Office of the Child Advocate Annual Data Report

FISCAL YEAR 2025

MAY 2026

THE COMMONWEALTH OF MASSACHUSETTS
MARIA Z. MOSSAIDES, DIRECTOR

HTTPS://WWW.MASS.GOV/LISTS/OCA-ANNUAL-REPORTS

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About the Office of the Child Advocate

The Office of the Child Advocate (OCA) is an independent executive branch state agency with oversight and ombudsperson responsibilities, established by the Massachusetts Legislature in 2008.[1] The OCA's mission is to ensure that children receive appropriate, timely and quality state services, with a particular focus on ensuring that the Commonwealth's most vulnerable and at-risk children have the opportunity to thrive. Through collaboration with public and private stakeholders, the OCA identifies gaps in state services and recommends improvements in policy, practice, regulation, and/or law. The OCA also serves as a resource for families who are receiving, or are eligible to receive, services from the Commonwealth. The OCA executes its mission by:

- Overseeing and monitoring the services delivered by child-serving state agencies.
- Improving the collection, use, and transparency of state agency data.
- Identifying gaps in and concerns with how state agencies and systems serve at-risk children, and recommending and advocating for solutions, including changes to improve coordination across agencies.
- Advising on and leading efforts for systemic change in policies, programs, and practices affecting vulnerable and at-risk children.
- Partnering with state agencies to improve service quality through the development and launch of innovation and incubation projects.
- Serving as an ombudsperson, including providing information and referral support, for families who are receiving, or are eligible to receive, services from the Commonwealth.
- Ensuring that state service agencies are trauma informed.
- Promoting child and family wellbeing.

OCA's Core Values:

- We are child centered.
- We are trauma informed and responsive.
- We believe diversity, equity, inclusion and belonging are central to our work.
- We value collaboration.
- We strive for excellence.

Read our full Statement of Values.

[1] Office of the Child Advocate statute. M.G.L. c. 18C. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter18C.

Children in Massachusetts

51% are Male

49% are Female

5% are Transgender

22% are LGBTQ+

Gender identity categories are not mutually exclusive.

29% have one or more emotional, behavioral, or developmental condition.

14% have two or more Adverse Childhood Experiences.

25% speak a language other than English at home.

33% have at least one non-US citizen parent.

11% live below the federal poverty level.

25% receive government assistance.

References:
Kids Count Data Center, accessed 09/10/2025.
MCLGBTQY Annual Recommendations FY 2024

See page 6 of this report for Racial and Ethnic Demographic Statistics

Massachusetts Child Services (FY25)

The Department of Public Health
reached at least **1,085,557 children** through early childhood screening, intervention, family-centered support programs, and services.

The Department of Elementary and Secondary Education
provided public education to **866,945 children and youth**.

The Department of Early Education and Care
licensed 9,330 child care and residential facilities, serving **273,000 children** in formal early education and care and 5,000 on average daily in residential care.

The Department of Children and Families
cared for **57,008 children and youth**
including 5,203 in foster care and 1,677 in congregate care.

The Department of Developmental Services
supported **12,310 children.**

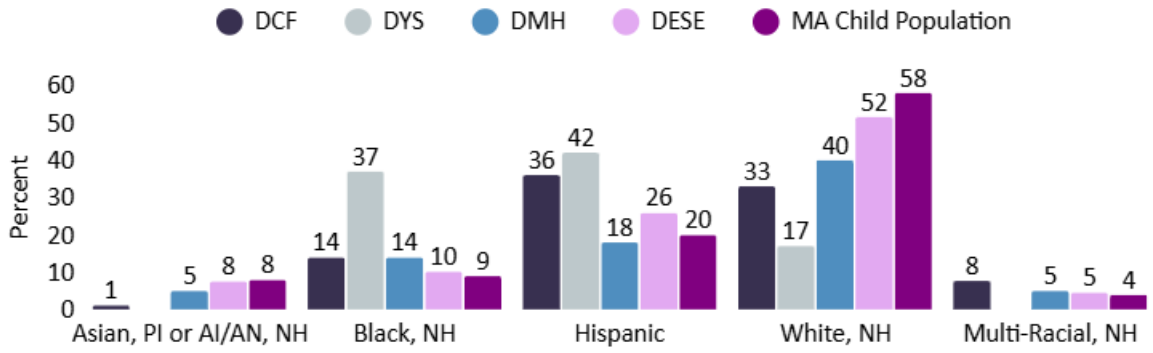
The Department of Mental Health
provided services to **2,375 children,** including 181 in residential services.

The Department of Youth Services
provided care to **1,016 youth** who were detained or committed to a residential facility.

References:
Department of Public Health's (DPH) Title V MCH Block Grant Program Massachusetts State Snapshot, Accessed 4/21/2026.
Department of Elementary and Seodondary Education (DESE) 2024-25 School Attending Children Report, Accessed 4/21/2026.
Deparrtment of Early Education and Care (EEC) Children Enrolled in Formal Early Education and Care, June 2025. Accessed 4/21/2026.
FY25 DCF "consumer child/youth" count for 0-17 open at any time. Data Request, 2026.
Department of Developmental Servies (DDS) active/eligible children under the age of 18 as of 6/30/2025. Data Request, 2026.
Department of Mental Health (DMH) full, limited and community services, JJPAD FY25 Annual Report. Residential Services Data Request, 2026.
Department of Youth Services (DYS) unduplicated detention and first time-commitment admissions, youth under 18. Data Request, 2026.

Race/Ethnicity of Children Served

Numbers displayed are percentages of children served by an agency and total child population



Hispanic and Black, Non Hispanic children disproportionately receive state services for a multitude of factors

DPH, DDS and EEC service race/ethnicity breakdown is not currently available.
DCF race/ethnicity breakdown is for open child/youth consumer at end of year.
DYS Data Source: JJPAD FY25 Annual Report
All other sources are the same as listed on page 5

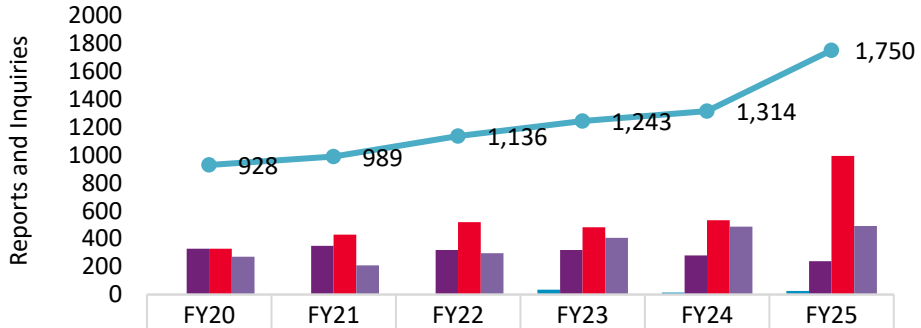
Executive Summary

The Office of the Child Advocate (OCA) provides independent oversight of state services for children and families to ensure they receive appropriate, timely and quality services, with a particular focus on ensuring that the Commonwealth's most vulnerable and at-risk children have the opportunity to thrive. Established under Chapter 18C of the Massachusetts General Laws, the OCA fulfills this mandate through several **core quality assurance functions**, including operating a Complaint Line and receiving and reviewing critical incident reports, Department of Children and Families (DCF) reports of supported allegations of abuse and/or neglect in out-of-home settings (institutional reports), and Foster Care Review safety alerts.

This report presents key data findings derived from the OCA's quality assurance activities from Fiscal Year 2019 (FY19) through Fiscal Year 2025 (FY25), with a focus on FY25 – highlighting trends, emerging risks to children and youth, and opportunities to strengthen service delivery.

As seen in **Figure 1: Reports and Complaint Line Inquires Received by the OCA, in FY25, the OCA received and reviewed 1,750 reports and Complaint Line inquiries involving nearly 2,000 children**, reflecting both increased engagement with oversight systems and concerning shifts in the nature of harm experienced by children across the Commonwealth. This is the **highest total volume of inquiries and reports in the OCA's history**, and an increase of 89% since FY20.

Figure 1:
Reports and Complaint Line Inquires Received by the OCA (FY20 - FY25)



	FY20	FY21	FY22	FY23	FY24	FY25
Foster Care Review Safety Alert	0	0	0	35	15	26
Critical Incident Report	328	349	320	320	281	240
Complaint Line	328	430	519	482	532	993
Institutional Report	272	210	297	406	486	491
Total	928	989	1,136	1,243	1,314	1,750

Key data insights in this report include:

- **There has been a substantial increase in outreach to the OCA's Complaint Line in recent years.** In FY25, the OCA received 993 Complaint Line inquiries, an 87% increase from FY24 and a 203% increase since FY20. This reflects growing public awareness of the OCA and increased demand for system navigation support.
- This growth coincided with a **fourfold increase in direct youth engagement** through the OCA's Youth Engagement Initiative, which reached 195 children in congregate care placements in FY25.
- **There was a 15% decline in the number of critical incident reports** sent to the OCA, **driven by a reduction in the number of reports of a child witnessing an overdose**. This aligns with a statewide reduction in overdose deaths. At the same time, **critical incidents involving physical abuse more than doubled (from 11 in FY24 to 27 in FY25)**.
- The OCA received the **highest number of institutional reports on record (491), continuing a multi-year upward trend.**[2] The multi-year increase is primarily driven by an increase in supported allegations from residential schools and public schools. Of deep concern, **supported allegations of physical abuse increased** from FY24 to FY25 across several out-of-home settings, including congregate care (driven by an increase in reports from residential schools), foster care (driven by an increase in reports from kinship foster care placements), public schools, and child care settings.

The OCA operates on the premise that independent investigation, monitoring, and public accountability can strengthen child serving state systems and reduce risks to children. By collecting and analyzing data on service concerns and serious incidents, the OCA identifies patterns of harm and emerging risks affecting vulnerable children and youth. This year's report shows that **indicators of serious harm to children increased across multiple data sources in FY25**. An increase in reports involving physical abuse, serious injury, and improper behavior management appeared in several OCA oversight streams.

The OCA translates its insights and findings into public reports, policy recommendations, and engagement with state leaders and agencies. By increasing transparency and elevating lessons learned from serious incidents, the OCA helps policymakers and agencies identify opportunities to strengthen safeguards, improve coordination across systems, and address gaps in services.

In FY25, to strengthen system accountability and improve outcomes for children, the OCA conducted 1,262 reviews of DCF cases, identifying case practice concerns in 38%. Additionally,

[2] These trends may reflect improved reporting practices, changes in investigative outcomes, and/or a shift toward more frequent harm.

the OCA provided case-specific feedback to state agencies more than 460 times, contributing to case-specific improvements, increased coordination, and broader system learning.

More broadly, the OCA has made substantive policy recommendations to better ensure child safety and wellbeing, including most notably the OCA's recommendations in the December 2025 Systemic Investigation Regarding the Death of A'zella Ortiz.[3] Additional details on OCA activities and recommendations to advance the OCA's mission can be found in the OCA's FY25 Annual Report.[4]

[3] Massachusetts Office of the Child Advocate. (2025). OCA Report Concerning A'zella Ortiz. https://www.mass.gov/doc/office-of-the-child-advocate-investigative-report-azella-ortiz-december-2025/download

[4] Massachusetts Office of the Child Advocate.(2025). OCA Annual Report Fiscal Year 2025. https://www.mass.gov/doc/oca-annual-report-fiscal-year-2025/download

Introduction

The Office of the Child Advocate (OCA) provides independent oversight of state services for children and families to ensure they receive appropriate, timely and quality services, with a particular focus on ensuring that the Commonwealth's most vulnerable and at-risk children have the opportunity to thrive. Established under Chapter 18C of the Massachusetts General Laws, the OCA fulfills this mandate through several core quality assurance functions, including operating a Complaint Line and receiving and reviewing critical incident reports, Department of Children and Families (DCF) reports of supported allegations of abuse and/or neglect in out-of-home settings (institutional reports), and Foster Care Review safety alerts.[5] See **Figure 2: Quality Assurance Core Functions at the OCA**, for more details.

This report presents key data findings derived from the OCA's quality assurance activities from Fiscal Year 2019 (FY19) through Fiscal Year 2025 (FY25), with a focus on FY25[6] – highlighting trends, emerging risks to children and youth, and opportunities to strengthen service delivery. This analysis provides critical insight into the experiences of children involved with state systems and highlights opportunities to improve safety, service quality, and system coordination across the Commonwealth.

The OCA operates on the premise that independent investigation, monitoring, and public accountability can strengthen child serving state systems and reduce risks to children. By collecting and analyzing data on service concerns and serious incidents, the OCA identifies patterns of injury and emerging risks affecting vulnerable children and youth. Through case reviews, investigations, systemic reviews, and research, the OCA examines not only individual incidents but also the broader policies, practices, and coordination challenges that contribute to those events and quality of services.

The OCA translates its insights and findings into public reports, policy recommendations, and engagement with state leaders and agencies. By increasing transparency and elevating lessons learned from serious incidents, the OCA helps policymakers and agencies identify opportunities to strengthen safeguards, improve coordination across systems, and address gaps in services. Over time, this process is intended to support evidence-informed reforms, strengthen accountability in child-serving systems, and promote policies and practices that better safeguard children.

Through sustained oversight and collaboration, the OCA seeks to ensure that children who receive state services are safe, supported, and less likely to experience preventable harm.

[5] OCA is not statutorily required to receive Foster Care Review safety alerts. For more information about Foster Care Review safety alerts, see the FY23 OCA Annual Report: https://www.mass.gov/doc/oca-annual-report-fiscal-year-2023/download

[6] The Massachusetts state fiscal year runs from July 1 through June 30. For example, FY25 is July 1, 2024, through June 30, 2025.

Complaint Line	•Inquiries received from the general public, including the legislature •Available to anyone who wants to express concerns, ask questions, or receive resources and information about state services for children and families •Learn more: https://www.mass.gov/guides/oca-complaint-line
Critical Incident Reports	•Child-serving state agencies are required to submit a critical incident report to the OCA when a child receiving state services sustains a fatality, near fatality, serious bodily injury, or emotional injury •OCA staff review the circumstances of the incident, the reporting agency's service delivery, and state involvement with the child and family
Institutional Reports	• DCF is required to submit their investigation report to the OCA when allegations of child abuse and/or neglect that occur in an out-of-home setting are supported • OCA staff review the DCF investigation to ensure the safety and wellbeing of the child(ren) involved, review the quality of the investigation, and confirm necessary licensing entities are notified
Foster Care Review Safety Alerts	•Received from DCF when a Foster Care Review panel is concerned for the safety of a child •OCA staff review DCF case practice and response to the alert •This is not a statutory obligation
Investigations	•Initiated by the OCA on a case-by-case basis when the OCA determines that the actions or inactions of a state agency were egregious and may have significantly contributed to the harm of a child or young adult •Not all investigations are made public •For more information, refer to the OCA Protocol on the Release of Confidential Information: https://www.mass.gov/doc/oca-protocol-on-the-public-release-of-confidential-information/download

Figure 2: Quality Assurance Core Functions at the OCA

OCA Quality Assurance Operations

The OCA's Quality Assurance (QA) Division is composed of professionals with expertise in clinical social work, child welfare, public health, data, and research. The QA Division works collaboratively to receive and document inquiries and reports submitted to the OCA. The following conventions guide the QA Division's work in carrying out its duties.

Case Reviews

When a complaint, critical incident report, Foster Care Review safety alert, or institutional report is received, the OCA conducts an immediate review to learn more about the circumstances that brought it to the attention of the OCA and any state agency involvement with the child and family.

While the OCA reviews all complaints and reports received from or about all child-serving state agencies, the OCA's statutory mandate is to focus on the children in the care and/or custody of DCF and the Department of Youth Services (DYS).[7] Complaints about DCF and reports received from DCF undergo a thorough review of the family's DCF electronic record. The purpose of this review is to understand the family and their needs, to substantively review DCF's understanding of the family and their needs, and to evaluate DCF's efforts to assist and engage the family and protect the child from harm. In this context, the OCA will identify what worked well and where there are opportunities for improvement in policy, case practice or service delivery across the system or with the specific family.

State Agency Follow-Up

When the OCA identifies immediate or escalating risk to a child, a need for clarifying information or improved service delivery for a child or family, or a system-wide pattern or trend, the OCA follows a standard operating procedure of contacting a designated senior leadership liaison at the agency involved. **Through these liaisons, the OCA ensures that all concerns identified through the OCA's review are resolved appropriately and in a timely manner to ensure the safety and wellbeing of the children involved and, as appropriate, to improve services for the child and family.** If the OCA determines that the actions or inactions of a state agency were egregious and significantly contributed to the harm of a child or young adult, the Child Advocate can choose to initiate an investigation.[8]

[7] See **Appendix F: Glossary of Terms** for a definition of state custody. Children in state custody are not always placed out-of-home.

[8] Not all investigations are made public; for more information, refer to the OCA Protocol on the Release of Confidential Information.

The OCA may follow up with an agency even when no case practice concerns are identified: for example, to point out an emerging issue, check on the wellbeing of a child, acknowledge the difficult nature of the work, and/or ensure trauma-informed practices are in place.

The OCA does not always request a response to the feedback provided to a state agency. For example, if the child and family are no longer receiving services from the state agency, or there is an unfixable administrative error, the OCA may bring the agency's attention to the matter for future policy, procedure, and training considerations without expecting a response.

Figure 3: Logic and Process of OCA Quality Assurance Operations provides a graphic depiction of the process, data collected, and insights gleaned from the OCA quality assurance functions.

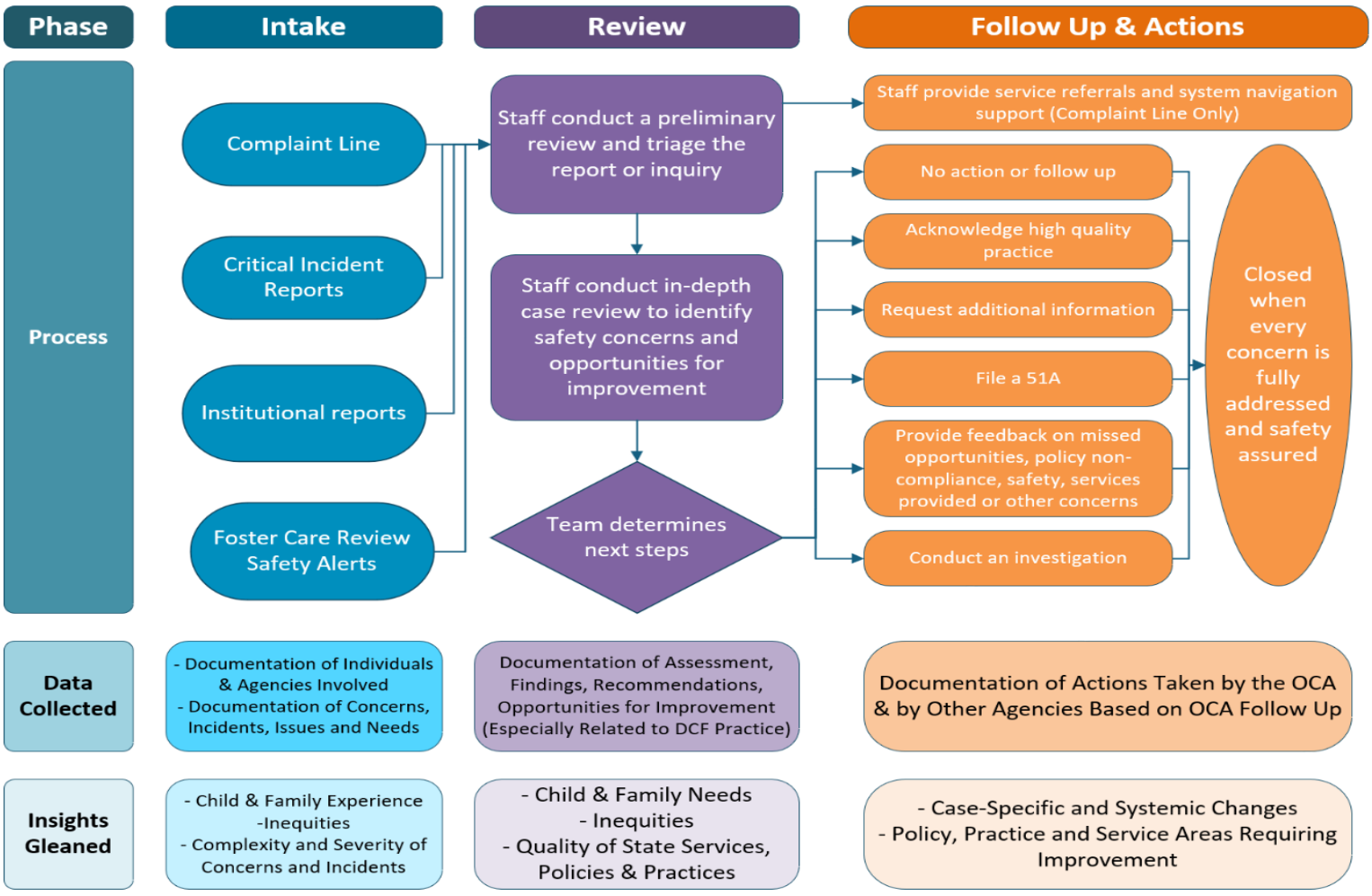


Figure 3: Logic and Process of OCA Quality Assurance Operations

Limitations of OCA Quality Assurance Data and Subsequent Analysis

The data the OCA collects through its quality assurance functions does not represent a random or representative sample of services provided by DCF, DYS, or other state agencies. Rather, the data reflects cases that come to the attention of the OCA through specific oversight mechanisms, including Complaint Line inquiries, critical incident reports, institutional reports, and Foster Care Review safety alerts.

Broadly, the OCA is dependent on reporting by state agencies. Variations in state agency reporting practices or internal compliance with reporting requirements may therefore affect the completeness of the data available to the OCA, including demographic information. The OCA is continuously working to improve data collection for identity characteristics including race, ethnicity, sex assigned at birth, gender, and sexual orientation.

The OCA's quality assurance data collection system was substantially redesigned in FY23 to improve consistency and comparability of data across oversight activities. As a result, some analyses presented in this report are limited to data collected since FY23. The OCA takes continuous quality improvement seriously. As such, data maintained in the OCA's database are continuously evolving. Comparison with prior year's OCA reports is not recommended due to the significant amount of data cleaning and systems revisions the OCA has undertaken in recent years.

Complaint Line Limitations

The OCA implemented an updated coding structure in FY24 to capture more detailed information about the reasons individuals contact the OCA. Changes in coding practices may affect comparisons with earlier years of Complaint Line data. Individuals served by the Complaint Line are invited but not required to share demographic information. While the OCA is almost always able to collect information about the individual's role/relationship to child (95% of the time), personal identity characteristics, such as race, ethnicity, gender identity, and sexual orientation are captured less often.

Critical Incident Report Limitations

Critical incident reporting requirements differ across agencies. DCF submits critical incident reports regarding children with any DCF involvement within the previous 12 months, including cases in which a report of abuse and/or neglect was screened out. In contrast, other agencies report only those critical incidents that occur while a child or family has an open case or is actively receiving services. These differences limit the comparability of reporting across agencies.

Institutional Report Limitations

The Massachusetts system of investigating child abuse and/or neglect[9] includes a mandatory report to the OCA (among other agencies) when DCF[10] determines that a child was abused and/or neglected in certain out-of-home settings. The OCA analyzes institutional report data based on the date DCF supported the allegations of abuse and/or neglect. The COVID-19 pandemic emergency period[11] may have affected the data presented in this report. As a result, trends in institutional reports from FY20-FY22 should be interpreted with caution. For comparison purposes, FY19 data are included as the last full fiscal year prior to the implementation of pandemic-related emergency orders.

[9] The Massachusetts system is governed by M.G.L. c. 119 § 51B(l).
[10] Only DCF is mandated to send abuse and/or neglect reports to the OCA. However, the OCA may request reports of abuse and/or neglect from other agencies, such as the Department of Early Education and Care (EEC), as necessary.
[11] On March 10, 2020, Governor Charlie Baker declared a state of emergency in response to the Coronavirus outbreak. The state of emergency and all Emergency and Public Health Orders issued pursuant to the emergency terminated on June 15, 2021.

OCA Quality Assurance Data Findings

Massachusetts maintains a broad and complex network of services designed to support the safety, health, and wellbeing of children and families. Across state agencies, providers, and community partners, these services reach hundreds of thousands of children each year and reflect a strong commitment to child protection, prevention, and care. Within this child-serving system, timely oversight and cross-agency coordination are essential to ensure that services function as intended—particularly for children with the most complex needs.

As shown in **Figure 4: OCA Quality Assurance by the Numbers**, in FY25, the OCA received and reviewed 1,750 reports and Complaint Line inquiries involving nearly two thousand children across Massachusetts and a wide range of topics. The data in this report reflects both the strengths and the challenges of the Commonwealth's child-serving systems. Through this report, the OCA seeks to share information about risks and harm faced by children receiving state services while still safeguarding the privacy of the children and families involved. These findings offer insight into how Massachusetts can build upon its existing service infrastructure to better prevent harm, respond to emerging risks, and support children and families more effectively across the Commonwealth.

Complaint Line	993 inquiries	826 individuals served
Critical Incident Reports	240 reports	310 children
Foster Care Review Safety Alerts	26 reports	36 children
Institutional Reports	491 reports	691 children
Youth Engagement Initaitive	7 site visits	195 youth reached

Figure 4: OCA Quality Assurance by the Numbers[12,13]

[12] Includes both complaints and information and referral inquiries.
[13] This is an unduplicated count of children named in critical incident reports, Foster Care Review safety alerts, institutional reports and adults and children named in Complaint Line inquiries. Complaint Line inquiries do not always name a specific child or children; therefore, this number is likely an undercount.

Complaint Line

OCA Complaint Line

Phone: (617) 979-8360

Email: childadvocate@mass.gov

Website: Complaint Line Webform

One of the most critical OCA statutory functions is responding to concerns about state services provided to children. The OCA Complaint Line serves as a **neutral, confidential resource** and is available for anyone to express concerns or seek information and resources about a state service a child is receiving or is eligible to receive. While the Complaint Line operates Monday through Friday, 9:00am -5:00pm, anyone can email, submit a webform, or leave a voicemail at any time, and OCA Complaint Line staff will reach out within two business days. Anyone with concerns for a child receiving state services is encouraged to contact the OCA Complaint Line.

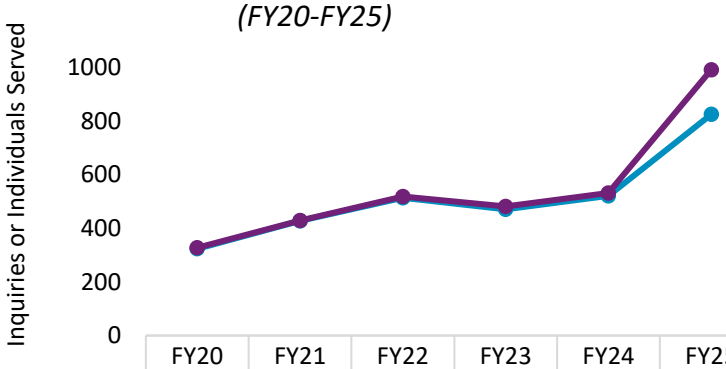
Complaint Line staff are experienced social workers who serve as system navigators and are available to provide support, information, resources, non-legal advice and, at times, be a neutral arbitrator between an individual and the agency of concern. When Complaint Line staff determine that the decision making or practices of a state agency places—or could place—a child at substantial risk, Complaint Line staff contact the state agency involved to ensure the child's safety and wellbeing, as well as improvement of services. As mandated reporters, if Complaint Line staff have reasonable cause to believe a child has been maltreated or is at substantial risk of maltreatment, a report of child abuse and/or neglect is filed with DCF.

Key Insights

There has been a substantial increase in outreach to the OCA's Complaint Line in recent years. In FY25, the OCA received 993 Complaint Line inquiries, an 87% increase from FY24 and a 203% increase since FY20, when the OCA received 328 inquiries. The OCA served 826 people in FY25, 89% (738) of whom had never contacted the Complaint Line before. The OCA primarily attributes this growth to the increased public visibility of the OCA, the OCA's substantial Complaint Line outreach efforts, including to youth, and the OCA's ability to provide solution-focused systems navigation support or information.

Figure 5: Complaint Line Inquiries shows the increase in use of the Complaint Line over time by individuals served and total inquiries. While each inquiry is presented as one case, an inquiry may involve additional conversations and information-gathering efforts between the OCA, the individual, and the state agency involved.

