all children into adulthood.

When I assumed leadership of the OCA in October 2015, I committed to serve as a strong advocate for children. I also expressed my intent that the OCA would operate in a collaborative spirit; working with all branches of state government, child advocacy organizations, and the private sector to bring forth the best ideas and evidence-based practices to address service challenges.

Below are highlights of our accomplishments during FY17:

- In April 2017, we released the *Interagency Working Group on Residential Schools: Review and Recommendations to Improve Oversight and Monitoring* report. At the request of Governor Baker in 2016, the OCA has led an effort to guide and coordinate a review of public and private residential and day school programs that provide services to

[1] The period from July 1, 2016 to June 30, 2017

[2] Child-serving state agencies in Massachusetts may provide services to children up to age 22. The OCA's reference to "children" in this annual report includes individuals up to age 22, uncles otherwise noted.

children who, based on their needs, require an out-of-home or substantially separate educational setting. This report provides detailed recommendations for the improvement of the licensing and monitoring of these schools, which some of the Commonwealth's most vulnerable children attend.

- In June 2017, the Child Sexual Abuse Prevention Task Force, co-chaired by the Children's Trust and the OCA, released *Guidelines and Tools for the Development of Child Sexual Abuse Prevention and Intervention Plans by Youth Serving Organizations in Massachusetts*. The report provides a five-point framework for every Youth Serving Organization (YSO) in the Commonwealth to develop child sexual abuse prevention policies and guidance. In FY17, the Task Force launched a community listening tour to engage local YSOs with the goal of learning about the types of implementation activities that will support this effort.

- The OCA deepened its commitment to improving data tracking, analysis and reporting on the information we receive through our Complaint Line, review of supported reports of abuse and/or neglect of children in out-of-home settings, and critical incident reports. Our goal is to maximize our knowledge and present the best available information within a context that explains the policy implications of the data. We made progress in reaching agreement with state agencies on definitions for critical incident reporting, which now includes the definitions of attempted suicide and emotional injury. Liaison relationships are in place with all Executive Office of Health and Human Services (EOHHS) child-serving agencies, as well as the Department of Elementary and Secondary Education (DESE), and the Department of Early Education and Care (DEEC). The OCA meets quarterly with the senior leadership at the Department of Children and Families (DCF), Department of Youth Services (DYS), and with other state agencies as needed.

In my role, I am fortunate to be involved in a multitude of activities that bring me in contact with state employees, service providers, advocates and families – all of whom provide rich and unique perspectives on a variety of issues impacting children and their families. Massachusetts should be proud that it is a leader in both human services and education. Children's services are delivered through highly specialized state agencies across two secretariats[3], 404 school districts, and a network of human service and health providers – yet there is always work to be done. The OCA makes the following recommendations, which I believe are essential to improving services to the children and families of the Commonwealth.

[3] EOHHS and the Executive Office of Education (EOE)

- **We recommend that a task force be assembled to review, update and improve the Commonwealth's child abuse mandated reporting law[4], and include clarification of reporting requirements so that every mandated reporter understands their duty.** Our system of protecting children relies on individuals who are mandated reporters to properly recognize and promptly report suspected child abuse and/or neglect to our child protection agency, DCF. Recent national events have highlighted the damage done when mandated reporters fail to report. Our work on the Child Sexual Abuse Prevention Task Force indicates that there continues to be confusion among mandated reporters about child abuse reporting requirements. This is especially true in out-of-home settings where the mandated reporter may also be required to notify a superior of their concerns, or where the actual filing of the abuse and/or neglect report is by specially designated staff. An updated reporting law would not only provide needed clarifications, but could include provisions for how mandatory training should be developed and implemented.

- **We encourage the continuation of the work begun by EOHHS to ensure better coordination between state agencies and across secretariats when a child or family is receiving services from more than one agency, or when transitioning between state agencies.** This includes developing policies and protocols for the interagency communication required whenever services are provided by multiple agencies, or when eligibility requirements, such as age, require a transfer of responsibility from one agency to another. It is essential that this crucial coordination is supported by agency policy and practice, rather than being dependent upon personal relationships at the agency level. Although services to children in the Commonwealth are divided among many agencies and across secretariats, there is little statutory guidance for coordination of services, and there are often barriers to sharing information. Families often experience difficulty in navigating our systems. We should do our best to provide the equivalent of "no wrong door." Having a robust and streamlined process of interagency information sharing and collaboration is essential to ensuring that children and their families receive the continuity of care and the full range of services needed for their success.

- **There needs to be a coordinated effort among state agencies, human services, and educational providers to address the recruitment and retention challenges facing the child-serving workforce.** The recruitment and retention of staff to serve our children, and the building of their capacity to provide the highest quality of care is an issue across the service delivery system. The Commonwealth is making investments in upgrading salaries and training opportunities for these employees. The *Interagency*

[4] Chapter 119, Section 51A

Working Group on Residential Schools: Review and Recommendations to Improve Oversight and Monitoring report identified the quality and experience of staff, supervisors and administrations as primary safety factors for children in residential schools. As a result, the Working Group plans to roll-out a professional development program that will include regional meetings between state agency and provider managers, and to create a resource website. Other efforts to improve the quality of the human services workforce include the Children's Behavioral Health Advisory Council prioritizing this as a focus of their efforts. The Children's Behavioral Health Knowledge Center is taking a leadership role in improving supervision, which is recognized as being critical to staff retention. The OCA recommends that state agencies continue to share information about their efforts and resources so that the maximum amount of training and support is delivered to the human services workforce.

Every adult in the Commonwealth shares responsibility for protecting our children and youth, and for ensuring that they have the tools to grow into healthy adults and productive members of their community. As we work towards this goal, the OCA is fortunate to have the support of the Governor and the Legislative leadership. I thank the leadership and staff of our state agencies, advocacy organizations, and the service provider network for their continuing collaboration. I also wish to acknowledge the families who have brought their concerns to the OCA. Finally, I commend the OCA staff for their tireless efforts on behalf of the Commonwealth's children.

Sincerely yours,

Maria Z. Mossaides
Director

Data Snapshot of Children in Massachusetts

The following data is from the Kids Count Data Center for calendar year 2016, unless otherwise noted. Kids Count uses a wide variety of sources to collect their data, including census data, the American Community Survey, and the National Survey of Children's Health, among others. For more information regarding data sources, please visit kidscount.datacenter.org.

Total Number of Children (0-18 years) in Massachusetts:

1,378,102

Counties with the Highest Number of Children

Middlesex

320,989

23% of child population

Worcester

178,309

13% of child population

Essex

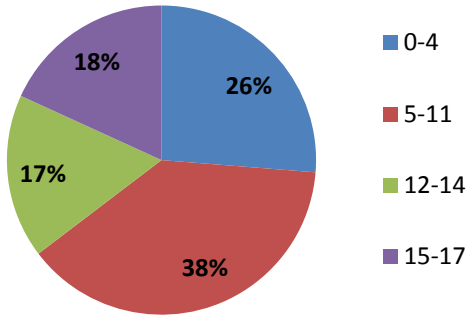
168,545

12% of child population

Racial/Ethnic Breakdown of Children in Massachusetts

- 63% of children are white (non-Hispanic)
- 18% of children are Hispanic or Latino
- 8% of children are black (non-Hispanic)
- 7% of children are Asian (non-Hispanic)
- 4% of children are of two or more racial groups (non-Hispanic)
- American Indian/Alaskan Native and Native Hawaiian and Other Pacific Islanders each make up less than 1% of the child population

Ages of Children in Massachusetts (in years)

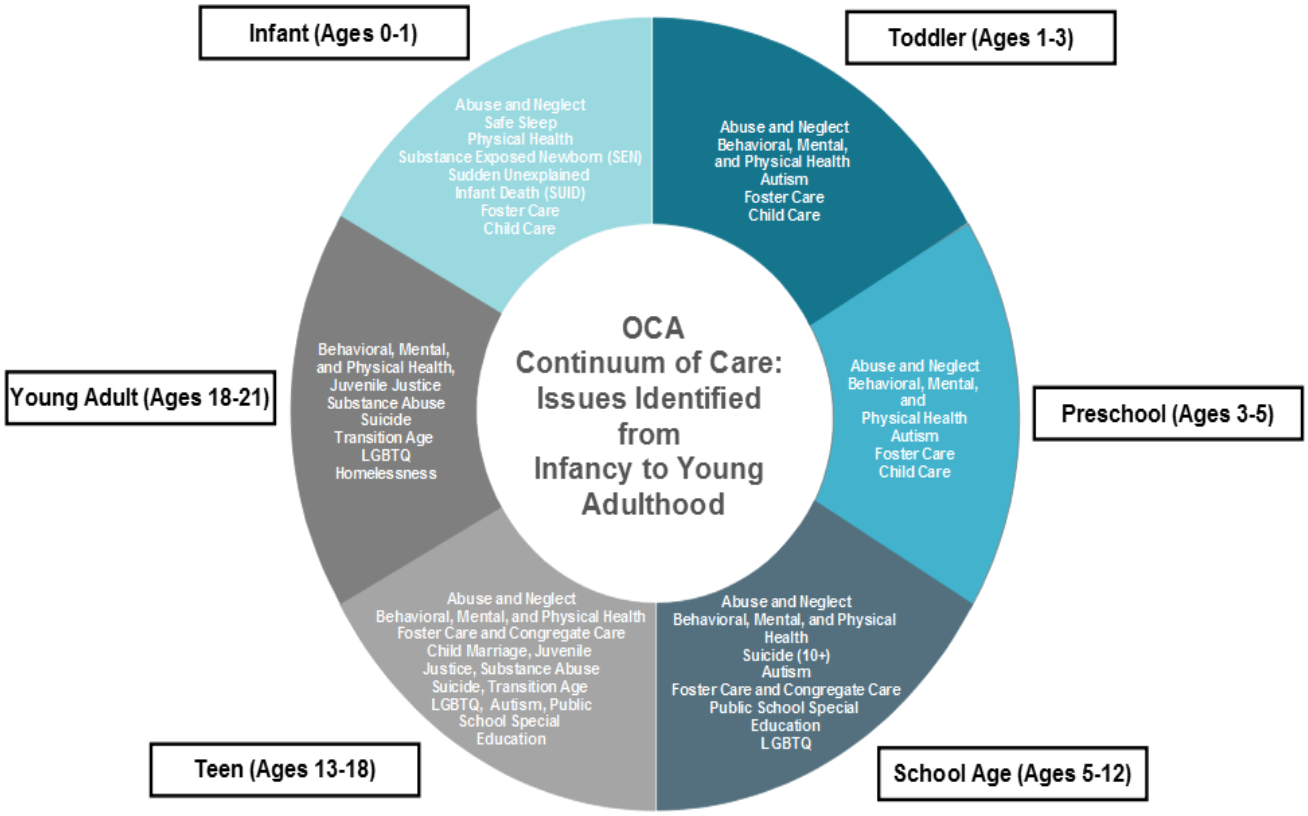


Fast Facts on Children in Massachusetts

- 87.5% of students graduate from high school in four years, though this varies by race and by school district (Department of Elementary and Secondary Education, 2016)
- 16% of children speak a language other than English at home (American Fact Finder, 2016)
- 14% of children live at or below the poverty line (Kids Count, 2016)
- 286,606 of children have special health care needs, including physical, developmental, behavioral, or emotional needs (Kids Count, 2015-2016)
- 201,791 children have experienced two or more adverse events in their lifetime (Kids Count, 2015-2016)
- 47,000 children have had a parent incarcerated (Kids Count, 2015-2016)

Childhood Continuum of Care

The OCA focuses on multiple issues that span childhood, from infancy to young adulthood.



Fiscal Year 2017 Activities

Child Fatality Review Program Needs Assessment

The statewide Child Fatality Review (CFR) program was created in 2000 with the goal of decreasing the incidence of preventable childhood deaths and injuries. The state child fatality review team is co-chaired by the Office of the Chief Medical Examiner (OCME) and the Department of Public Health (DPH). Eleven local child fatality review teams meet under the leadership of the District Attorneys' (DA) offices to conduct multidisciplinary reviews of individual child 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 a member of the state team, and OCA staff members attend local CFR meetings.

In FY17, the OCA began a needs assessment of the CFR program to determine if improvements are needed in the CFR process. The OCA started the needs assessment with the local CFR teams. The purpose of the local needs assessment was to understand similarities and differences between local teams, identify common strengths and challenges, and learn how the state team can better support the local teams. From February to April 2017, the OCA conducted interviews with ten out of 11 local teams. In June 2017, OCA completed its report, *Child Fatality Review Needs Assessment: Finding from Local Teams*[5], and staff presented the findings at the statewide child fatality review conference. The key findings are as follows:

- In general, local teams prepare for and conduct their meetings in similar ways. Local teams collect many of the same types of records prior to reviews (e.g. medical records, police records, and DCF records), send out similar information to team members prior to meetings, and use the sign-in sheet as the confidentiality agreement.

- Common challenges of local teams include the amount of time it takes to prepare for the CFR meetings, competing priorities within the DA's office, and a lack of staffing.

- Local teams differ when it comes to choosing which deaths they are going to review:
    - Local teams have different rules for choosing deaths to review based on the child's residency.
    - Some local teams choose to review all child deaths, while others choose to only review deaths that the team considers preventable. These variations appear to stem from different interpretations of the purpose of child fatality review across local teams.

[5] https://www.mass.gov/files/documents/2018/01/02/Massachusetts%20CFRT%20Local%20Needs%20Assessment%20Report%20FINAL.pdf

- Local teams want the state team to share more information about common issues (e.g. safe sleep, suicide prevention), to improve communication between the state and local teams, and to create guidelines that will develop more consistency in death selection, review and recommendations.

The OCA developed a series of action steps based on the local team findings, including creating a clearinghouse of available resources on specific topics, and developing new guidelines for local teams to address the issues identified in the report. The OCA is working with DPH and the OCME, with assistance from the National Center for Fatality Review and Prevention, to move forward on these action items. The OCA also started a similar needs assessment of the state team, and will combine the findings from both assessments in a final report with action items in the spring of 2018.

Child Sexual Abuse Prevention Task Force

In 2014[6] the Legislature created a multidisciplinary Task Force on the prevention of child sexual abuse. The Child Advocate and the executive director of the Children's Trust serve as co-chairs, and the Task Force is comprised of over 40 representatives from the Legislature, state agencies that serve children, and representatives of a broad range of YSOs. The Task Force is charged with:

- Developing guidelines for child sexual abuse prevention and intervention plans by organizations serving children and youths
- Developing tools for the development of child sexual abuse prevention and intervention plans by organizations serving children and youths
- Recommending policies and procedures for implementation and oversight of the guidelines
- Recommending strategies for incentivizing such organizations to develop and implement child sexual abuse prevention and intervention plans
- Developing a five-year plan for using community education and other strategies to increase public awareness about child sexual abuse, including how to recognize signs, minimize risk and act on suspicions or disclosures of such abuse

During FY17, the Child Advocate continued to co-chair the Task Force, and six subcommittees also met frequently. In June, the Task Force finalized guidelines for child sexual abuse prevention in YSOs, and delivered its report, *Guidelines and Tools for the Development of Child*

[6] Chapter 431 of the Acts of 2014

Sexual Abuse Prevention and Intervention Plans by Youth Serving Organizations in Massachusetts[7], to the Legislature.

In the final report, the Task Force presented a proactive child abuse prevention framework for YSOs that helps identify and prevent child sexual abuse before it occurs, or ensure its earliest possible detection and reporting. The elements of the framework include:

- Codes of conduct and monitoring
- Education and training
- Responding and reporting
- Safe physical environments and safe technology
- Screening, hiring and criminal background checks
- Policies and procedures

In June, the Task Force launched its first in a series of community meetings with YSOs to present the report and its recommendations, and for the Task Force to gain an understanding of the types of supports local YSOs need to implement the recommended framework.

Looking Ahead to Fiscal Year 2018

In FY18, the Task Force will continue to host community meetings with YSOs, with the goal of having at least one in each region of the Commonwealth. The Task Force also expects to continue its work to address several additional areas of child sexual abuse prevention, including:

- Child-on-child sexual abuse
- Commercial sexual exploitation of children and youth
- Issues of "consensual" sexual encounters among minors
- Children with physical or intellectual disabilities or other special needs that may render them more vulnerable to sexual abuse or exploitation
- Child and adult mentoring, and other one-on-one relationships that require special provisions to accommodate

[7] http://childrenstrustma.org/uploads/files/PDFs/Child_Sexual_Abuse_Prevention_Task_Force_Report.pdf

Creating Safe School Environments

Children's' "work" is often defined as being in school and learning. During FY17, the OCA focused on supporting safe environments in public schools in two important ways.

