ANNUAL REPORT

July 1, 2019-June 30, 2020
Office of the Child Advocate
www.ct.gov/oca

A MESSAGE FROM THE CHILD ADVOCATE- SARAH HEALY EAGAN, JD

March 2020 brought a shut-down of everyday life as we have known it in Connecticut, spurred by a global pandemic that has aggravated already unsustainable disparities in how children's basic needs are met in our state. Too often, where a child is born, where they live, the color of their skin, their gender, whether they have a disability, still influences the trajectory of their childhood: whether they have a home that is safe and secure, whether they go to bed hungry or worrying that a loved one is hungry, whether they have meaningful opportunities to learn, or whether they grow up healthy, breathing clean air, drinking clean water, and playing outdoors.

Our mission at the Office of the Child Advocate is to ensure that publicly-funded services for children meet the needs of all vulnerable children, and that these systems, our systems, are effective and accountable to the citizens and families of Connecticut. We have seen more than ever in the last several months that many people love and care for someone who is in need, someone who needs help. The OCA will continue to advocate for public policies that ensure necessary services are provided for all who need them, not as a net to be stretched and frayed, but as a foundation, strong and sturdy, to support children's right to family, safety, healthcare, education, housing and dignity. We are truly grateful to work on behalf of Connecticut's children and families and to partner with many valued colleagues across the state who work tirelessly to be of service to families in need during this time of crisis in our community.

Pandemic Response

While much of the fiscal year the OCA continued individual and systemic investigations on behalf of children, as the public health emergency of COVID-19 engulfed the state, OCA's work shifted to identifying and responding to the unmet needs of those who are most vulnerable in the midst of the pandemic-driven shut-down. Since March, OCA expanded and re-framed its List Serve to provide regular updates regarding resources, hotlines, and children's legal rights to colleagues and families across the state. We convened multiple *ad hoc* groups to brainstorm with state and local partners regarding the special needs of pregnant women and infants, young children at risk for maltreatment, and educational and service needs of children with disabilities and children of color in underserved communities. OCA has provided individual advocacy to children and families who have struggled to access necessary supports during the shut-down. OCA continues to meet regularly with legislators and state agency leaders to review strategies for supporting children and families during the pandemic.

OCA Statutory Responsibilities

- Evaluate the delivery of services provided to children.
- Investigate complaints regarding services provided to children.
- Advocate on behalf of children in Connecticut.
- Review the circumstances of the death of any child due to unexplained causes.
- Take all possible action necessary to secure the legal and civil rights of children.
- Review the needs of children in foster care.
- Periodically review facilities in which juveniles are placed.

CHILD FATALITY OVERVIEW

The Child Fatality Review Panel (CFRP) is tasked with reviewing the circumstances of the death of any child from unexpected or unexplained causes. The purpose of the state's fatality review process is to identify and address patterns of risk to children, improve coordination of services to children and their families, and strengthen fatality prevention strategies. The CFRP is comprised of professionals must multiple disciplines and is currently co-chaired by State Child Advocate Sarah Eagan and Dr. Kirsten Bechtel, an emergency-room pediatrician at Yale New Haven Hospital. Prior to COVID-19 the CFRP met monthly at the Office of the Chief Medical Examiner (OCME), however meetings currently take place on a virtual platform.

From January 1, 2019 to December 31, 2020, 76 child fatality cases were reported to the OCA by OCME for purpose of an autopsy for an unexpected/untimely death of a child. Of those child fatality cases, 63 deaths were from unintentional or intentional injuries and 13 deaths were determined to be from natural causes. Children of color, similar to other years, make up a disproportionate percentage of preventable deaths, including accidental deaths of children of all ages and undetermined deaths of infants (typically associated with unsafe sleep environments which may have pillows-blankets-heavy clothing- or involve an infant sleeping with one or more adults or other children).