Figure 5:
Complaint Line Inquiries
(FY20-FY25)

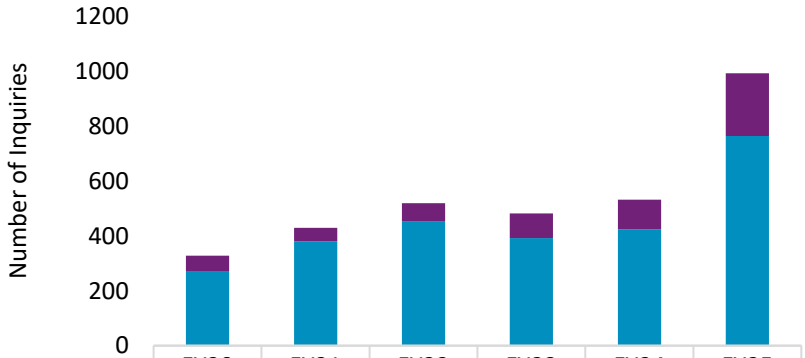


	FY20	FY21	FY22	FY23	FY24	FY25
Individuals Served	324	429	514	472	522	826
Total Inquiries	328	430	519	482	532	993

Similar to recent years, 77% (765) of the Complaint Line inquiries involved a complaint while 23% (228) were requests for information or a referral.[14] Information and referral inquiries, as a proportion of all inquiries, increased slightly from FY20 (17%), suggesting a growing need for system navigation support or increased awareness of the Complaint Line as a resource. This data, as shown in **Figure 6: Complaint Line Inquiries by Type of Inquiry**, reinforces the Complaint Line's important and growing role as a public entry point for families and professionals seeking to navigate complex child-serving systems.

[14] The OCA categorizes Complaint Line inquiries in one of two ways, complaint and information and referral. **Complaint**: An expression of dissatisfaction with any agency or program that provides services to a child of the Commonwealth. **Information and referral**: A request for information, referral, or education on a specific topic.

Figure 6:
Complaint Line Inquiries by Type of Inquiry (FY20-FY25)



	FY20	FY21	FY22	FY23	FY24	FY25
Information and Referral	56	49	65	90	108	228
Complaints	272	381	454	392	424	765
Total Inquiries	328	430	519	482	532	993

Why Do Individuals Contact the Complaint Line?

Most individuals contact the Complaint Line because they or their child have not received what they believe to be appropriate, adequate, or high-quality service. Often, they are contacting the OCA regarding interactions they had with specific personnel – whether that is a DCF caseworker, a judge, their attorney, or school personnel – or because they are unhappy with a decision that was made regarding the services a child is (or is not) receiving.

As shown in **Figure 7: Topic of Inquiry**, year over year, the most frequent topic of Complaint Line inquiries is about **DCF** (634, 64% of inquiries). In FY25, inquiries related to DCF increased 77% compared to the prior year (359); a large increase after years of relative stability. Complaints about DCF personnel (293) are consistently the largest portion of DCF inquiries year over year. Inquries in this category increased 89% from FY24 to FY25 and drove the overall increased volume of inquiries about DCF. [15]

Complaint Line inquiries also involve the **court system** (125, 13% of inquiries). While the same proportion of inquiries involved the court system as last year, the number of inquiries increased 81% from FY24 (69) to FY25 (125). A higher proportion of these inquiries related to disagreements with a judge's decision and concerns about legal representation in FY25

[15] See **Appendix A: Complaint Line Data, DCF** for additional information.

compared to FY24. The OCA added visitation as a subcategory in FY25, and inquiries in this subcategory now account for 21% of inquiries about the court system.

While making up a smaller portion of inquiries, those involving **education** (102, 10% of inquiries) increased 73% between FY24 (59) and FY25 (102), following a few years of slow growth. These inquiries most frequently involve special education, school staff responsiveness, and bullying.

Complaint Line inquiries about the **alleged abuse and/or neglect of a child** (77, 8% of inquiries) also increased substantially, up 51% from FY24 (51) to FY25 (77). However, this variable has evolved over time both in definition and in coding structure. Prior year data is a helpful reference but may be unreliable.[16] Abuse and/or neglect inquiries often involve concern expressed by the individual that a child has been abused or neglected in out-of-home care or by their custodial parent, or the individual is seeking information about what to do if they suspect abuse and/or neglect of a child.

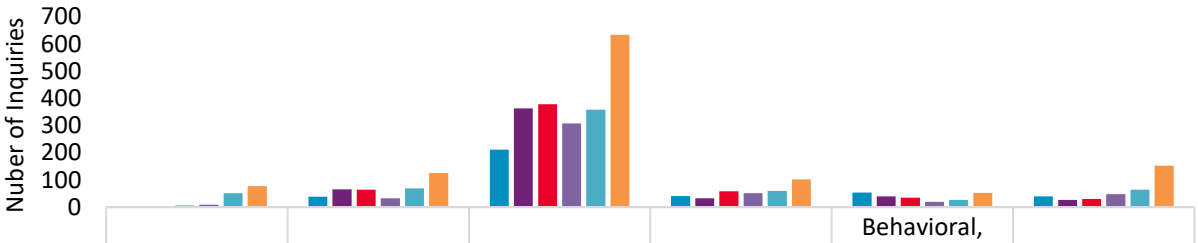
Inquiries also involved **behavioral, mental and physical health** (53, 5% of inquiries), and **other services and system** (152, 15% of inquiries).[17] Inquiries in the "other" category are related to child treatment[18], housing and homelessness, concerns for the physical conditions of a child's living space, and access to financial resources and vouchers. There was an increase in every Complaint Line category in FY25 compared to FY24.

[16] "Abuse and/or Neglect" were originally a sub-category of the OCA Complaint Line category for DCF related complaints. However, the OCA observed that many of these Complaint Line inquiries did not involve current or prior DCF history for the child or family involved in the complaint. As such, the OCA removed Abuse and/or Neglect from the DCF-related Complaint Line category and made it a separate category under "Reason for Call."

[17] Percentages will not sum to 100 because a Complaint Line inquiry may involve more than one area of concern.

[18] See **Appendix F: Glossary of Terms** for the definition of child treatment.

Figure 7:
Topic of Inquiry
(FY20 - FY25)



	Abuse/ Neglect	Court System	DCF	Education	Behavioral, Mental and Physical Health	Other
FY20	3	38	211	41	54	40
FY21	1	65	363	32	40	27
FY22	5	64	379	58	35	30
FY23	9	32	308	51	19	48
FY24	51	69	359	59	26	64
FY25	77	125	634	102	53	152

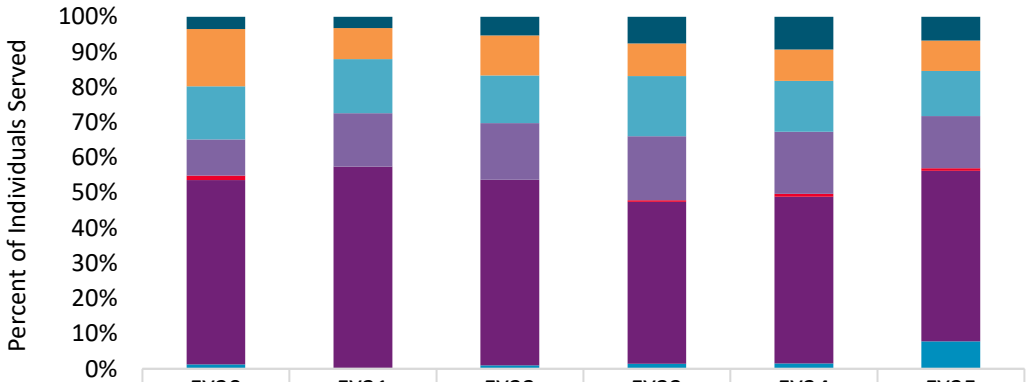
Note: Counts will not sum to total number of inquiries. More than one topic may be selected for any inquiry.

Who Contacts the Complaint Line?

As shown in **Figure 8: Complaint Line: Role or Relationship to Child**, individuals who contact the Complaint Line are historically and predominantly biological parents. Youth and providers – such as foster parents, educators, behavioral health workers, case managers, attorneys, medical staff, legislators, legislative staff, and law enforcement – contact the Complaint Line less often, and for different reasons:

- **Parents** are seeking insights and options about decisions affecting their children.
- **Providers** often seek guidance or escalate concerns about child safety and system response.
- **Youth** reach out to advocate for themselves or a peer, primarily concerning how they are treated, or for help accessing education, financial literacy, and behavioral health supports.

Figure 8:
Complaint Line: Role or Relationship to Child (FY20-FY25)



	FY20	FY21	FY22	FY23	FY24	FY25
Unknown	11	13	27	36	48	57
Other	52	36	58	44	46	73
Other Relative	48	63	69	81	75	108
Provider	33	62	82	86	91	125
Adoptive Parent	4	0	0	2	4	6
Biological Parent	167	234	269	218	245	408
Child/Self	4	1	5	7	8	66

The OCA Complaint Line data indicates that many concerns raised by families, providers, and youth relate to system processes—such as communication, responsiveness, and decision-making—rather than allegations of immediate child safety risks. Within DCF-related inquiries, nearly half of complaints involve concerns about staff responsiveness, communication, or follow-through by DCF personnel. These patterns suggest that the challenges individuals are contacting the OCA about arise from difficulties navigating agency processes or understanding decision-making, rather than solely from disagreement about safety determinations.

Overall, the substantial increase in Complaint Line inquiries and individuals served highlights the growing role of the OCA as both a system navigation resource and a venue for individuals seeking to raise concerns about Massachusetts' child-serving systems. Through these interactions, the OCA hears daily about the challenges individuals navigating child-serving systems encounter as these systems work to meet children's complex and evolving needs within the constraints of limited workforce capacity, resource limitations, and a complex statutory and regulatory framework. These trends underscore the importance of continued attention to workforce stability, service availability, and clear pathways for families and professionals seeking assistance.

For additional Complaint Line data including an analysis of trends in specific issue areas, who is contacting the OCA, demographic data to the extent it is available, and additional details about the inquiries, refer to **Appendix A: Complaint Line Data.**

Spotlight: Youth Engagement Initiative

In FY25, the OCA launched a youth-focused outreach campaign to increase awareness of the Complaint Line, with an initial emphasis on congregate care settings. The OCA distributed posters statewide through the Children's League of Massachusetts and to the Department of Mental Health (DMH) and DYS run residential programs, communicating the expectation that these posters be hung in a visible place within the facility. The OCA also conducted site visits to seven congregate care facilities between March and June 2025. OCA staff met with youth and program staff, shared information about the OCA, offered individual meetings, and treated them to pizza and snacks.

Through these site visits, the OCA engaged 195 youth in group settings and met individually with 85 youth in FY25. The site visits resulted in 47 Complaint Line cases involving 46 youth. The campaign significantly increased youth engagement with the Complaint Line: youth contacts rose from 2% of inquiries in FY24 to nearly 8% in FY25, including growth in youth reaching out independently of site visits to advocate for themselves or a peer.

Complaint Line inquiries from youth most often focus on family visitation, the appropriateness and quality of placements, permanency planning, and access to education. Youth have contacted the OCA seeking access to general education curricula and financial literacy resources. They also advocate for improved treatment—both for themselves and their peers—by DCF personnel and program staff, including more frequent contact with caseworkers and clearer communication about their cases and available options while in placement.

One example the OCA heard from youth in DCF custody during site visits is that they either did not know about or were unable to participate in Foster Care Reviews due to scheduling conflicts. When the OCA brought this to the attention of DCF senior leadership, DCF shifted practice to ensure Foster Care Reviews were held at times that accommodate youth schedules and is working to improve communication about the scheduling of the reviews.

OCA's advocacy on behalf of youth reached during site visits also resulted in DCF case reviews, leadership engagement in resolutions, clinical consultations, and corrected documentation errors among other improvements.

This outreach made it clear that many concerns surface only after youth are contacted directly, and that the concerns youth bring to the attention of the OCA differ from concerns received by parents and providers. These findings indicate that proactive outreach provides important additional visibility into youth experiences and system performance. The OCA plans to continue and grow the Youth Engagement Initiative, starting with hiring a youth engagement manager in FY26.

Critical Incident Reports

The OCA statute requires state agencies providing services to children or youth to notify the OCA if a child who is receiving a state service suffers a fatality, near fatality, serious bodily injury, or emotional injury.[19] These are called critical incident reports (CIRs).

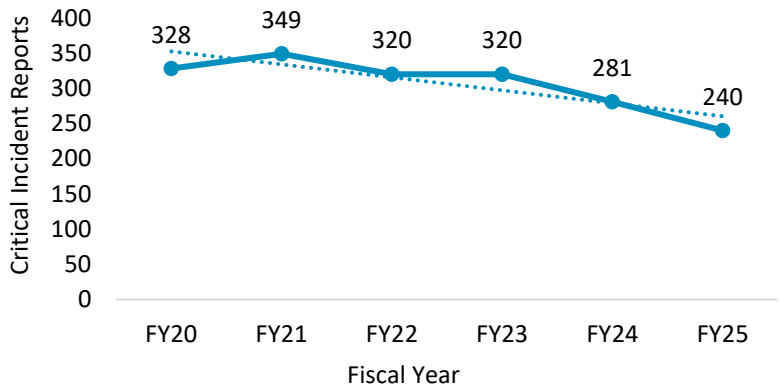
The OCA categorizes and analyzes all events that led to the injury or death of the child involved in the critical incident. The Office of the Chief Medical Examiner (OCME) makes the final determination regarding the cause and manner of death; the critical incident report to the OCA provides information about the nature and circumstances of the event that led to the injury or death of a child or youth.

Critical incident reports do not necessarily reflect evidence of wrongdoing by an agency; a critical incident can result from a car crash, illness, or other factors that are likely unrelated to the services provided by the reporting agency.

Key Insights

In FY25, the OCA received 240 critical incident reports involving 310 children and youth,[20] which is lower than the number the OCA received in previous years. **Figure 9: Critical Incident Reports Received by the OCA** shows year-over-year critical incident reporting trends, pointing to a steady decline in the receipt of these reports.

Figure 9:
Critical Incident Reports Received by the OCA (FY20-FY25)

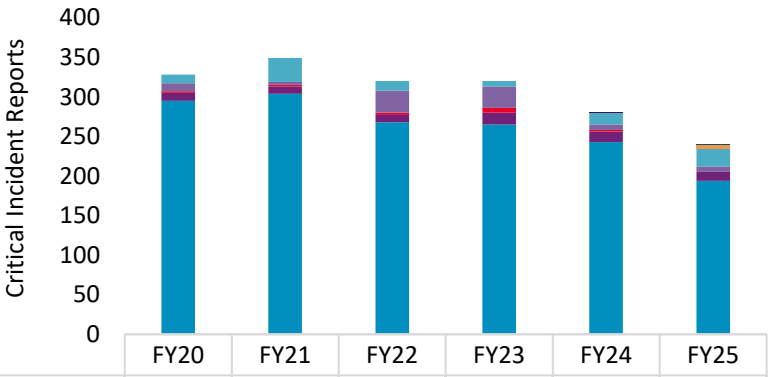


[19] See **Appendix F: Glossary of Terms** for definitions of fatality, near fatality, serious bodily injury and emotional injury.
[20] Each child can experience more than one incident within a report, for example both a serious bodily injury and an emotional injury. The total number of incidents in FY25 is 315.

Figure 10: Critical Incident Reports Received by State Agencies show the critical incident reports submitted each fiscal year by each child-serving state agency. The number of reports submitted by each agency is not a qualitative comparison between agencies. The number of children and youth served by each agency varies significantly as do the challenges faced by the populations served. Additionally, when a child or youth is receiving services from multiple agencies, each agency may submit a critical incident report, as appropriate.

Notably, the number of reports from DCF decreased for the fourth fiscal year in a row from 243 in FY24 to 194 in FY25. Additionally, in FY25 the OCA began receiving critical incident reports from the Executive Office of Housing and Livable Communities (EOHLC), which submitted four reports.

Figure 10:
Critical Incident Reports Received by State Agencies (FY20-FY25)

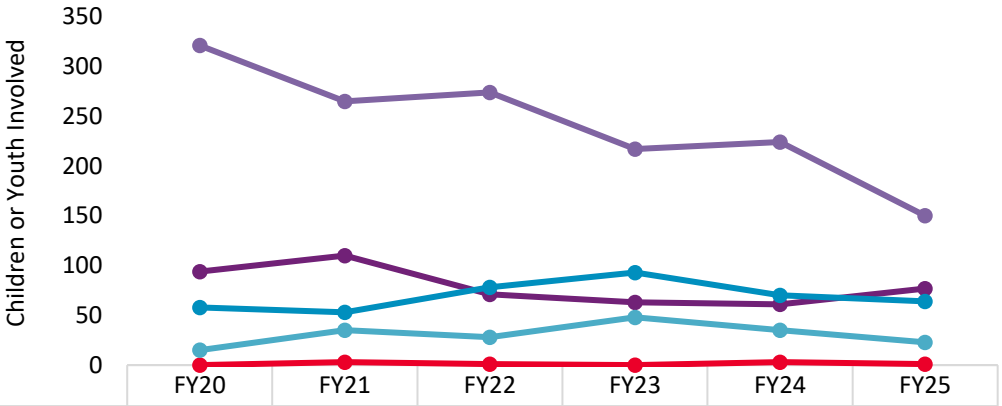


	FY20	FY21	FY22	FY23	FY24	FY25
MCB	0	0	0	0	1	0
MassHealth	0	0	0	0	0	1
EOHLC	0	0	0	0	0	4
DYS	11	30	12	7	15	23
DPH	10	4	28	27	7	7
DMH	2	2	3	6	2	0
DDS	10	9	9	15	13	11
DCF	295	304	268	265	243	194

Emotional injury critical incidents remain the most frequently reported type of incident (150 incidents in FY25), although the number of reported incidents in this category has decreased over time —a decrease of 33% from FY24 to FY25 and 53% from FY20 to FY25. **Figure 11: Critical Incident by Type** shows the type of critical incidents from FY20-FY25. The reduction in

emotional injuries is primarily driven by a decrease in reports of a child witnessing an overdose. This aligns with a statewide reduction in overdose deaths.[21]

Figure 11:
Critical Incident by Type
(FY20-FY25)



	FY20	FY21	FY22	FY23	FY24	FY25
Other	0	3	1	0	3	1
Emotional Injury	321	265	274	217	224	150
Serious Bodily Injury	94	110	71	63	61	77
Near Fatality	15	35	28	48	35	23
Fatality	58	53	78	93	70	64

Note: Counts will not sum to total number of critical incident reports or Child or Youth Involved. Multiple children may appear in each report, and each child may experience more than one type of incident in a report.

What are the Causes of Critical Incidents?

The death or serious bodily injury of a child or young adult is a significant event that deserves prompt attention. Critical incident reports provide the OCA timely information about the cause and circumstances of the injury or death of a child or young adult. Using this information, the OCA categorizes the causes of all critical incidents, as shown in **Figure 12: Cause of Critical Incidents**.

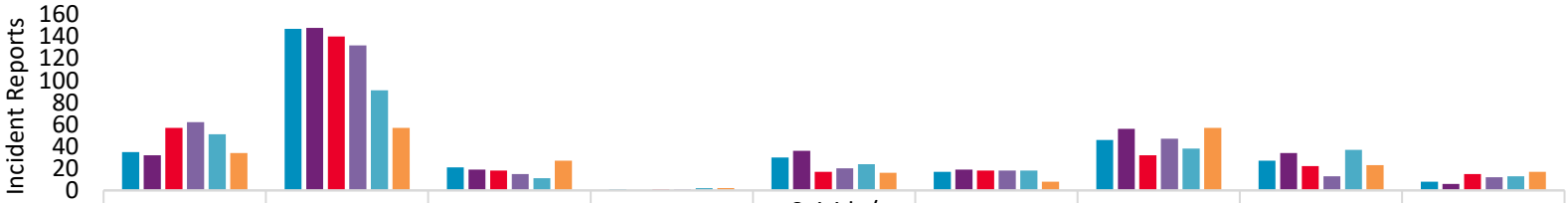
While the OCA receives critical incident reports involving different forms of violence, for the purposes of critical incident cause classification, the OCA categorizes these reports based on the relationship between the child and the individual causing harm.

- **Physical Abuse** refers to incidents where a child is physically harmed by a caregiver.

[21] For additional information, see **Appendix B: Critical Incident Report Data, Overdose**

- **Violence** refers to situations in which a child is harmed by someone other than a caregiver, including community violence. Incidents in which a child witnesses' domestic violence that results in a near fatality or fatality of another individual are classified as **violence**.[22]

Figure 12:
Cause of Critical Incidents
(FY20 - FY25)



	Medical	Overdose	Physical Abuse	Sexual Assault	Suicide/ Suicide Attempt	SUID	Unintentional Injury	Violence	Unknown
FY20	35	147	21	1	30	17	46	27	8
FY21	32	148	19	0	36	19	56	34	6
FY22	57	140	18	1	17	18	32	22	15
FY23	62	132	15	1	20	18	47	13	12
FY24	51	91	11	2	24	18	38	37	13
FY25	34	57	27	2	16	8	57	23	17

Note: One child may be reported by multiple agencies with different causes of a critical incident. Sum will not equal the total number of children.

Trends in the Causes of Critical Incidents

Despite the overall reduction in the total number of critical incident reports received, critical incident reports about **physical abuse** rose in FY25 (27) after several lower years. All children harmed by physical abuse in a critical incident were under the age of 10, with more than half of the critical incidents resulting in the serious bodily injury or fatality of an infant (20). Most of the physical abuse happened in the child's home, regardless of their age. Emotional injury critical incidents from witnessing the physical abuse of another child in the home, a category in which the OCA had rarely seen reports in prior years, also increased. Overall, this points to heightened vulnerability among infants and toddlers and suggests either increased incidence, improved reporting, or both.[23]

[22] To qualify for reporting to our office, sexual assault must result in fatality, near fatality or serious bodily injury to a child.
[23] For additional information see **Appendix B: Critical Incident Report Data, Physical Abuse**.

Critical incident reports involving an **overdose** declined from FY24 (91) to FY25 (57) for the sixth consecutive year. The decrease is driven by a reduction in emotional injury incidents from a child witnessing someone else's overdose. These trends align with statewide reductions in overdose deaths reported by public health authorities. According to data from the Center for Disease Control, opioid-related overdose deaths in Massachusetts decreased by 36% in 2024, falling to the lowest levels since 2013.[24] Still, the issue remains significant with many incidents related to witnessing an overdose submitted yearly. Comparatively, the numbers of fatalities, near fatalities or serious bodily injuries of a child from an overdose decreased even more steeply from FY24 (23) to FY25 (11), this is the first such reduction the OCA has reported. Near fatalities and fatalities are evenly split between children ages one-four and 10-19. For younger children, this suggests that children overdose after ingesting substances that have not been properly secured in the home, while older children are more likely to have experienced an overdose after purposefully consuming a substance. Most incidents occurred at home, underscoring the ongoing impact of the opioid crisis on family environments even as mortality trends improve.

Encouragingly, the OCA received fewer critical incidents about a **suicide or suicide attempt** in FY25 (16) compared to FY20 (30) and FY21 (36), when the pandemic emergency orders were in place. Children between 10 and 14 were reported to witness suicides and attempts most often, while youth ages 10 to 19 were more prevalent in suicide attempts and fatalities. Most of these incidents occur at the child's home, though some occurred at foster care placements and secure facilities.

The OCA received eight critical incident reports regarding the sudden unexpected death of an infant (**SUID**). This is substantially fewer SUID reports compared to prior years when between 15 and 17 SUIDs were reported to the OCA. While the number of reported deaths decreased, the number of children who witnessed these deaths remained the same (13), speaking to the consequential effects of SUID on older children.

Medical critical incidents continue to account for a substantial share of child fatalities reported to the OCA, often involving children with complex health needs and predominantly affecting younger age groups, particularly children under 10. While critical incident reports due to a medical cause decreased in FY25 (34), it remains within the typical ranges over the past six years. These incidents highlight both the fragility of medically complex children and the reliance

[24] Massachusetts Department of Public Health. (2025). Healey-Driscoll Administration Observes Overdose Awareness Day and Upcoming Recovery and Prevention Months. https://www.mass.gov/news/healey-driscoll-administration-observes-overdose-awareness-day-and-upcoming-recovery-and-prevention-months?_ga=2.265695304.673041.1772545387-1022298048.1769014593&_gl=1*1xu4iox*_ga*MTAyMjI5ODA0OC4xNzY5MDE0NTkz*_ga_MCLPEGW7WM*czE3NzI2NDcwODYkbzkkZzEkdDE3NzI2NDcwOTkkajQ3JGwwJGgw

on the state system of care when medical complexity is beyond a caregiver's capacity, financial or otherwise.

Unintentional injury critical incident reports increased in FY25 (57), particularly those resulting in serious bodily injury to a child. Injuries due to a car crash increased substantially from FY24 (9) to FY25 (13). This mirrors a national pattern of injuries as a leading and increasing cause of child mortality: data from the National Highway Traffic Safety Administration shows a nationwide increase in motor vehicle occupant fatalities among 15-17 years olds in 2022 and 2023.[25] Children of all ages are represented in the unintentional injury critical incidents reported to the OCA, with children ages 15-19 and under four years old more likely to be the subject of a report.

Unknown causes of a critical incident in a report (17) involved 22 children. These events most frequently involve emotional injuries where the cause of death is not reported, fatalities and serious bodily injuries for which the intent was not determined at the time of reporting, or unexplained deaths. The vast majority (84%, 11) of the children who sustained physical harm from an unknown cause were under the age of 4.

Finally, **violence**-related critical incident reports declined overall in FY25 (23) compared to FY24 (37), including fewer firearm-related incidents However, when violence did occur, it disproportionately affected older teens, ages 15-19, often involved weapons, and frequently impacted youth already connected to state systems for violence intervention and prevention. These children were not at home or in an out-of-home placement when they experienced violence – typically they were in a public place, motor vehicle, or another private residence other than their home. A smaller but important subset of children experienced trauma from witnessing violence, most often involving harm to a parent.

Demographics

Race and ethnicity information is available for 75% (233 of the 310) of children involved in critical incident reports. Demographic data is more consistently available for children involved with DCF than for those connected to other agencies. **Figure 13: Cause of Critical Incidents Stratified by Race and Ethnicity of Children** presents the distribution of reports by race and ethnicity across OCA critical incident cause categories.

The high proportion of missing race and ethnicity data is a key limitation, particularly for suicide-related events, where "unknown" accounts for a substantial share of incidents. As a result, findings related to these categories should be interpreted with caution.

[25] National Highway Traffic Safety Administration. (2025). Fatal Analysis Reporting System. https://www-fars.nhtsa.dot.gov/Main/index.aspx. Data beyond 2023 not available at time of writing.

Among incidents with available data, Black, non-Hispanic infants are disproportionately represented in sleep-related infant deaths (SUID), while Hispanic/Latino children are overrepresented in violence and physical abuse incidents. In contrast, medical related incidents are more evenly distributed across racial and ethnic groups compared to other categories. Overdose incidents more closely reflect the racial and ethnic distribution of the overall Massachusetts child population, suggesting that substance use impacts families across demographic groups.

Overall, these findings should be interpreted cautiously given the extent of missing demographic data. The figure is intended to provide context on patterns of under- and overrepresentation by critical incident outcome, as well as the distribution of causes of critical incidents across racial and ethnic groups.

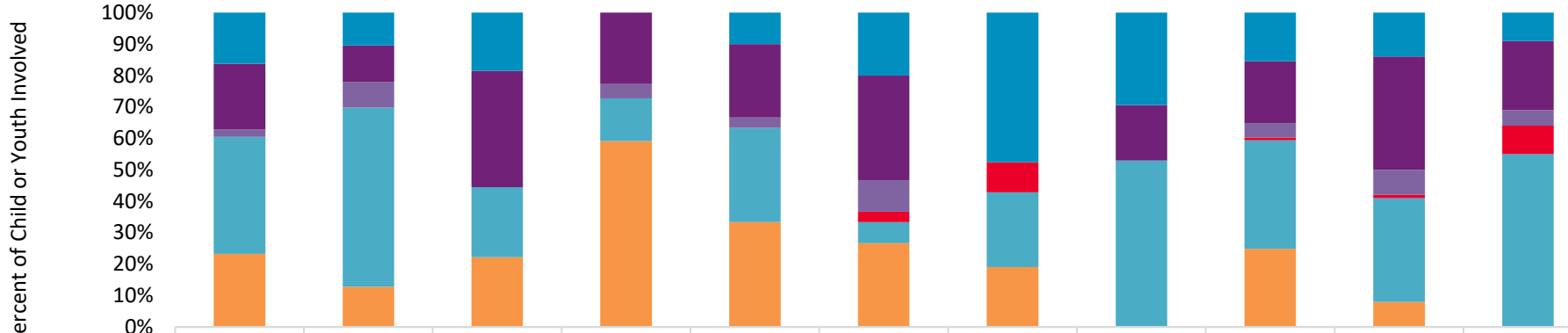
Critical Incident Takeaways

Critical incident reports provide an important lens into serious events affecting children involved with state agencies. Taken together, the FY25 critical incident report data reflects a complex landscape: the overall number of reports has decreased, driven primarily by a decrease in emotional injury reports from DCF, but reports of physical abuse and other physical harm are increasing or remaining the same.