Steps Toward Child Abuse Prevention & Creating Safe School Environments

The OCA collaborated with representatives of the Children's Trust, DCF and DESE to revise the second edition of the "how-to" manual for educators, *Steps Toward Child Abuse Prevention & Creating Safe School Environments*[8]. This newly published third edition provides updated guidance to schools and other child-serving organizations on how to create safe environments for children, including:

- Codes of conduct
- Safe screening and hiring practices
- New information on building a safe cyber environment
- Recent updates to Massachusetts laws
- Updated DCF policies

Interagency Child/Adolescent Restraint/Seclusion Prevention Initiative (R/S Initiative)

In response to growing concern about restraint and seclusion in child-serving treatment[9] and educational settings, in 2009 the Commonwealth 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, service providers, schools, and community advocates to focus on preventing and reducing the use of potentially traumatizing behavior management techniques. The vision for the multi-year effort is that all child-serving educational and treatment settings will use trauma informed, positive behavior support practices that respectfully engage youth and their families. The Child Advocate was an active participant in the quarterly meetings held during FY17, which advanced restraint and seclusion efforts, shared data, and highlighted best practices in trauma-informed prevention/alternative strategies.

On January 1, 2016 both DEEC and DESE promulgated new restraint and seclusion regulations that were intended to prohibit the use of seclusion, minimize and/or prevent the use of restraint, and significantly restrict the use of prone restraint which is considered more harmful and fatal than other techniques. The new regulations also created data tracking and reporting measurements and mechanisms for increased parent/family involvement.

[8] http://childrenstrustma.org/uploads/files/PDFs/child_abuse_prevention_manual.pdf

[9] This does not include psychiatric facilities licensed by DMH. DMH has long standing regulations, policies and practices concerning the use of restraints and seclusion in treatment facilities they license.

While the data from the first year of restraint regulation implementation is still being analyzed, it appears there has been a reduction in restraint use in EEC licensed treatment and educational programs since the R/S Initiative began. Restraint data from DEEC (2008) identified 65,150 episodes of restraint use (OCA annual report 2009), and aggregate restraint data from DEEC (2017) appears to indicate approximately 20,000 episodes of restraint use across their licensee providers. This recent data suggests a promising direction and improvement in reducing restraints in child-serving treatment and educational settings in Massachusetts.

Interagency Working Group (IWG) on Residential Schools

In the spring of 2016, Governor Charlie Baker asked the OCA to guide and coordinate a review of public and private residential and day programs that provide educational services to children who require a residential or substantially separate educational setting to meet their needs. In response, the OCA formed the IWG on residential schools, and continued to lead this review throughout FY17. The IWG includes representatives from the state agencies responsible for the oversight of residential schools[10], and is guided by a Steering Committee comprised of the Child Advocate, Undersecretaries of EOE and EOHHS, and a representative from the Governor's Office.

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The IWG's initial review concentrated on improving the Commonwealth's systemic capacity to prevent harm to children by more quickly identifying residential schools at risk of experiencing operational challenges, and how to provide appropriate support and technical assistance to these schools to ensure their safe operation. The OCA engaged the Public Consulting Group (PCG) to conduct best practices research in oversight of residential schools, review the current oversight processes and procedures in Massachusetts, and identify key safety and risk factors to inform recommendations for improvements. The residential school providers, who share the goal of ensuring the well-being of and the best outcomes for the Commonwealth's children, cooperated fully in the review. Immediate changes were implemented, which include:

- DESE and DPPC information sharing is now integrated more closely with DCF and DEEC, who have statutorily required information sharing responsibilities about allegations of abuse and/or neglect in DEEC licensed residential schools.

- Quarterly interagency meetings were established between DCF, DEEC, and DESE to discuss residential schools, and identify patterns, trends, or areas of concern.

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[10] DCF, DMH, DEEC, DESE, and the Disabled Persons Protection Commission (DPPC), which has investigative power for individual incidents, not oversight of the schools.

The report, *Interagency Working Group on Residential Schools: Review and Recommendations to Improve Oversight and Monitoring*[11] was prepared by PCG in consultation with the IWG, and issued by the OCA in April 2017. The report documents the complex licensing and approval, contract monitoring, and incident investigation processes of all the state agencies responsible for these functions. The report also identifies 26 risk and safety factors for residential schools. While the majority of these indicators were already being collected and reviewed by DCF, DEEC, DESE, or DPPC, the report makes recommendations for ensuring that this information is collected, shared and used more effectively to improve oversight, align monitoring, and streamline incident notification and response.

By statutory design, services to children are overseen by highly specialized state agencies. The licensure of residential schools is by DEEC. The investigation of abuse and/or neglect in residential schools is done by DCF, DEEC or DPPC. Although there is limited statutorily mandated information sharing among these oversight agencies, they have sought ways to collaborate. Ensuring timely and coordinated information sharing is one of the challenges to be addressed by the IWG.

In November 2016, the Child Advocate testified at an informational hearing before the Joint Committee on Education regarding the work of the IWG. The Child Advocate described the progress made in assessing the agencies current practices for licensing and approval, contract monitoring, and incident response. In April 2017, the Child Advocate briefed the Committee members on the content and recommendations of the IWG Report.

Looking Ahead to Fiscal Year 2018

The IWG will continue to meet in FY18 to implement the recommendations outlined in the report, and the OCA will continue to lead this effort. The expectation is that this next phase will lead to the reengineering of current practices so that information about critical risk and safety factors will be routinely collected and timely shared across all agencies, and monitoring and response activities will be better coordinated. There is a plan to pilot these changes before proposing any needed statutory or regulatory changes, and to continue to make interim improvements as processes are redesigned.

[11] http://www.mass.gov/childadvocate/docs/residential-schools-report-april-2017.pdf

Mapping of Children's Services

In FY16, the OCA initiated a mapping project to develop a greater understanding of state services available to children and families in Massachusetts. The OCA also wanted to better understand the internal processes for five EOHHS agencies[12] that provide services to children. The OCA met with senior staff from each agency to collect information on the services available, the eligibility criteria for those services, data collection processes, and how agencies partner with one another in these areas.

In FY17, the OCA began using the information collected from the mapping project to create an online resource guide to children's services in Massachusetts. Using the mapping project data as a foundation, the OCA conducted additional research on children's programs and services offered by DCF, DDS, DMH, DPH and DYS. The OCA expanded its research to include the Department of Transitional Assistance and the Massachusetts Commission for the Deaf and Hard of Hearing in the resource guide, as these agencies also provide important services for children and families. In FY18, the OCA will reach out to the Massachusetts Commission for the Blind to include their services in the resource guide.

The OCA is working with the agencies to ensure the guide has accurate information and that the language used in the guide is easy to understand, especially for those who may not be familiar with state services. This resource guide will provide useful information for parents, caregivers, and professionals who are interested in state services available to children. The OCA expects the resource guide to be available on our website in the spring of FY18.

[12] DCF, DDS, DMH, DPH, DYS

Complaint Line

The OCA is mandated to receive complaints about services provided to children by state agencies. In addition, anyone who needs help finding resources related to the health, safety, and well-being of a child or youth may contact the OCA. Family members, foster parents, advocates, attorneys and others contact the OCA to express concerns about the treatment of a child or youth receiving services. OCA staff is available to help identify services or resources, provide information and referrals, and assist with resolving a problem that involves a state agency.

The OCA maintains a confidential database of concerns from the Complaint Line and analyzes the information to improve our understanding of child welfare and all child-serving systems. The Complaint Line informs our interagency and policy work and assists the OCA to establish priorities.

In FY16, the OCA made changes to the Complaint Line to provide clarity about the role of our office, to improve public access to our office and referrals, and to develop a better understanding of the service needs and issues facing the children and families of the Commonwealth. In FY17, the OCA remained committed to examining and improving our Complaint Line. Our FY17 improvements include:

- Establishing a direct liaison relationship with the Director of the DCF Office of the Ombudsman. This liaison relationship allows the OCA to quickly relay concerns received on the Complaint Line about DCF. The DCF Office of the Ombudsman is available to answer questions about a DCF case, DCF policy or procedure, and can directly respond to concerns.

- Updating the resources on our website, available under the *Resources for Children and Families* tab. Individuals can find updated information about child welfare, juvenile justice, legal representation, mental and behavioral health, substance abuse, crisis hotlines and education resources. It is the goal of the OCA to provide useful information and resources to allow the public to best advocate for themselves and resolve their concerns.

- Continuing to examine and improve our internal policies, procedures and data tracking methods, which enhances our ability to identify service gaps and trends.

On October 30, 2017, the OCA shared our FY16 and FY17 Complaint Line improvements during the annual meeting of the OCA Advisory Council. In response to feedback from the OCA Advisory Council, the OCA reexamined our data tracking methods and implemented immediate changes, retroactive to the beginning of FY17. The most significant change is that we

acknowledge not all contacts on our Complaint Line are a complaint or concern. Rather, some individuals contact our office seeking only information and resources. To distinguish between these two types of contacts, the OCA now has two categories for the Complaint Line:

- Complaint: An individual contacts the OCA to express dissatisfaction with any agency or program that provides services to children of the Commonwealth.

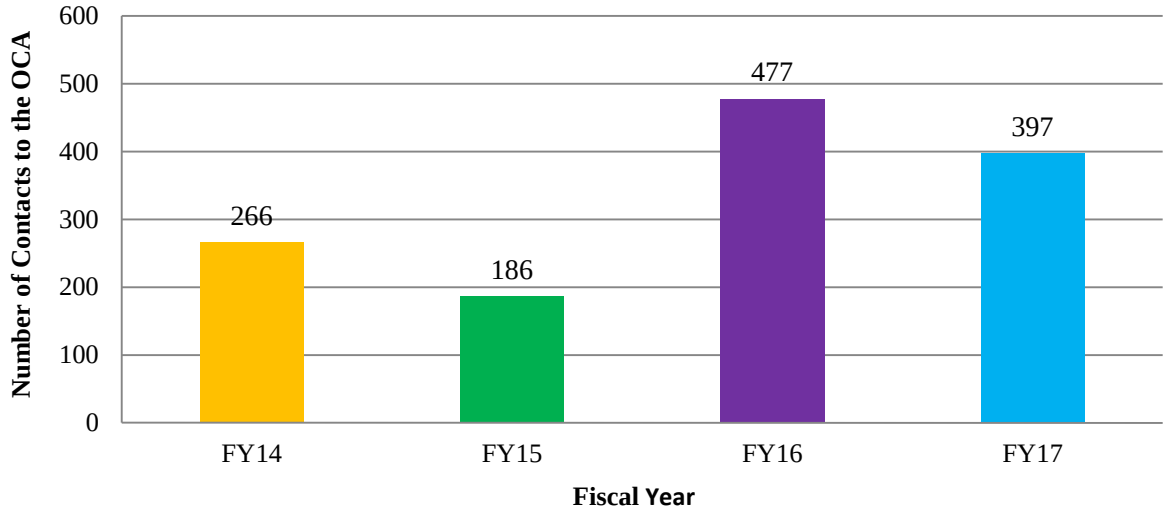
- Information and Referral: An individual contacts the OCA to request information, resources or education on a specific topic, and does not express dissatisfaction with any agency or program that provides services to children of the Commonwealth.

Overview of OCA Complaint Line Contacts

In FY17, the OCA received 397 Complaint Line initial contacts. Of these contacts, 85% (339) were **complaint** contacts, and the remaining 15% (58) were **information and referral** contacts.

As shown in Figure A, the total number of contacts decreased by 17% from FY16 to FY17. These numbers only reflect an individual's initial contact with the OCA. Any follow-up contact from the same individual, about the same issue, is not included in the chart below. Thus, the actual number of calls, emails, and letters the OCA receives in a given year is higher than what is reflected in this chart.

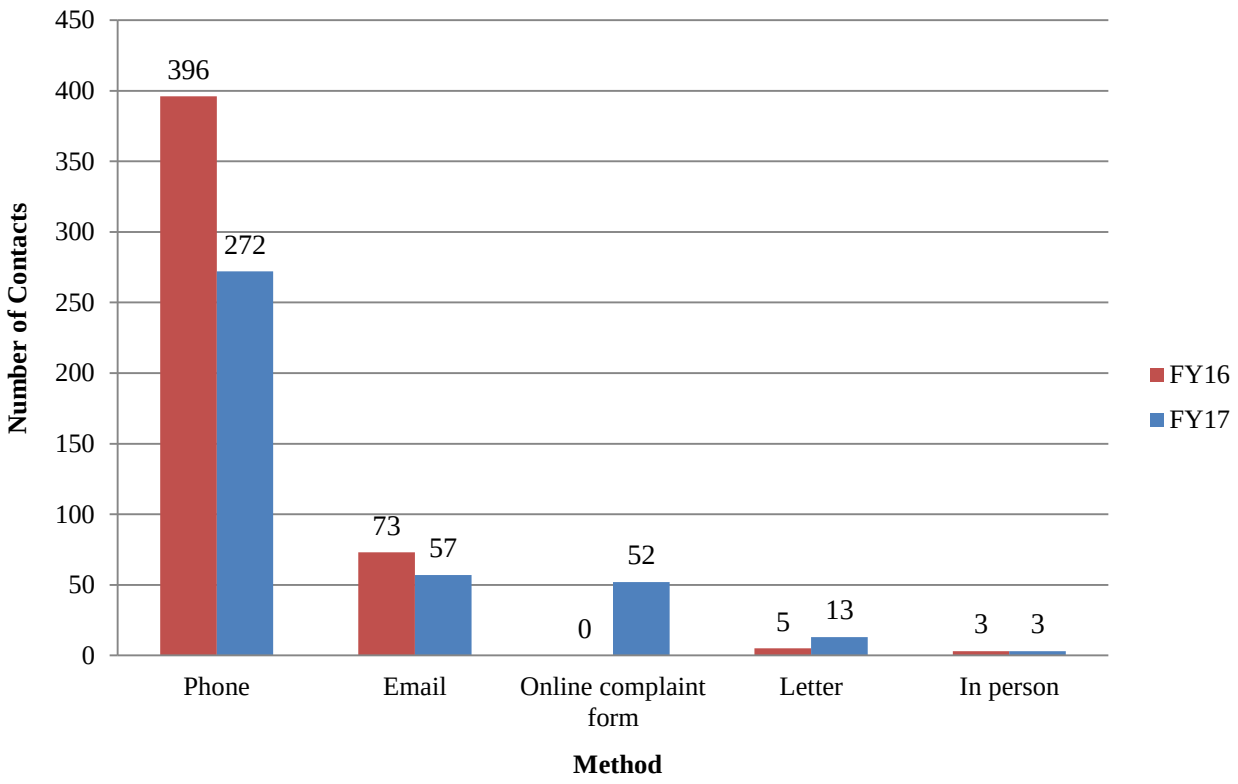
Figure A: Total Individual Complaint Line Contacts FY14-FY17



In FY17, 46% of individuals who contacted the OCA, either to file a complaint or to receive information/referral, were biological parents or grandparents. The OCA also received calls and emails from other relatives (e.g. aunts and uncles), other adults in the child's life (e.g. friends and neighbors), foster parents, and professionals who have contact with the child (e.g. attorneys, teachers, therapists). Three children contacted the OCA on their own behalf. The OCA continuously considers methods of improving our outreach to children to let them know about our Complaint Line.

Figure B shows the different methods that individuals used to contact the OCA in FY16 and FY17. The OCA primarily receives inquiries via telephone. In FY17, the OCA launched a new online complaint form that is available on our website. As a result, the number of contacts received through online methods (email and the complaint form) has increased from 15% in FY16 to almost 30% in FY17.