Unintentional/Accidental Deaths of Children (25)

Motor Vehicle - Driver (4)

- Gender: 3 girls and 1 boy
- Ages: All were 17 years-old
- Race: 2-White, 1-Hispanic/White
- 1-Hispanic/Black
- Details: All were sole occupants in the car

Motor Vehicle - Passenger (2)

- Gender: 1 boy & 1 girl
- Age: 17 years-old
- Race: 1-Hispanic/White 1-White

Motor Vehicle Roll-over (1)

- Age: 2
- Race: White
- Details: Driveway

Drowning Fatalities (3)

- Gender: All were boys
- Ages: 12, 14, 17
- Race: 2 were Hispanic/White, (1) Other
- Details: All were natural bodies of water

Positional Asphyxia (5)

- Gender: All were boys
- Ages: 4 were under 3 months-old and 1 was 7 months-old
- Race: 3 were White and 2 were Hispanic/White
- Details: All infant deaths were associated with complications of an unsafe sleep environment.

Fire (1), Overdose (1), ATV/Scooter (3), Other (5)

Intentional Homicide (7)

- Gender: 5 boys and 2 girls
- Age: 4 months, 2, 15, (2) 16, (2) 17
- Race: (1) Hispanic, (3) Black, (2) White
- Details: 5 died from gunshot wounds and 2 deaths were from fatal child abuse/blunt head trauma

Intentional Suicide (10)

- Gender: 5 boys & 5 girls
- Age: 12, (2) 14 (2) 15, 16, (4) 17
- Race: 7-White 1-Black, 2-Hispanic/White
- Details: 6 youth died from asphyxia/hanging, 3 were blunt trauma, and 1 was acute intoxication/overdose

Undetermined (21)

- Gender: 12 boys & 9 girls
- Ages: 18 were less than 4 months old, 2 were under 12 months old, and 1 was a year old.
- Race: (8) Black, (5) White, (4) Hispanic/White, (2) Hispanic/Black, and (2) other.
- Details: 18 infants had some modifiable factor associated in their sleep space.
- Undetermined/Undetermined=13 (all 13 were infants of which 11 had identified modifiable risk factors such as stuff in sleep environment—pillows-blankets-heavy clothing- sleeping with one or more adults or other children, and one product recall device).
- Undetermined/SUID=7 (all infants with associated bed-sharing/co-sleeping and some with additional risk factors—prone, pillows, etc.).
- Undetermined/Positional Asphyxia=1

Gun Violence 2001-2019 (131)

In Connecticut, between January 1, 2001 and December 31, 2019, **131 children** died from injuries as a result of gunshot wounds. **Homicides** accounted for 103 (78%) child deaths. **Suicides** accounted for 23 (17%) child deaths, 2 cases were classified as **Accidents,** and 3 were classified as **Undetermined**.

Age

39 children were between Birth-14 years old of which. 20 were from the mass murder at Sandy Hook Elementary School;

92 (70%) children were ages 15 through 17

Race

White=59 (45%).
Black=56 (43%).
Hispanic=15 (11%).
Other=1

Gender

Boys=105 (80%)
Girls=26 (20%).

The Purpose of Child Death Review

To conduct a comprehensive, multidisciplinary review of child deaths, to better understand how and why children die, and use the findings to take action that can prevent other deaths and improve the health and safety of children.