Continued monitoring of critical incident reporting patterns will be important to determine whether the observed decline reflects genuine improvements in child safety or changes in reporting practices. Ensuring consistent and comprehensive reporting remains critical to the Commonwealth's ability to identify emerging risks, understand the experiences of vulnerable children, and strengthen systems designed to protect them.

For additional critical incident report data and information, including presentation by the cause of the critical incident, reporting by state agencies, and additional demographic information, refer to **Appendix B: Critical Incident Report Data.**

Figure 13:
Cause of Critical Incidents Stratified by Race and Ethnicity of Children (FY25 n=310)



	Medical	Overdose	Physical Abuse	Suicide/ Suicide Attempt	Unintentional Injury	Violence	SUID	Unknown	All CIRs	DCF Population	MA Child Population
Black/African American, NH - n = 48	16%	10%	19%	0%	10%	20%	48%	29%	15%	14%	9%
Hispanic/Latino - n = 61	21%	12%	37%	23%	23%	33%	0%	18%	20%	36%	22%
Multi-racial, NH - n = 14	2%	8%	0%	5%	3%	10%	0%	0%	5%	8%	5%
Another Race, NH - n = 3	0%	0%	0%	0%	0%	3%	10%	0%	1%	1%	9%
White, NH - n = 107	37%	57%	22%	14%	30%	7%	24%	53%	35%	33%	55%
Unknown - n = 77	23%	13%	22%	59%	33%	27%	19%	0%	25%	8%	0%

Note: Another Race includes Asian, NH (8%), American Indian Alaska Native, NH <1%, Pacific Islander, NH <1%.

Data sources:

- DCF Population: DCF Data Request, 2026
- MA Child Population: KidsCount, accessed September 2025

Foster Care Review Safety Alerts

Federal and state laws require that DCF implement a Foster Care Review (FCR) process.[26] This review applies only to children who are removed from the custody of their parents and occurs every six months while the child remains in placement. The review is a monitoring and quality assurance mechanism to measure progress toward a child's permanency goal.

A Foster Care Review is facilitated by a three-person panel consisting of a member of the DCF Foster Care Review Unit (an independent unit within DCF), an administrator from a DCF area office, and a community volunteer. When the Foster Care Review panel, through its review of progress toward a child's permanency goal, becomes concerned for the safety of a child, the panel generates a safety alert. In July 2022 the OCA began receiving Foster Care Review safety alerts as part of the OCA's long-term efforts to strengthen the Foster Care Review process. By receiving the Foster Care Review safety alert and conducting a review of the related DCF case, the OCA provides an additional layer of oversight to ensure that the needs and wellbeing of the child(ren) are addressed.[27]

Key Insights

In FY25, more than 11,000 Foster Care Reviews occurred, leading to 26 Foster Care Review safety alerts involving 36 children. This is higher than the number of alerts received in FY24 (15) and lower than the first year of data collection, FY23 (35). As shown in **Table 1: Age of Children Appearing in Foster Care Review Safety Alerts**, the children ranged in age from infants under one to 21 years old, with more 15–19-year-olds the subject of a safety alert compared to other age groups.

Table 1: Age of Children Appearing in Foster Care Review Safety Alerts, FY25

Age Grouping	Percent of Children involved	Number of Children
0-4 Years old	19%	7
5 -9 Years old	22%	8
10-14 Years old	25%	9
15-19 Years old	31%	11
20+	6%	2
Total	**100%**	**36**

Note: One child appears in two reports, at two different ages.

As shown in **Table 2: Reasons for Foster Care Review Safety Alert**, concerns that prompted a safety alert include clinical issues regarding placement and safety concerns. Foster Care Review

[26] United States Social Security Act, 42 USC 675 Sec 475 (5)(B); Department of Children and Families statute MGL c. 18B, §6A.
[27] For more information about the OCA's efforts to improve Foster Care Review, see the FY23 OCA Annual Report: https://www.mass.gov/doc/oca-annual-report-fiscal-year-2023/download

safety alerts about older foster children often involve self-harm, a child missing from care, and/or sibling gang-involvement. Concerns for younger children typically involved safety planning and placement visits.

Table 2: Reasons for Foster Care Review Safety Alert, FY23-FY25[28]			
Safety Alert Reason	**FY23**	**FY24**	**FY25**
51A Filed by Reviewer	2	0	0
Adolescent Planning	0	0	1
Clinical Issues Regarding Placement	4	0	7
ICPC: Lack of Contact, Communication, Information	1	0	0
Insufficient Contact with Child	1	6	3
Medical Concerns	0	0	3
Not In Placement	16	4	3
Other	10	3	0
Placement Concerns: Caregiver Capacity or Higher Level of Care Needed	0	2	1
Safety Concern	0	0	6
Visitation Issues	1	0	2
Total Safety Alerts	**35**	**15**	**26**

DCF Institutional Reports: Abuse and/or Neglect in Out-of-Home Settings

A critical part of the OCA's responsibility is to ensure that children are safe and protected from harm across all settings, with a particular focus on children in out-of-home settings. The Massachusetts system of investigating child abuse and/or neglect[29] includes a mandatory report to the OCA (among other agencies) when DCF[30] determines that a child was abused and/or neglected in out-of-home settings. Out-of-home settings include foster care, congregate care, childcare, public schools, private schools, after-school and summer programs, residential and inpatient therapeutic programs, and school-funded transportation companies.[31]

OCA staff review and analyze each report to evaluate the safety and wellbeing of the child(ren) involved in the incident, policy and practice concerns with the out-of-home setting, the quality of the DCF investigation, and trends and patterns related to the care of children in out-of-home settings. If the OCA identifies a concern in any of these areas, the OCA will immediately follow

[28] Foster Care Review safety alert categories are defined by DCF. For more information, see DCF's Annual Foster Care Review Report.
[29] The Massachusetts system is governed by M.G.L. c. 119 § 51B(l).
[30] Only DCF is mandated to send abuse and/or neglect reports to the OCA. However, the OCA may request licensing reports from other agencies, such as the Department of Early Education and Care (EEC), as necessary.
[31] For information about DCF's intake and response to allegations of abuse and/or neglect, refer to the DCF Protective Intake Policy.

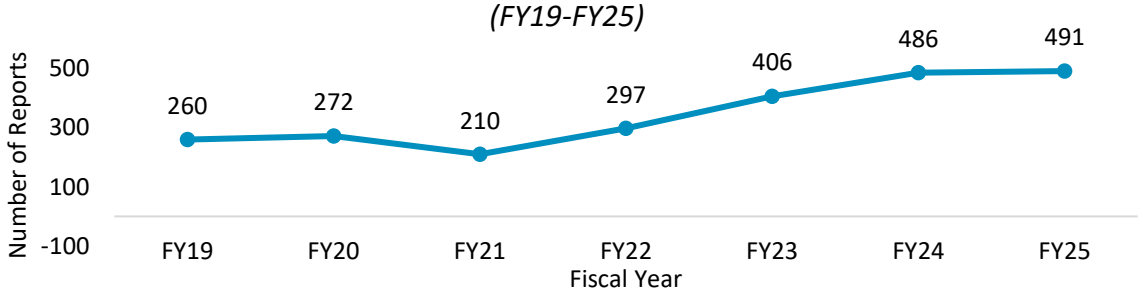
up with DCF (as either the investigator of the report of abuse and/or neglect or the entity responsible for providing ongoing case management services to the child and family) and/or the licensing, regulatory, or funding agency to gather more information and ensure the concerns are addressed.

The OCA acknowledges that the institutional reports submitted to the OCA do not provide a full picture of harm that occurs in out-of-home settings. The OCA only receives reports that were brought to the attention of DCF, screened in, and supported.

Key Insights

In FY25, the OCA received 491 institutional reports involving 691 children and 541 alleged perpetrators[32] across out-of-home settings. As seen in Figure 14: Institutional Reports, this represents the highest volume of institutional reports on record, continuing a multi-year upward trend. While these numbers and trends are concerning, the OCA notes that there are two possible causes of an increase in reports: an increase in children experiencing harm in out-of-home settings, and an increase in professionals appropriately identifying and reporting harm experienced by children in out-of- home settings. The OCA cannot say, based on available data, to what extent the increase in institutional reports is driven by either of these potential causes.

Figure 14:
Institutional Reports
(FY19-FY25)



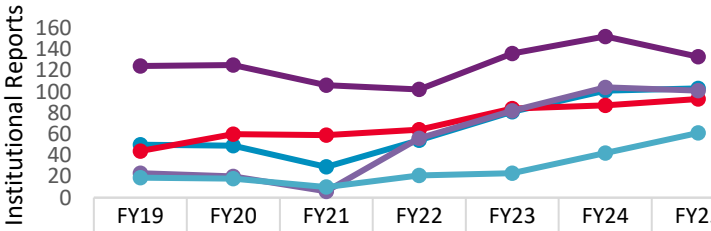
Insights by Out-of-Home Setting

As shown in **Table 3: Children Involved in Institutional Reports by Type of Out-of-Home Setting** and **Figure 15: Institutional Reports by Type of Out-of-Home Setting**, the OCA classifies institutional reports by setting[33] and collects information on the number of children impacted as well as the number of alleged perpetrators involved and reports received.

[32] While there are 541 known alleged perpetrators, many institutional reports also involved unknown or unnamed perpetrators. This is likely an undercount of perpetrators.
[33] See **Appendix F: Glossary of Terms** for definitions.

Table 3: Children Involved in Institutional Reports by Type of Out-of-Home (OOH) Setting, FY25				
Type of OOH Setting	**Reports**	**Children**	**Alleged Perpetrators**	**Service Provision or Capacity**
Child Care	103	170	133	247,989[34]
Congregate Care	133	174	152	3,679[35]
Foster Care	93	151	119	5,203[36]
Schools	101	128	94	989,576 [37]
Other[38]	61	73	70	NA
Grand Total	**491**	**691**	**541**	**NA**
Note: Children can appear in more than one setting. Total of children and alleged perpetrators will not equal sum.				

Figure 15:
Institutional Reports by Type of Out-of-Home Setting (FY19-FY25)



	FY19	FY20	FY21	FY22	FY23	FY24	FY25
Child Care	50	49	29	54	81	101	103
Congregate Care	124	125	106	102	136	152	133
Foster Care	44	60	59	64	84	87	93
Schools	23	20	6	56	82	104	101
All Other	19	18	10	21	23	42	61

[34] Department of Early Education and Care. Children Enrolled in Formal Early Education and Care, June 2025. Accessed 4/21/2026.
[35] DCF served 1,677 children and youth in congregate care (Data Request 2025); DYS served 1,016 in residential placements for detained and committed youth (Data Request 2026); DMH served 181 children in residential services (Data Request 2025); DPH's Bureau of Substance Additional Services treated 12 youth in residential programs (JJPAD Annual Report FY25); DESE served 793 students in residential schools (Data Request 2026). Data is unduplicated at the agency level, but a child may appear in more than one agency data set.
[36] DCF foster care. Data Request, 2025.
[37] Public and private schools only. Department of Elementary and Secondary Education. 2024-25 School Attending Children Report. Accessed 4/21/2026. https://profiles.doe.mass.edu/profiles/student.aspx?orgtypecode=5&fycode=2025&orgcode=02850000
[38] Other includes shelters, transportation companies, community-based programs, hospital and health care organizations, and unspecified settings. Combined because of small numbers.

As in prior years, the OCA received the highest number of reports regarding abuse and/or neglect in **congregate care** settings (133 reports), with allegations regarding abuse/neglect in residential schools occurring most frequently (85 reports).

Although the total number of reports in congregate care has remained relatively stable over the past few years, supported allegations of physical abuse have increased (57 in FY25 compared to 45 in FY24).[39] This increase is driven by supported physical abuse allegations in residential schools. Reports of physical abuse are more common in secure facilities operated by DYS and residential schools, where the use of restraints, higher-acuity behavioral needs, and strict reporting requirements intersect. Common contributing factors identified by the OCA include improper behavior management in residential schools and secure facilities operated by DYS, and inadequate supervision and boundary issues in group homes.

The number of institutional reports about children in **foster care** increased 7% from FY24 (87) to FY25 (93), following several years of slow but steady increases. This increase is especially concerning considering the overall reduction in the number of children placed in DCF foster care.[40] Supported allegations of abuse and/or neglect in kinship foster care increased more than in the other types of foster care. Adding to the concern, physical abuse (24) increased both in count and as a proportion of reports from foster care settings, driven by reports from kinship foster care (12). Common contributing factors identified by the OCA include caregiver substance use, domestic violence, and inappropriate discipline practices, highlighting challenges in supporting foster parents to meet the needs of the children in their care.

The number of reports from **public schools** stayed the same from FY24 (95) to FY25 (94), following several years of steep increases. There was a 340% increase in institutional reports from schools from FY19-FY25. These increases are primarily driven by allegations of neglect, but increases in physical abuse are also observed. Compared to other settings, public schools show a higher proportion of reports involving sexual abuse (13, 14%). Common contributing factors identified by the OCA include boundary issues and misconduct by caregivers.

Institutional reports from **child care** settings (103) increased for the fourth consecutive year, doubling since FY19 (50). EEC licenses two types of child care: center-based and family-based (aka in-home). The increase in reporting is primarily driven by reports from center-based settings. However, supported allegations of abuse and/or neglect in child care remain rare, affecting less than 1% of children served in child care. Reported allegations from family child care settings involved physical abuse more frequently than allegations from center-based child

[39] The OCA began collecting subcategories for congregate care institutions (group home, residential school, DYS operated secure facilities) in FY24. Prior year data is not available.
[40] As reported by DCF. Data request 2025. See **Appendix C: Institutional Report Data** for additional foster care service numbers.

care. Common contributing factors identified by the OCA include improper behavior management in center-based child care and inadequate supervision in family child care.

Institutional Reports Takeaways

Overall, the FY25 institutional reports reflect a system under increasing pressure, with rising report volume and increasing reports of physical abuse. While most children in out-of-home care do not experience abuse and/or neglect, the persistence of fundamental caregiving concerns—particularly around supervision, behavior management, and emotional harm—points to systemic challenges that cut across settings. This underscores the need for continued oversight, stronger support for caregivers, and consistent, high-quality practices to better protect children across all environments.

For additional institutional report data and information, including service population estimates, allegations, and the OCA incident concern categories by type of institution and subtype, refer to **Appendix C: Institutional Report Data**.

Actions Taken and State Agency Follow-Up

When a Complaint Line inquiry, a critical incident report, institutional report, or Foster Care Review safety alert is received, the OCA conducts an initial review of the reported circumstances to triage the OCA's response based on any immediate safety concerns for the child or needs of the family.[41] When the OCA identifies immediate or escalating risk to a child, a need for clarifying information or improved service delivery for a child or family, or a system-wide pattern or trend, the OCA follows a standard operating procedure of contacting a designated senior leadership liaison at the agency involved on an immediate and ongoing basis. **Through these liaisons, the OCA ensures that all concerns identified through the OCA's review are resolved appropriately and in a timely manner to ensure the safety and wellbeing of the children involved and, as appropriate, to improve services for the child and family.** If the OCA determines that the actions or inactions of a state agency were egregious and significantly contributed to the harm of a child or young adult, the Child Advocate can choose to initiate an investigation.[42]

Actions Taken by the OCA

Following the standard rigorous response to Complaint Line inquiries and review of critical incident reports, institutional reports, and Foster Care Review safety alerts received, the OCA took additional action in 47% (818) of the 1,750 reports and inquiries received.[43] **Table 4: OCA Actions Involving an External Agency** shows the OCA action and follow-up with a state agency during FY25.

A larger percentage of cases resulted in OCA action in FY25 (47%) compared to FY24 (38%), driven by increased referrals to services.[44] In order of most to least frequently occurring, the OCA took the following actions in FY25:

- Feedback to state agencies (462)
- Referrals to services or providing system navigation support to Complaint Line contacts (347)[45]

[41] While all cases submitted to the OCA are reviewed, an in-depth review takes time; priority is determined based on the initial review and an assessment of current risk to the child(ren) involved.
[42] Not all investigations are made public; for more information, refer to the OCA Protocol on the Release of Confidential Information
[43] The OCA responds to all Complaint Line inquiries within two business days of the date of contact and reviews all cases it receives. These are standard expectations of the work and are not recorded as separate actions.
[44] This increase may be due to improved record collection about referrals to services.
[45] Referrals to service and system navigation often involves explaining to an individual how to navigate the state agency involved to resolve their concerns. For example, the OCA may explain the DCF chain of command and how the individual can access the DCF Ombudsman office.

- Filed a 51A[46] report of abuse and/or neglect with DCF (6)
- Conducted an investigation (2)[47]

The OCA may choose not to take additional action if, for example, the OCA does not hear back from someone who contacted the Complaint Line, no case practice concerns are identified, the issue identified is known to the agency involved and being resolved through other avenues, or a variety of other reasons.

Table 4: OCA Actions Involving an External Agency, FY25

Function	Reports or Inquiries	Reports or Inquiries with any OCA Action	Percent Resulting in Additional Action
Complaint Line	993	522	53%
Critical Incident Reports	240	117	49%
Foster Care Review Safety Alerts	26	16	62%
Institutional Reports	491	163	33%
Total	**1,750**	**818**	**47%**

State Agency Follow-Up

In FY25, the OCA followed-up with designated state agency liaisons at DCF, the Department of Mental Health (DMH), the Department of Public Health (DPH), DYS, EEC, the Department of Elementary and Secondary Education (DESE), the Department of Transitional Assistance (DTA), and the Executive Office of Health and Human Services (EOHHS) regarding 26% (462) of the 1,750 reports and inquiries received,[48] including:

- 17% (167) of 993 Complaint Line inquiries (153 complaints and 14 requests for information or a referral)
- 49% (117) of 240 critical incident reports
- 62% (16) of 26 Foster Care Review safety alerts
- 33% (162) of 491 institutional Reports

Proportionally, fewer cases resulted in follow-up with a state agency in FY25 compared to FY24 (33%). The OCA followed-up with DCF in 396 of the 462 cases while 86 cases involved a state

[46] MGL c. 119 § 51A. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter119/section51a
[47] Not all investigations are made public; for more information, refer to the OCA Protocol on the Release of Confidential Information
[48] As of the writing of this report, 19 cases remain open for FY25 as the OCA monitors the cases to ensure that all concerns are addressed.

agency other than DCF.[49] The reasons for follow-up varied by agency, as did the actions taken by an agency to resolve the issues. OCA follow-up with agencies resulted in a variety of responses including case decision changes, clinical consultations, corrective documentation, workforce development and more. **Table 5**: **Number and Description of Reports or Inquiries Prompting OCA Follow-Up with State Agencies** provides an agency-by-agency overview of the number of reports or inquiries about which the OCA followed up and the reasons for that follow-up.

[49] The OCA may reach out to more than one agency to provide feedback in any given case.

Table 5: Number and Description of Reports or Inquiries Prompting OCA Follow-Up with State Agencies, FY25[50]			
Agency	**Report or Inquiries**	**OCA Reason for Follow-Up**	**Agency Response to OCA Feedback**
DCF	396	See "DCF Case Review and Follow-Up" for more information.	
DESE	1	Reporting and investigation coordination for children with disabilities following an institutional report.	OCA convened a meeting with DESE and EEC to ensure cross-agency information sharing.
DMH	7	Information about actions taken following a complaint or institutional report.	DMH provided additional services and support; concern was discussed at the OCA led Interagency Residential School meeting; concerns were addressed with appropriate staff and by agency leadership.
DPH	7	Ensuring mandated reporting, background checks and expectations are clear within a program following a complaint, critical incident report, and institutional report.	Retraining based on OCA feedback; concerns were addressed with appropriate staff; clarification and rationale provided.
DYS	20	See "DYS Follow-Up" for more information.	
EEC	47	Clarification on investigation outcomes, steps taken to monitor or otherwise hold programs accountable, status of programs (opened, closed), employment status of staff, cross agency-response coordination.	Provided OCA with additional information or context that resolved any concerns and took steps, such as training, that resolved concerns with appropriate staff.
Other	11	Other: national and out of state partners, such as professional associations and other state child welfare agencies DTA: interagency coordination and collaboration EOHHS: eligibility criteria and Interagency Review Teams for Complex Case Resolution	Action steps were taken to resolve concerns.

[50] Number will not sum to total because the OCA occasionally reached out to more than one agency based on a report or inquiry.

DCF Case Review & Follow-Up

While the OCA receives and reviews reports and inquiries from all executive child-serving state agencies, the OCA's statutory mandate is to focus particularly on children in the care or custody of DCF or DYS. The OCA has established robust policies and protocols for in-depth review of DCF cases, which includes a thorough administrative review of the family's DCF electronic record.[51] The multifaceted goals of the OCA's DCF case review are to: [52]

- Ensure the safety and wellbeing of the children involved.
- Gain an understanding of the child, family, and their needs.
- Ensure DCF's clinical formulation and resulting intervention and services provided to the child and family are appropriate and evolving.
- Evaluate DCF's efforts to promote the safety and permanence of the children involved.

The OCA evaluates two DCF process points within the case review. These two categories are based on DCF policies and procedures and how they structure family engagement. They are:

- **Intake/Response**: The DCF process of receiving, screening, and determining their response to a report of abuse and/or neglect[53] and investigation into the report of abuse and/or neglect.[54]
- **Ongoing Case Practice**: The DCF process of providing case management services to the child and family through an open DCF case.

In this context, the OCA identifies what worked well in DCF case practice and where there are opportunities for improvement at the DCF area office level, at the regional level, across the system, or with a specific family.

In FY25, the OCA received a total of 1,750 reports and Complaint Line inquiries. Those reports and inquiries led OCA to conduct **1,262 DCF case reviews**.[55] **The OCA identified case practice concerns in 485 of the 1,262 (38%) DCF submitted or involved reports and inquiries.**[56] This includes case practice concerns in the following categories:

- 195 Complaint Line inquiries (30% of all DCF involved Complaint Line inquiries (634))
- 113 critical incident reports (58% of all DCF reported critical incident reports (194))

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[51] DCF's electronic database is iFamilyNet.
[52] While the OCA reviews all cases brought to its attention with the same goals, the OCA does not have access to other state agency data systems that would allow for detailed case review and more informed oversight. For that reason, case review findings are only presented for DCF.
[53] MGL c. 119 § 51A. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter119/section51a
[54] MGL c. 119 § 51B. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter119/section51b
[55] DCF case reviews are not conducted if the report or inquiry does not involve DCF. See OCA's Review of DCF Cases for more information.
[56] See **OCA Quality Assurance Operations, Case Reviews** for more information.

- 22 Foster Care Review safety alerts (85% of all Foster Care Review Safety Alerts (26))
- 155 institutional reports (32% of all institutional reports (491)).

Concerns with ongoing case practice were more prevalent than with intake and response practices. Engagement with a child's caregiver, particularly engagement with fathers, during ongoing case practice was the most frequently occurring concern noted by the OCA. Second most frequently occurring are concerns about clinical formulation during ongoing case practice, particularly DCF's assessment of risk and neglect. Administrative concerns, such as documentation, occurred during both intake and response and ongoing case practice.

The OCA followed up with DCF with a request for feedback regarding 396 case reviews (31%).[57] Most frequently, DCF addressed the feedback the OCA brought to them directly with the staff involved (81 case reviews) and involved agency leadership in the corrective action (51 case reviews). According to DCF, 63 case reviews that the OCA brought to the agency's attention resulted from pertinent information not being documented in the DCF electronic record at the time of the OCA review. This year, a smaller portion of the concerns identified were a result of documentation concerns (63, 16% in FY25 compared to 110, 31% in FY24), which may hopefully signal an improvement in DCF case documentation, though many other factors may be at play.

DCF also convened an Area or Regional Clinical Review Team (ACRT/RCRT) or specialist consultation to address the OCA-identified concerns within the appropriate area office in 52 cases, took action to retrain staff using case examples highlighted by the OCA in 24 cases, corrected 12 administrative issues, and changed eight case decisions. DCF also filed 10 reports of abuse and/or neglect and modified four permanency plans based on OCA feedback. **Table 6: DCF Response to OCA Feedback** describes DCF's response to the feedback OCA provided based on case review.

Table 6: DCF Response to OCA Feedback, FY25[58]

DCF Response	Inquiries/Reports
Concerns Addressed with Appropriate Staff	81
Documentation Issue	63
ACRT/RCRT/Specialist Consultation was Convened to Review Case	52
Concerns Addressed by DCF Leadership	51
Case Used as Example for Retraining	24
Other[59]	13

[57] The OCA does not always request a response to the feedback provided to a state agency. For example, if the child and family are no longer receiving services from the state agency, or there is an unfixable administrative error, the OCA may bring the agency's attention to the matter for future policy, procedure and training considerations without expecting a response.
[58] Number will not sum to total because DCF may provide more than one response to OCA's feedback.
[59] Other responses to OCA feedback include the agency providing additional services to the child and/or family, changes in practice, clarification or rationale to the OCA on the issue brought to their attention or addressing concerns with agency leadership.

Table 6: DCF Response to OCA Feedback, FY25[58]	
DCF Filed a Report of Abuse and/or Neglect	10
Administrative Issue Corrected	12
Case Decision Change	8
Permanency Plan Changed or Paused	4
Total Case Reviews Resulting in Feedback to DCF	**396**
Note: **Number will not sum to total** as **DCF may provide more than one response to OCA's feedback**, or a response might not be expected/requested from OCA. See **OCA Quality Assurance Operations, State Agency Follow Up** for additional information.	

For additional information on OCA DCF case review and follow-up, refer to **Appendix D: DCF Case Review Data**

DYS Follow-Up

The OCA followed-up with DYS regarding 20 reported cases, including 13 critical incident reports, one Complaint Line inquiry and six institutional reports. The incidents the OCA followed up on include the use of force and serious injuries related to improper restraints, mental health crisis, community violence, and staff misconduct. When the OCA conducted follow-up with DYS, it was to seek information about the youth's wellbeing and to ensure that safety planning was appropriately conducted and that youth are protected from further harm. In response, DYS provided clarification about the youth's wellbeing and information about the action steps taken to ensure their protection. DYS also provided information about accountability actions against staff, such as termination, and progress on internal reviews.

Conclusion

In FY25, the Office of the Child Advocate's oversight activities revealed both encouraging developments and areas of concern across Massachusetts' child-serving systems. Increased engagement with the OCA, particularly through the Complaint Line and Youth Engagement Initiative, suggests growing awareness of the OCA as a resource for families, youth, and professionals seeking assistance or raising concerns. At the same time, data collected through the OCA's quality assurance functions point to several troubling patterns that warrant continued attention.

Although the overall number of critical incident reports declined, **indicators of serious harm to children increased across multiple data sources**. Reports involving physical abuse, serious injury, and improper behavior management appeared in several oversight streams, including institutional reports, critical incident reports, and Complaint Line inquiries. The OCA also filed more reports of abuse and/or neglect with DCF based on information received through these oversight activities than in prior years, and several cases the OCA reviewed involved particularly egregious harm to children.

One such case resulted in the OCA's systemic investigation into the death of A'zella Ortiz, a young child whose death in October 2024 occurred while she and her family were involved with DCF. The investigation identified practice concerns related to clinical formulation, the identification and assessment of chronic neglect, and engagement with fathers—issues that have appeared in other cases reviewed by the OCA. While the OCA's investigation benefits from retrospective analysis and access to information not always available to state agency staff, it nonetheless highlights critical areas where system practice can be strengthened.

Taken together, the findings presented in this report underscore the importance of strong, consistent assessment and engagement practices in child protection work. Ensuring that patterns of chronic neglect are recognized, that family dynamics are fully understood, and that caregivers receive appropriate support are essential steps in preventing serious harm to children. Many of these issues were raised by the OCA in the A'zella Ortiz investigation report, and the OCA's recommendations from that report are summarized in the text box below, **Recommendations from the OCA Systemic Investigation Regarding the Death of A'zella Ortiz.**

Through continued oversight, transparency, and collaboration with state partners, the OCA will continue working to identify risks, strengthen systems of care, and promote policies and practices that improve safety and wellbeing for children and families across the Commonwealth.

Recommendations from the OCA's Systemic Investigation Regarding the Death of A'zella Ortiz

- **Revise and update the DCF Case Closing Policy** to provide greater clarity and guidance, with a particular focus on scenarios where a family has prolonged DCF involvement and/or their whereabouts are unknown.
- **Establish a structured quality assurance framework** to guide DCF casework with intact families that is well-researched, well-resourced, and multifaceted.
- **Develop and implement a stand-alone policy about case consultations** with the already existing DCF clinical specialists that includes procedures to make sure the recommendations are addressed.
- **Strengthen the definition of "clinical formulation,"** to ensure that it is child-centered and guides assessment, casework, and decision-making.
- **Create and embed an understanding of chronic neglect into DCF casework,** recognizing that chronic neglect is a subset of neglect with its own unique characteristics and risks.
- **Conduct a training needs-assessment of the DCF workforce to systematically identify the knowledge, skills, and capacity gaps** with a particular focus on clinical formulation, child development and growth, parental engagement, substance use, and neglect.