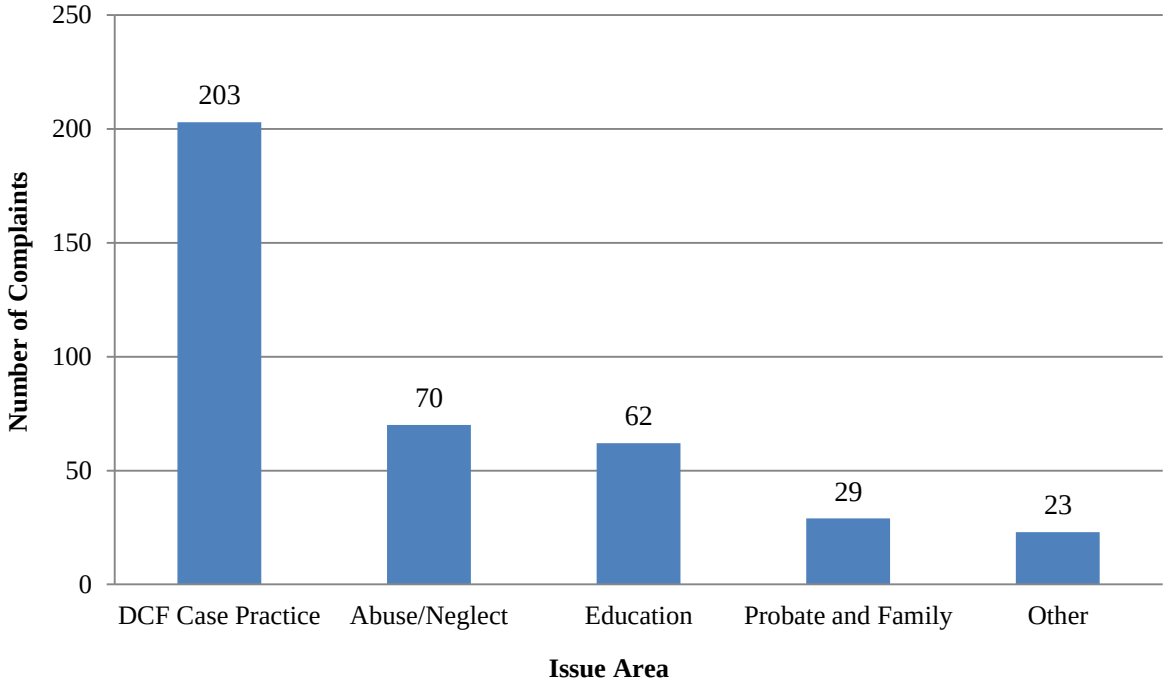
Figure B: Complaint Line Method of Contact
FY16 vs. F717



Complaint Category

Of the 339 contacts in the **complaint** category, over half (60%) included concerns about DCF case practice. Many of these concerns were about placement, visitation, adoption, and changes in permanency planning. The second most common complaint was about abuse and/or neglect. In many of these contacts, individuals were reporting concerns that a child was being abused and/or neglected. In these instances, the OCA provided the individual with the phone number for the Child-at-Risk Hotline to file a report of abuse and/or neglect with DCF. Finally, the third highest complaint area was regarding education. In this category, individuals reported complaints and concerns regarding issues such as inappropriate school discipline, bullying, and special education issues. Figure C shows the distribution of complaint contact concerns for FY17.[13]

Figure C: Complaint Line Topic Areas, FY17 (n=387 complaints)



[13] The number of complaints in Figure C is higher than the number of complaint contacts because individuals may report more than one type of complaint when they contact the OCA.

Information and Referral Category

Review of the FY17 **information and referral** (58) contacts show that the requests for information covered a wide variety of topics. Table 1 lists examples of the common questions the OCA receives for these types of contacts.

Table 1: Types of Questions Asked in Information and Referral Contacts

Abuse and Neglect	Child Welfare
How do I report abuse or neglect? What happens after a report of abuse or neglect is filed?	How do I become a foster parent? How do I become an adoptive parent? My grandchild is involved with DCF: what are my rights as a grandparent?
Education	**Legal**
How do I find an education advocate? How do I find additional support for my child's upcoming IEP meeting? How do I find more information on residential schools?	How do I find an attorney? How do I obtain a Guardian ad Litem? How do I find a mediator for my custody case?

Complaint Line Concerns by Topic Area

DCF Case Practice
- Lack of agency responsiveness
- Client/DCF communication and expectations
- Decisions made by social worker and agency staff
- DCF social worker not meeting home visiting requirements

Placement
- Kinship placement rights
- Appropriateness of placement

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

Education
- Bullying
- Advocacy for special education services
- Restraints and discipline policies in schools
- Individual Education Plan (IEP) questions and process

Abuse & Neglect
- Maltreatment in school settings
- Filing a report of abuse and/or neglect
- Restraints in residential and group homes
- DCF's response to a report of abuse and/or neglect

Courts & Legal Representation
- Court rulings
- Rolling trials
- Contested custody issues
- Ineffective legal representation
- Role of attorney and Guardian ad Litem
- Obtaining an attorney or Guardian ad Litem
- Infrequent contact between attorney and client
- Grandparent and kin custody and visitation rights

Visitation
- Grandparent visitation rights
- Appropriateness of visitation plan

Permanency
- Legal risk
- DCF goal changes
- Premature reunification
- Adoption and guardianship
- Delay in achieving permanency
- Length of time in out-of-home placement

Other/Systemic Issues
- Denial of services
- Insurance limitations
- Lack of professionalism
- Coordinating multi-agency involvement
- Cost share for out-of-home placement
- Difficulty accessing services for children with complex needs

Abuse or Neglect in Out-of-Home Settings

The OCA receives reports of abuse and/or neglect[14] that have been investigated and supported by DCF regarding children in out-of-home settings. These settings include foster care, residential treatment programs, licensed and unlicensed child care, preschool, elementary and secondary schools, hospitals, and transportation services. The reports include demographic information on the child and the alleged perpetrator of the abuse and/or neglect (e.g. foster parents, other adults in a foster home, residential treatment program staff), details of the investigation, and the basis for the decision to support the allegations.

OCA staff review, analyze and discuss each report, obtain more information in select incidents, and collaborate with the agencies involved. In FY17, the OCA contacted a number of state agencies and service providers to discuss emerging issues and trends. Examples of these contacts include:

- DCF concerning details and/or decisions about specific foster homes
- DCF concerning staffing and programmatic issues in congregate care programs
- DYS concerning staffing and programmatic issues in detention and treatment programs
- Provider agencies to learn about improvements to their services to children
- The Child Advocate and OCA staff visited two provider agency residential treatment programs, and three DYS residential treatment programs to learn about their treatment models, staffing and programmatic improvements

In addition to collaborating with agencies, the OCA uses what is learned from the review of these reports to inform our interagency work. For example, in FY17 this information helped the OCA led *Interagency Working Group on Residential Schools* project.

Overview of Abuse or Neglect Reports

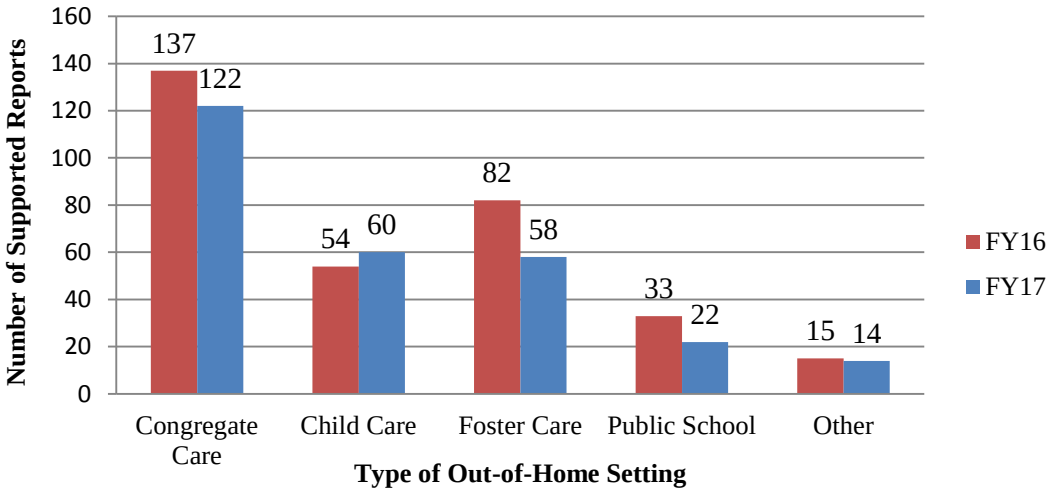
In FY17, the OCA reviewed 276 supported reports of abuse and/or neglect that occurred in out-of-home settings. In these reports, 655 individual allegations of neglect, physical abuse, or sexual abuse were supported, and at least 429 children were the victims of these supported allegations.[15] There are more supported allegations than number of reports because in each report of abuse and/or neglect there can be more than one type of allegation (neglect, physical abuse, sexual abuse, etc.) and/or more than one child or alleged perpetrator involved in the incident.

[14] A report of abuse and/or neglect filed with DCF is a "51A" report. The "51B" report is the DCF investigation into the allegations of abuse and/or neglect. (Chapter 119 of Massachusetts General Laws)

[15] One report of abuse and/or neglect was supported for neglect on "children unknown", so there may have been more children involved in these incidents than we have identified here.

Figure D shows the distribution of supported reports of abuse and/or neglect received across the different types of out-of-home settings. The OCA received the most reports from congregate care, child care, and foster care. The total number of supported reports in congregate care decreased by 11% from FY16 to FY17, while the number of supported reports from child care increased by 11%. The total number of supported reports received from foster care decreased by almost 30%. It is not clear why the number of supported reports of abuse and/or neglect from foster care has decreased over the past two fiscal years.

Figure D: Number of Supported Abuse/Neglect Reports by Type of Out-of-Home Setting FY16 vs. FY17



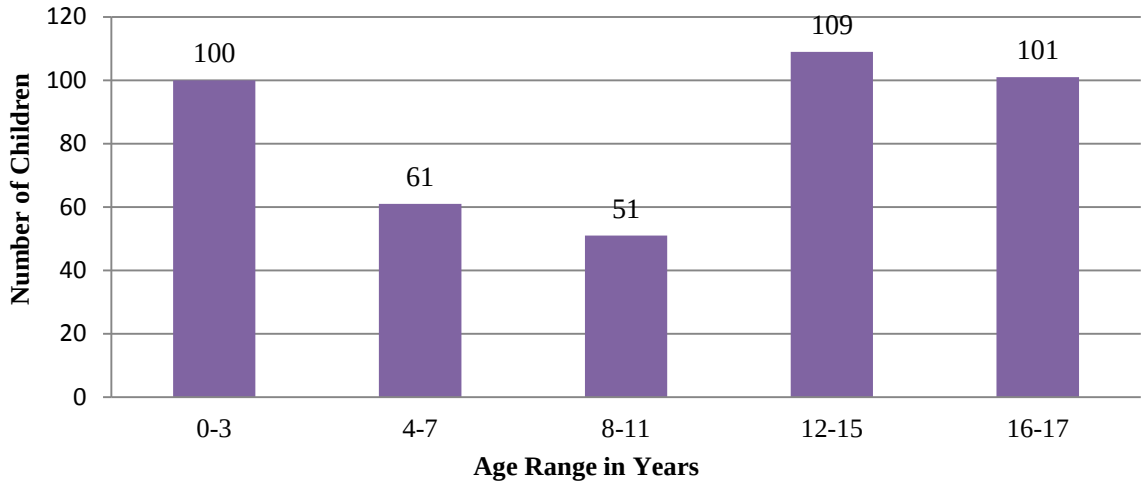
Demographics of Children Identified in Supported Abuse and/or Neglect Reports

Of the children for whom we have data on gender, males comprised 54% (219) of the children with supported abuse and/or neglect allegations.[16] Females were 46% (185) of the population, and one child was identified as transgender.

Figure E shows how many children appeared in each age category for FY17. Age information was not included for seven children identified in supported reports of abuse and/or neglect in FY17. Children 12-17 years-old are half of this population.

[16] Gender information was not included for 24 children identified in supported reports of abuse and/or neglect.

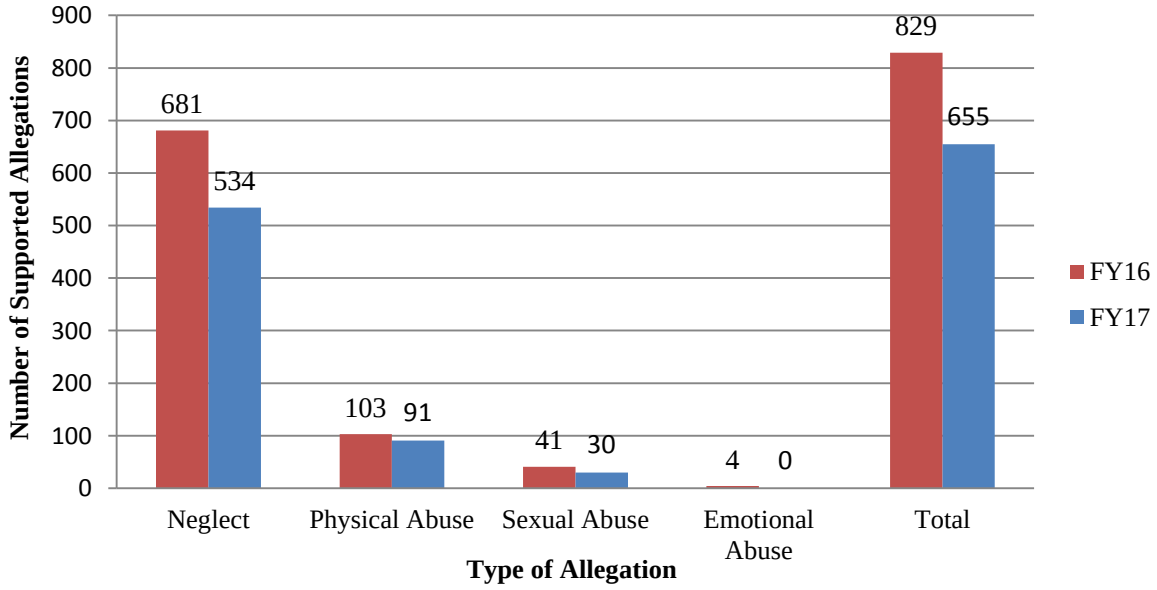
Figure E: Age Range of Children with Supported Allegations, FY17 (n=422 children)



Supported Allegations by Type

From FY16 to FY17, there was a 21% decrease in the number of total supported allegations. Figure F shows that there was a 22% decrease in the total number of supported neglect allegations, a 12% decrease in the total number of supported physical abuse allegations, and a 27% decrease in the total number of supported sexual abuse allegations.

Figure F: Supported Allegations by Type FY16 vs. FY17



While the raw number of supported allegations has gone down, the distribution of supported allegations has not changed significantly over the past two fiscal years. As seen in Figures G and H, neglect allegations comprised over 80% of all allegations in both fiscal years. The distribution of supported physical, sexual, and emotional abuse allegations has also remained relatively constant. There were no supported allegations of emotional abuse in FY17.

Figure G: FY16 Distribution of Supposed Abuse/Neglect Allegations (n=829 supported allegations)

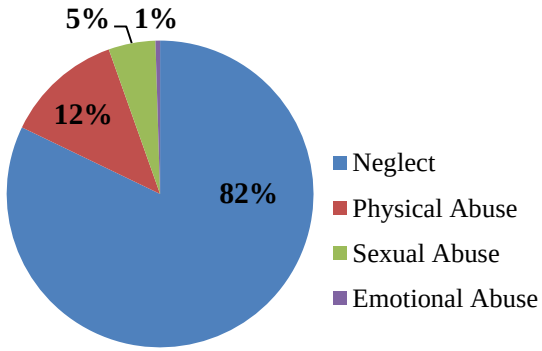
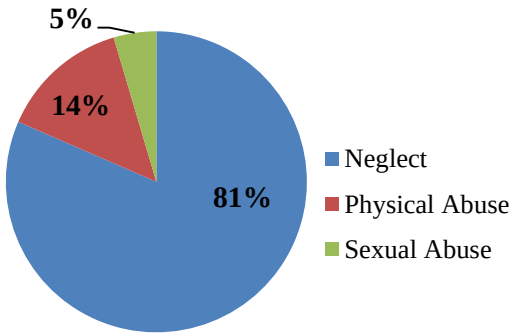


Figure H: FY17 Distribution of Supported Abuse/Neglect Allegations (n=655 supported allegations)

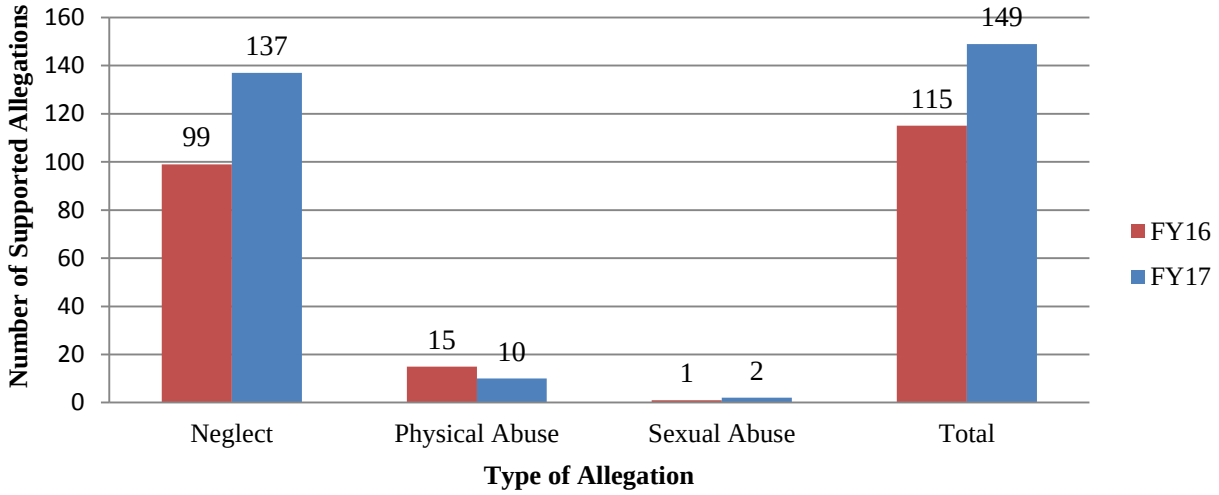


Supported Allegations by Type of Out-Of-Home Setting

Child Care

Figure I shows that child care settings had a total of 149 supported allegations of abuse and/or neglect in FY17, which is a increase of 30% over FY16. Of these supported allegations, 92% of them were for neglect. There were no supported allegations of emotional abuse in child care settings. This count includes child care licensed by DEEC, those operating without a license, family and center-based child care.

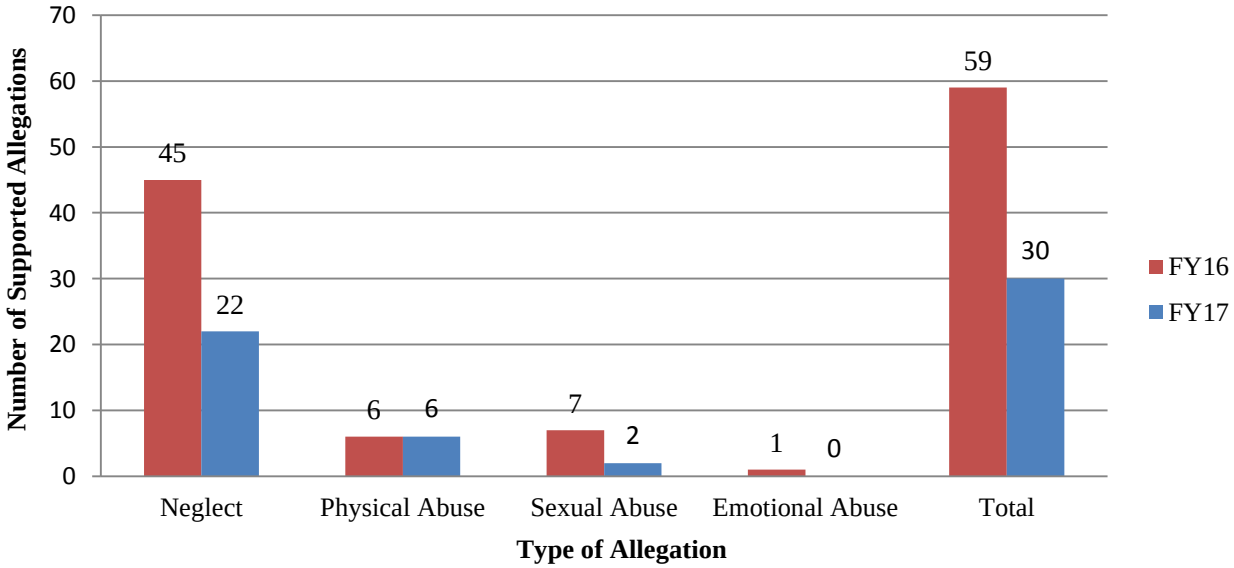
Figure I: Supported Allegations in Child Care
FY16 vs. FY17



Public Schools

Public schools had a total of 30 supported allegations of abuse and neglect in FY17, which is almost a 50% decrease since FY16. Neglect is the most commonly supported allegation in these settings.

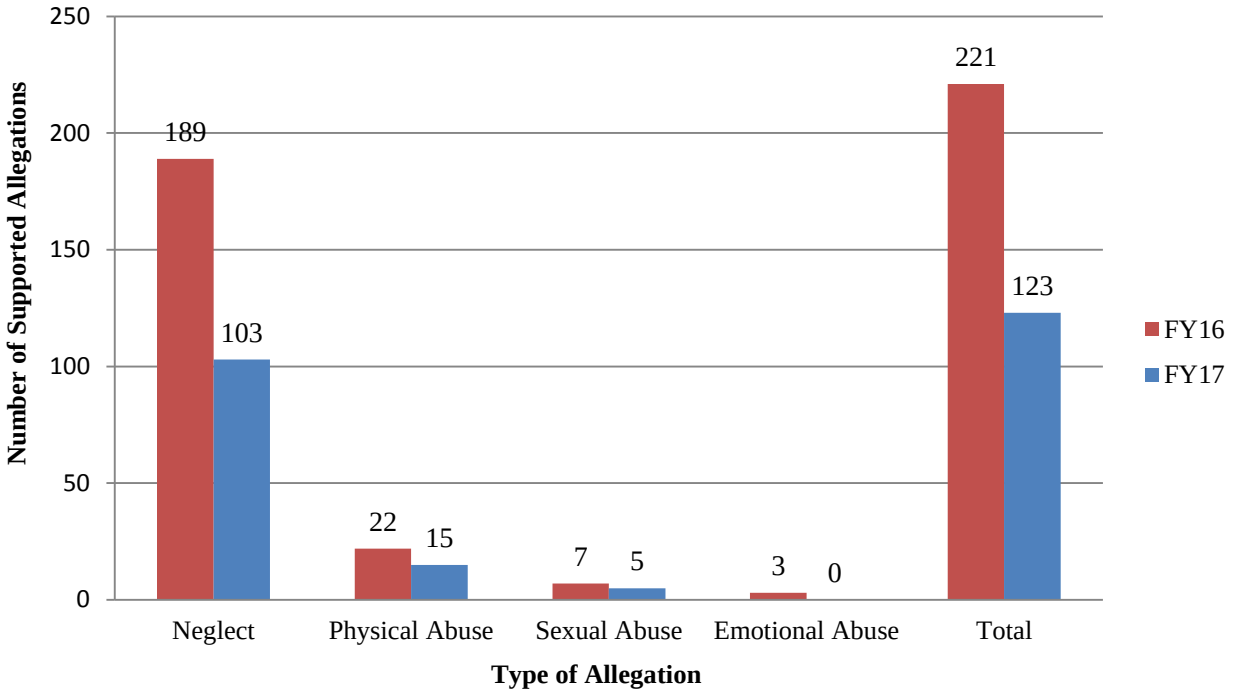
Figure J: Supported Allegations in Public School
FY16 vs. FY17



Foster Care

Foster care had a total of 123 supported allegations of abuse and/or neglect in FY17, which is a 44% decrease from FY16. This includes supported allegations for all types of foster care homes, including DCF unrestricted, child-specific, kinship, and comprehensive foster care. Neglect continues to be the most commonly supported allegation in foster care, although the number of supported neglect allegations has decreased. As noted earlier, the number of supported reports of abuse and/or neglect decreased by almost 30% over the past two fiscal years, so the OCA expected that the number of supported allegations in foster care would also decrease.

Figure K: Supported Allegations in Foster Care FY16 vs. FY17

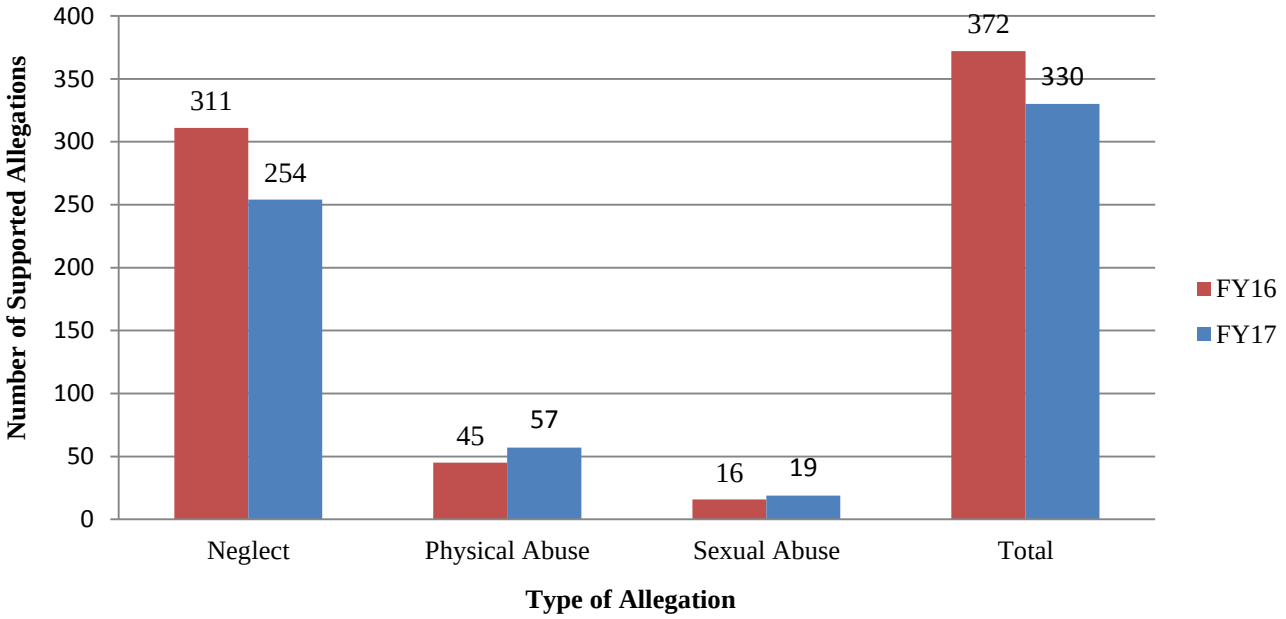


Congregate Care

Congregate care programs are for children who have needs that require care in a placement setting other than their home or foster care. Congregate care includes short-term stabilization programs, as well as long-term group care. In FY17, there were a total of 330 supported allegations of abuse and/or neglect of children in congregate care.

Figure L shows the distribution of these supported allegations by type for FY16 and FY17. Neglect was the most commonly supported allegation in both FY16 and FY17, followed by physical abuse and sexual abuse. While the total number of supported neglect allegations has decreased, the number of supported physical abuse and sexual abuse allegations has increased since FY16. There were no supported allegations of emotional abuse in congregate care in the past two fiscal years.

Figure L: Type of Supported Allegations for Congregate Care FY16 vs. FY17



OCA Analysis of Neglect in Foster Care

When a child needs to be removed from their home for abuse and/or neglect, foster care is one type of placement setting they may experience. DCF placed 14,532 children in foster care throughout FY17. Table 2 lists the types of foster care homes and the number of children placed in each type.[17]

Table 2: Number of Children in Each Type of Foster Home

Type of Foster Home	Total Number of Children in Foster Care as of June 30, 2017
DCF Kinship/Child-Specific	2,197
DCF Unrestricted	2,239
DCF Pre-Adoptive	555
Comprehensive Foster Care	1,523
Total	**6, 514**

In FY17, reports of supported neglect allegations in foster care affected 88 children in 56 foster homes. This represents less than 1% of the population of children placed in foster care throughout FY17, and approximately 1% of the foster homes in Massachusetts.

Neglect continues to be the most commonly supported allegation in foster care. The OCA believes that it is important to understand the different kinds of neglect occurring in these settings to determine if there are any trends in the different types of foster care. With this information, the OCA can identify potential gaps in support services for foster families, and make recommendations for policy and program changes to lower incidents of neglect in foster care.

[17] **Kinship** foster care providers are related to the child by blood, marriage, adoption or may be a significant adult in the child's life to whom the parents ascribe the role of family. **Child specific** foster care providers are non-kinship individuals who are licensed for a particular child (e.g. a child's school teacher). A **DCF unrestricted** and/or **pre-adoptive** foster care provider is an individual who has been licensed by DCF to provide foster/pre-adoptive care for a child usually not previously known to the individual. **Comprehensive foster care** programs provide therapeutic services and supports in a family-based placement setting to children for whom a traditional foster care environment will not be sufficiently supportive; are transitioning from a residential/group home level of care and require the intensity of services available through this program; or are discharging from a hospital setting.

In FY16, the OCA developed a coding structure[18] to categorize the most common reasons why a foster parent might have a supported neglect allegation. Based on an extensive review of past supported reports of neglect in foster care, the OCA developed five categories of neglect, as shown in Table 3.

Table 3: Types of Neglect in Foster Care, as Defined by the OCA

Code Name	Definition
Education	Failure to assure the child has proper educational opportunities.
Failure to Provide for Basic Needs	Failure to provide the child with proper food, shelter, clothing.
Healthcare	Failure to assure the child has proper and/or timely physical, dental or behavioral health care.
Improper/Inadequate Supervision	Foster parent engages in behaviors, activities, or actions that compromise their ability to properly supervise the child.
Risk of Emotional/Psychological Harm	Foster parent exposes the child to behaviors, activities or actions that pose a risk of harming the child's emotional or psychological well-being.

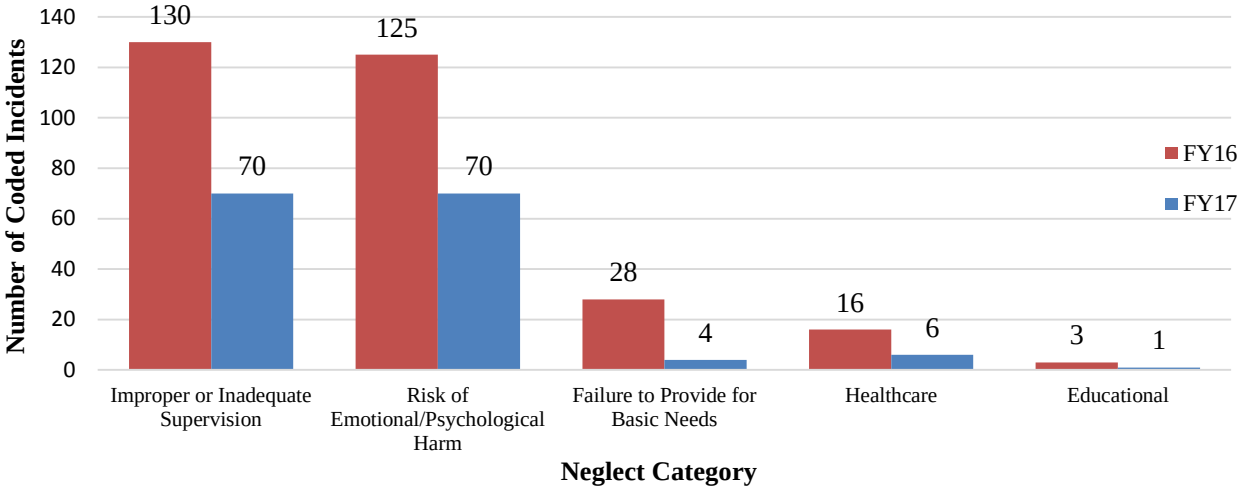
OCA staff review each supported report of abuse and/or neglect in foster care, and code all types of neglect that are supported in the investigation. Often, one report of abuse and/or neglect with supported neglect allegations may involve multiple types of neglect. For example, if the investigation concludes that a foster parent left a child home alone, and also did not bring a child to a medical appointment, these incidents[19] would be coded under both Improper/Inappropriate Supervision and Healthcare.

[18] Detailed information about the methodology used to develop these categories is available in Appendix C.
[19] The OCA uses the term "incident" to describe the specific behaviors or actions that lead to a supported neglect allegation.

Overview of Neglect in Foster Care

The OCA categorized 151 incidents of neglect in all foster care for FY17, and Figure M compares the results from FY16 to FY17. In FY16, Improper/Inadequate Supervision was the most common neglect category by a small margin. In FY17, Improper/Inadequate Supervision and Risk of Emotional/Psychological Harm are equal at 70 incidents each. Overall, all of the categories have decreased from FY16 to FY17 due to the large decrease in the total number of reports substantiated in FY17.