Appendix A: Complaint Line Data

The following section provides additional data regarding inquiries received through the OCA Complaint Line. The data is organized by "reason for inquiry". The high-level reasons for the inquiry that the OCA captured in FY25 are:

- **DCF:** A complaint or request for information about the Department of Children and Families.
- **Abuse and/or Neglect**: A complaint or request for information about child abuse and/or neglect. The child may or may not be involved with DCF at the time of the complaint or request for information.
- **Behavioral, Mental and/or Physical Health**: A complaint or request for information about services and systems related to physical, behavioral, and/or mental health.
- **Court System**: A complaint or request for information about court systems, including probate and juvenile court.
- **Education**: A complaint or request for information about access to and quality of education provided to a child.
- **Other**: Complaints and requests for information not classified elsewhere.

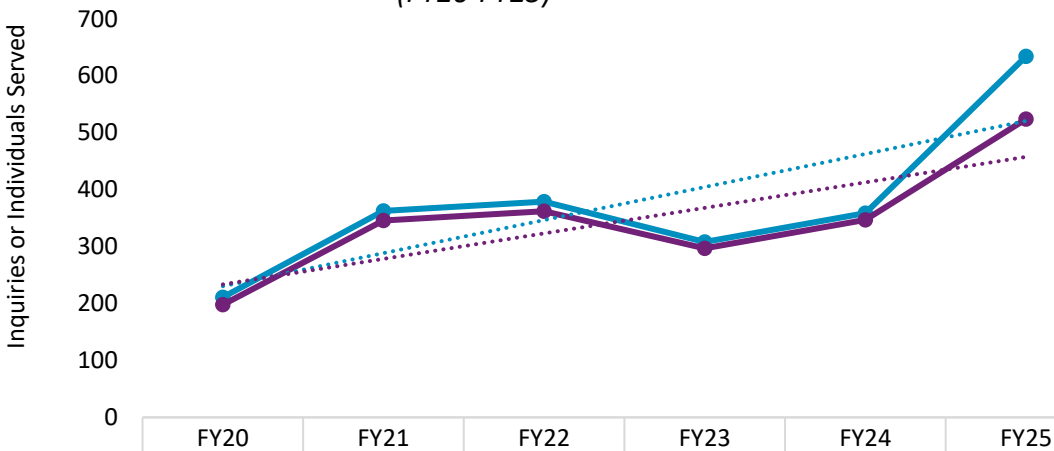
These topics are not mutually exclusive; a Complaint Line inquiry may involve more than one "reason for inquiry". Additionally, the number of individuals served differs from the number of inquiries because individuals may contact the Complaint Line more than once and/or for different reasons. Each time an individual contacts the Complaint Line after their inquiry is closed, a new inquiry is created.

The OCA categorizes Complaint Line inquiries in one of two ways: complaint and information and referral. A **complaint** is an expression of dissatisfaction with any agency or program that provides services to a child of the Commonwealth. **Information and referral** are a request for information, referral, or education on a specific topic.

DCF

As shown in **Figure 16: Complaint Line Inquiries and Individuals Served involving DCF**, the OCA received 634 inquiries related to DCF involving 524 individuals in FY25. From FY24 to FY25, there was a 77% increase in the number of Complaint Line inquiries after several years of relative stability. Despite the increase, the most frequent reasons individuals contacted the Complaint Line regarding DCF were similar to prior years.

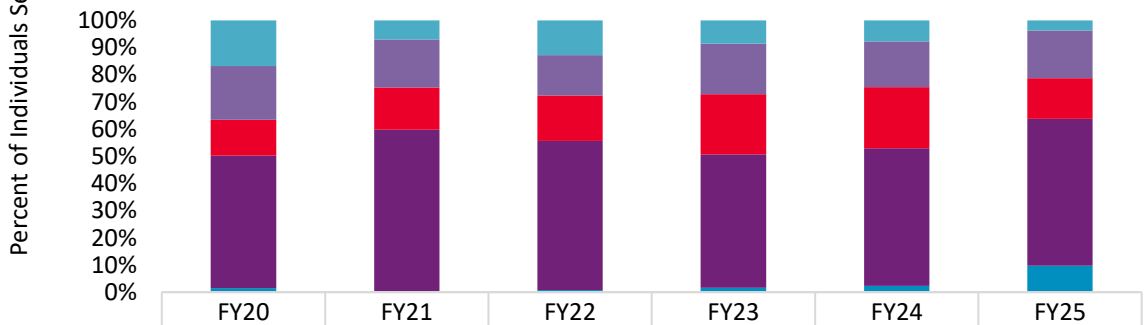
Figure 16:
Complaint Line Inquiries and Individuals Served involving DCF (FY20-FY25)



	FY20	FY21	FY22	FY23	FY24	FY25
DCF	211	363	379	308	359	634
Individuals Served	198	346	362	297	347	524

As shown in **Figure 17: Who Is Calling: Complaint Line Inquiries about DCF**, biological parents are most frequently contacting the Complaint Line: 43% (272) of inquiries involving DCF were brought to the OCA by a biological parent in FY25.

Figure 17:
Who Is Calling: Complaint Line Inquiries about DCF (FY20-FY25)



	FY20	FY21	FY22	FY23	FY24	FY25
Other	16%	7%	12%	8%	7%	4%
Other Relative	19%	17%	14%	19%	16%	17%
Provider	13%	15%	16%	22%	22%	14%
Parent	47%	58%	53%	49%	49%	52%
Child/Self	1%	0%	1%	2%	2%	9%

Note: Chart does not include unknown or N/A categories. Totals will not sum to 100%.

Of the 634 inquiries about DCF the OCA received in FY25, 93% (588) were complaints and 7% (46) were requests for information and referral. As shown in **Table 7: Complaint Line Inquiries about DCF**, inquiries about DCF were most frequently about DCF personnel (293), including allegations of DCF staff not responding to an individual's outreach, alleged disrespect by DCF personnel, missing paperwork (including safety plans and family assessments), and lack of follow-through of a family member's visitation rights with children in out-of-home placements. This subcategory increased 89% from FY24 to FY25 and drove the overall increased volume of complaints about DCF.

The second most frequent reason for DCF-related inquiries was concerns about a child's placement (150)[60] including concerns about inappropriate placements, placement changes or denial, length of time in a placement, and quality of placement. Some individuals expressed concerns about the type of placement, or inconsistent placement visits by workers.

Concerns about the care and/or custody of a child involved with DCF was the third largest category (89). This includes complaints about removal or non-removal of children. Concerns about a Family Assessment and Action Plan came up in 30 inquiries.

DCF-related information and referral requests included inquiries about what to do in case of suspected abuse and/or neglect, help understanding DCF policies and procedures, options for out-of-home placements, service coordination, payments and vouchers, records requests, and more.

Table 7: Complaint Line Inquiries about DCF, FY24 & FY25

Reason for Call	FY24	FY25
Care and Custody of Child(ren)	70	89
DCF Case Management	31	8
DCF Personnel	155	293
Family Assessment and Action Plan	12	30
Family Visits	1	65
Parent/Caregiver Engagement	13	26
Payment and Vouchers	2	9
Permanency Goal Change	6	24
Placement	98	150
Policies and Procedure	3	30
Records Requests	1	16
Reunification	25	69
Service Coordination	25	58

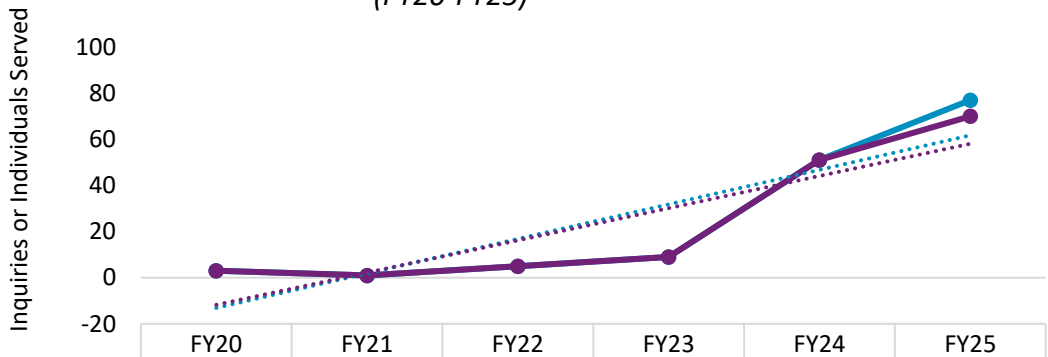
[60] Placement refers to an out-of-home placement. See **Appendix F: Glossary of Terms** for more information.

Table 7: Complaint Line Inquiries about DCF, FY24 & FY25		
Other[61]	77	140
Total Cases	**359**	**634**
Note: Sum will not equal number of inquiries. Multiple options may be selected for each inquiry.		

Alleged Abuse and/or Neglect

As shown in **Figure 18: Complaint Line Inquiries and Individuals Served: Abuse and/or Neglect of Children**, the OCA received 77 inquiries about abuse and/or neglect, involving 70 individuals in FY25; 83% (64) were complaints while 17% (13) were requests for information and referral. The number of inquiries in this subcategory increased 51% from FY24 (51) to FY25 (77). However, this variable has evolved over time both in definition and in coding structure. Prior year data is a helpful reference but may be unreliable.[62] Abuse and/or neglect inquiries often involve concern expressed by the individual that a child has been abused or neglected in out-of-home care or by their custodial parent, or the individual is seeking information about what to do if they suspect abuse and/or neglect of a child.

Figure 18:
Complaint Line Inquiries and Individuals Served: Alleged Abuse and/or Neglect of Children
(FY20-FY25)

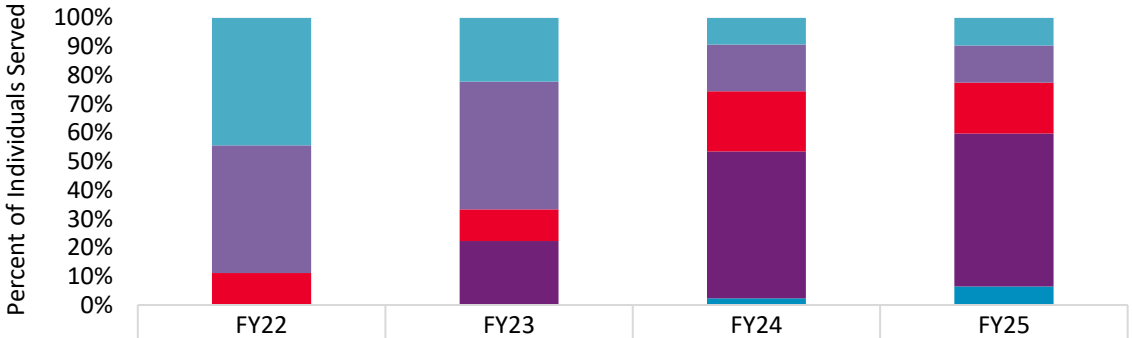


	FY20	FY21	FY22	FY23	FY24	FY25
Abuse/ Neglect	3	1	5	9	51	77
Individuals Served	3	1	5	9	51	70

[61] Other DCF inquiries are regarding concerns about the lack of or inconsistent home visits or placement visits by a social worker and multi-agency involved youth.
[62] "Abuse and/or Neglect" was originally a sub-category of the OCA Complaint Line category for DCF related complaints. However, the OCA observed that many of these Complaint Line inquiries did not involve current or prior DCF history for the child or family involved in the complaint. As such, the OCA removed Abuse and/or Neglect from the DCF-related Complaint Line category and made it a separate category under "Reason for Call."

As shown in **Figure 19: Who is Calling: Complaint Line Inquiries about Abuse and/or Neglect**, most inquiries in this category come from a parent, though children themselves contacted the OCA more about this topic in FY25.

Figure 19:
Who is Calling: Complaint Line Inquiries about Alleged Abuse and/or Neglect (FY22-FY25)



	FY22	FY23	FY24	FY25
Other	44%	22%	8%	9%
Other Relative	44%	44%	14%	13%
Provider	11%	11%	18%	17%
Parent	0%	22%	44%	52%
Child/Self	0%	0%	2%	6%

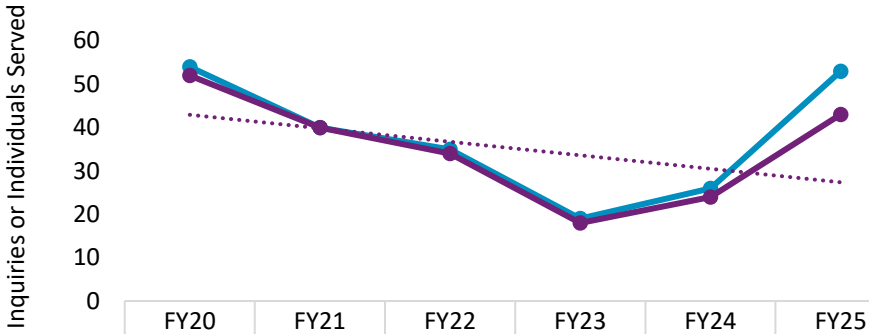
Note: Chart does not include unknown or N/A categories. Totals will not sum to 100%.

Behavioral, Mental, or Physical Health

As shown in **Figure 20: Complaint Line Inquiries and Individuals Served: Behavioral, Mental, and Physical Health Systems**, the OCA received 53 inquiries related to behavioral (46) or physical health (7) involving 43 individuals in FY25.[63]

[63] The OCA began using "behavioral health" as a unique category beginning in FY23.

Figure 20:
Complaint Line Inquiries and Individuals Served: Behavioral, Mental and Physical Health Systems (FY20-FY25)



	FY20	FY21	FY22	FY23	FY24	FY25
Behavioral, Mental and Physical Health	54	40	35	19	26	53
Individuals Served	52	40	34	18	24	43

As shown in **Figure 21: Who is Calling: Complaint Line Inquiries about Behavioral, Mental, and Physical Health**, inquiries in this subcategory typically come from parents followed by providers.

Figure 21:
Who Is Calling: Complaint Line Inquiries about Behavioral, Mental and Physical Health (FY20 - FY25)

	FY20	FY21	FY22	FY23	FY24	FY25
Other	13%	15%	3%	11%	24%	3%
Other Relative	4%	2%	16%	5%	0%	5%
Provider	9%	27%	22%	32%	28%	36%
Parent	72%	51%	53%	53%	31%	56%
Child/Self	0%	0%	6%	0%	14%	0%

Note: Chart does not include unknown or N/A categories. Totals will not sum to 100%.

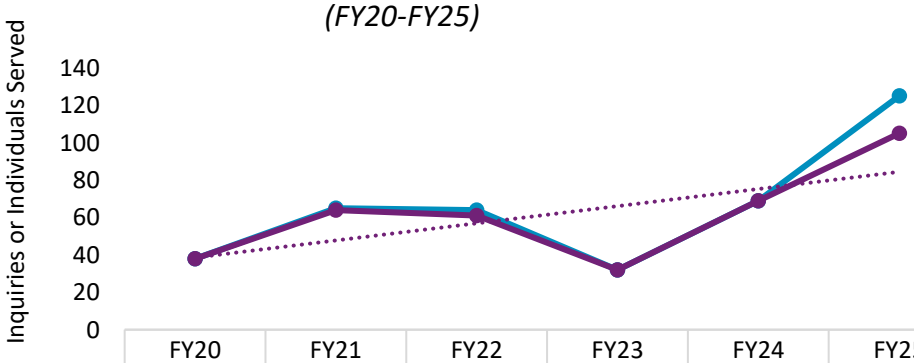
Of the 53 behavioral, mental, and physical health inquiries the OCA received in FY25, 62% (33) were complaints and 38% (20) were requests for information and referrals. As shown in **Table 8: Complaint Line Inquiries about Behavioral, Mental, and Physical Health,** inquiries about supportive services are the most frequently occurring, followed by service delivery. Other inquiries include questions and concerns about medication management.

Table 8: Complaint Line Inquiries about Behavioral, Mental and Physical Health, FY24 and FY25		
Reason for Call	**FY24**	**FY25**
Access to Medication and Treatment	1	4
Child is Not Receiving Enough Services/Supports	9	19
Emergency Department Boarding	3	6
Insurance and Payments	0	3
Malpractice	2	2
Out-of-home Placement Not Related to DCF	7	2
Service Delivery	6	16
Other	5	12
Total	**26**	**53**
Note: Sum will not equal number of inquiries. Multiple options may be selected for each inquiry.		

Court System

As shown in **Figure 22: Complaint Line Inquiries and Individuals Served: Court System**, the OCA received 125 inquiries regarding the court system involving 105 individuals in FY25. This was an increase of 81% from FY24 (69) to FY25 (125), and 229% since FY20 (38).

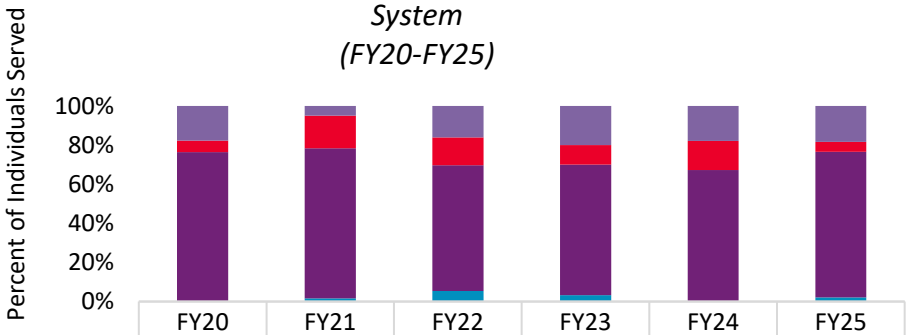
Figure 22:
Complaint Line Inquiries and Individuals Served: Court System (FY20-FY25)



	FY20	FY21	FY22	FY23	FY24	FY25
Court Involvement	38	65	64	32	69	125
Individuals Served	38	64	61	32	69	105

As shown in **Figure 23: Who Is Calling: Complaint Line Inquiries about the Court System**, inquiries in this subcategory overwhelmingly came from a parent, with a smaller proportion coming from providers in FY25.

Figure 23:
Who Is Calling: Complaint Line Inquiries about the Court System (FY20-FY25)



	FY20	FY21	FY22	FY23	FY24	FY25
Other Relative	15%	5%	15%	19%	17%	17%
Provider	5%	15%	13%	10%	14%	5%
Parent	65%	70%	59%	65%	64%	71%
Child/Self	0%	2%	5%	3%	0%	2%

Note: Chart does not include unknown or N/A categories. Totals will not sum to 100%

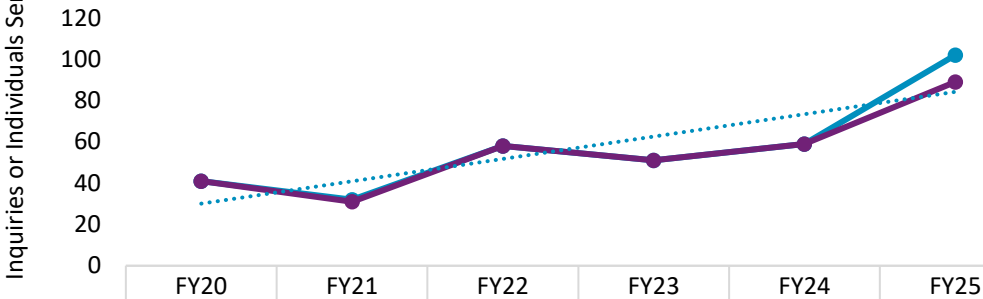
Of the 125 court system inquiries the OCA received in FY25, 68% (85) were complaints and 32% (40) were requests for information and referrals. **Table 9: Complaint Line Inquiries about the Court System** describes the reasons that individuals contacted the Complaint Line about the court system. These inquiries often involved concerns about nonadherence or non-enforcement of a judge's orders, perceived conflicts of interest with judges and attorneys, what to do in case of disagreement with a judge's decisions, how to obtain legal representation, understanding visitation rights and opportunities, and navigating the legal system.

Table 9: Complaint Line Inquiries About the Court System, FY24 & FY25		
Court Involvement Detail	**FY24**	**FY25**
Bias During Court Proceedings	3	21
Concerns with Legal Representation	11	36
Delay in Court Proceedings	4	5
Disagreement with a Judge's Decision	28	72
Visitation	-	26
Other	24	19
Total	**69**	**125**
Note: Sum will not equal number of inquiries. Multiple options may be selected for each inquiry.		

Education

As shown in **Figure 24: Complaint Line Inquiries Involving the Education System**, the OCA received 102 inquiries about education involving 89 individuals in FY25. This is an increase of 73% between FY24 (59) and FY25 (102) following a few years of moderate increases.

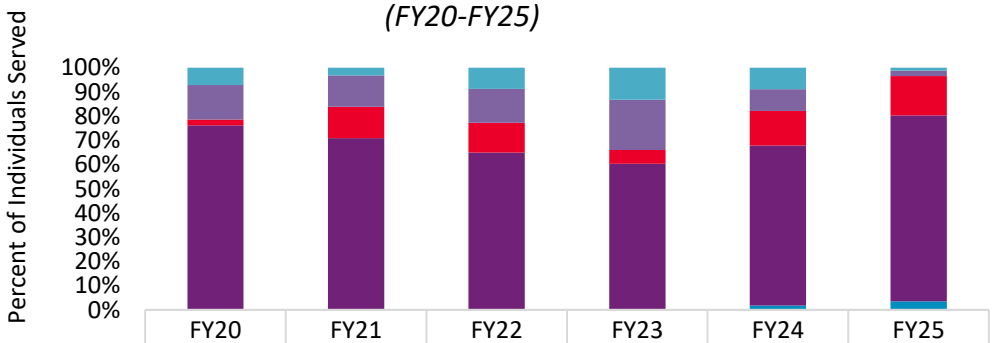
Figure 24:
Complaint Line Inquiries Involving the Education System (FY20-FY25)



	FY20	FY21	FY22	FY23	FY24	FY25
Education	41	32	58	51	59	102
Individuals Served	41	31	58	51	59	89

As shown in **Figure 25: Who Is Calling: Complaint Line Inquiries about Education**, although most inquiries in this subcategory are from a parent, there was a small increase in the number of inquiries coming from a youth in FY24 and FY25.

Figure 25:
Who Is Calling: Complaint Line Inquiries about Education (FY20-FY25)



	FY20	FY21	FY22	FY23	FY24	FY25
Other	7%	3%	9%	13%	9%	1%
Other Relative	14%	13%	14%	20%	9%	2%
Provider	2%	13%	12%	6%	14%	16%
Parent	76%	71%	64%	59%	64%	75%
Child/Self	0%	0%	0%	0%	2%	3%

Note: Chart does not include unknown or N/A categories. Totals will not sum to 100%

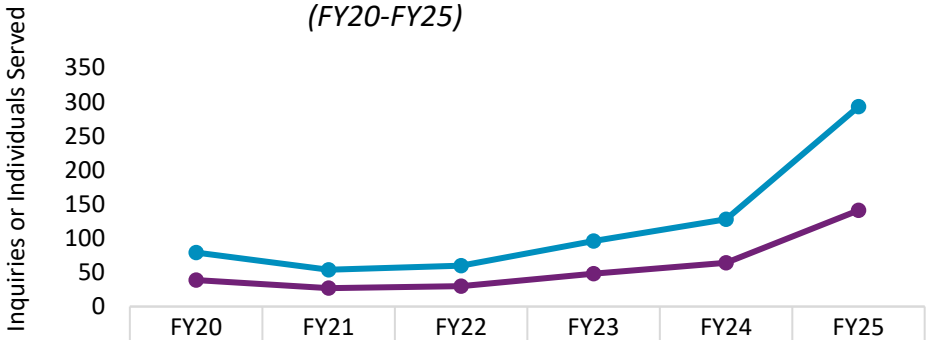
Of the 102 education inquiries the OCA received in FY25, 70% (71) were complaints and 30% (31) were requests for information and referrals. **Table 10: Complaint Line Inquiries about Education** describes the reasons people contacted the Complaint Line regarding education. While the reasons people contacted the OCA in FY25 are similar to FY24, the increase is particularly pronounced for concerns about school discipline, bullying, and Individualized Education Plans (IEPs) or 504 plans. Complaints about education often involved concerns about a school administration's response to a student's needs or concerns, including discipline practices, accessing or adhering to an Individualized Education Plan (IEP) or 504 plan, and the need for a different educational placement. Information and referral inquiries often involved bullying prevention, immigration, navigating the DESE problem resolution system, accessing education records, and accessing educational advocates.

Table 10: Complaint Line Inquiries About Education, FY23 - FY25			
Education Detail	**FY23**	**FY24**	**FY25**
Bullying	1	11	18
Individualized Education Plan (IEP) and/or 504 Plan	3	23	40
Lack of Responsiveness of School Staff/Administrator	3	28	42
Need for a Different Educational Placement	0	14	20
Transportation Services	0	1	3
Unfair or Inappropriate School Discipline	1	11	22
Other	1	9	30
Total	**51**	**59**	**102**
Note: Sum will not equal number of inquiries. Multiple options may be selected for each inquiry.			

Other Systems and Services

As shown in **Figure 26: Complaint Line Inquiries and Individuals Served: Other Systems and Services**, the OCA received 152 inquiries involving 141 individuals in FY25. This was an increase of 138% from FY24 (64) to FY25 (152) after several years of moderate increases.

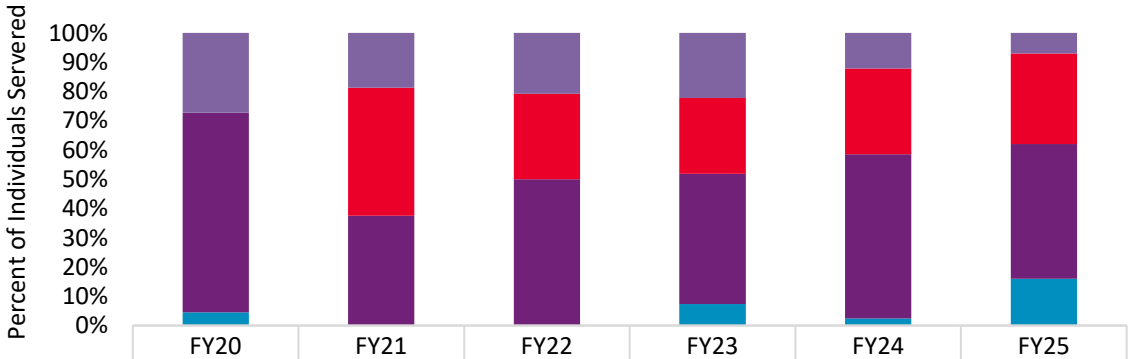
Figure 26:
Complaint Line Inquries and Individuals Served: Other Systems and Services (FY20-FY25)



	FY20	FY21	FY22	FY23	FY24	FY25
Other	40	27	30	48	64	152
Individuals Served	39	27	30	48	64	141

As shown in **Figure 27: Who Is Calling: Complaint Line Inquiries about Other Systems and Services**, although inquiries in this category are most frequent from parents, an increasing number of inquiries are coming from youth in FY25. This category also has a higher proportion of providers compared to other categories.

Figure 27:
Who Is Calling: Complaint Line Inquiries about Other Systems and Services (FY20-FY25)



	FY20	FY21	FY22	FY23	FY24	FY25
Other Relative	15%	10%	17%	13%	8%	5%
Provider	0%	24%	23%	15%	19%	24%
Parent	38%	21%	40%	26%	37%	36%
Child/Self	3%	0%	0%	4%	2%	13%

Note: Chart does not include unknown or N/A categories. Totals will not sum to 100%

Of the 152 Other inquiries the OCA received in FY25, 45% (68) were complaints and 55% (84) were requests for information and referral. **Table 11: Complaint Line Inquiries about Other Systems and Services** describes the reasons people contacted the complaint about other services and systems not previously mentioned above. Inquiries in the Other category include complaints related to: child maltreatment that does not rise to the DCF definition of abuse and/or neglect, housing and living conditions, alleged false allegations against the individual contacting the Complaint Line, complaints about agencies in states other than Massachusetts, alleged professional misconduct and ethics violations against Commonwealth employees or contractors, alleged failure to respect legal rights, privacy violations, alleged discrimination by service providers, and barriers to accessing benefits.

Information and referral inquiries include questions about mandated reporting, housing, financial assistance, and state service and systems navigation. Additional inquiries include the OCA's position on policy debates and legislative actions and requests for previously released OCA reports.

Table 11: Complaint Line Inquiries about Other Systems and Services, FY24 and FY25

Other Detail	FY24	FY25
Child Treatment	7	30
Financial Assistance	4	5
Housing	6	12
Living Conditions	2	5
Mandated Reporter Training	5	10
Perceived Discrimination	1	4
Records Requests	2	3
Missing or Absent Child	0	6
Other	16	69
Total	**64**	**152**

Note: Sum will not equal number of inquiries. Multiple options may be selected for each inquiry.

Demographics

The following tables provide additional context about demographic information collected through Complaint Line inquiries. Individuals contacting the Complaint Line are invited but not required to share demographic information. While the OCA is almost always able to collect information about the individual's role/relationship to the child (95% of the time), personal identity characteristics, such as race, ethnicity, gender identity and sexual orientation are captured less often.