Figure M: Types of Neglect for All Foster Care
FY16 vs. FY17



Neglect by Type of Foster Care

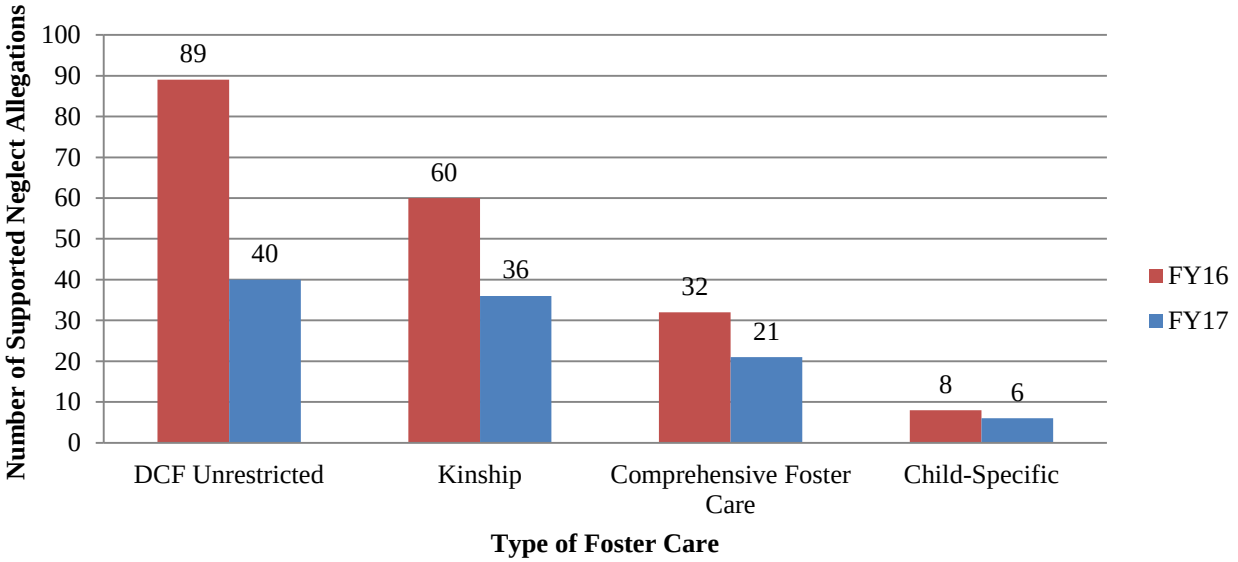
Figure N shows the number of supported neglect allegations by type of foster care. The OCA expected to see more supported neglect allegations from DCF unrestricted and kinship foster care, as the majority of children are placed in one of these two types of foster homes (see Table 2). DCF unrestricted foster care have the highest number of supported neglect allegations (40), followed by kinship foster care (36) and comprehensive foster care (21). The decrease in supported neglect allegations from FY16 to FY17 reflects the decrease in the number of supported reports received about foster care in FY17.

In FY16, one foster home had a dual designation of a DCF unrestricted and kinship home. In FY17, six foster homes had this dual designation. Having this designation means that the foster parent(s) had a kinship placement in their home, and they were also approved by DCF to take in

foster children. In these supported neglect incidents, the OCA categorized the foster home as either a DCF unrestricted or kinship, depending on the child's relationship to the adult perpetrator.

Based on the information available in the abuse and/or neglect reports, it can be difficult to determine if a DCF foster home is pre-adoptive or independent living. For the purpose of this analysis, all pre-adoptive and independent living foster homes are incorporated into the DCF unrestricted foster care category.

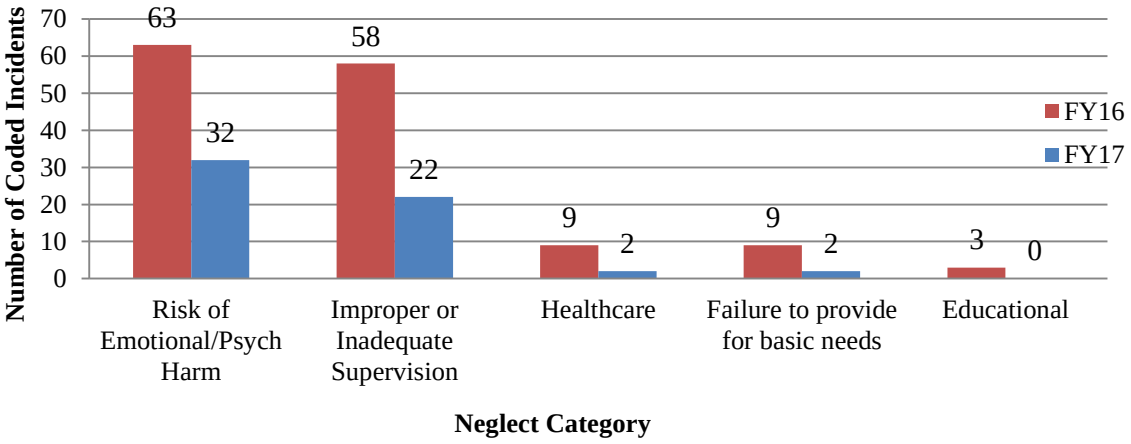
Figure N: Number of Supported Neglect Allegations by Type of Foster Care FY16 vs. FY17



DCF Unrestricted Foster Care

At the end of FY17, there were 2,217 DCF unrestricted foster care homes. The OCA coded 58 incidents of neglect in DCF unrestricted foster care in FY17, compared to 142 incidents in FY16. This is an almost 60% decrease in the number of incidents over the past two fiscal years. Figure O shows the types of neglect that appear in DCF unrestricted care. In FY17, Risk of Emotional/Psychological Harm comprised 55% of the incidents, followed by Improper/Inadequate Supervision at 37%. There were no incidents of educational neglect in DCF unrestricted foster care in FY17. The distribution of the neglect categories is the same as it was in FY16.

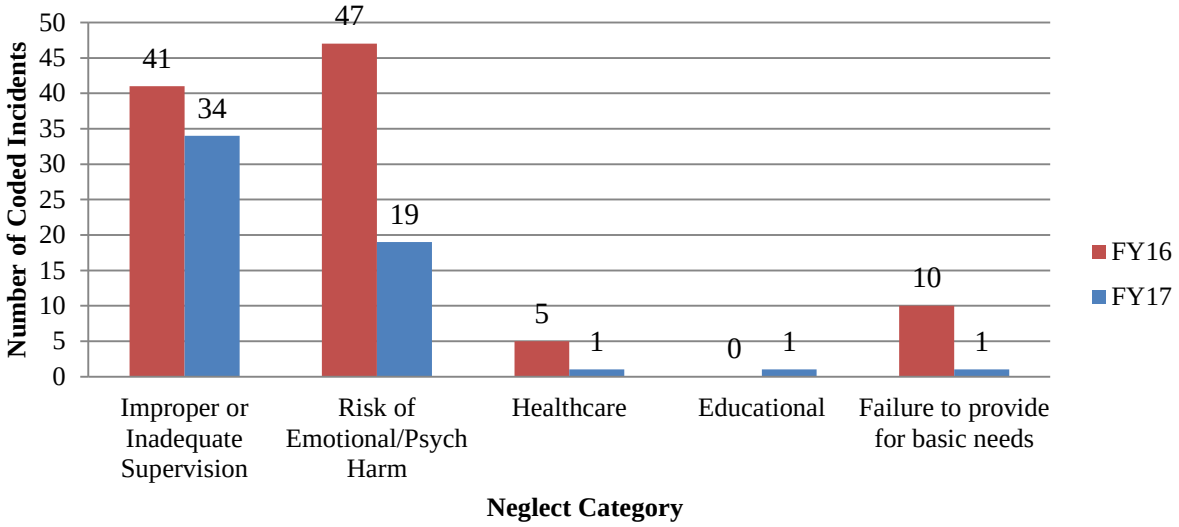
Figure O: Types of Neglect in DCF Unrestricted Foster Care FY16 vs. FY17



Kinship Foster Care

The OCA coded 56 incidents of neglect in kinship foster care homes, which is a decrease of 46% since FY16. In addition to fewer incidents, Figure P shows that the distribution of neglect categories has also changed over the past two fiscal years. While Risk of Emotional/Psychological Harm was the most common neglect category in FY16, Improper/Inadequate Supervision is the top category for FY17. Supervision issues comprise 61% of all incidents of neglect in kinship care in FY17.

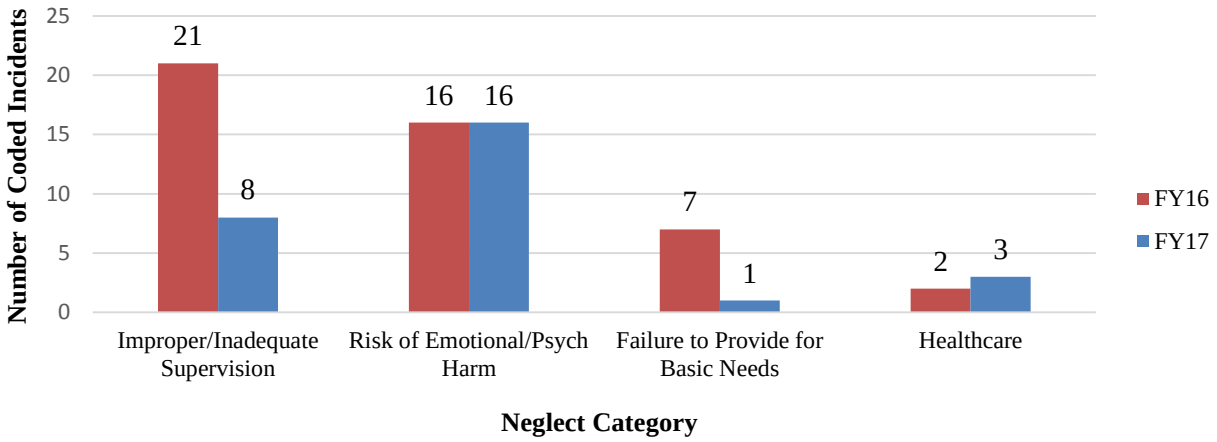
Figure P: Types of Neglect in Kinship Foster Care FY16 vs. FY17



Comprehensive Foster Care

Figure Q shows the types of neglect found in comprehensive foster care. The OCA coded 28 incidents of neglect in FY17. In FY16, the most common type of neglect in these foster homes was Improper/Inadequate Supervision. However, in FY17, this changed to Risk of Emotional/Psychological Harm, even though the number of incidents in this category did not change over the past two fiscal years. There were no incidents of educational neglect in FY16 or FY17.

Figure Q: Types of Neglect in Comprehensive Foster Care FY16 vs. FY17



Child-Specific Foster Care

In child-specific foster care, there were nine coded incidents of neglect. Three of these were in the category of Risk of Emotional/Psychological Harm, and the remaining six were in the category of Improper/Inadequate Supervision.

Next Steps

With only two fiscal years of data, the OCA is not able to determine if this is the beginning of a downward trend of supported neglect allegations in foster care, or if it is an anomaly. However, even with this decrease, Improper/Inadequate Supervision and Risk of Emotional/Psychological Harm continue to be the common types of neglect in foster care. The OCA will continue to review, examine and monitor how agencies and other services providers can better support foster parents with additional resources and trainings so they can meet the needs of this vulnerable population.

OCA Analysis of Neglect in Congregate Care

Congregate care programs are for children who have needs that require care in a placement setting other than their home or foster care. Congregate care includes short-term stabilization programs, as well as long-term group care. A child in congregate care may be placed by DCF, or other entities within or outside of Massachusetts, such as state agencies, local school districts, and parents. For this reason, the actual number of children placed in congregate care in Massachusetts is not readily available. Table 4 shows number of children receiving services from DCF who are placed in congregate care.

Table 4: DCF Children Placed in Congregate Care

Type of Congregate Care	Total Number of DCF Children in Congregate Care as of June 30, 2017
Group Home	816
Continuum	24
Residential	464
STARR (short-term residential)	380
Teen Parenting	16
Total	**1,700**

Neglect is the most commonly supported allegation in congregate care. To understand the different kinds of neglect occurring in these settings, the OCA did a qualitative review of previous reports of abuse and/or neglect in congregate care with supported neglect allegations. This analysis led to the development of a coding structure[20] to categorize the types of neglect that appeared in these reports.

While the types of neglect that occur most often in congregate care are similar to those in foster care, there are some important differences. As a result, the OCA created four categories of neglect specifically for congregate care, as shown in Table 5.

[20] Detailed information about the methodology used to develop these categories is available in Appendix C.

Table 5: Types of Neglect in Congregate Care, as Defined by the OCA

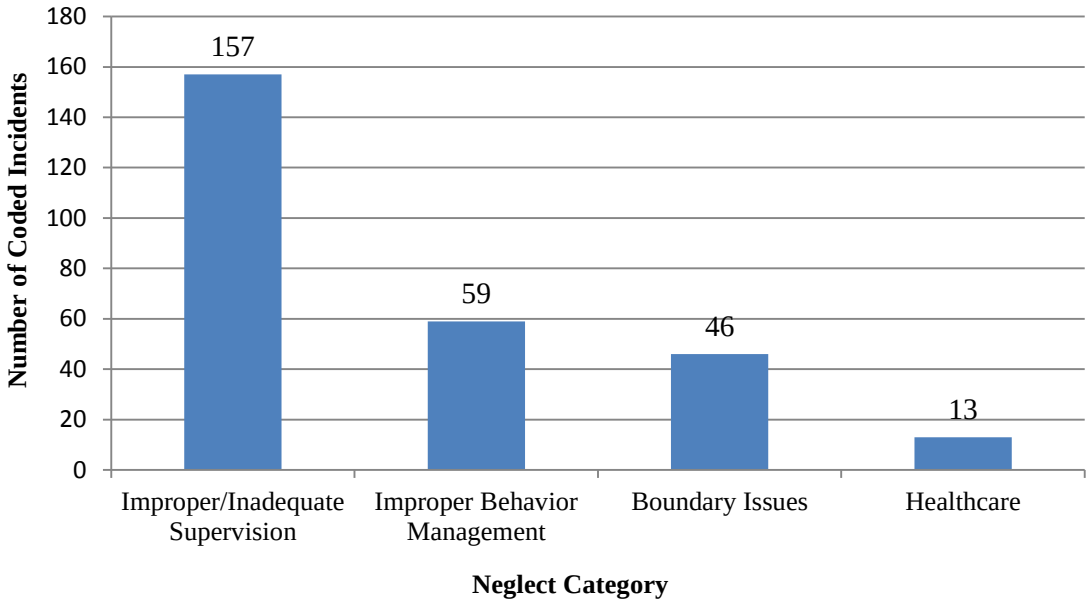
Code Name	Definition
Boundary Issues	Congregate care program staff members violate physical, emotional, and/or sexual boundaries with a child.
Healthcare	Congregate care program staff members fail to assure the child has proper physical, dental or behavioral health care.
Improper Behavior Management	Congregate care program staff members do not respond properly to a child who is exhibiting concerning behaviors.
Improper/Inadequate Supervision	Congregate care program staff members engage in behaviors, activities, or actions that prevent them from being able to properly supervise the child.

There are more coded incidents of neglect than there are supported allegations, because one allegation may contain multiple kinds of neglect. For instance, if the investigation concludes that a program staff member used social media to contact a child and allowed children to be unsupervised, that would be categorized as both Boundary Issues and Improper/Inadequate Supervision.

Types of Supported Neglect Allegations in Congregate Care Settings

In FY17, the OCA received 110 reports of abuse and/or neglect with supported allegations of neglect in congregate care. There were 254 supported neglect allegations that affected 173 children. OCA staff coded 275 incidents of neglect that appeared in supported reports of abuse and/or neglect from congregate care settings. Figure R shows that over half (57%) of the incidents of neglect were the result of Improper/Inadequate Supervision. Improper Behavior Management and Boundary Issues follow at 21% and 17%, respectively, and Healthcare appears in only 5% of these incidents.

Figure R: Types of Supported Neglect Allegations in Congregate Care (n= 275 coded incidents)



Injuries in Congregate Care

The OCA tracked any injuries a child sustained during the course of one of these incidents, if these injuries were the result of staff actions, and whether or not the report supported on neglect only, or if it was supported on neglect and physical abuse. Of the 173 children identified in these reports:

- 51 children (29%) sustained injuries
- Abrasions were the most common types of injuries (e.g. cuts, bumps, and bruises)
- 78% of these injuries were the result of staff actions, including inappropriate restraints
- 71% of these cases were supported on both neglect and physical abuse

Workforce Accountablity

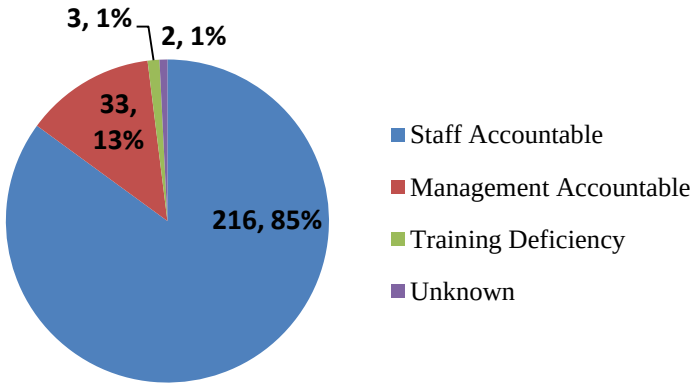
In addition to identifying the types of neglect and injuries in congregate care, the OCA wanted to determine who or what was responsible for the behavior that resulted in the supported neglect allegation. After a qualitative review of previous reports of abuse and/or neglect, the OCA developed four categories of workforce accountability, as shown in Table 6.

Table 6: Workforce Accountability in Congregate Care, as Defined by the OCA

Code Name	Definition
Staff Accountable	A staff member is aware of the program policy and/or a child's therapeutic plan, but does not follow the policy or plan. A staff member engages in a behavior that common sense should tell them is not appropriate (e.g. smoking marijuana with child).
Management Accountable	When a staff member was acting on the directive of a supervisor/program manager. When a member of the management team does not properly address an issue.
Training Deficiency	When a staff member's actions were the result of a lack of proper training, and that lack of training led to the staff member's inappropriate actions.