Table 12: OCA Collection of Identity Characteristics for Individuals Served on the Complaint Line, FY25		
Characteristics	**Percent with Data**	**Count with Data**
Sex Assigned at Birth	41%	341
Gender Identity	34%	282
Race, Ethnicity	35%	285
Role/Relationship to Child	95%	783
Sexual Orientation	26%	211
Total	--	**993**

As shown in **Table 13: Availability of Race/Ethnicity of Individuals Served on the Complaint Line**, in FY25, more demographic data was collected compared to prior years. The OCA is working to improve identity characteristic collection through continuous quality improvement initiatives.

Table 13: Availability of Race/Ethnicity of Individuals Served on the Complaint Line						
Race/Ethnicity Category	**FY20**	**FY21**	**FY22**	**FY23**	**FY24**	**FY25**
Unknown/Unable to Determine/Decline to answer/Blank	306	409	492	453	393	541
Data Available	5	4	5	9	116	285
Individuals Served	311	413	496	462	509	826
Percent with Data	**2%**	**1%**	**1%**	**2%**	**23%**	**35%**

To the extent it is known, data on the race and ethnicity, sex assigned at birth, gender identity, and sexual orientation of individuals who contacted the Complaint Line is presented in **Tables 14-17**. Where possible, data are compared with the Massachusetts and DCF consumer population.

Table 14: Race and Ethnicity of Individuals Served on the Complaint Line Compared to the DCF Child/Youth Consumer Population and the Massachusetts Child Population, FY25			
Race, Ethnicity	**Complaint Line Contacts**	**DCF Consumers[64]**	**Massachusetts Population[65]**
American Indian/Alaska Native, NH	<1%	<1%	<1%
Asian & Pacific Islander, NH	1%	1%	9%
Black, NH	5%	14%	10%
Hispanic or Latino	7%	36%	22%
Multiple Races, NH	2%	7%	5%
White, NH	19%	33%	55%

[64] Calculated based on child and youth consumers. DCF data request 12/22/2025
[65] Kids Count Data Center, accessed 09/10/2025

Table 14: Race and Ethnicity of Individuals Served on the Complaint Line Compared to the DCF Child/Youth Consumer Population and the Massachusetts Child Population, FY25			
Unknown	65%	9%	-
Total	**100% (826)**	**100% (57,008)**	**100% (1,355,719)**
Note: Percents may not equal 100% because of rounding.			

Table 15: Sex Assigned at Birth of Individuals Served on the Complaint Line Compared to the Massachusetts Child Population, FY25		
Sex Assigned at Birth	**Complaint Line Contacts**	**Massachusetts Population[58]**
Female	31%	49%
Male	10%	51%
Unknown	59%	-

Table 16: Gender Identity of Individuals Served on the Complaint Line, FY25	
Gender Identity	**Complaint Line Contacts**
Female	25%
Male	8%
Gender Non-Conforming	<1%
Non-Binary	<1%
Unknown	66%

Table 17: Sexual Orientation of Individuals Served on the Complaint Line, FY25	
Sexual Orientation	**Percent of Individuals Served**
Straight/Heterosexual	22%
Gay	<1%
Lesbian	1%
Bisexual	1%
Pansexual/Omnisexual	<1%
Queer	<1%
Questioning	<1%
Not Listed	1%
Unknown	74%

Appendix B: Critical Incident Report Data

The following section provides additional data regarding critical incidents reported to the OCA. The data is organized by the cause of the critical incident.

The critical incident causes presented are mutually exclusive. Causes can result in physical injury (fatality, near fatality, serious bodily injury) or potential psychological harm (emotional injury). More than one child may be referenced in any given report; while the cause of the critical incident will remain the same for all children in the report, the type of incident (fatality, near fatality, serious bodily injury, emotional injury) is specific to the child who experienced the incident and may vary from one child to the next within the same report.

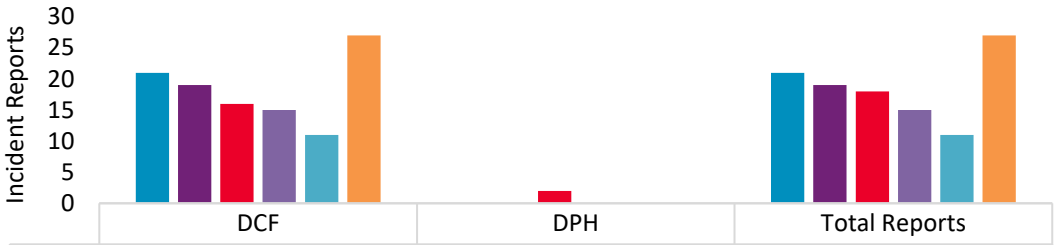
Data presented includes year-over-year trends, ages of children involved, and reporting agency. The OCA may receive more than one report about the same child(ren) and incident(s) if they are served by more than one state agency, and the reported cause may vary based on the agency's knowledge of events.

Physical Abuse

Figure 28: Physical Abuse Critical Incident Reports by Reporting Agency shows that the OCA received 27 critical incident reports about physical abuse. These reports involved 31 children, and 34 separate critical incidents. This includes seven fatalities, 23 serious bodily injuries and four emotional injuries as seen in **Figure 29: Physical Abuse by Type of Critical Incident**.

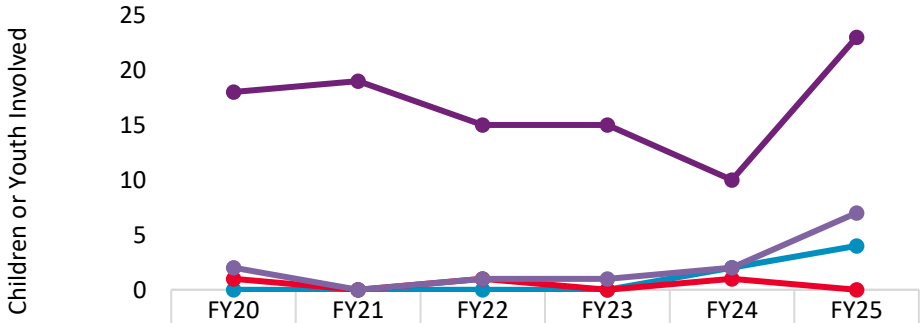
There was a sharp increase in physical abuse critical incident reports in FY25 (27) compared to FY24 (11). This increase was primarily driven by reports of serious bodily injury and fatalities, following years of stability or declines**.** All critical incident reports related to physical abuse in FY25 came from DCF.

Figure 28:
Physical Abuse Critical Incident Reports by Reporting Agency (FY20-FY25)



	DCF	DPH	Total Reports
FY20	21	0	21
FY21	19	0	19
FY22	16	2	18
FY23	15	0	15
FY24	11	0	11
FY25	27	0	27

Figure 29:
Physical Abuse by Type of Critical Incident (FY20-FY25)



	FY20	FY21	FY22	FY23	FY24	FY25
Emotional Injury	0	0	0	0	2	4
Serious Bodily Injury	18	19	15	15	10	23
Near Fatality	1	0	1	0	1	0
Fatality	2	0	1	1	2	7

Note: Will not sum to number of reports as children may experience more than one type of critical incident in a single report.

As shown in **Table 18: Age of Children Appearing in Physical Abuse Critical Incidents**, in FY25, all the children involved in a physical abuse critical incident were five years old or younger, and 56% were one year old or younger. One was in state custody, residing in foster care, at the time of the incident. The child's parent or stepparent was the alleged perpetrator(s) in all but three cases.

Table 18: Age of Children Appearing in Physical Abuse Critical Incidents, FY25				
Physical Abuse	**Under 1**	**1 to 4**	**5 to 9**	**Grand Total**
Fatality	5	2	0	7
Near Fatality	0	0	0	0
Serious Bodily Injury	15	7	1	23
Emotional Injury	0	3	1	4
Grand Total	**20**	**12**	**2**	**34**
Note: Will not sum to number of reports or children as multiple children may experience more than one type of critical incident in a single report.				

Overdose

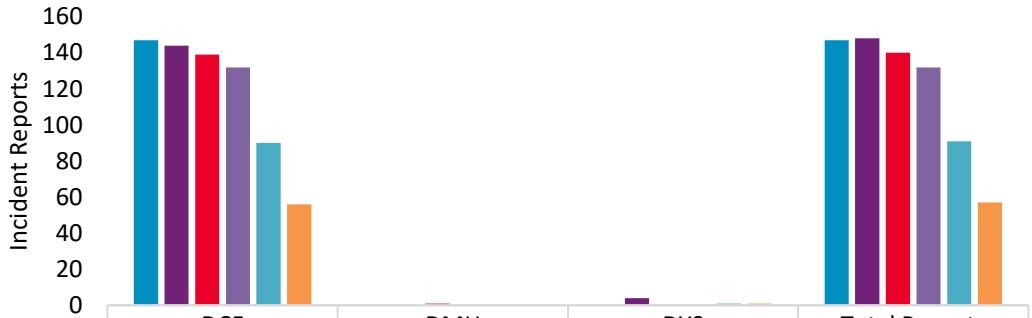
Figure 30: Overdose Critical Incident Reports by Reporting Agency shows that in FY25, the OCA received 57 critical incident reports related to an overdose. These reports involved 86 children and 86 critical incidents. This includes two fatalities, nine near fatalities, and 75 emotional injuries as shown in **Figure 31: Overdose by Type of Critical Incident.**

This is a decrease from FY24 (91) and the sixth year in a row with a substantial decline in the number of overdose critical incident reports. Although the decrease is primarily driven by a decline in the number of emotional injuries due to an overdose, there has also been a small decline in the number of physical injuries to a child or youth from an overdose (23 in FY24 compared to 11 in FY25).

Most overdose critical incidents were reported by DCF (56) and of those, 75% (42) occurred at home. One child was in a DYS independent living arrangement at the time of the overdose.

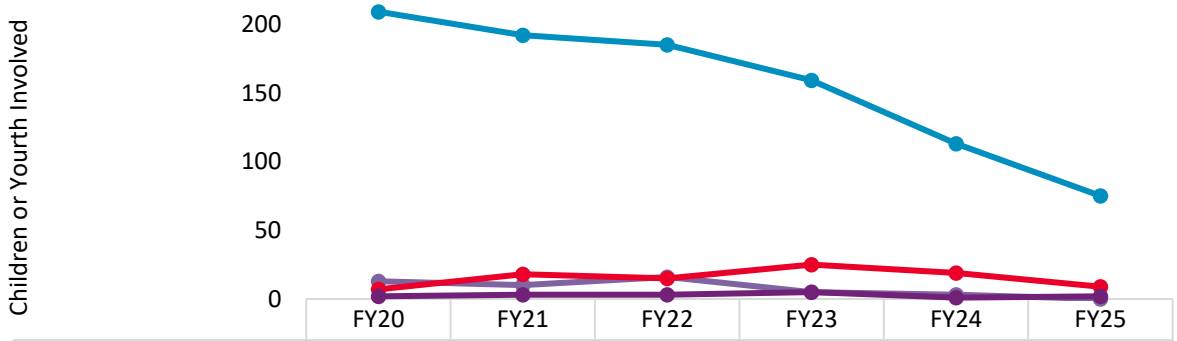
The substances involved included illicit opioids, over the counter medications, and alcohol, with older children often combining multiple substances.

Figure 30:
Overdose Critical Incident Reports by Reporting Agency (FY20-FY25)



	DCF	DMH	DYS	Total Reports
FY20	147	0	0	147
FY21	144	0	4	148
FY22	139	1	0	140
FY23	132	0	0	132
FY24	90	0	1	91
FY25	56	0	1	57

Figure 31:
Overdose by Type of Critical Incident (FY20-FY25)



	FY20	FY21	FY22	FY23	FY24	FY25
Emotional Injury	209	192	185	159	113	75
Serious Bodily Injury	13	10	16	5	3	0
Near Fatality	7	18	15	25	19	9
Fatality	2	3	3	5	1	2

The age of children appearing in critical incident reports about an overdose ranged from one to 19, as shown in **Table 19: Age of Children Appearing in Overdose Critical Incidents**. Children who were reported to have overdosed were more likely to be female (64%).

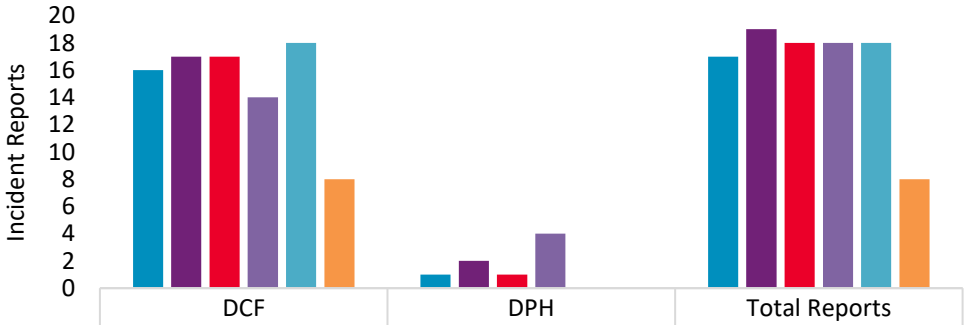
Table 19: Age of Children Appearing in Overdose Critical Incidents, FY25							
Overdose	**Under 1**	**1 to 4**	**5 to 9**	**10 to 14**	**15 to 19**	**20 to 26**	**Grand Total**
Fatality	0	0	0	1	1	0	2
Near Fatality	0	5	0	1	3	0	9
Serious Bodily Injury	0	0	0	0	0	0	0
Emotional Injury	0	24	19	21	11	0	75
Grand Total	**0**	**29**	**19**	**23**	**15**	**0**	**86**

Sudden Unexpected Infant Death (SUID)

Figure 32: SUID Critical Incident Reports by Reporting Agency shows that in FY25, the OCA received eight critical incident reports regarding the sudden unexpected death of an infant (SUID). These reports involved 21 children and 21 critical incidents. This included eight fatalities and 13 emotional injuries as shown in **Figure 33: SUID by Type of Critical Incident**.

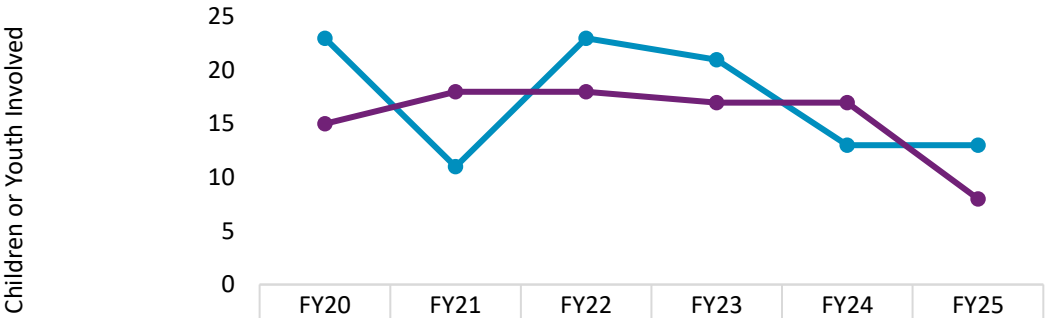
SUID-related fatality critical incidents reported to the OCA declined in FY25 (8) compared to prior reported years (15-18 each year). All SUID fatalities involved infants under 12 months. The age of children experiencing an emotional injury from witnessing a SUID ranged in age from one to 14 years old. All SUID related critical incidents reported to the OCA in FY25 were from DCF.

Figure 32:
SUID Critical Incident Reports by Reporting Agency (FY20-FY25)



	DCF	DPH	Total Reports
FY20	16	1	17
FY21	17	2	19
FY22	17	1	18
FY23	14	4	18
FY24	18	0	18
FY25	8	0	8

Figure 33:
SUID by Type of Critical Incident
(FY20 - FY5)



	FY20	FY21	FY22	FY23	FY24	FY25
Emotional Injury	23	11	23	21	13	13
Fatality	15	18	18	17	17	8

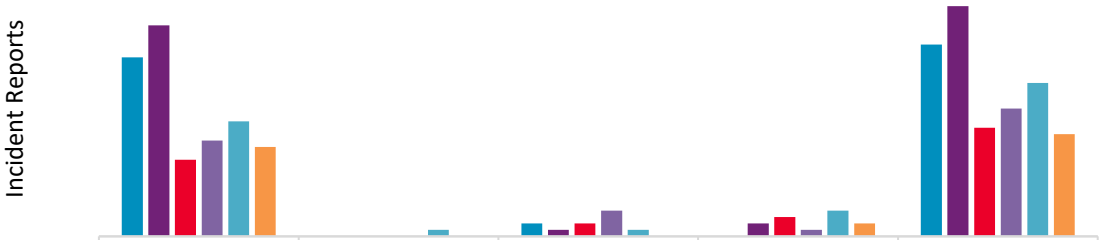
Suicide and Suicide Attempt

Figure 34: Suicide and Attempt Critical Incident Reports by Reporting Agency shows that in FY25, the OCA received 16 critical incident reports regarding a suicide or suicide attempt. These reports involved 22 children and 22 critical incidents. This includes five fatalities, two near fatalities, four serious bodily injuries and 11 emotional injuries as shown in **Figure 35: Suicide and Attempt by Type of Critical Incident.**

This is a marked decrease, driven primarily by a decrease in children experiencing an emotional injury from witnessing a suicide or suicide attempt – following two years of increases.

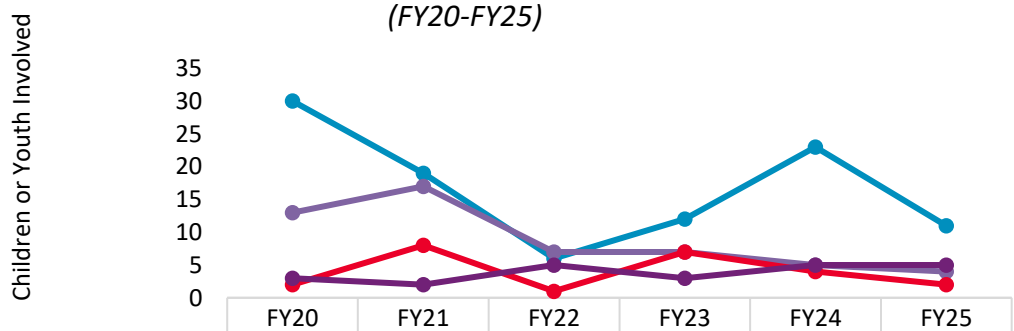
Most reports in FY25 were from DCF (14), with two reported by DYS. Most youth were in care and/or custody of the state at the time of the incident, including one in a residential facility and one in foster care. Neither of the incidents that occurred in an out-of-home setting resulted in fatality.

Figure 34:
Suicide and Attempt Critical Incident Reports by Reporting Agency (FY20-FY25)



	DCF	DDS	DMH	DYS	Total Reports
FY20	28	0	2	0	30
FY21	33	0	1	2	36
FY22	12	0	2	3	17
FY23	15	0	4	1	20
FY24	18	1	1	4	24
FY25	14	0	0	2	16

Figure 35:
Suicide and Attempt by Type of Critical Incident (FY20-FY25)



	FY20	FY21	FY22	FY23	FY24	FY25
Emotional Injury	30	19	6	12	23	11
Serious Bodily Injury	13	17	7	7	5	4
Near Fatality	2	8	1	7	4	2
Fatality	3	2	5	3	5	5

As shown in **Table 20: Age of Children Appearing in Suicide and Suicide Attempt Critical Incidents,** youth who experienced a physical injury from a suicide or suicide attempt were between 10 to 22 years old. Youth who experienced an emotional injury from witnessing a suicide or a suicide attempt were primarily between the ages of 11 and 15. The person who attempted or died by suicide was their parent, a parent's spouse, or a sibling.

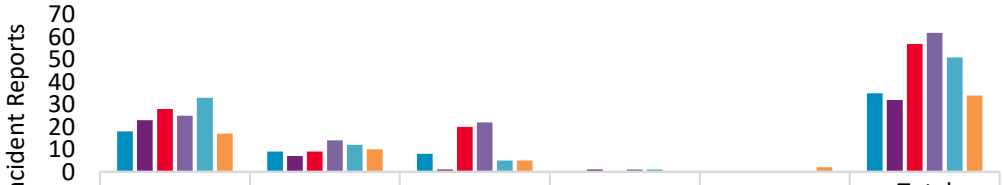
Table 20: Age of Children Appearing in Suicide and Attempt Critical Incidents, FY25							
Suicide/Suicide Attempt	**Under 1**	**1 to 4**	**5 to 9**	**10 to 14**	**15 to 19**	**20 to 26**	**Grand Total**
Fatality	0	0	0	3	1	1	5
Near Fatality	0	0	0	0	2	0	2
Serious Bodily Injury	0	0	0	2	2	0	4
Emotional Injury	0	1	0	8	2	0	11
Grand Total	**0**	**1**	**0**	**13**	**7**	**1**	**22**

Medical Events

Figure 36: Medical Event Critical Incident Reports by Reporting Agency show that in FY25, the OCA received 34 medically related critical incident reports. These reports involved 43 children and 43 critical incidents. This includes 24 fatalities, two near fatalities, and 17 emotional injuries, as shown in **Figure 37: Medical Events by Type of Critical Incident.** These reported events decreased from FY24 (51) to FY25 (34).

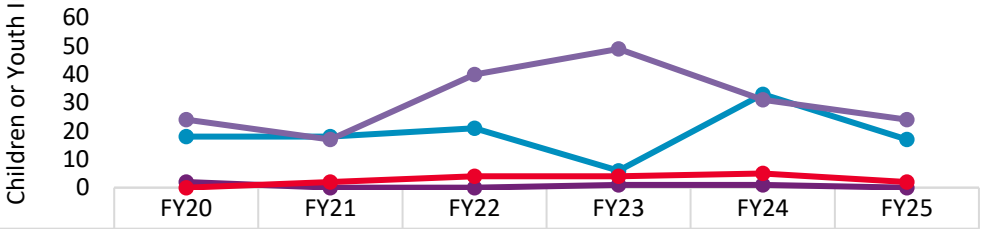
Medical critical incident reports in FY25 came from DCF (17), DDS (10), DPH (5), and EOHLC (2).

Figure 36:
Medical Event Critical Incident Reports by Reporting Agency (FY20-FY25)



	DCF	DDS	DPH	DYS	EOHLC	Total Reports
FY20	18	9	8	0	0	35
FY21	23	7	1	1	0	32
FY22	28	9	20	0	0	57
FY23	25	14	22	1	0	62
FY24	33	12	5	1	0	51
FY25	17	10	5	0	2	34

Figure 37:
Medical Events by Type of Critical Incident (FY20-FY25)



	FY20	FY21	FY22	FY23	FY24	FY25
Emotional Injury	18	18	21	6	33	17
Serious Bodily Injury	2	0	0	1	1	0
Near Fatality	0	2	4	4	5	2
Fatality	24	17	40	49	31	24

As shown in **Table 21: Age of Children Appearing in Medical Event Critical Incidents**, youth who experienced a physical injury due to a medical cause ranged in age from birth to 19 years old, with 80% being under the age of 10.

The 26 children who died or nearly died were mostly at home. Two children were in state custody, one was in a shelter, one in a private residence other than home, and the location of the child's death was not reported in one case. Up to half of medical event child fatalities reported to the OCA involve a child with complex medical needs.

Seventeen children experienced an emotional injury by witnessing an unexpected medical death or near fatality related to pre-existing chronic conditions of a sibling, a parent, or another relative. The events were the result of complications from pre-existing medical conditions as well as incidents of cardiac arrest.

Table 21: Age of Children Appearing in Medical Event Critical Incidents, FY25

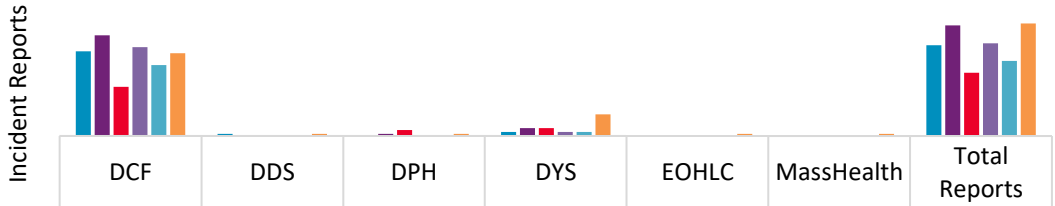
Medical	Under 1	1 to 4	5 to 9	10 to 14	15 to 19	Unknown	Grand Total
Fatality	5	8	6	0	4	1	24
Near Fatality	1	0	0	0	1	0	2
Serious Bodily Injury	0	0	0	0	0	0	0
Emotional Injury	1	2	7	5	2	0	17
Grand Total	**7**	**10**	**13**	**5**	**7**	**1**	**43**

Unintentional Injury

Figure 38: Unintentional Injury Critical Incident Reports by Reporting Agency shows that in FY25, the OCA received 57 critical incident reports regarding an unintentional injury. These reports involving 60 children and 61 critical incidents. This includes 10 fatalities, five near fatalities, 38 serious bodily injuries and eight emotional injuries, as shown in **Figure 39: Unintentional Injury by Type of Critical Incident.** This is an increase from FY24 (38) to FY25 (57), primarily driven by an increase in reports from DYS. The number of reports in this category is within normal range when compared with prior years.

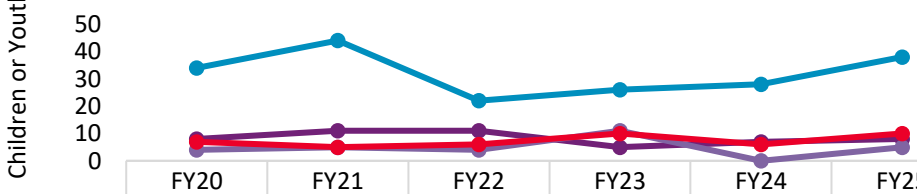
Most reports came from DCF (42), followed by DYS (11).

Figure 38:
Unintentional Injury Critical Incident Reports by Reporting Agency (FY20-FY25)



	DCF	DDS	DPH	DYS	EOHLC	MassHealth	Total Reports
FY20	43	1	0	2	0	0	46
FY21	51	0	1	4	0	0	56
FY22	25	0	3	4	0	0	32
FY23	45	0	0	2	0	0	47
FY24	36	0	0	2	0	0	38
FY25	42	1	1	11	1	1	57

Figure 39:
Unintentional Injury by Type of Critical Incident (FY20-FY25)

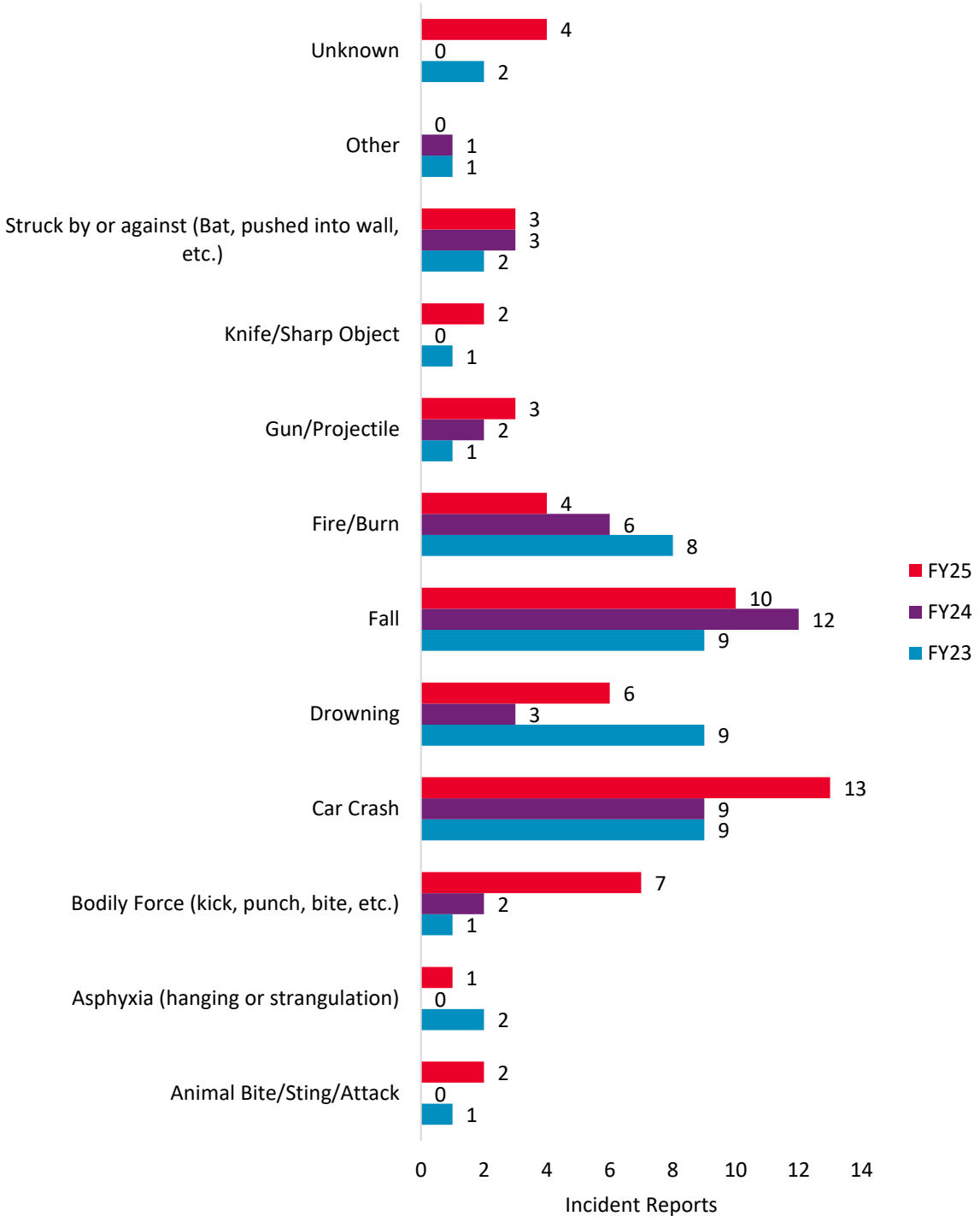


	FY20	FY21	FY22	FY23	FY24	FY25
Emotional Injury	8	11	11	5	7	8
Serious Bodily Injury	34	44	22	26	28	38
Near Fatality	4	5	4	11	0	5
Fatality	7	5	6	10	6	10

As shown in **Figure 40: Mechanism Involved in Unintentional Injury**, the most frequently reported unintentional injury mechanisms are car crashes (15), falls (10), fires/burns (4), bodily force (i.e., restraint) (7), and drowning (7). Six emotional injuries were caused by a child witnessing the fatal or life-threatening injury of another individual due to a car crash (4), drowning (1), and a fall (1). According to DPH, injuries are a leading cause of death among Massachusetts children, particularly drowning, poisoning, and transportation injuries.[66]

[66] Massachusetts Department of Public Health. Injury Surveillance Program, Injury Fatalities Among MA Children Aged 0-17 Years 2021 (2023). https://www.mass.gov/doc/2021-child-injury-deaths-summary-pdf/download#:~:text=In%202021%2C%20there%20were%2065,suffocations%2C%20poisonings%2C%20and%20drownings

Figure 40:
Mechanism Involved in Unintentional Injury Incidents (FY23-FY25)



As shown in **Table 22: Age of Children Appearing in Unintentional Injury Critical Incidents**, the age of children appears in a critical incident report about an unintentional injury ranged from under one to 26.

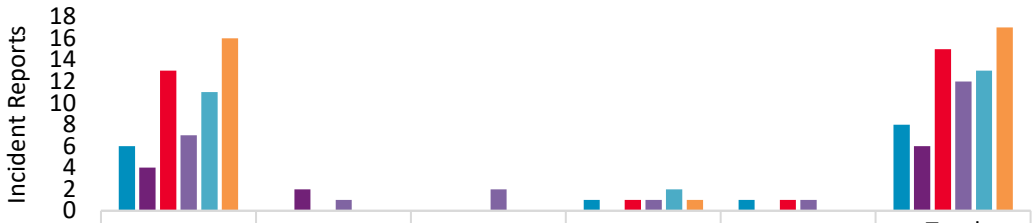
Table 22: Age of Children Appearing in Unintentional Injury Critical Incidents, FY25								
Injury	**Under 1**	**1 to 4**	**5 to 9**	**10 to 14**	**15 to 19**	**20 to 26**	**Unknown**	**Grand Total**
Fatality	1	3	1	3	1	1	0	10
Near Fatality	0	2	0	1	2	0	0	5
Serious Bodily Injury	12	8	0	4	12	1	1	38
Emotional Injury	0	1	3	2	2	0	0	8
Grand Total	**13**	**14**	**4**	**10**	**17**	**2**	**1**	**61**

Unknown Cause

Figure 41: Unknown Cause Critical Incident Reports by Reporting Agency shows that in FY25, the OCA received 17 critical incident reports regarding unknown causes. These reports involved 22 children and 22 critical incidents. This includes eight fatalities, one near fatality, four serious bodily injuries, and nine emotional injuries, as shown in **Figure 42: Unknown Cause by Type of Critical Incident**.

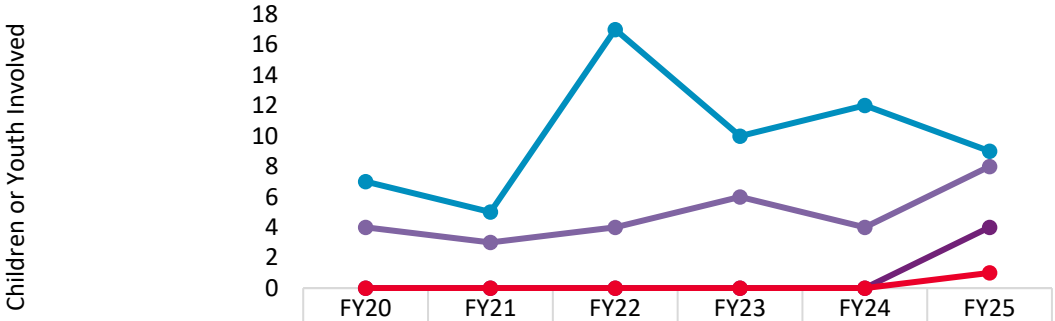
This is a 31% increase in FY25 (17) compared to FY24 (13), driven by an increase in reports from DCF. Most of the reports involve infants and very young children who received services from DCF (94%, 16) while 6% (1) were involved with DPH. Two children were in state custody at the time of the event, including one who sustained a serious bodily injury, and one who witnessed a near fatality or fatality from unknown causes. One child was in foster care, one in a shelter, one in a residence other than their home, and one in a public place, while the remainder were at home. These events most frequently involve emotional injuries where the cause of death is not reported, fatalities and serious bodily injuries for which the intent was not determined at the time of reporting, or unexplained deaths.

Figure 41:
Unknown Cause Critical Incident Reports by Reporting Agency (FY20-FY25)



	DCF	DDS	DMH	DPH	DYS	Total Reports
FY20	6	0	0	1	1	8
FY21	4	2	0	0	0	6
FY22	13	0	0	1	1	15
FY23	7	1	2	1	1	12
FY24	11	0	0	2	0	13
FY25	16	0	0	1	0	17

Figure 42:
Unknown Cause by Type of Critical Incident (FY20-FY25)



	FY20	FY21	FY22	FY23	FY24	FY25
Emotional Injury	7	5	17	10	12	9
Serious Bodily Injury	0	0	0	0	0	4
Near Fatality	0	0	0	0	0	1
Fatality	4	3	4	6	4	8

Note: One child may experience more than one critical incident. Number of children in chart will not sum to total number of children involved.

As shown in **Table 23: Age of Children Appearing in Unknown Cause Critical Incidents**, 84% (11) of the children who sustained physical harm from an unknown cause (13) were under the age of four.

Table 23: Age of Children Appearing in Unknown Cause Critical Incidents, FY25					
Unknown Cause	**0 to 4**	**5 to 9**	**10 to 14**	**15 to 19**	**Grand Total**
Fatality	6	2	0	0	8
Near Fatality	1	0	0	0	1
Serious Bodily Injury	4	0	0	0	4
Emotional Injury	3	2	2	2	9
Grand Total	**14**	**3**	**3**	**2**	**22**
Note: One child may experience more than one critical incident. Number of critical incidents will not sum to total number of children involved.					

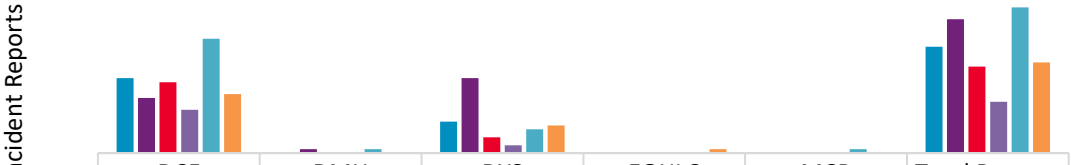
Violence

Figure 43: Violence Critical Incident Reports by Reporting Agency shows that in FY25, the OCA received 23 critical incident reports regarding violence. These reports involved 26 children and 27 critical incidents. This includes one fatality, four near fatalities, nine serious bodily injuries, 13 emotional injuries, as shown in **Figure 44: Violence by Type of Critical Incident**. Thirteen children were reported to the OCA as having witnessed violence. The victim of violence was the child's parent in nine of the reports. One of the child witnesses was in state custody, though they were missing from care at the time of the incident.

This is a decrease in FY25 (23) compared to FY24 (37), primarily driven by a decrease in reports from DCF. Most of the reports involving youth who experienced a violence-related critical incident were receiving services from DCF (73%, 19) while 30% (7) were involved with DYS, and four percent (1) was involved with EOHLC. Eight children were in state custody at the time of the event, including one who died, three who were near fatally injured, and four who sustained serious bodily injuries. None of the children were in an out-of-home placement at the time of the incident.

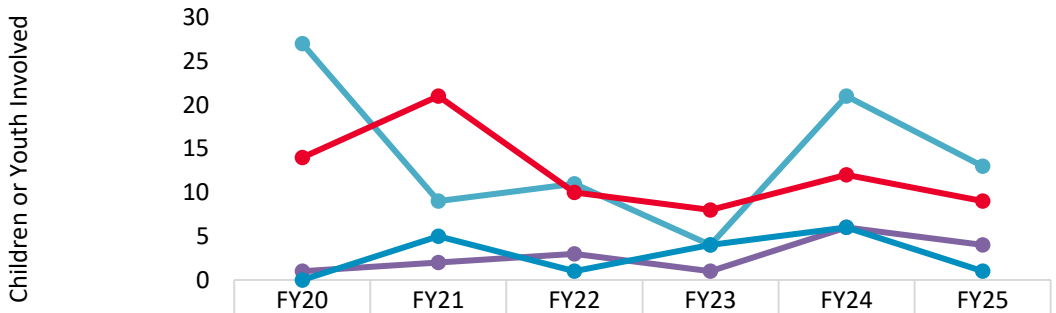
There is a not discernable trend in critical incident reports of violence. Firearms played a role in 56% (15) of these physical injuries, although there were fewer gun-involved incidents reported in FY25 compared to FY24.

Figure 43:
Violence Critical Incident Reports by Reporting Agency (FY20-FY25)



	DCF	DMH	DYS	EOHLC	MCB	Total Reports
FY20	19	0	8	0	0	27
FY21	14	1	19	0	0	34
FY22	18	0	4	0	0	22
FY23	11	0	2	0	0	13
FY24	29	1	6	0	1	37
FY25	15	0	7	1	0	23

Figure 44:
Violence by Type of Critical Incident (FY20-FY25)



	FY20	FY21	FY22	FY23	FY24	FY25
Emotional Injury	27	9	11	4	21	13
Serious Bodily Injury	14	21	10	8	12	9
Near Fatality	1	2	3	1	6	4
Fatality	0	5	1	4	6	1

Note: One child may experience more than one critical incident. Number of children in chart will not sum to total number of children involved.

As shown in **Table 24: Age of Children Appearing in Violence Critical Incidents**, 77% (20) of the children who sustained physical harm from violence were between the ages of fifteen to eighteen.

Table 24: Age of Children Appearing in Violence Critical Incidents, FY25					
Violence	**1 to 4**	**5 to 9**	**10 to 14**	**15 to 19**	**Grand Total**
Fatality	0	0	0	1	1
Near Fatality	0	0	0	4	4
Serious Bodily Injury	0	0	0	9	9
Emotional Injury	1	2	4	6	13
Grand Total	**1**	**2**	**4**	**20**	**27**
Note: One child may experience more than one critical incident. Number of critical incidents will not sum to total number of children involved.					

Critical Incident Reports by State Agencies and Cause of Critical Incident, FY20-FY25

Figure 45 through **Figure 48** below shows the total critical incident reports by each state agency, broken down by the cause of the critical incident. Charts for agencies with five or fewer reports are not included (DDS, EOHLC, MassHealth, MCB).

Figure 45:
*Cause of Critical Incident: **DCF**, All Types of Incidents (FY20 - FY25)*

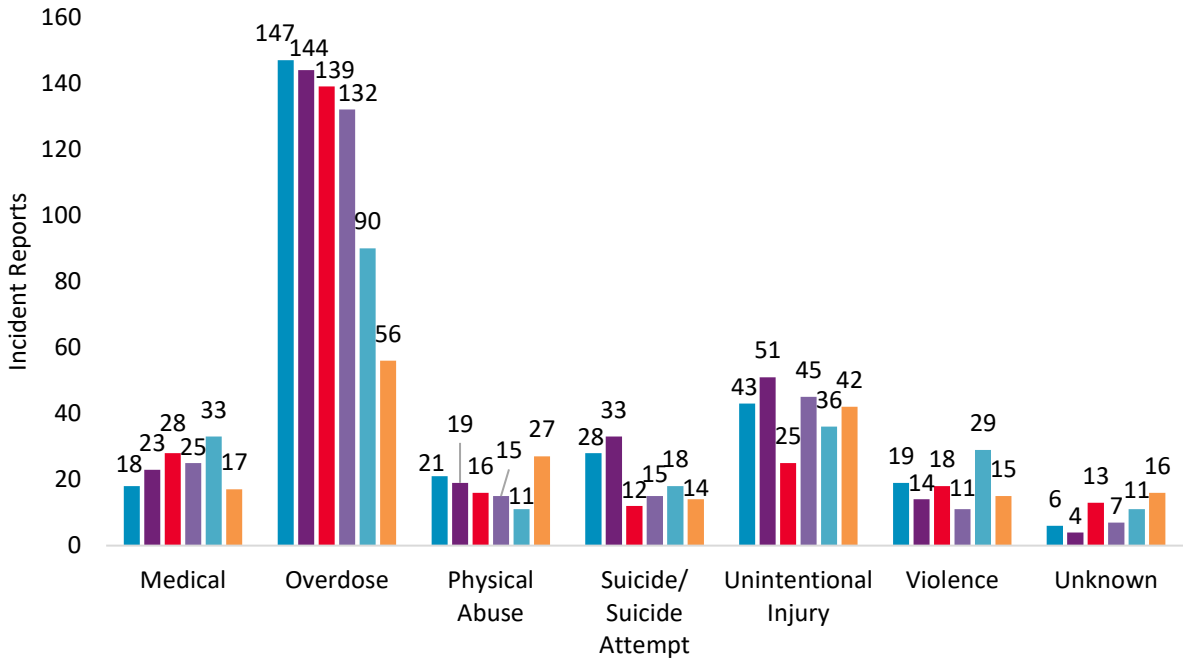


Figure 46:
*Cause of Critical Incident: **DMH**, All Types of Incidents*
(FY20 - FY25)

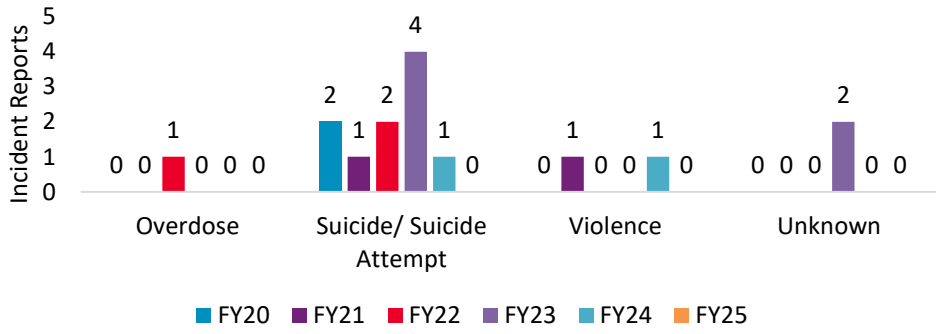


Figure 47:
*Cause of Critical Incident: **DPH**, All Types of Incidents*
(FY20 - FY25)

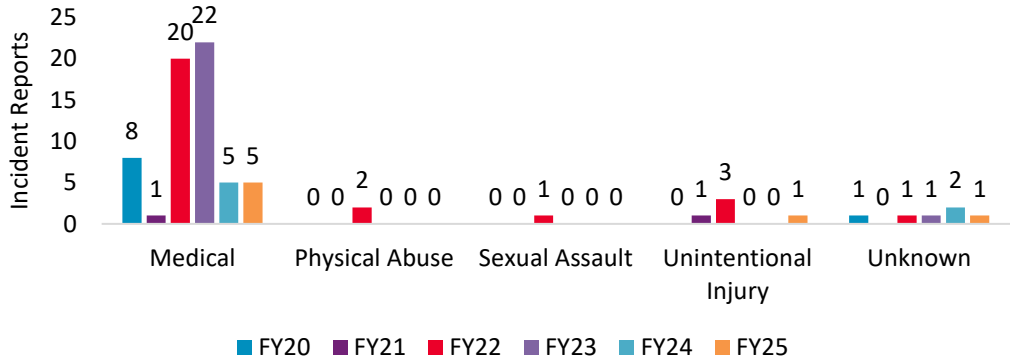
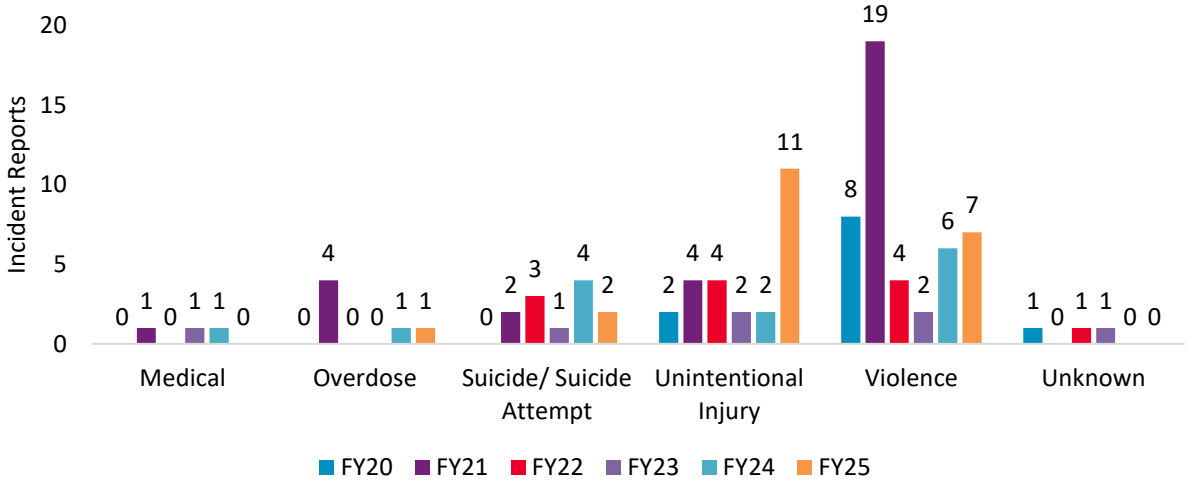


Figure 48:
*Cause of Critical Incident: **DYS**, All Types of Incidents*
(FY20 - FY25)

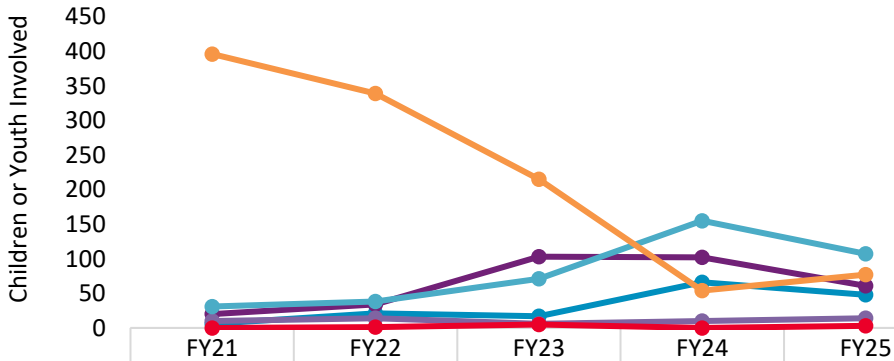


Demographic Data

Figure 49 through **Figure 51** provide additional details about the race, ethnicity, age, and gender of children named in critical incident reports. These data are presented to promote transparency regarding data availability and quality. They should be interpreted with caution, as the OCA only has demographic and identity characteristics if it is reported to us, and often those data are not reported. Improvements in data collection and coding over time have increased the completeness of demographic information; as a result, observed increases in reports for certain groups may reflect enhanced data capture rather than changes in risk.

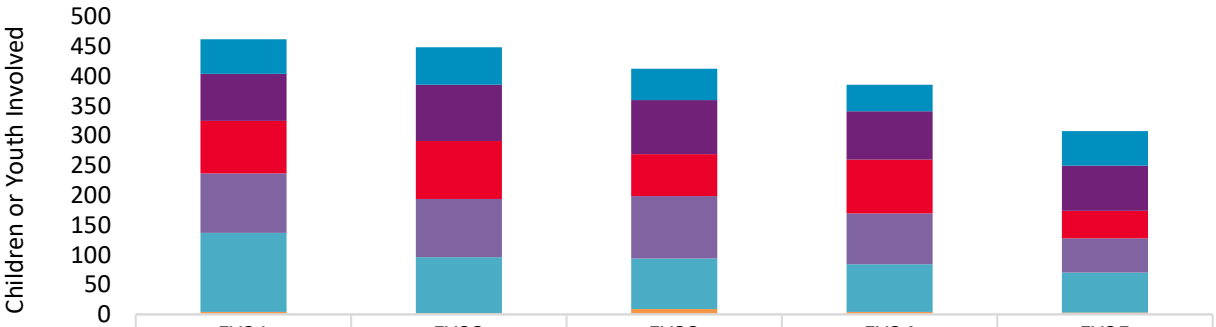
Recent reductions in critical incident reporting—particularly from DCF—appear to influence the demographic composition of cases received by the OCA. Currently, the OCA does not have sufficient information to report on sexual orientation or transgender status of children and youth appearing in critical incident reports.

Figure 49:
Race/Ethnicity of Children Appearing in Critical Incident Reports (FY21-FY25)



	FY21	FY22	FY23	FY24	FY25
Black/African American, NH	6	21	17	66	48
Hispanic/Latino	20	34	103	102	61
Multi-racial, NH	10	14	6	10	14
Another Race, NH	0	1	5	0	3
White, NH	31	38	71	155	107
Unknown	396	339	215	54	77

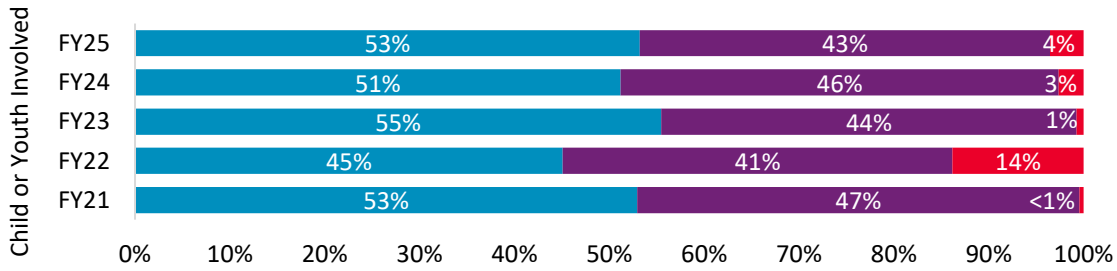
Figure 50:
Age of Children Appearing in Critical Incident Reports (FY21-FY25)



	FY21	FY22	FY23	FY24	FY25
Under 1	58	63	53	45	58
1 to 4	79	95	91	81	76
5 to 9	88	97	70	90	46
10 to 14	100	98	105	86	58
15 to 19	133	94	85	80	67
20 to 26	4	2	9	4	3

Note: Age is missing/unknown for two children who appeared in critical incident reports in FY25.

Figure 51:
Sex Identified at Birth of Children Appearing in Critical Incident Reports (FY21-FY25)



	FY21	FY22	FY23	FY24	FY25
Male	244	202	223	195	165
Female	215	184	176	176	134
Unknown	2	62	3	10	11

Appendix C: Institutional Report Data

The following section provides additional data about institutional reports submitted to the OCA. The data is organized by the following types and sub-types of institutions:

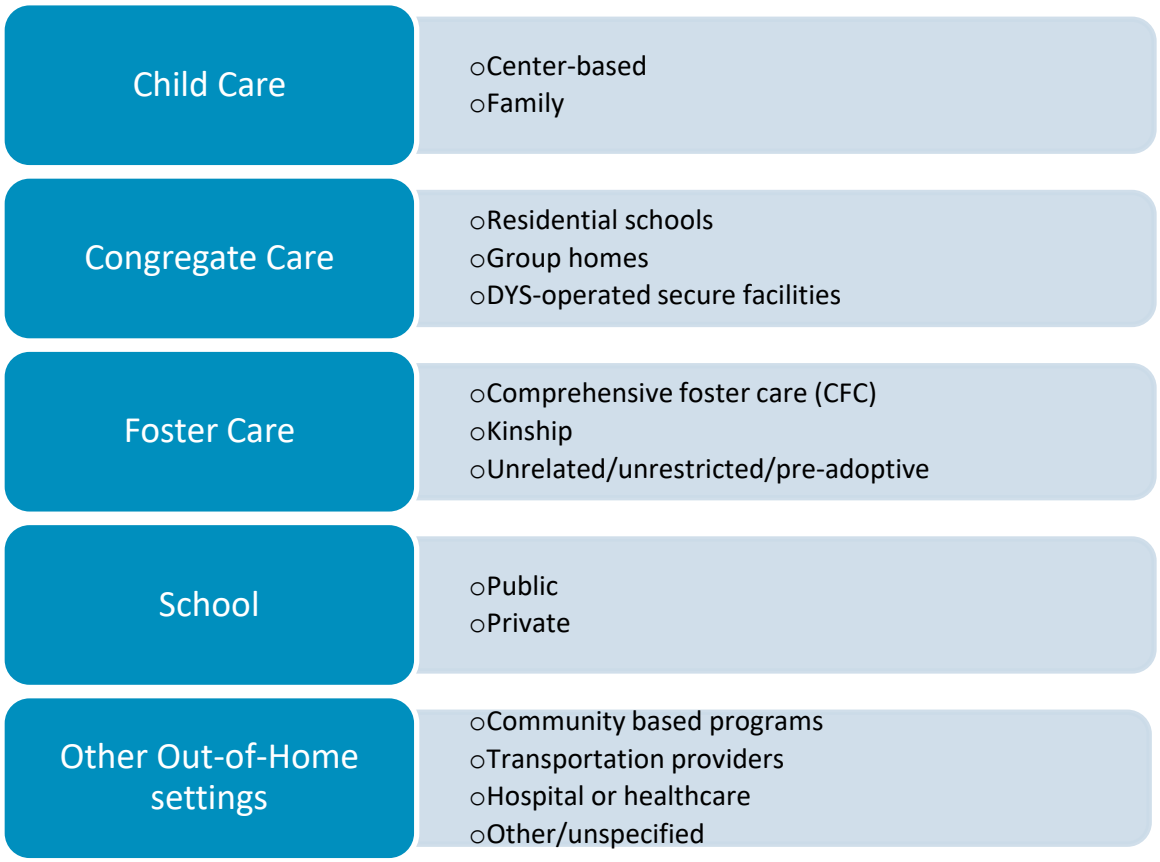


Figure 52: Out-of-Home Settings and Sub-Settings

This appendix includes information on the estimated service population size for each type of institution, year-over-year trends in reporting, and the distribution of maltreatment types within supported allegations, including neglect, physical abuse, sexual abuse, and commercial sexual exploitation of children (exploitation).

To better identify trends and patterns about harm to children occurring out-of-home, the OCA developed an *incident concern* categorization system. This system describes the nature of supported allegations. It is unique to the OCA and referred to as contributing factors. Incident concerns do not always meet the DCF threshold for supported or substantiated concern for abuse and/or neglect. Prevalence of incident concerns are also presented for each type and sub-type of institution.

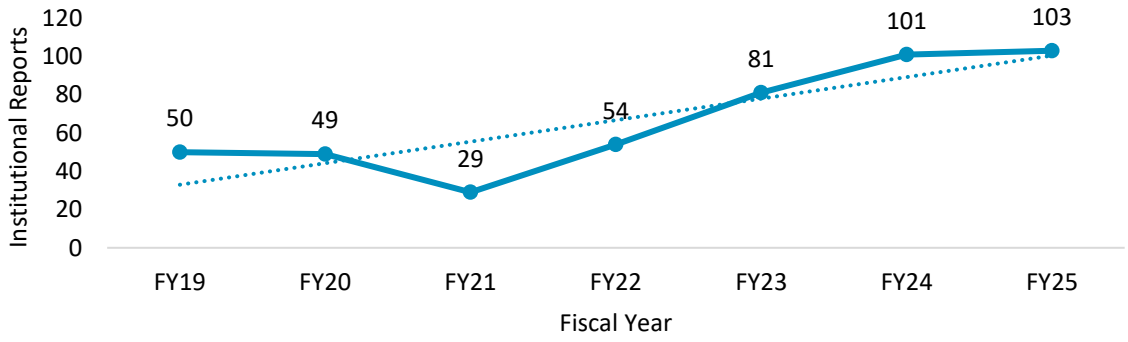
FY19 data are included when analyzing institutional reports to account for the potential influence of the COVID-19 pandemic emergency orders from March 2020 through June 2021.[67] FY19 is the last full fiscal year before the orders were put into place.