Figure S shows that for the majority of the 254 supported neglect allegations, individual staff members (216) were found accountable for their actions. This means that the staff member was aware of program policies or procedures prior to their actions, so they are personally accountable for their behavior. Management was accountable for 13% (33) of the supported allegations. This means that the behavior was the result of poor management, such as not giving proper directives to staff members. Finally, only three incidents were determined to be the result of a lack of training of staff, and two were categorized as unknown. The unknown category is used when during the investigation it cannot be determined which staff member is responsible for the incident.

Figure S: Workforce Accountability (n= 254 supported allegations)



Program Accountability

In the vast majority of supported reports of abuse and/or neglect, DCF investigators support allegations against individuals, not programs. Programmatic issues are typically handled by DEEC, which licenses congregate care programs. It is only in very rare instances that a DCF investigation report will support neglect allegations on a program, rather than an individual.

In most incidents of neglect in congregate care, the OCA found that individual staff members were in fact responsible for their actions. The OCA determined that in 25% of the reports with supported neglect allegations, the entire program should be held accountable. This means that in the course of the investigation, there was evidence of systemic problems and/or training deficiencies in the program, or that there were multiple staff members involved in the incident, including management.

Next Steps

As with foster care, the OCA will continue to refine these neglect categories to better understand the kinds of behaviors that result in neglect in congregate care. The OCA will continue building this foundational data to strengthen policy discussions, which includes identifying what additional resources and/or trainings may be needed to address common issues in these programs.

Critical Incident Reports (CIR)

A critical incident is when a child who is in the custody of or receiving services from a state agency suffers a fatality, near fatality or serious bodily injury[21]. When a critical incident occurs, the involved agency or agencies report it to the OCA. The OCA conducts a careful review of the circumstances surrounding the incident, and often will communicate with the reporting agency to determine what could be learned from the incident.

In July 2016, statutory changes broadened the OCA definition of critical incident to mandate that all child-serving executive agencies, not just those within EOHHS, report critical incidents to the OCA. At the same time, the definition of critical incidents was expanded to include emotional injury[22].

As highlighted in the audit of DCF issued by the Office of the State Auditor on December 7, 2017, one challenge of critical incident reporting is that an agency's definition of a critical incident may be different than the OCA's definition.[23] Recognizing the need for greater clarity between the OCA and the EOHHS reporting agencies about what constitutes a critical incident, the OCA met with DCF, DMH and DYS to strengthen our shared understanding of reporting requirements. In FY18, the OCA will meet with DDS and DPH, as well as the relevant agencies organized under the EOE. These ongoing conversations are a part of the OCA's commitment to accurate, thorough data collection and reporting and to collaborate with state agencies.

In FY17, the following EOHHS agencies reported critical incidents on the populations they serve:

- DCF reported critical incidents involving children in DCF custody or receiving services, as well as children whose families had DCF involvement within the preceding six months.
- DDS reported critical incidents involving children receiving services in the community.
- DMH reported critical incidents involving children who are DMH clients in the community, acute care, residential treatment programs, and hospital settings.

[21] A **near fatality** is when a child suffers an act that places them in a critical or serious condition. A **serious bodily injury** involves a substantial risk of death, extreme physical pain, protracted or obvious disfigurement or protracted or loss or impairment of the function of a bodily member, organ or mental faculty or emotional distress. (OCA statute, Chapter18C).
[22] For purposes of critical incident reporting, the OCA considers **emotional injury** to include when a child witnesses an unexpected fatality or near fatality of an individual related to an overdose, violent act or suicide. .
[23] See Office of the State Auditor's 2017 report, *Department of Children and Families For the period January 1, 2014 through December 31, 2015.* https://www.mass.gov/files/documents/2017/12/07/201610583s.pdf.pdf

- DPH reported critical incidents involving children receiving DPH funded services in the community and in residential treatment programs licensed and funded by DPH.
- DYS reported critical incidents involving youth detained or 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.

Overview of Critical Incident Reports

While only the OCME can make the final determination regarding the cause and manner of a child's death, the critical incident report provides important information about the nature of the incident that led to the injury or death of a child. The OCA analyzes all critical incidents, as the risk of injury or death due to unsafe sleep environments, suicide, and violence can be decreased with proper outreach and interventions. The OCA prioritizes preventable childhood injury and death as one of its key issue areas. In FY18, the OCA will examine the critical incident report data by looking at specific issues, including infant mortality and suicide. The goal is to identify trends and patterns in the data that will inform future policy and program work.

In FY17 the OCA received 110 statutorily required critical incident reports regarding 97 critical incidents involving 98 children and youth. [24] Of these reports, 69% (76) were regarding fatalities, 23% (25) were near fatalities, and 8% (9) were serious bodily injuries. Males comprised 62% (61) of the children identified in CIRs, and females comprised 36% (35). One child was identified as transgender, and the OCA is missing gender information for one child. [25]

Figure T shows the number of statutorily required CIRs received by category from FY15 to FY17. The number of reports across categories has increased over the past three fiscal years. Some of these increases may be a result of the ongoing conversations the OCA is having with the EOHHS agencies to further clarify the definitions of CIRs, and the types of incidents that must be reported.

[24] When a child is receiving services from more than one state agency, each agency must submit a critical incident report to the OCA. For this reason, in some instances the OCA received two reports concerning the same incident.
[25] Data on gender is based on what the agency lists as the child's gender in the CIR and/or information in related agency reports, if available. Children do not self-identify in these reports.

Figure T: Number of Reports Received by CIR Category FY15-FY17

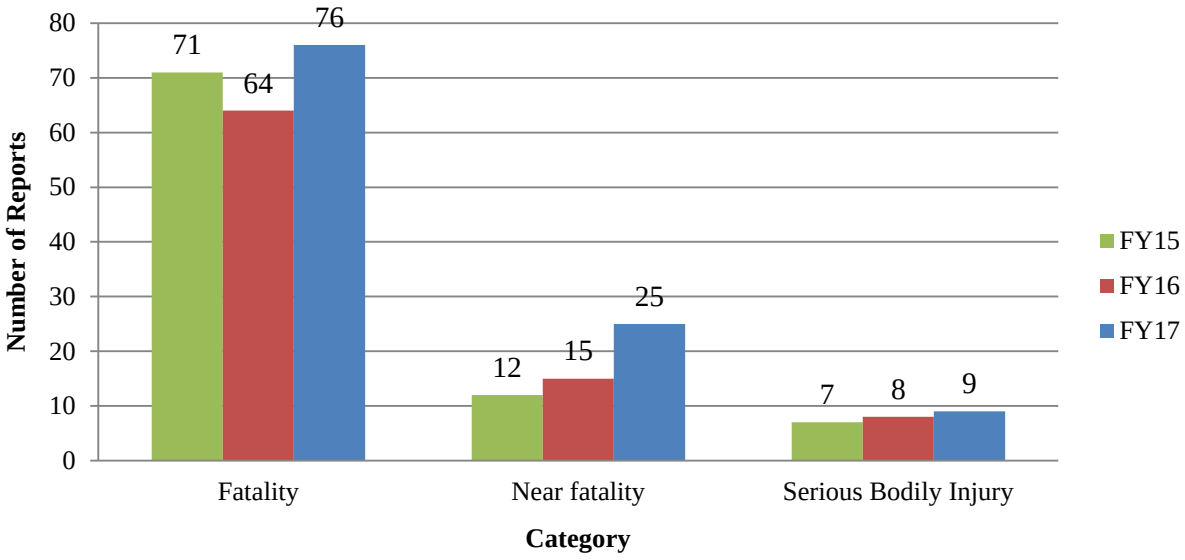
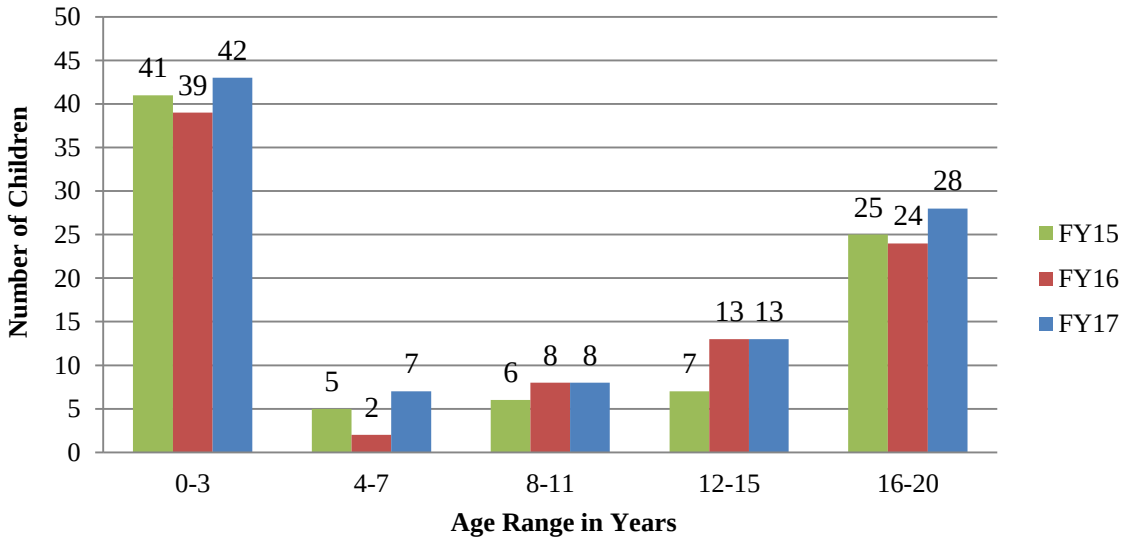


Figure U shows the age distribution for the children who were identified in CIRs, and for whom we have age information. Young children between the ages of zero-to-three and children 16 years-old and older are the most highly represented age groups in CIRs. In FY17, zero-to-three year-olds and older adolescents accounted for 70% of the critical incident population.

Figure U: Age Range of Children in CIRs FY15-FY17



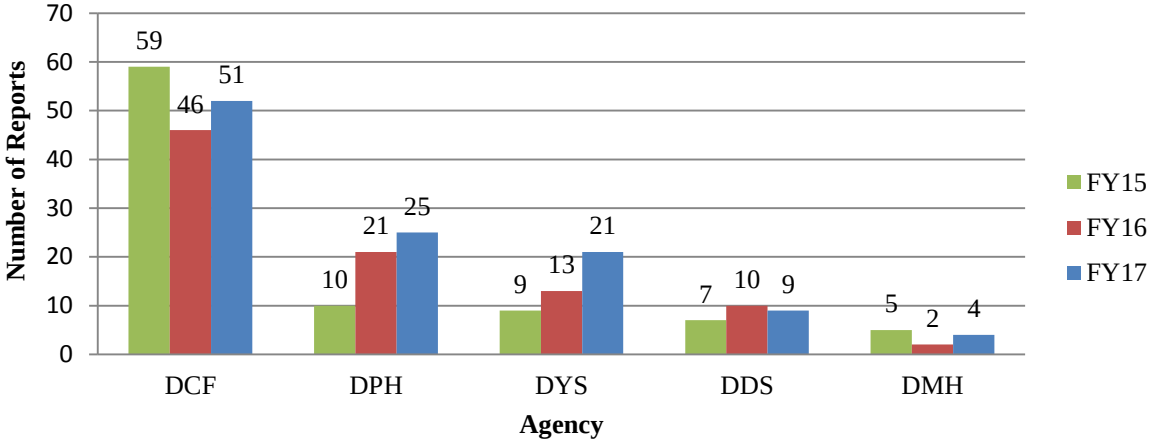
Overview of Critical Incident Reports by EOHHS Agency[26]

When the OCA receives a CIR it conducts an immediate review to learn more about the circumstances of the incident and the reporting agency involvement with the individual. For children receiving services from DCF, the review focuses on whether or not maltreatment may have contributed to the injury or death, and whether there was a missed opportunity for DCF to assist the family and protect the child. OCA staff review case practice and ensure that a managerial review is done at the area or regional level. For children receiving services from agencies other than DCF, OCA staff request additional information in select incidents to review case management practices and promote accountability.

When the OCA is concerned that the actions or inactions of a reporting agency may have contributed to the incident, OCA staff may speak with agency staff, review case records to learn more about the family history and involvement and promote accountability.

The OCA maintains a database of all critical incident reports, which contains important information about each incident, such as child-specific and family information, state agency history with the family, past or current allegations of abuse and/or neglect, and any follow-up the OCA has with the agency involved. This information is helpful to the identification of case practice concerns specific to the child and family involved, as well as system-wide patterns and trends about child maltreatment or associated risk factors. One of the OCA's top priorities is to ensure complete and accurate data collection for all critical incidents.

Figure V: Number of CIRs Submitted per Agency FY15-FY17



[26] In FY16, the OCA received a CIR from the Office of Behavioral Health (OBH) and one from the Executive Office of Elder Affairs (EOEA). Since the OCA does not typically receive reports from OBH or EOEA, these two reports are not included in Figure V.

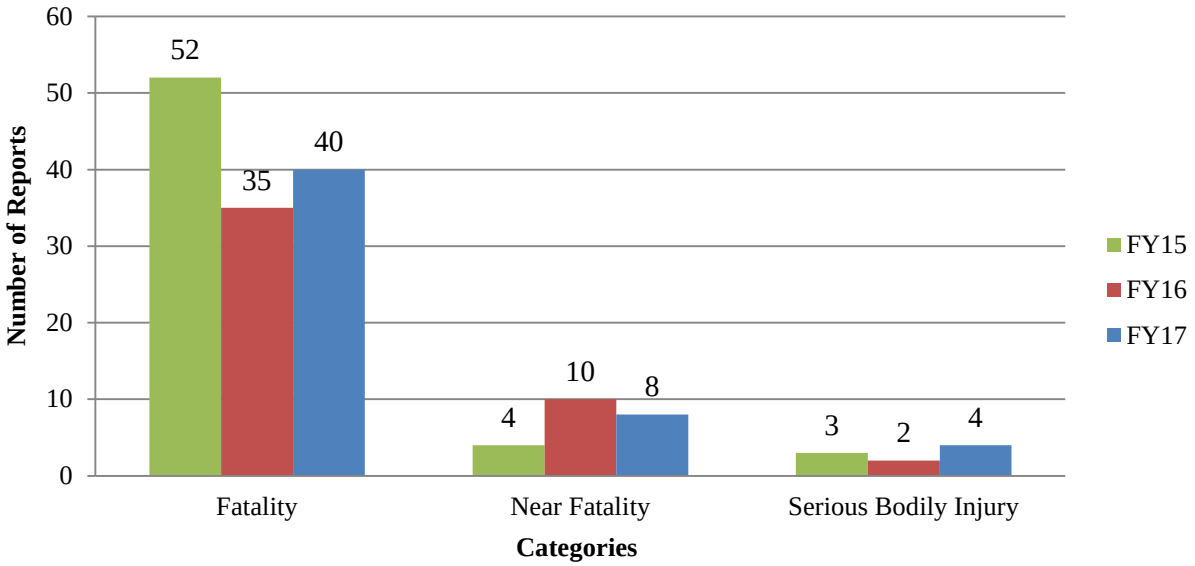
Department of Children and Families (DCF)

The OCA receives CIRs from DCF when a child is either in DCF custody, receiving services, or when the child's case closed within the preceding six months. Custody means that a judge has granted legal custody, which includes the right to determine the placement of a child, to DCF. Children in the custody of DCF may be placed with their parents, with kin, in licensed foster care, group homes, or in residential treatment programs. Children receiving services from DCF are those whose families have an open case with the agency, but who remain at home with their parents or caregivers rather than being placed out of the home, and youth who are 18 years old or older who have asked for voluntary services.

In FY17, 113,335 children under the age of 18 received services from DCF. In FY17, the OCA received 51 critical incident reports from DCF involving 52 children and youth. DCF submitted 40 reports regarding fatalities, eight reports regarding near fatalities, and four reports regarding serious bodily injuries.

The number of children identified in DCF CIR reports submitted to the OCA is 0.05% of the total population of children served by DCF in FY17.

Figure W: DCF CIR Categories
FY15-FY17



On the basis of our FY17 CIR analysis, the OCA determined:

Zero-to-three year-olds

- Of the 28 fatalities, 18 appear to have been sudden and unexpected (SUID)[27]. In more than half of the 18 (14), the DCF investigation revealed that a parent was co-sleeping with their child and/or the child was in an unsafe sleep environment. An unsafe sleep environment is a known risk factor for infant mortality.
- Five fatalities resulted from medical conditions.
- Other fatalities were caused by drownings (two), house fires (two), and suspected physical abuse (one).
- The two near fatalities resulted from head trauma, with one being a case of suspected physical abuse and the other injury was of unknown origin.
- The three serious bodily injuries involved an accidental burn, an accidental fall out of a window, and head trauma due to suspected physical abuse.