Child Care

In 2025, EEC licensed over 9,000 child care facilities and served 247,989 children as of June 2025.[68] Most (80%) of children who attend child care are served in a center-based child care, while approximately 20% are served in a provider's home (family child care).[69]

As shown in **Figure 53: Institutional Reports: Child Care**, in FY25 the OCA received 103 institutional reports that occurred in child care settings involving 170 children and 133 alleged perpetrators. There was a small (2%) increase in institutional reports from child care settings from FY24 to FY25 and a large (110%) increase from FY20 to FY25. There is a concerning post-pandemic (after FY22) increase in institutional reports from child care settings, primarily center-based child care.

Figure 53:
Institutional Reports: Child Care
(FY19-FY25)



As shown in **Table 25: Type of Child Care Involved in Institutional Reports**, supported allegations of abuse and/or neglect in child care facilities remain rare. The OCA estimates that less than 1% (170) of children who were served in an EEC licensed or funded child care program sustained a supported allegation of abuse and/or neglect in FY25.[70]

[67] On March 10, 2020, Governor Charlie Baker declared a state of emergency in response to the Coronavirus outbreak. The state of emergency and all Emergency and Public Health Orders issued pursuant to the emergency terminated on June 15, 2021.
[68] Massachusetts Department of Early Education and Care. About the Department of Early Education and Care. Accessed 4/21/2026. https://www.mass.gov/about-the-department-of-early-education-and-care-eec
[69] Data Request, 2025
[70] Calculated as the number of children with a supported allegation of abuse and/or neglect in child care (170) divided by total EEC child care service capacity (269,940). Limitations: Actual children served may be lower (unused capacity) or higher (child turnover resulting in more unique children served annually).

Table 25: Type of Child Care Involved in Institutional Reports, FY25			
Metric	**Center-Based Child Care**	**Family Child Care**	**All Child Care**
Number of Reports Received	79 (77%)	24 (23%)	103 (100%)
Number of Children Appearing in Reports	130 (76%)	40 (24%)	170 (100%)
Number of Children Served	201,278 (81%)[71]	46,711 (19%)[72]	247,989 (100%)[73]
Number of Alleged Perpetrators	102 (77%)	31 (23%)	133 (100%)
Estimate of Abuse/Neglect in the System	<1%	<1%	<1%

Figures 54: Institutional Reports: Center Based Child Care and **Figure 55: Institutional Reports: Family Child Care** show institutional reports over time for each child care license type, broken down by the type of maltreatment involved (e.g. neglect, physical abuse, sexual abuse/exploitation).

[71] Massachusetts Early Education and Care. Number and Capacity of EEC Licensed and Funded Program, Center-Based Child Care June 2025. Accessed 4/21/2026. https://app.powerbigov.us/view?r=eyJrIjoiZmNlNjUwMmEtYzM1NC00OGU2LWIyYWQtMzg1MDk2MmE3MDJkIiwidCI6IjNlODYxZDE2LTQ4YjctNGEwZS05ODA2LThjMDRkODFiN2IyYSJ9&pageName=9949865fcf248b434d7d

[72] Massachusetts Early Education and Care. Number and Capacity of EEC Licensed and Funded Program, Family Child Care June 2025. Accessed 4/21/2026. https://app.powerbigov.us/view?r=eyJrIjoiZmNlNjUwMmEtYzM1NC00OGU2LWIyYWQtMzg1MDk2MmE3MDJkIiwidCI6IjNlODYxZDE2LTQ4YjctNGEwZS05ODA2LThjMDRkODFiN2IyYSJ9&pageName=9949865fcf248b434d7d

[73] Massachusetts Early Education and Care. Children Enrolled in Formal Early Education and Care, June 2025. Accessed 4/21/2026. https://app.powerbigov.us/view?r=eyJrIjoiZmNlNjUwMmEtYzM1NC00OGU2LWIyYWQtMzg1MDk2MmE3MDJkIiwidCI6IjNlODYxZDE2LTQ4YjctNGEwZS05ODA2LThjMDRkODFiN2IyYSJ9&pageName=9949865fcf248b434d7d

Figure 54:
Institutional Reports: ***Center-Based Child Care*** *(FY19-FY25)*

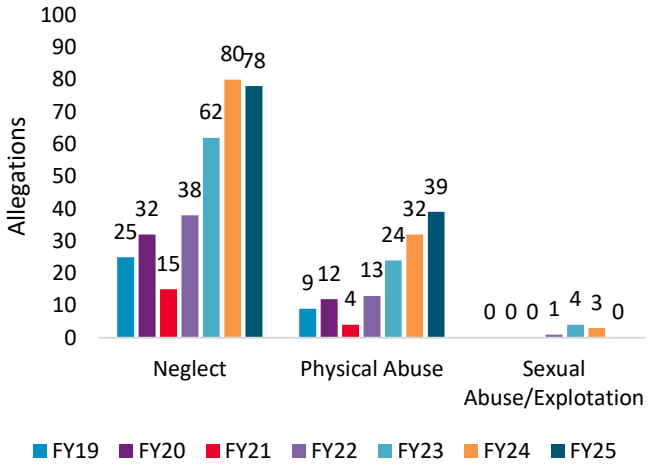
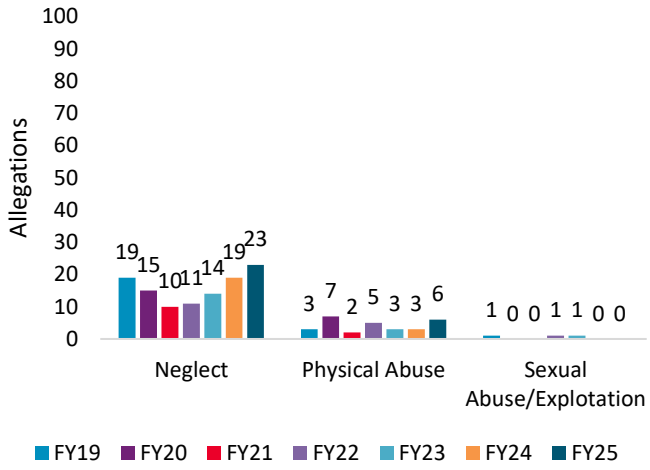


Figure 55:
Institutional Reports: ***Family Child Care*** *(FY19-FY25)*



Note: Totals will not sum to number of reports or children. Multiple allegations and children may appear in each report.

Table 26: Type of Maltreatment Involved in Institutional Reports from Child Care presents information on the type of maltreatment involved in institutional reports, broken down by child care license type. Physical abuse is more prevalent in center-based child care compared to family child care. Neither license type sustained supported allegations of sexual abuse or exploitation in FY25.

Table 26: Type of Maltreatment Involved in Institutional Reports from Child Care, FY25[74]			
Form of Maltreatment	**Center-Based Child Care**	**Family Child Care**	**All Child Care**
Neglect	99% (78)	96% (23)	**98% (101)**
Physical Abuse	49% (39)	25% (6)	**44% (45)**
Sexual Abuse/Exploitation	0% (0)	0% (0)	**0% (0)**
Total Institutional Reports	**79**	**24**	**103**
Note: Percents will not sum to 100%. Cases can contain more than one supported allegation.			

As shown in **Table 27: OCA Incident Concern Categories Institutional Reports from Child Care**, overall, there were high levels of improper behavior management, inadequate supervision, and

[74] Percents will not sum to 100%. Cases can contain more than supported allegation.

risk of emotional harm in institutional reports reviewed by the OCA. Inadequate supervision is more prevalent in center-based child care, while improper behavior management is more prevalent in family child care.

Table 27: OCA Incident Concern Categories Institutional Reports from Child Care, FY25[75]		
OCA Incident Concern Category	**Center-Based Child Care**	**Family Child Care**
Boundary Issues	0%	0%
Failure to Provide for Basic Needs	0%	8%
Failure to Provide Health/Medical Care	3%	8%
Improper Behavior Management	57%	38%
Improper/Inadequate Supervision	41%	58%
Risk of Emotional/Psychological Harm	30%	33%
Physical Injury	19%	21%
Sexual Abuse/Exploitation	0%	8%
Total Institutional Reports	**79**	**24**
Note: Percents will not sum to 100%. Cases can contain more than one Incident Concern Category.		

Congregate Care

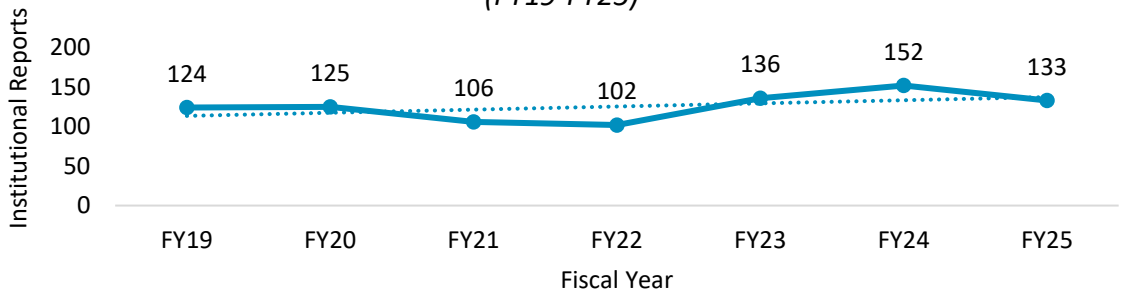
In 2025, EEC licensed 322 congregate care facilities with the capacity to provide services on average to 5,254 children daily.[76] In FY25, congregate care was provided by the following state agencies:

- DCF provided congregate care services to 1,677 children[77]
- DMH served 181 youth in residential treatment programs[78]
- DPH served 12 youth in residential substance use treatment programs[79]
- DYS served 1,016 youth in a staff or hardware secure facility[80]

[75] Percents will not sum to 100%. Cases can contain more than one incident concern category.
[76] Data Request, 2025. Daily service capacity should not be compared with annual service provision.
[77] Data Requests, 2025 and 2026.
[78] Data Requests, 2025 and 2026.
[79] Massachusetts Juvenile Justice Policy and Data Board. (2025). JJPAD Annual Report Fiscal Year 2025. https://www.mass.gov/doc/oca-annual-report-fiscal-year-2025/download
[80] Relevant Agency Data Requests, 2025 and 2026.

As shown in **Figure 56: Institutional Reports: Congregate Care**, in FY25, the OCA received 133 institutional reports from congregate care settings involving 174 children. Year over year, congregate care settings yield the most institutional reports.[81] In FY25, these reports came from residential schools (85, 64%), group homes (30, 23%), and secure facilities (18, 14%). [82,83] Reports from congregate care settings decreased by 13% from FY24 to FY25 but increased 7% from FY19 to FY25. The trend is relatively stable over time.

Figure 56:
*Institutional Reports: **Congregate Care***
(FY19-FY25)



As shown in **Table 28: Type of Congregate Care Involved in Institutional Reports**, supported allegations of abuse and/or neglect in child care facilities are most frequently occurring in residential schools. The OCA estimates that 14% of students sustain an allegation of abuse and/or neglect in residential schools.[84]

Table 28: Type of Congregate Care Involved in Institutional Reports, FY25

Metric	Residential Schools	Group Homes	DYS Operated Secure Facilities	All Congregate Care
Number of Reports Received	85 (64%)	30 (23%)	18 (14%)	133 (100%)
Number of Children Appearing in Reports	113 (65%)	48 (28%)	21 (12%)	174 (100%)
Number of Children Served	793	1,870	1,016[85]	3,679
Number of Alleged Perpetrators	95 (63%)	32 (21%)	25 (16%)	152 (100%)
Estimate of Abuse/Neglect in the System	14%	2%	2%	5%
Note: Children can appear in more than one setting. Total of children will not equal sum.				

[81] These settings have strict protocols for mandated reporting, high levels of accountability, and children with high needs, including those receiving residential services related to juvenile justice, behavioral health and disability services.
[82] Numbers will not sum to 100% because reports can be supported for multiple allegations, such as abuse and/or neglect.
[83] Some cases involve more than one type of abuse; sums will not equal 100%.
[84] Calculated as the number of children with a supported allegation of abuse and/or neglected in a residential school (113) divided by the total number of children served by a residential school in FY25 (793).
[85] Data corrected 9/2/2026

Figures 57 through **Figure 59** show institutional reports over time for each congregate care setting type, broken down by the type of maltreatment involved (e.g. neglect, physical abuse, sexual abuse/exploitation). The number of reports from congregate care settings involving physical and/or sexual abuse is higher in FY25 compared to FY24, although that is driven entirely by increases in reports from residential schools.

Figure 57:
Institutional Reports: ***Secure Facility***
(FY24-FY25)

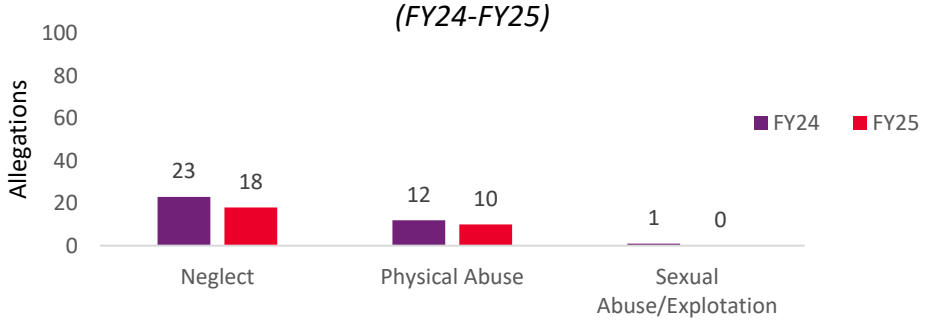


Figure 58:
Institutional Reports: ***Group Home***
(FY24-FY25)

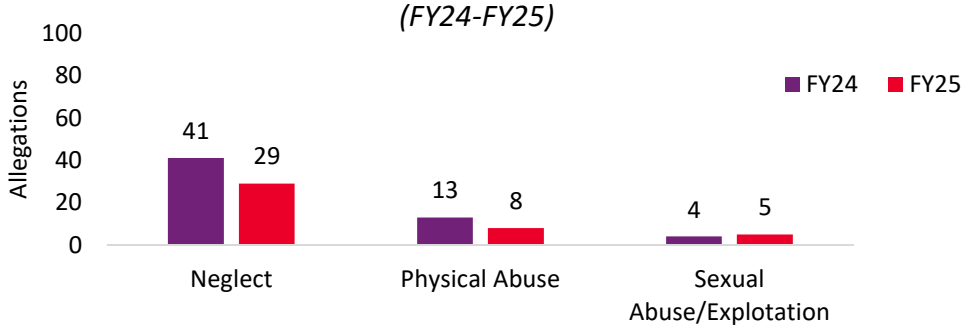


Figure 59:
Institutional Reports: ***Residential Schools*** *(FY24-FY25)*

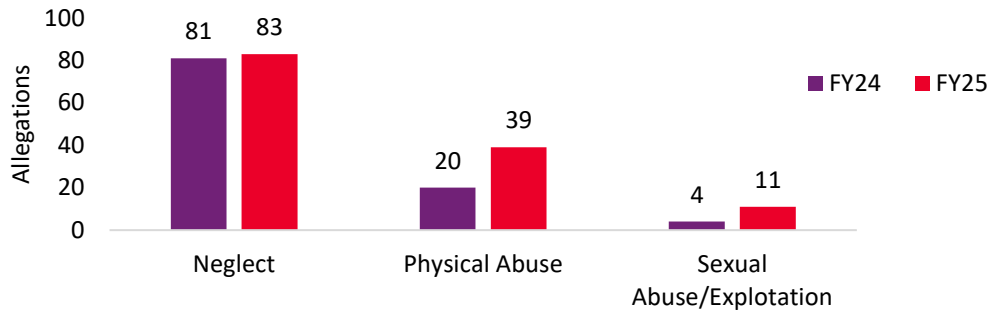


Table 29: Type of Maltreatment Involved in Institutional Reports from Congregate Care presents information on the type of maltreatment involved in institutional reports, broken down by the type of congregate care setting.

Table 29: Type of Maltreatment Involved in Institutional Reports from Congregate Care, FY25				
Form of Maltreatment	**Residential Schools**	**Group Homes**	**Secure Facilities**	**All Congregate Care**
Neglect	98% (83)	97% (29)	100% (18)	**98% (130)**
Physical Abuse	46% (39)	27% (8)	56% (10)	**43% (57)**
Sexual Abuse/Exploitation	13% (11)	17% (5)	0%	**12% (16)**
Total Institutional Reports	**85**	**30**	**18**	**133**
Note: Percents will not sum to 100%. Cases can contain more than supported allegation.				

Table 30: OCA Incident Concern Categories Institutional Reports from Congregate Care presents the percentage of reports with an OCA incident concern category, broken down by congregate care setting.

Table 30: OCA Incident Concern Categories Institutional Reports from Congregate Care, FY25			
OCA Incident Concern Category	**Residential Schools**	**Group Homes**	**Secure Facilities**
Boundary Issues	22%	43%	22%
Failure to Provide for Basic Needs	1%	4%	6%
Failure to Provide Health/Medical Care	2%	4%	0%
Improper Behavior Management	52%	25%	67%

Table 30: OCA Incident Concern Categories Institutional Reports from Congregate Care, FY25			
Improper/Inadequate Supervision	31%	43%	26%
Risk of Emotional/Psychological Harm	31%	39%	22%
Physical Injury	31%	7%	39%
Sexual Abuse/Exploitation	14%	18%	0%
Total Institutional Reports	**85**	**30**	**18**
Note: Percents will not sum to 100%. Cases can contain more than one incident concern category.			

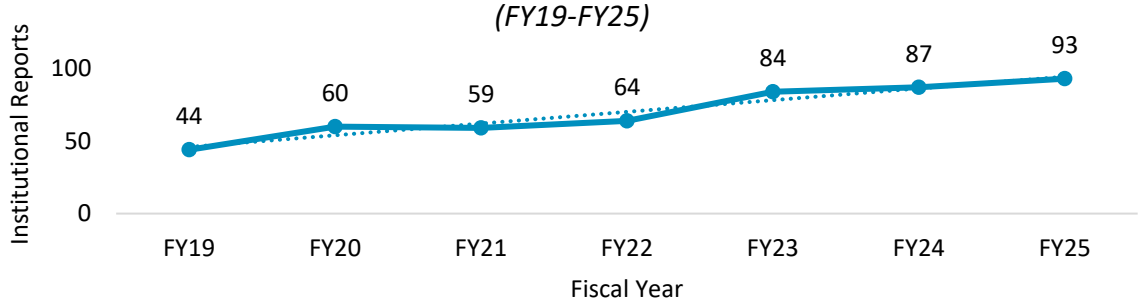
Foster Care

As seen in **Table 31: Number of Children and Youth Served in Foster Care by DCF**, in FY25 5,203 children and youth received foster care services through DCF, including kinship placements, comprehensive foster care placements, and unrelated/pre-adoptive/unrestricted foster care placement types.[86,87] The number of children served in foster care was lower in FY25 than prior years.[88]

Table 31: Number of Children and Youth Served in Foster Care by DCF, FY22-FY25				
Type of Foster Care	**FY22**	**FY23**	**FY24**	**FY25**
Comprehensive Foster Care	1,081	962	992	881
Kinship Foster Care	3,169	3,001	2,923	2,612
Unrelated/Pre-adoptive/Unrestricted	2,387	2,204	1,923	1,710
Total	**6,637**	**6,167**	**5,838**	**5,203**

As shown in **Figure 60: Institutional Reports: Foster Care**, in FY25 the OCA received 93 institutional reports from foster care settings involving 151 children. There was a small increase

Figure 60:
*Institutional Reports: **Foster Care***
(FY19-FY25)



[86] See **Appendix F. Glossary of Terms** for definitions of each foster care type.
[87] Data Request, 2025
[88] Massachusetts Department of Children and Families. (n.d). DCF Annual Reports. https://www.mass.gov/info-details/dcf-reports-and-dashboards

in reports from FY24-FY25 (7%) and an 111% increase from FY19 to FY25, driven by increases in reports involving kinship foster care. During the same time, the number of foster care placements, including the number of children placed in kinship foster care, decreased.

As shown in **Table 32: Type of Foster Care Involved in Institutional Reports**, the OCA estimates that up to 3% (151) of children and youth in foster care were the victim of a supported allegation of abuse and/or neglect in FY25.[89]

Table 32: Type of Foster Care Involved in Institutional Reports, FY25

Metric	Comprehensive Foster Care	Kinship	Unrelated/Pre-adoptive/ Unrestricted	All Foster Care
Number of Reports Received	16 (17%)	54 (58%)	23 (25%)	93 (100%)
Number of Children Appearing in Reports	27 (18%)	88 (58%)	39 (26%)	151 (100%)
Number of Children Served	881 (17%)	2,612 (50%)	1,710 (33%)	5,203 (100%)
Number of Alleged Perpetrators	20 (17%)	73 (61%)	26 (22%)	119 (100%)
Estimate of Abuse/ Neglect in the System	3%	3%	2%	3%

Note: Children can appear in more than one setting. Total of children will not equal sum.

Figure 61 through **Figure 63** show institutional reports over time for each type of foster care setting, broken down by the type of maltreatment involved (e.g. neglect, physical abuse, sexual abuse/exploitation). In FY25, reports from kinship placements were the largest portion of reports from foster care settings.

[89] Calculated as the number of children with a supported allegation of abuse and/or neglect in foster care (151) divided by the total number of children served in foster care (5,203).

Figure 61:
Institutional Reports: ***Kinship Foster Care***
(FY19-FY25)

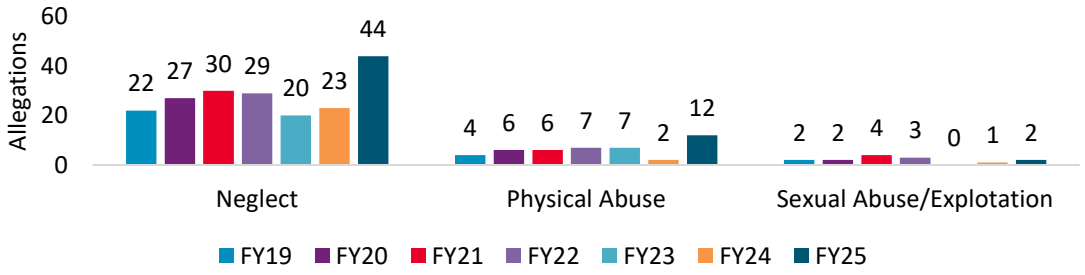


Figure 62:
Institutional Reports: ***Unrelated, Unrestricted and Preadoptive Foster Care***
(FY19-FY25)

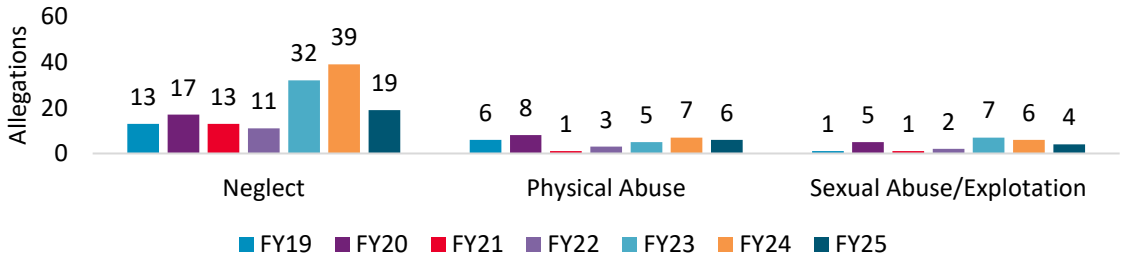
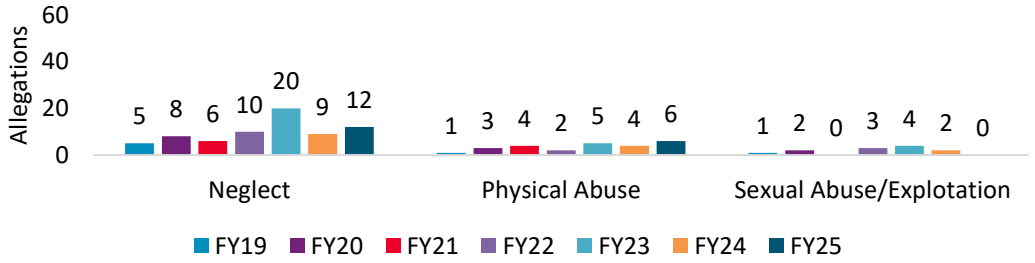


Figure 63:
Institutional Reports: ***Comprehensive Foster Care***
(FY19-FY25)



As shown in **Table 33: Type of Maltreatment Involved in Institutional Reports from Foster Care**, of the 93 supported reports, 81% (75) involved neglect, 26% (24) involved physical abuse,

and 6% (6) involved sexual abuse/exploitation.[90] Compared to FY24, this is a decrease in the prevalence of neglect (-94%) and sexual abuse (-13%), and an increase in the prevalence of physical abuse (17% in FY24) in reported cases.

Table 33: Type of Maltreatment Involved in Institutional Reports from Foster Care, FY25				
Form of Maltreatment	**Comprehensive Foster Care**	**Kinship**	**Unrelated/ Pre-adoptive/ Unrestricted**	**All Foster Care**
Neglect	75% (12)	81% (44)	89% (19)	**81% (75)**
Physical Abuse	38% (6)	22% (12)	26% (6)	**26% (24)**
Sexual Abuse/Exploitation	0% (0)	4% (2)	17% (4)	**6% (6)**
Total Institutional Reports	**16**	**54**	**23**	**93**
Note: Percents will not sum to 100%. Cases can contain more than one supported allegation.				

Table 34: OCA Incident Concern Categories Institutional Reports from Foster Care presents the percentage of reports with an OCA incident concern category, broken down by type of foster care setting. The most prevalent OCA-identified incident concern category for foster care is risk of emotional and/or psychological harm (58%) followed by improper or inadequate supervision (40%). The type of concerns presented varied by foster care setting, however:

- **Kinship**: Events include substance use by the kinship foster parent(s), inadequate supervision in the home, and domestic violence/intimate partner violence. Supported reports of physical abuse were the result of the kinship foster parent's use of inappropriate physical discipline.
- **Comprehensive Foster Care**: Events include lack of supervision, substance use, and failure to seek mental health support for children in their care. Supported reports of physical abuse were the result of inappropriate physical discipline. Sexual abuse reports related to inappropriate physical touch and sexual contact with a foster parent or foster sibling.
- **Unrelated, Unrestricted, and Pre-adoptive**: Events include foster parent substance use, domestic violence between foster parents, improper behavior management, and inadequate supervision resulting in harm. Physical abuse reports related to a foster parent's inappropriate discipline practices. Sexual abuse reports related to inappropriate physical touch and sexual contact with a foster parent or foster sibling.

[90] Some reports involve more than one type of abuse; sums will not equal 100%.

Table 34: OCA Incident Concern Categories Institutional Reports from Foster Care, FY25			
OCA Incident Concern Category	**Comprehensive Foster Care**	**Kinship**	**Unrelated/ Pre-adoptive/ Unrestricted**
Boundary Issues	6%	13%	9%
Failure to Provide for Basic Needs	0%	9%	17%
Failure to Provide Health/Medical Care	0%	9%	9%
Improper Behavior Management	44%	18%	26%
Improper/Inadequate Supervision	31%	44%	39%
Risk of Emotional/Psychological Harm	56%	69%	35%
Physical Injury	25%	18%	22%
Sexual Abuse/Exploitation	13%	4%	17%
Total Institutional Reports	**16**	**54**	**23**
Note: Percents will not sum to 100%. Cases can contain more than one incident concern category.			