Four-to-seven year-olds

- Two fatalities were due to medical conditions, and one was the result of a house fire.

Eight-to-11 year-olds

- One fatality was due to a train accident.
- Two fatalities were the result of medical condition.
- One fatality was the result of a completed suicide.

12-15 year-olds

- The four fatalities were the result of two gunshot wounds, one medical condition, and one completed suicide.
- The two near fatalities were the result of overdoses.

16-20 year-olds

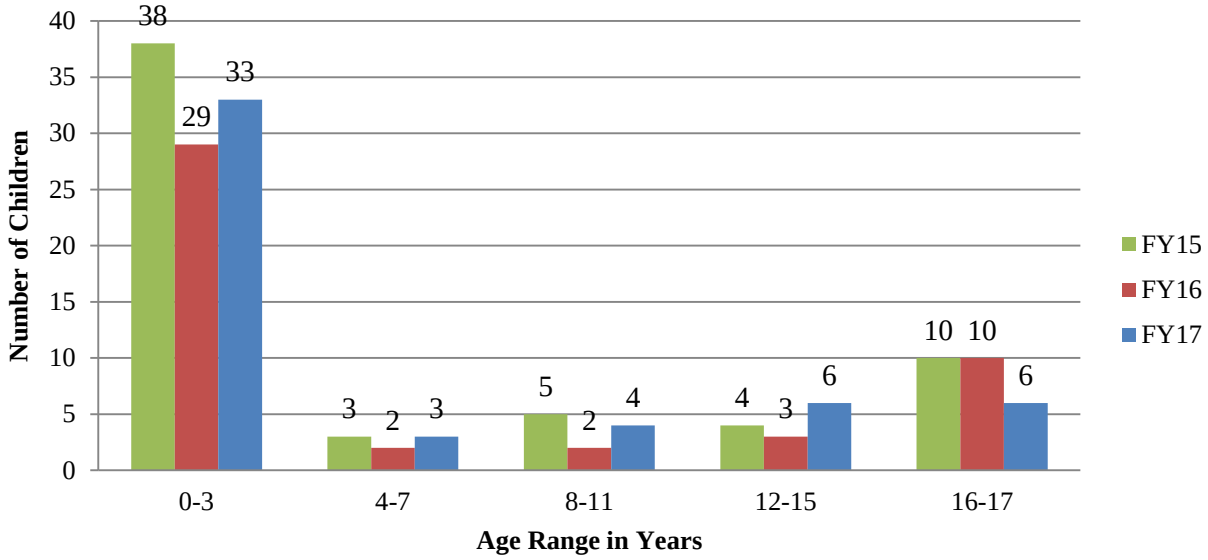
- The cause of one fatality was not determined at the time of the critical incident report.
- The near fatalities included one an attempted suicide and three gunshot wounds.
- The serious bodily injury was from a car accident.

[27] **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. SUID is the most common type of death for infants between the ages of one month and one year in Massachusetts. A death cannot be definitively categorized as SUID until a medical examiner has determined the cause and manner of death.

In FY17, males are the majority of children identified in DCF CIRs. There were 25 fatalities for males compared to 15 fatality reports for females. Males also had more reports of serious bodily injuries (five) compared to females (two).

As shown in Figure X, the majority of the children identified in DCF CIRs are between zero-to-three years-old. There was a 14% increase in the number of zero-to-three year-olds over the past two fiscal years. There were also increases in the number of children between eight-11 years-old, and 12-15 year-olds. The only age group that saw a decrease between FY16 and FY17 was youth 16-17 years-old.

Figure X: Age Range of Children in DCF CIRs
FY15-FY17



Department of Developmental Services (DDS)

DDS provides services on a voluntary basis to children, and custody remains with the parent or guardian, even when the child is placed in a hospital or acute treatment setting. In FY17, DDS reported nine critical incidents to the OCA. DCF also reported one of these incidents. All nine reports were regarding fatalities of children between the ages of two and 15 years-old, and the cause of death in each incident was a medical condition.

Department of Mental Health (DMH)

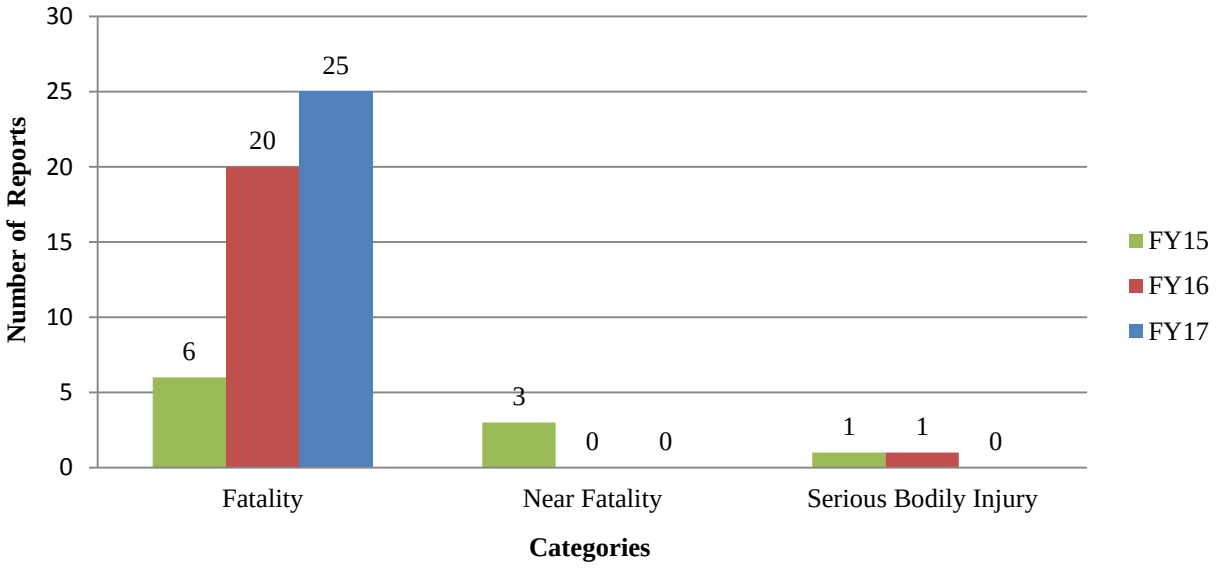
DMH provides services on a voluntary basis to children and custody remains with the parent or guardian, even when the child is placed in a hospital, group home, or residential treatment program. In FY17, DMH reported four critical incidents involving five children between the ages of nine and 17. DCF also reported one of these incidents. One incident was a fatality, two were near fatalities, and two were serious bodily injuries.

The one fatality was due to a medical condition, and the two near fatalities were the result of a stabbing and an attempted suicide. The two serious bodily injuries were due to abrasions suffered while the children were in DMH programs.

Department of Public Health (DPH)

DPH provides services on a voluntary basis to children while custody remains with the parent or guardian, even when the child is placed in a hospital or acute treatment setting. DPH reports critical incidents involving children receiving DPH funded services in the community and in substance abuse programs licensed and funded by DPH. In FY17, DPH reported 25 critical incidents to the OCA involving 25 children, and all of these reports were fatalities. DCF also reported three of these incidents. Figure Y compares DPH CIR categories from reports received between FY15 and FY17.

Figure Y: DPH CIR Categories
FY15-FY17



Review of the DPH CIRs show that the majority of fatalities (18) involved children born with life-limiting medical conditions. Fatalities reported by DPH frequently involved a child receiving care coordination services provided by DPH's Bureau of Family Health and Nutrition. Care coordination services are for families with a child or youth (up to age 23) who has special health care and/or complex coordination needs and is experiencing difficulty in obtaining or maintaining services.

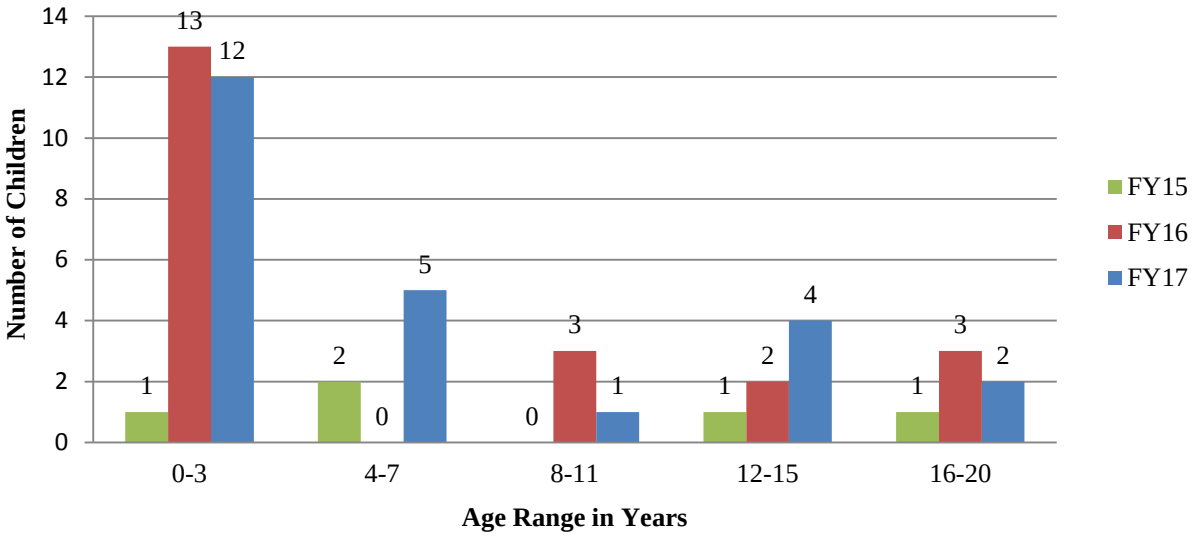
For infants and toddlers:

- One fatality was a stillborn birth
- Five fatalities were due to medical causes
- Two fatalities involved head trauma; one accidental and the other a suspected case of physical abuse
- Three fatalities were due to unsafe sleep environments and/or co-sleeping with a parent
- The cause of one fatality is unknown

The remaining fatalities in all age groups were due to complex medical conditions.

Figure Z shows the age distribution for children in DPH CIRs for whom we have age information. For the past two fiscal years, the majority of DPH CIRs concern children zero-to-three years-old. Zero-to-three year-olds are almost half of the DPH CIR population for FY17.

Figure Z: Age Range of Children in DPH CIRs
FY15-FY17



Department of Youth Services

DYS reports CIRs involving youth detained or committed by the Juvenile Court to DYS. 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. DYS youth receive services in the community, in a foster home, group home, residential treatment program, and secure treatment center. DYS served 2,184 youth during FY17.

The FY17 DYS CIRs received by the OCA reflect less than 1% of the most recently reported DYS population.

In FY17, DYS reported 21 critical incidents to the OCA involving 21 youth, which is a 62% increase in CIRs received from FY16. DCF also reported one of these incidents.
Figure AA shows that while the number of DYS fatality reports has decreased from FY16 to FY17, the number of near fatality reports more than quadrupled since FY16.

Figure AA: DYS CIR Categories
FY15-FY17

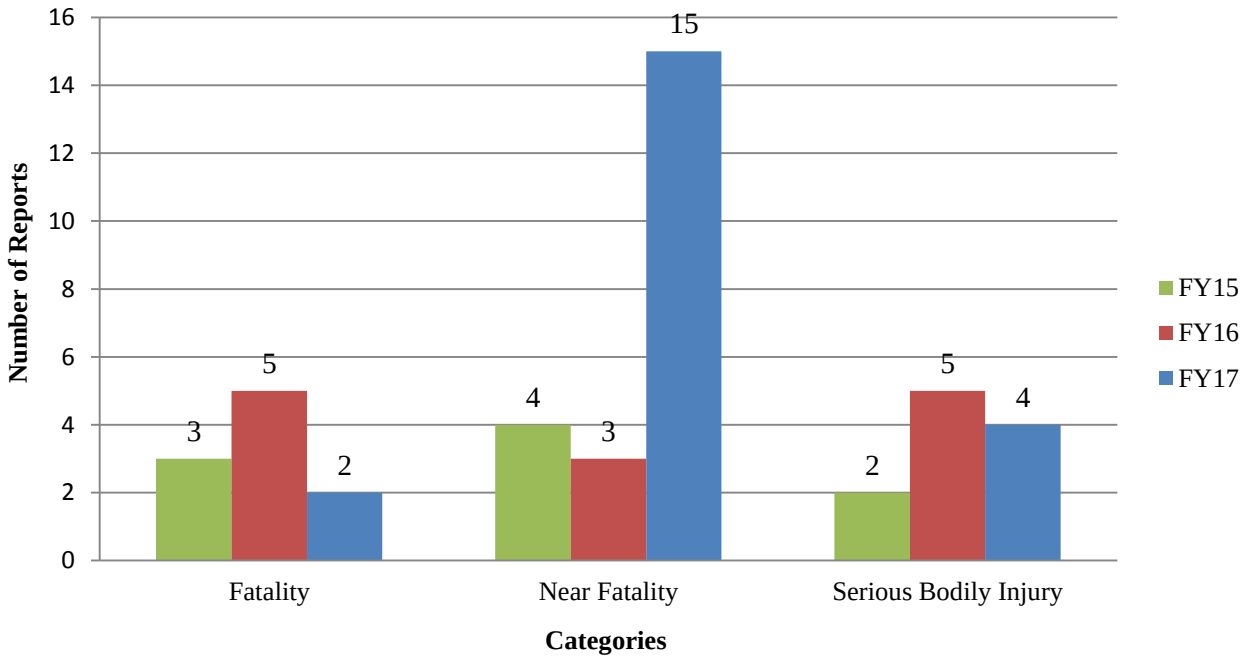
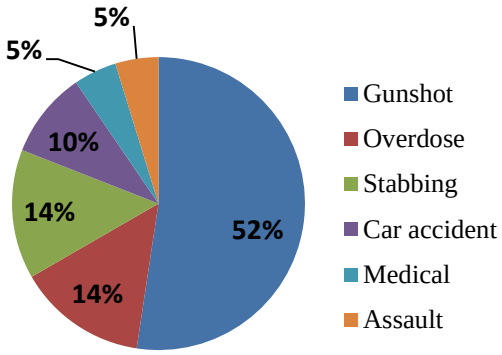


Figure BB shows that of the 21 reported fatalities (two), near fatalities (15), or serious bodily injuries (four), more than half (11) were due to incidents where the youth was the victim of violence in the community. Similar to FY16, gunshot wounds accounted for more than half (11) of the fatalities, near fatalities, and serious bodily injuries. In addition, the three overdoses and one of the three stabbings were attempted suicides.

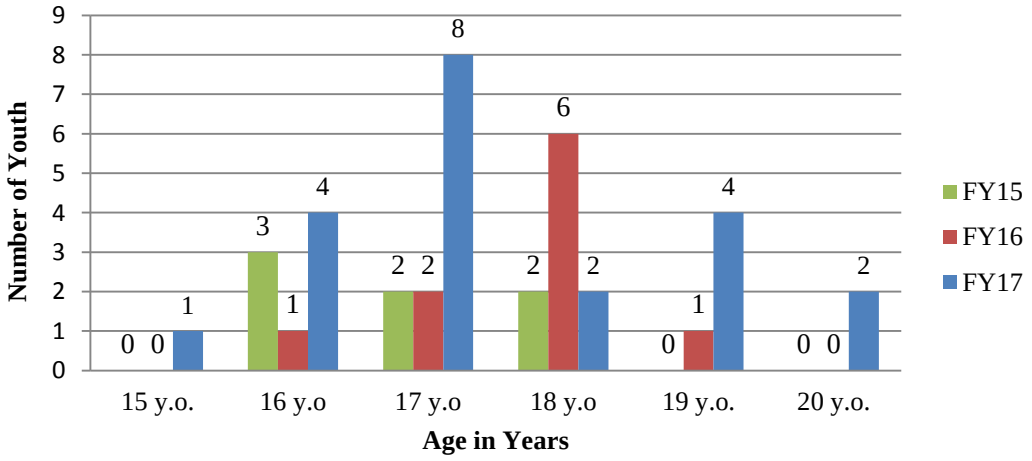
Figure BB: DYS Cause of Death or Injury, FY17 (n=21 youth)



Nineteen of the 21 youth identified in DYS CIRs are male. This reflects the gender distribution of the DYS population, which is disproportionately male. In FY17, 82% of DYS youth were male and 18% were female.

Since DYS primarily serves adolescents and young adults, the OCA conducts age analysis of DYS youth differently than the other agencies. Figure CC show how many youth age 14 to 20 were involved in DYS CIRs from FY15 to FY17. This includes all youth for whom the OCA has age information. There is a sharp increase in the number of 17 year-olds in DYS CIRs from FY16 to FY17. In the 2016 *Raise the Age* report, DYS stated that since the 2013 passage of "An Act Expanding Juvenile Jurisdiction" from age 16 to 17, the 17 year-old youth population have become "the largest cohort of youth in the care of the Department of Youth Services."

Figure CC: Age Range of Youth in DYS CIRs FY15-FY17



Additional Reports

Agencies submit reports to the OCA for "other" types of serious incidents that do not meet the OCA statutory definition of a critical incident, such as a runaway or the arrest of a youth in the community. The OCA reviews of CIRs received, including these additional reports.

The OCA received a total of 30 "other" reports involving 41 children in FY17. Of the 41 children, over 70% (30) are 16-20 year-olds. The OCA received one of these reports from DMH, eight from DPH, and 21 from DYS. The DMH report involved an incident at a facility that was instigated by a child and resulted in several adults being injured. Four of the DPH reports involved inappropriate and/or unprofessional behavior by staff at DPH programs. The remaining DPH reports were regarding:

- A runaway child
- An respiratory syncytial virus (RSV) outbreak at a day care center
- A report of a mother slapping a child at a DPH substance abuse program
- A report of a child who fell down the stairs during a lead inspection

Finally, one report from DYS was regarding a shooting that occurred outside a youth's home. Five of the 21 DYS reports were regarding runaway youth, and 15 reports were regarding DYS involved youth that were arrested in the community. These youth were arrested for a variety of serious charges, including murder, intent to murder, and most commonly, assault and battery with a dangerous weapon.

Legislative Focus

In January 2017, the first year of the two-year Legislative session began. The OCA testified frequently on bills that impact children and families, and/or the OCA. In addition, the OCA worked extensively on two pieces of legislation that primarily involved protecting girls and young women; a bill to end child marriage and a bill to ban female genital mutilation.

An Act to end child marriage (S 785/H 2310)

According to data from DPH and the advocacy group Unchained at Last, nearly 1200 children as young as 14 were married in Massachusetts between 2000 and 2014.[28] Of the 1200 children, 84% were girls that were married to adult men. Studies show that child marriage undermines the child's health, education and economic opportunities. According to a 2017 report from the Tahirih Justice Center, girls who are married before the age of 19 are 50% more likely to drop out of high school, and four times less likely to graduate from college. Child marriage also increases the risk of domestic violence and divorce.

Married children face many obstacles because, as minors, they do not have the full protection of the law. They may not be able to obtain services from their child welfare agency, seek shelter admission, or bring legal action for divorce. [29] In Massachusetts, married children may also have difficulty renting a home or opening their own checking or credit card account.[30] The gaps in legal protection and the barriers to living independently place under age spouses at risk.

Several states, including Massachusetts, have no statutory lower age limit to marry. Under current law, both young women and men can marry with parental and judicial consent before they reach the age of majority, 18. Massachusetts does not have an emancipation statute, and the current law does not require judges to inquire whether it is the interest of the minor to marry, or whether they are mature enough and capable of being granted emancipation. To address this important issue, the Child Advocate joined a legislative Working Group led by Senator Harriette L. Chandler and Representative Kay Kahn, who are sponsoring bills to ban marriage under the age of 18. These bills address the potential of a minor being forced into a marriage.

[28] Child marriage by state (n.d.) *Unchained at Last.* Retrieved from http://www.unchainedatlast.org/child-marriage-shocking-statistics/

[29] Tahirih Justice Center (2017). Falling through the cracks: How laws allow child marriage to happen in today's America. Retrieved from http://www.tahirih.org/wp-content/uploads/2017/08/TahirihChildMarriageReport-1.pdf

[30] *Slaney v. Westwood Auto*, 322 N.E. 2d 768, 771 (Mass. 1975) states that with the exception of "necessaries," a contract with an un-emancipated minor can be voided by the minor if the child no longer wishes to agree to the terms. Landlords and other business may avoid signing contracts with minors because those contracts may not be enforceable.

The Working Group has collaborated with the Probate and Family Court to identify the number of minors who have been married in Massachusetts, and the age discrepancies between the spouses. The Probate and Family Court also conducted a survey to identify how judges handle these cases. While the legislation is pending, the Working Group is drafting guidelines for the judges to ensure that no undue pressure is being placed on these young women. Among the options being explored is providing minors with information on their rights, as well as requiring interviews with family service officers.

An Act to protect girls from genital mutilation (S788/H2333)

Female Genital Mutilation (FGM) is defined and classified by the World Health Organization as procedures that cause injury to the female genital organs for non-medical reasons. Most often, girls between the ages of eight-12 undergo the procedure, which can result in serious medical and psychological harm. In FY17, the Child Advocate testified in support of a bill that would clarify the child abuse reporting law to specifically mandate FGM as a reportable form of abuse and to criminalize the practice in Massachusetts. Currently, there is no specific crime that covers FGM.

An Act relative to preventing the sexual abuse of children and youth (S295)

The OCA testified in favor of a bill sponsored by Senator Joan B. Lovely aimed at improving the recognition of, and response to, allegations of sexual abuse in school settings and in child-serving programs licensed by the Commonwealth. This bill would require additional background checks and training of employees.

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 attends meetings of selected working groups and initiatives. Involvement with these groups helps to inform and educate staff about work being done across the state on issues involving children, and provides an opportunity for us to share information and help synchronize policy.

Caring Together Implementation Advisory Committee
This Advisory Committee, composed of representatives from state agencies and human service providers, meets regularly to guide the implementation of the Caring Together Initiative. This is the first joint DCF and DMH procurement for residential services. The Child Advocate attends these meetings.

Children's Behavioral Health Initiative Advisory Council
The Council was established in 2008 as an independent advisor to the Governor and the Legislature on matters affecting families and children with emotional disorders and behavioral health needs. The Council meets monthly, and met nine times between October 2016 and September 2017. During this reporting period, which overlaps with FY17, the Council focused on MassHealth's comprehensive restructuring, children being boarded in hospital emergency departments, the need to reinforce outpatient services, and co-occurring disorders. These policy and practice discussions were overlaid by concerns about the capacity of the workforce to meet the needs of the clients. The Council's deliberations were informed by the work of the CBH Knowledge Center and other organizations who are initiating efforts to improve the skills of supervisors, and the organizational strategies that support quality supervision. The Council has set workforce development as a priority area for FY18. For information visit: http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/childrens-behavioral-health-advisory-council.html

Children's League of Massachusetts (CLM)
CLM is a non-profit association of over 80 private and public organizations, including many service providers and individuals that collectively advocate for policies and quality services in the best interest of the Commonwealth's children, youth and families. As a state agency, the Child Advocate is a "special member" of the CLM and attends its monthly meetings. In addition, OCA staff participates in CLM's Child Welfare Reform Task Force and Transition Age Youth Task Force. http://www.childrensleague.org/

Children's Trust
Children's Trust is a leader in efforts to prevent child abuse and neglect by supporting parents and strengthening families. Children's Trust funds over 100 family supports 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. For information visit: http://childrenstrustma.org/

The Children's Mental Health Campaign (CMHC)
CMHC is a coalition of families, advocates, health care providers, educators, and consumers from across Massachusetts dedicated to comprehensive reform of the children's mental health system. In FY17, the CMHC continued to focus on the issue of children "boarding" in emergency departments (ED). Boarding is when a child in crisis requires inpatient psychiatric care, but there is no available inpatient program, resulting in a prolonged stay in an ED or on medical units. OCA staff attends the CMHC meetings to stay informed on this issue. For information visit: http://www.childrensmentalhealthcampaign.org/

DYS Safety Task Force
In the fall of 2016, Commissioner Peter Forbes established the DYS Safety Task Force. The Task Force included representatives of the Legislature, EOHHS, and several state agencies including the OCA, the DYS collective bargaining units, and DYS staff. The Task Force was charged with making recommendations for reducing injury to youth receiving services from DYS, and reducing injury to DYS staff as a result of assaults by youth, or due to staff intervention during youth-on-youth assaults. The Task Force met nine times over a year and reviewed DYS policies, procedures, and practices that informed operations.

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 created a new service system, replacing the Child in Need of Services system, to better serve 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 Juvenile Court, and requires EOHHS to develop a network of 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 its progress. While prior years have focused on program design and implementation, the primary focus in FY17 was on expanding the number of children and families served, training staff to deliver evidence based programs, and developing comprehensive information technology. The Child Advocate is a member of the Advisory Board.

Governor's Council to Address Sexual and Domestic Violence
The Council was established in 2007 by Governor Patrick, and relaunched in April 2017 by Governor Baker and Lieutenant Governor Karyn Polito, who chairs the Council. The Council's charge is to advise the Governor on how to help residents of the Commonwealth live a life free of sexual assault and domestic violence by improving prevention for all, enhancing support for individuals and families affected by sexual assault and domestic violence, and insisting on accountability for perpetrators. Though not a member of the Council, the OCA's Director of Quality Assurance participates in a Working Group. For information visit: http://www.mass.gov/governor/administration/groups/sexualassaultanddomesticviolencecouncil/

Leadership Advisory Board of the Massachusetts Child Welfare Trafficking Grant
Two years ago, Massachusetts received a five-year federal grant from the Administration for Children and Families to increase the capacity of the child welfare system to address child trafficking. The grant supports efforts to build greater interagency collaboration, enhanced infrastructure, and new policies and practices to improve the prevention, identification, and response to trafficked children across the Commonwealth. The Leadership Advisory Board meets quarterly to guide and inform the work of the grant. This Advisory Board represents a cross-section of top leadership in the agencies and departments, both state and federal, involved in supporting and protecting at-risk and trafficked children. The Child Advocate is a member of the Advisory Board and the Director of Policy and Legal Counsel attends the quarterly meetings.

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. The goal of PAC is to ensure universal access to quality mental health services for all children in Massachusetts. PAC makes recommendations to DMH, other child-serving agencies, and the Legislature regarding service access and quality, best practices, system change and design, and public policies that will promote quality behavioral health services for children and adolescents. The Child Advocate and OCA staff attends meetings to discuss the concerns and ideas of this group of advisors.

Psychotropic Medication Steering Committee
This Steering Committee meets bimonthly to help improve oversight of psychotropic medication for children in DCF custody. In FY17, Massachusetts Behavioral Health Partnership (MBHP) was welcomed onto the Steering Committee to provide collaboration and oversight efforts. MBHP is the largest mental health insurer for children in state custody. FY17 accomplishments include: approving guidelines for DCF social workers and field staff about psychotropic medications that outline a standard of care for children in custody; helping guide a pilot program that implemented a retrospective review of preschool children on high risk medication to identify them quickly and refer them to the psychotropic medication oversight program, Pediatric Behavioral Health Medication Initiative (PBHMI); and examining the issue of informed consent

by looking closely at the current landscape of psychotropic medication consent for children in state custody. The Steering Committee identified key areas where informed consent for psychotropic medications could be strengthened. In collaboration with PBHMI and MBHP, the Steering Committee approved a pilot program for informed consent targeting high risk children in residential placement. The pilot will roll out in FY18, with the goal of streamlining the consent process for community providers, and ensuring children are on appropriate medication by having a DCF psychiatric review prior to obtaining consent for an extraordinary medication regime.

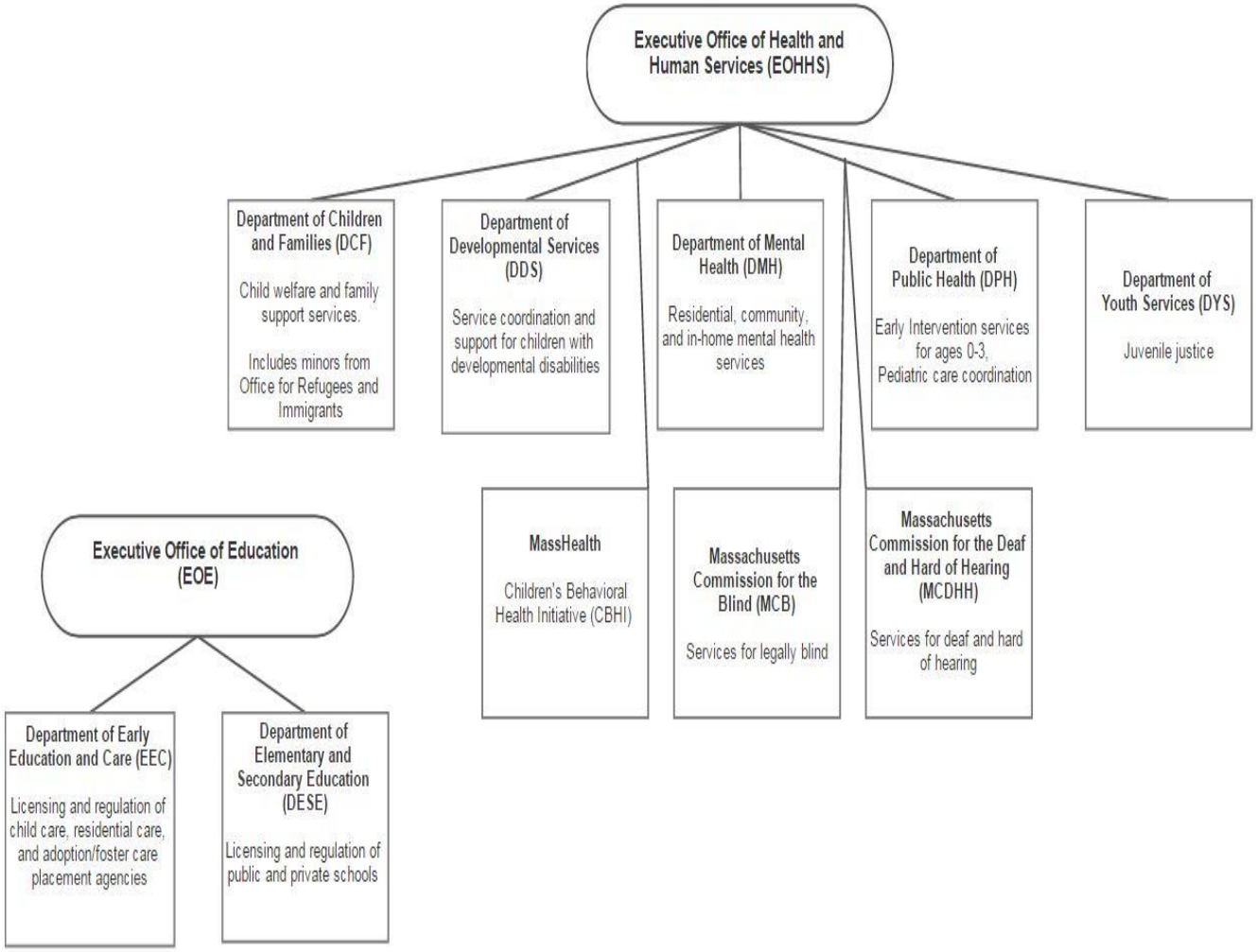
Young Children's Council (YCC)

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.ecmhmatters.org/Pages/ECMHMatters.aspx.

Appendix A: 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
DPPC	Disabled Persons Protection Commission
DYS	Department of Youth Services
EOEA	Executive Office of Elder Affairs
EOE	Executive Office of Education
EOHHS	Executive Office of Health and Human Services
MCB	Massachusetts Commission for the Blind
MCDHH	Massachusetts Commission for the Deaf and Hard of Hearing

Appendix B: Child-Serving Public Entities



Appendix C: Developing Categories for Different Types of Neglect

Foster Care

In FY16, the OCA wanted to understand the different actions or inactions that led to supported neglect allegations in foster care. The OCA reviewed existing literature about categories of neglect that commonly appear in child welfare investigations. These categories include inadequate supervision, educational neglect, medical neglect, and physical neglect.[31] Using this information as a foundation, the OCA engaged in a qualitative review of FY16 supported neglect allegations in foster care. This process led the OCA to develop categories and definitions that are relevant to the types of neglect that occur in the supported reports of abuse and/or neglect the OCA reviews concerning foster care.

In early FY17, the OCA wrote a codebook for foster care neglect that includes categories and definitions, and details the coding process. The codebook is considered a living document that will be adapted and changed as necessary.

Congregate Care

In FY17, the OCA began coding incidents of neglect in congregate care settings. Following the same process we did for foster care, the OCA drafted a list of categories and definitions. Then, the OCA did a qualitative review of supported neglect allegations in congregate care. Working together, OCA staff developed a common understanding of each category, definition, and applicability to supported neglect allegations.

The OCA wrote a codebook for neglect in congregate care that includes categories and definitions, and details the coding process. This codebook is a living document and subject to further refinement as necessary.

Child Care

In FY18, the OCA will engage in a similar process to develop categories for incidents of neglect in child care settings.

[31] Child Welfare Information Gateway (2012). *Acts of Omission: An Overview of Child Neglect*. Retrieved from https://www.childwelfare.gov/pubPDFs/acts.pdf

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