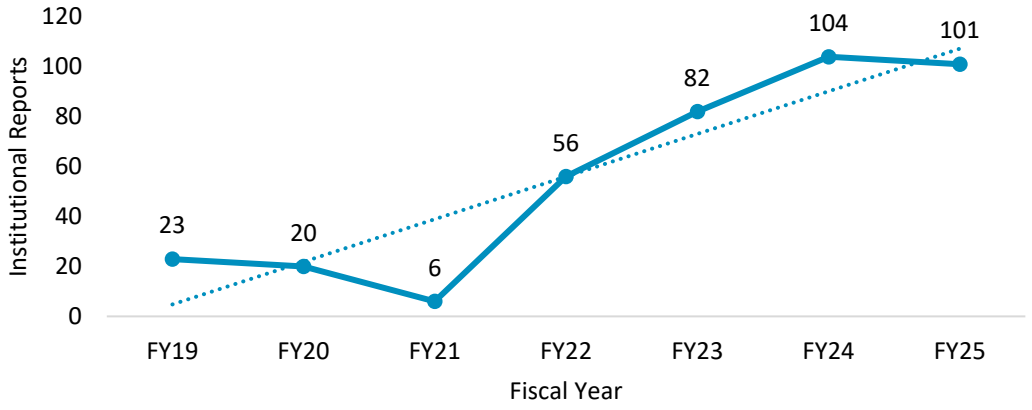
School

DESE reported that 866,945 children were enrolled in public schools and 102,631 in private school in the 2024/25 school year.[91]

As shown in **Figure 64: Institutional Reports: Schools**, in FY25, the OCA received 101 institutional reports about schools, including 128 children or youth. Ninety-four institutional reports were about public schools, involving 121 children, while seven institutional reports were about private schools involving seven children. Institutional reports concerning abuse and/or neglect in public schools have increased steadily and substantially since FY19.

[91] Massachusetts Department of Elementary and Secondary Education. (2025). 2024-25 School Attending Children Report. Accessed 4/21/2026. https://profiles.doe.mass.edu/statereport/schoolattendingchildren.aspx

Figure 64:
Institutional Reports: ***Schools***
(FY19-FY25)



As shown in **Table 35: Type of School Involved in Institutional Reports**, the OCA estimates that less than 1% (121) of children served in public schools sustained a supported allegation of abuse and/or neglect in FY25.[92]

Table 35: Type of School Involved in Institutional Reports, FY25			
Metric	**Public school**	**Private School**	**All Schools**
Number of Reports Received	94 (93%)	7 (7%)	101 (100%)
Number of Children Appearing in Reports	121 (94%)	7 (6%)	128 (100%)
Number of Alleged Perpetrators	86 (91%)	8 (9%)	94 (100%)
Number of Children Served	866,945 (90%)	102,631 (10%)	989,576 (100%)
Estimate of Abuse/Neglect in the System	<1%	<1%	<1%

Figure 65: Institutional Reports: Public School and **Figure 66: Institutional Reports: Private School** shows institutional reports over time for school type (public or private), broken down by the type of maltreatment involved (e.g. neglect, physical abuse, sexual abuse/exploitation).

[92] Calculated as the number of children with a supported allegation of abuse and/or neglect in public schools (121) divided by total children enrolled in public schools (915,932). Limitations: Actual children served may be lower or higher because of churn within schools.

Figure 65:
Institutional Reports: ***Public School***
(FY19-FY25)

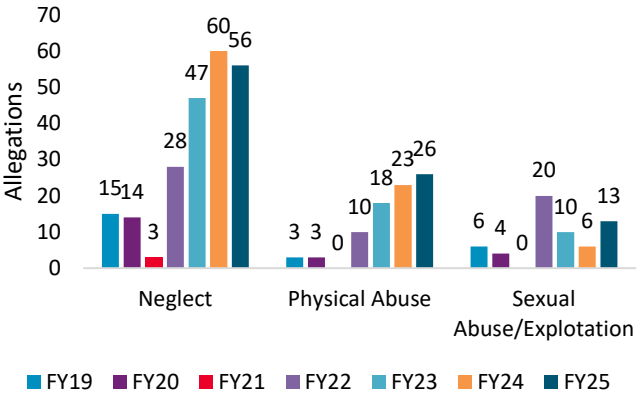


Figure 66:
Institutional Reports: ***Private School***
(FY19-FY25)

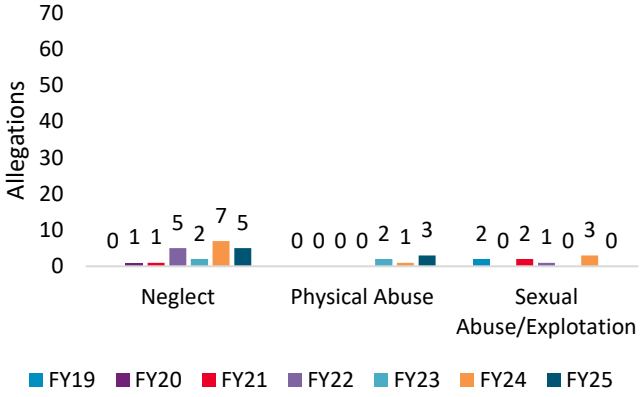


Table 36: Type of Maltreatment Involved in Institutional Reports from Schools presents information on the type of maltreatment involved in institutional reports, broken down by school type.

Table 36: Type of Maltreatment Involved in Institutional Reports from Schools, FY25[93]			
Form of Maltreatment	**Public school**	**Private Schools**	**All Schools**
Neglect	60% (56)	71% (5)	60% (61)
Physical Abuse	28% (26)	43% (3)	29% (29)
Sexual Abuse/Exploitation	14% (13)	0% (0)	13% (13)
Total Institutional Reports	**94**	**7**	**101**
Note: Percents will not sum to 100%. Cases can contain more than one supported allegation.			

As shown in **Table 37: OCA Incident Concern Categories Institutional Reports from Schools,** improper behavior management and risk of emotional/psychological harm were the most frequently occurring incident concern categories identified by the OCA in reports from schools.

Table 37: OCA Incident Concern Categories Institutional Reports from Schools, FY25[94]		
OCA Incident Concern Category	**Public School**	**Private School**
Boundary Issues	20%	14%

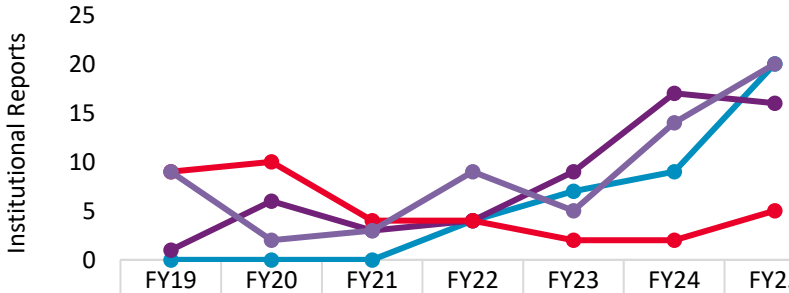
[93] Percents will not sum to 100%. Cases can contain more than supported allegation.
[94] Percents will not sum to 100%. Cases can contain more than one incident concern category.

Table 37: OCA Incident Concern Categories Institutional Reports from Schools, FY25[94]		
Failure to Provide for Basic Needs	2%	0%
Failure to Provide Health/Medical Care	4%	29%
Improper Behavior Management	47%	57%
Improper/Inadequate Supervision	21%	29%
Risk of Emotional/Psychological Harm	40%	29%
Physical Injury	17%	29%
Sexual Abuse/Exploitation	15%	0%
Total Institutional Reports	**94**	**7**
Note: Percents will not sum to 100%. Cases can contain more than one Incident Concern Category.		

Other Out-of-Home Settings

Other out-of-home settings include community-based organizations, hospital and healthcare settings, and transportation providers (e.g. school bus providers). As shown in **Figure 67: Institutional Reports: Other Settings**, reports from these settings have gone up since FY21, although the overall numbers remain relatively low.

Figure 67:
*Institutional Reports: **Other Settings***
(FY19-FY25)



	FY19	FY20	FY21	FY22	FY23	FY24	FY25
Community Based Program	0	0	0	4	7	9	20
Hospital/Health Care	1	6	3	4	9	17	16
Other/Unspecified	9	10	4	4	2	2	5
Transportation	9	2	3	9	5	14	20

Table 38: Type of Institution Involved in Other/Unknown Institutional Reports, FY25				
Metric	**Community Based Program**	**Hospital/ Health Care**	**Other/ Unspecified**	**Transportation**
Number of Reports Received	20	16	5	20
Number of Children Appearing in Reports	25	19	6	23
Number of Alleged Perpetrators	21	21	7	21

Figure 68 through **Figure 71** show institutional reports over time for each "other" setting type, broken down by the type of maltreatment involved (e.g. neglect, physical abuse, sexual abuse/exploitation).

Figure 68:
Institutional Reports: ***Community Based Organization***
(FY19-FY25)

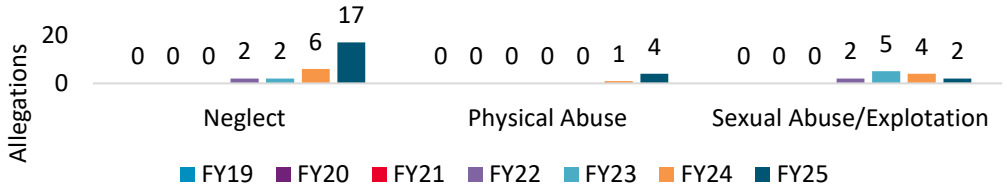


Figure 69:
Institutional Reports: ***Hospital or Health Care***
(FY19-FY25)

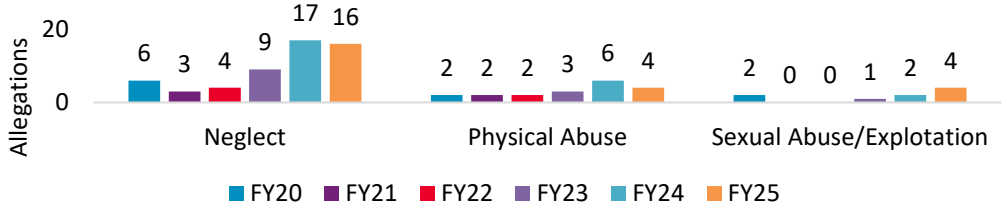


Figure 70:
Institutional Reports: ***Other or Unspecified Setting***
(FY19-FY25)

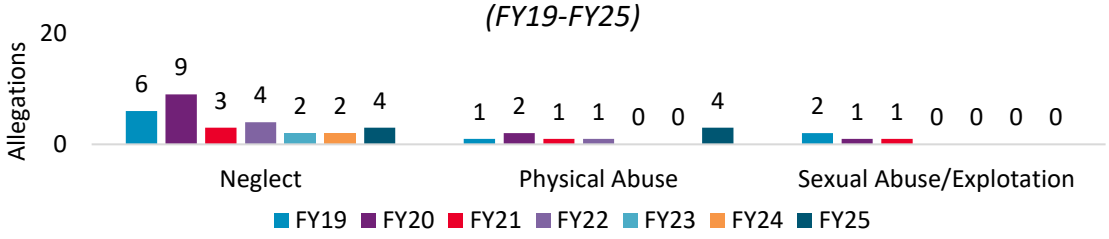


Figure 71:
Institutional Reports: ***Transportation Provider***
(FY19-FY25)

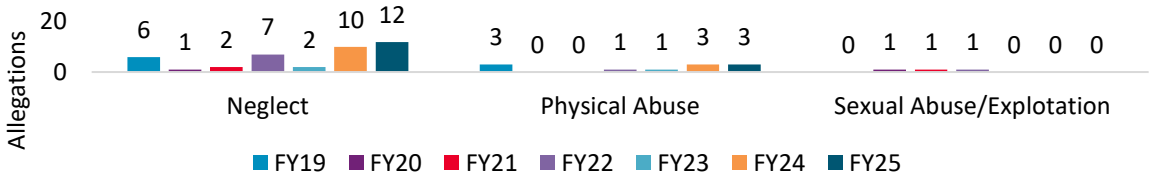


Table 39: Type of Maltreatment Involved in Institutional Reports from Other Settings presents information on the type of maltreatment involved in institutional reports, broken down by "other" setting type.

Table 39: Type of Maltreatment Involved in Institutional Reports from Other Settings, FY25				
Form of Maltreatment	**Community Based Programs**	**Hospital or Healthcare**	**Other/Unspecified**	**Transportation Providers**
Neglect	85% (17)	100% (16)	80% (4)	60% (12)
Physical Abuse	20% (4)	25% (4)	80% (4)	15% (3)
Sexual Abuse/Exploitation	10% (2)	25% (4)	0% (0)	0% (0)
Total Institutional Reports	**20**	**16**	**5**	**20**
Note: Percents will not sum to 100%. Cases can contain more than one supported allegation.				

As shown in **Table 40**: **OCA Incident Concern Categories Institutional Reports from Foster Care** the most common incident concern category identified by the OCA in "other" reports were improper/inadequate supervision and risk of emotional/psychological harm.

Table 40: OCA Incident Concern Categories Institutional Reports from Foster Care, FY25				
OCA Incident Concern Category	**Community Based Programs**	**Hospital or Healthcare**	**Other/ Unspecified**	**Transportation Providers**
Boundary Issues	25%	38%	20%	10%
Failure to Provide for Basic Needs	0%	6%	0%	15%
Failure to Provide Health/Medical Care	5%	13%	0%	5%
Improper Behavior Management	40%	31%	80%	20%
Improper/Inadequate Supervision	50%	31%	40%	45%

Table 40: OCA Incident Concern Categories Institutional Reports from Foster Care, FY25				
Risk of Emotional/Psychological Harm	50%	50%	80%	35%
Physical Injury	25%	6%	40%	10%
Sexual Abuse/Exploitation	15%	25%	0%	0%
Total Institutional Reports	**20**	**16**	**5**	**20**
Note: Percents will not sum to 100%. Cases can contain more than one Incident Concern Category.				

Appendix D: DCF Case Review Data

OCA insights into DCF policy and case practice are described through structured and narrative fields in the OCA data collection system, which the OCA analyzes to identify opportunities for systemic improvement.

The following provides additional information about OCA findings from DCF case reviews resulting from reports and inquiries involving DCF in FY25, stratified by two process points and in alignment with how DCF work is organized: intake/response and ongoing case practice.

Refer to **Appendix F: Glossary of Terms** for case review categories and definitions.

Total OCA Reviews of DCF Cases: 1,262

Table 41: Practice Concerns Identified in DCF-Involved Reports and Inquiries, FY25

Case Practice Concerns	Intake/Response	Ongoing	Total Cases
Administrative	67	31	98
Adult Consumer Engagement	14	60	74
Care and Custody	6	18	24
Clinical Formulation	6	49	55
Collateral Contact	15	51	66
DCF Specialist Consultation	11	66	77
Family Visits	NA	4	4
Inadequate Service Provision, Coordination, or Access	NA	13	13
Inconsistent Home Visits	NA	20	20
Inconsistent Placement Visits	NA	35	35
Interagency Collaboration	NA	14	14
Interviewing/Engaging Children	16	47	63
None	811	513	1324
Not Applicable	194	394	588
Other Concern	16	58	74
Outcome Decision	57	NA	NA
Permanency Planning	NA	33	NA
Physical and Medical Needs Not Met	NA	14	NA
Policy Non-Compliance	14	29	43
Premature Case Closing	NA	10	NA
Safety Planning	14	27	41
Total Cases with a Concern	**129**	**226**	**485**

Note: Counts will not sum to total. Cases can contain more than one concern at either process point.

Appendix E: Acronyms

State Agencies

DCF Department of Children and Families

DDS Department of Developmental Services

DESE Department of Elementary and Secondary Education

DMH Department of Mental Health

DPH Department of Public Health

DTA Department of Transitional Assistance

DYS Department of Youth Services

EEC Department of Early Education and Care

EOHHS Executive Office of Health and Human Services

EOHLC Executive Office of Housing and Living Communities

MassHealth Massachusetts Medicaid Program

MCB Massachusetts Commission for the Blind

OCA Office of the Child Advocate

Other Acronyms Appearing in the Report

ACE Adverse Childhood Experience

ACRT/RCRT Area or Regional Clinical Review Team

CCWT Center for Childhood Wellbeing and Trauma

CDC Centers for Disease Control and Prevention

CFC Comprehensive Foster Care

CIR or CIRs Critical Incident Report(s)

CL OCA Complaint Line

EI Emotional Injury

IEP Individualized Education Plan

ICPC Interstate Compact on the Placement of Children

F Fatality

FCR Foster Care Review

FCR SA Foster Care Review Safety Alert

FY Fiscal Year

JJPAD Juvenile Justice Policy and Data

NF Near Fatality

NH Non-Hispanic

QA OCA Quality Assurance Division

SBI Serious Bodily Injury

SUID Sudden Unexpected Infant Death

Appendix F: Glossary of Terms

Key Terms

51A/51B: A report of suspected child abuse and/or neglect filed under Massachusetts General Laws Chapter 119, Section 51A and subsequent 51B response.

Area or Regional Clinical Review Team: A collaborative, multidisciplinary group designed to ensure consistent, safety-focused, and clinically informed decision-making for children and families involved with the Department of Children and Families.

Child Treatment: An individual who contacts the Complaint Line to express concern, ask questions or seek resources about how a caregiver is or is not caring for and/or providing for the safety and wellbeing of a child that does not rise to the DCF definition of abuse and/or neglect.

Critical Incident Report: State agencies providing services to children or youth must notify the OCA if a child suffers a fatality, near fatality, serious bodily injury, or emotional injury. These are referred to as critical incident reports.[95]

Emotional Injury: An emotional injury occurs when a child is known to witness the fatality or life-threatening incident of an individual related to an unexpected medical event, overdose, violent act, or suicide.

Fatality: In terms of a critical incident, fatality occurs when a child between birth to 24 years old dies.

Foster Care Review Safety Alert: Safety alerts are generated by Foster Care Reviewers at the end of a Foster Care Review if an immediate safety concern is identified for the child/youth. The safety alert is immediately sent to the DCF area office responsible for the case. The DCF Area Director must document a response to the safety alert within one working day.

Foster Care Review: A Foster Care Review panel convenes every six months for every child in out-of-home placement to provide oversight and ensure that every child and youth under the state's custody has a permanency plan, which is defined as a safe and permanent home. The implementation of a Foster Care Review process is a federal requirement.[96]

Institutional Report: DCF reports of supported allegations of abuse and/or neglect occurring in facilities or programs serving children. For more information refer to the DCF Protective Intake Policy.

[95] Office of the Child Advocate statute. M.G.L. c. 18C. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter18C
[96] United States Social Security Act, 42 USC 675 Sec 475 (5) (B). https://www.ssa.gov/OP_Home/ssact/title04/0475.htm

Medical Event: In terms of a critical incident, a medical event relates to a non-injury health event, such as a heart attack. Medical events can result in fatality, near fatality, or serious bodily injury. If they are witnessed, they can result in an emotional injury.

Near Fatality: Near fatalities are accidental, the result of a medical condition, or the result of abuse and/or neglect. A near fatality designation is dependent on verbal certification by a physician that the child or young adult's condition is considered life-threatening.

Out-of-Home Setting: Out-of-home settings include foster care, congregate care, child care, public schools, private schools, after-school and summer programs, residential and inpatient therapeutic programs, school-funded transportation companies, and more.

Physical Abuse: In terms of a critical incident, physical abuse relates to an intentional act that causes injury or physical suffering and is perpetrated by a caregiver. Physical abuse can result in fatality, near fatality, or serious bodily injury. If witnessed, it can result in an emotional injury.

Serious Bodily Injury: Serious bodily injuries are accidental, the result of an underlying medical condition, or the result of abuse and/or neglect, and lead to bodily injury "which involves a substantial risk of death, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty, or emotional distress."[97]

Sexual Assault: In terms of a critical incident, sexual assault results in a fatality, near fatality, or serious bodily injury. If witnessed, it can result in an emotional injury.

State Care and/or Custody: A state agency, such as DCF or DYS, has obtained temporary or permanent legal custody of a child. Children in state custody may stay in their home or be placed out-of-home.

Unintentional Injury: In terms of a critical incident, injury relates to non-medical physical harm that is unintentional. Injuries can result in a fatality, near fatality, or serious bodily injury. If they are witnessed, they can result in an emotional injury.

Violence: In terms of a critical incident, violence relates to an intentional act that causes injury or physical suffering that is not sexual in nature and is not perpetrated by a caregiver. Violence can result in a fatality, near fatality, or serious bodily injury. If witnessed, it can result in an emotional injury.

[97] M.G.L. c. 18C § 5. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter18C/Section5

Settings and Sub-Settings

Center Based Child Care: Group and school age child care and includes several types of early education and care programs, such as preschools, kindergarten, before/after school programs and summer programs.[98]

Child Care: Regular, non-residential, out-of-home care for children under 14 (or under 16 with special needs).

Community Based Program: Programs that provide services to children and their families that do not meet the other type of institutional categories. This includes religious, recreational, and educational programs.

Comprehensive Foster Care: Foster homes that offer more intense therapeutic care and supports for children with more complex needs. This service is only provided by licensed foster care agencies in accordance with the licensing requirements of EEC and DCF.[99]

Congregate Care: A wide range of out-of-home group placements for children that provide 24-hour supervision in a variety of structured settings. This includes group homes, residential treatment programs, and secure facilities for those involved in the juvenile justice system. These placements offer both short-term stabilization as well as longer-term group care. Parents and caregivers can place their child in select congregate care programs, though children are commonly placed in congregate care through DCF, DMH, DYS or other state agencies within or outside of Massachusetts.

Family Child Care: Family Child Care programs are a type of child care for a small group of children in a private residence.[100]

Foster Care: When a child is removed from their home due to abuse and/or neglect, foster care is one type of setting in which they may be placed. As the Commonwealth's designated child protective services agency and the one that serves more children and families than any other EOHHS agency, DCF places the most children in foster care, however DYS can also place children in foster care.

Group Home: Out-of-home 24/7 services that provide flexible individualized treatment, rehabilitation, and support/supervision services that vary in intensity based upon individual youth and family needs. Educational services are not provided on site. Includes DCF placements

[98] Massachusetts Department of Early Education and Care. (n.d.). Learn about Group and School Age Child Care programs. https://www.mass.gov/info-details/learn-about-group-and-school-age-child-care-programs
[99] Massachusetts Department of Children and Families. (2026). Annual Report FY2024. https://www.mass.gov/doc/fy2024-dcf-annual-report/download
[100] Massachusetts Department of Early Education and Care. (n.d.). Learn about Group and School Age Child Care programs. https://www.mass.gov/info-details/learn-about-group-and-school-age-child-care-programs

for treatment residence, medically complex, emergency residence, and independent living programs.[101]

Independent living: A wide range of residential options that afford youth to live on their own and still access resources.

Kinship Foster Care: Foster care placements provided by persons related by either blood, marriage, or adoption (e.g., adult sibling, grandparent, aunt, uncle, first cousin) or other adult to whom the child and/or parent(s) ascribe the role of the family based on cultural and affectional ties or individual family values. This can include a person who the family or child has a strong bond with and is significant in their life (e.g., teacher or parent(s) of the placed child's friend).[102]

Residential School: Out-of-home 24/7 treatment services that are integrated with an onsite special education school. Children receiving residential school services need self-contained, integrated treatment, and educational program due to severity of behavioral risk to self or others preventing them from safely attending school offsite.[103]

Secure Facility: Operated by DYS, secure facilities are staff-secured or locked facilities where education and other services are provided on site to youth who are held pretrial or because they have been committed to DYS post-adjudication.

Unrelated Foster Care: An individual(s) who has been licensed by DCF as a partnership resource to provide foster/pre-adoptive care for a child, usually not previously known to the individual(s). Formerly called unrestricted foster care.

OCA DCF Case Review & Institutional Report Incident Concern Categories

Adult Consumer Engagement: In relation to case review findings, this refers to a determination that one or more of the following occurred: The parent was not assessed as part of a family assessment and action plan; the parent was not contacted as part of ongoing case management; or the parent was not visited or contacted monthly, and a reasonable explanation is not documented in the case record to support why these actions did not occur.

Boundary Issues: In relation to an institutional report, this refers to a concern that a provider violated physical and/or emotional boundaries with a child.

[101] Massachusetts Department of Children and Families. (2024). Annual Report FY2023. https://www.mass.gov/doc/fy2023-dcf-annual-report/download
[102] Massachusetts Department of Children and Families. (2026). Annual Report FY2024. https://www.mass.gov/doc/fy2024-dcf-annual-report/download
[103] Massachusetts Department of Children and Families. (2024). Annual Report FY2023. https://www.mass.gov/doc/fy2023-dcf-annual-report/download

Care and/or Custody of Child: In relation to OCA case review findings, this refers to a concern that DCF left the child in the care and/or custody of a parent or caregiver or removed the child from the care and/or custody of a parent or caregiver.

Clinical Formulation: DCF is not holistically assessing the family based on all available information to create a realistic plan of required changes that will promote a child's safety, permanency, and wellbeing. Clinical formulation requires a thorough review of DCF's history with the family.

Collateral Contact: In relation to OCA case review findings, this refers to a determination that the risk posed to the child was not fully assessed because the DCF case management team did not contact professionals and/or natural supports or did not ask questions that elicited information necessary to inform clinical formulation. Cases are not identified for this concern if the barrier to obtaining information is the result of parent/caregiver refusal to provide releases of information.

DCF Case Management: In relation to the Complaint Line, this refers to DCF's response to a report of abuse and/or neglect; removal of a child; service coordination or case oversight; frequent changes in social workers.

DCF Personnel: In relation to the Complaint Line, this refers to delay or lack of response to a parent or caregiver's questions or concerns; unprofessional communication; non-adherence to home-visiting requirements as outlined in the DCF Ongoing Casework and Documentation Policy.

DCF Specialist Consultation: In relation to case review findings, this refers to a determination that a DCF specialist consultation was not completed during the response although there were identified complex or high-risk factors that warranted one.

Delayed or no Health Care: In relation to an institutional report, this refers to a concern that a provider failed to ensure the child had proper and timely physical, dental, or behavioral health care.

Failure to Meet Basic Needs: In relation to an institutional report, this refers to a concern that the provider did not meet the child's needs for food, shelter, and clothing. This also includes situations where there are safety concerns regarding the physical environment where services are provided.

Improper Behavior Management: In relation to an institutional report, this refers to a concern that a caregiver and/or staff did not respond properly to a child who is exhibiting problematic and/or concerning behaviors.

Improper/Inadequate Supervision: In relation to an institutional report, this refers to a concern that a caregiver and/or staff engaged in behaviors, activities, or actions that prevented them from being able to properly supervise the child, such as not conducting required bed checks, sleeping while working, etc.

Inadequate Education: In relation to an institutional report, this refers to a concern that a caregiver did not ensure the child had proper educational opportunities.

Inconsistent Home Visits: In relation to case review findings, this refers to a determination that family participants in an open DCF case have not been visited by the DCF social worker monthly, and there is a lack of documentation regarding attempts to visit the family if such attempts were made.

Inconsistent Placement Visits: In relation to case review findings, this refers to no documentation in the record that a child in DCF custody is being visited monthly in their placement, such as foster care or congregate care.

Interagency Collaboration: In relation to case review findings, this refers to a child having additional agency involvement (DDS, DMH, DYS) and no documentation in the record that DCF is collaborating on an ongoing basis with the agency.

Interviewing/Engaging Children: In relation to case review findings, this refers to a determination that the social worker is not performing full, protective, developmentally appropriate interviews with the child as part of their ongoing case management responsibilities.

Outcome Decision: In relation to case review findings, this refers to an OCA disagreement with an intake or response decision either regarding a critical incident or a prior DCF intake and response involving the same family. This could mean a disagreement with a screening decision, with a finding of abuse and/or neglect, with a finding on the alleged perpetrator, or with a categorization of a case as either emergency or nonemergency.

Payments/Voucher: In relation to the Complaint Line, this refers to assistance with child care tuition and eligibility for guardianship subsidy.

Permanency Planning: A formalized strategy or set of actions designed to ensure long-term stability, wellbeing, and security of a child who is involved in the child welfare protection system, typically due to circumstances such as abuse, neglect, or family disruption. The primary goal of a permanency plan is to provide a safe and permanent living arrangement for the child, focusing on their best interests and overall welfare. In relation to case review findings, this refers to at least one of the following areas: There was not a permanency planning conference for a child in DCF custody in conjunction with DCF's permanency planning policy and/or when it

was clinically appropriate; a child in DCF custody was not progressing toward their permanency goal; the current permanency goal for the child was not appropriate.

Placement/Permanency: In relation to the Complaint Line, this refers to length of stay in out-of-home placement; delays in reunification; foster care placement and/or denial of placement with kin; concern for the wellbeing of a child in foster care or congregate care.

Premature Case Closing: In relation to case review findings, this refers to a determination that a DCF case was closed with one or more of the following conditions: the protective concerns that led to the family's involvement were not addressed; the case closed with protective concerns due to lack of family cooperation; collateral contacts were not performed prior to case closure; the case closed after the critical incident without appropriate services/supports in place.

Risk of Emotional/Psychological Harm: In relation to an institutional report, this refers to a concern that a caregiver and/or staff allowed children to be exposed to behaviors, activities, or actions that pose a risk of harming a child's emotional or psychological state.

Safety Planning: In relation to case review findings, this refers to a concern that DCF approved an individual(s) responsible for ensuring a child's safety and that individual was not an appropriate caregiver and/or was not aware of the safety plan and DCF's concern for the child.

Visitation: In relation to the Complaint Line, this refers to concerns about the frequency of visits with children in DCF custody; concerns about interactions between a child and parent during DCF supervised visits.

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