National Center for Child Death Review and Prevention

Ex-Officio Government Members

Office of the Child Advocate
Sarah Healy Eagan, JD

Office of the Chief States Attorney
Anne Mahoney, JD

Office of the Chief Medical Examiner
Gregory Vincent, MD

Department of Emergency Services & Public Protection
Lt. Seth Mancini, JD

Department of Children and Families Ken Mysogland, MSW

Department of Public Health
Amy Mirizzi, MPA

Legislative Appointment

Governor
Kirsten Bechtel, MD
Yale New Haven Hospital

Majority Leader of the Senate
Andrea Barton Reeves, JD

Minority Leader of Senate
Thomas C. Michalski, Jr. LCSW

Minority Leader of the House
Steven Rogers, MD:
CT Children's Medical Center

Majority Leader of the House
Regina Wilson, PhD

Speaker of the House
Pina Violano, PhD Injury Prevention

President Pro Tempore
Law Enforcement, Vacant

CFRP Appointments

University of CT Medical Center
Ted Rosenkrantz, MD

CT Coalition Against Domestic Violence
Tonya Johnson, MPA

CT Children's Medical Center
Michael Soltis, MD

Fatality Review At-A-Glance 2011-2019

	Accident	Undetermined	Suicide	Homicide
2011	34	16	9	13
2012	33	18	12	27
2013	35	17	10	12
2014	18	21	6	15
2015	30	19	12	11
2016	30	19	8	7
2017	29	15	15	12
2018	23	19	7	8
2019	25	21	10	7
Total	257	165	89	112

FACILITY OVERSIGHT

The OCA staff visit and otherwise maintain contact with children and youth in publicly operated or regulated settings including, but not limited to, hospitals, residential treatment programs, juvenile detention, correctional institutions and schools. OCA's governing statute authorizes its staff to meet with children, assess the safety and appropriateness of their environment, interview program staff and administration and review program and child-specific records thus allowing for a full review of the efficacy of state-funded services provided. OCA's facility oversight efforts are determined by a) concerns reported to the Office, b) vulnerability of children and youth served by the program and c) legislative mandates.

The COVID-19 pandemic has had a particularly powerful impact on the hundreds of CT children (many with extremely complex special needs), served in congregate care settings. Treatment services have been dramatically altered, including the often critically needed therapeutic family and community reintegration work. Families have been unable to visit in person. Some youth have endured prolonged isolation. In addition, many youth have had limited access to meaningful education for the past several months. During this last quarter of the 2019-20 year, COVID-19 has also challenged OCA's work related to facility inspection and oversight of the care and treatment provided to children. Initially unable to do in-person site visits, OCA staff redoubled efforts to find alternative means of providing critically important oversight such as participation in virtual youth-specific treatment reviews, record reviews, and telephone/virtual contact with children, families, providers and regulators. By June of 2020, OCA resumed site visits adhering to facilities' public health protocols.

OCA MONITORING OF CONDITIONS OF CONFINEMENT FOR DETAINED/INCARCERATED YOUTH

Conn. Gen. Stat. § 46a-13*l*(12) requires the OCA to regularly report to the legislature regarding conditions of confinement for youth detained or incarcerated in the juvenile and adult criminal justice systems. OCA published its first such report in January 2019, providing detailed findings regarding several key areas impacting incarcerated youth: (1) suicidal behavior and suicide prevention; (2) use of force and physical isolation; (3) availability and utilization of clinical and rehabilitative programming; (4) utilization of educational programming; (5) access to family visits and family therapy/engagement; and (6) child abuse/neglect reporting and prevention. OCA's initial report contained several recommendations to improve the circumstances and outcomes for confined youth. OCA continues to meet with Court Support Services Division (CSSD) and the Department of Corrections (DOC) administrators regularly to check in on the status of implementation of needed reforms. OCA is nearing completion of updates regarding conditions of confinement for youth in the adult criminal justice system. (https://portal.ct.gov/-/media/OCA/V4/ConditionsofConfinementfinalJanuary2019pdf.pdf)

COURT SUPPORT SERVICES DIVISION (CSSD): JUVENILE DETENTION AND POST-ADJUDICATION SECURE CARE

Following the 2018 closure of the CT Juvenile Training School (operated by DCF), the Connecticut legislature assigned full responsibility for juvenile justice services to CSSD, effective July 1, 2019. Despite historical responsibility for the operation of or contracting for short-term pre-adjudication detention programs for youth and community supervision of court-involved juveniles, CSSD now has

additional responsibility for providing longer-term secure care and supervision for adjudicated youth. Efforts remain underway to ensure that adequate educational, rehabilitative, mental health, social-emotional and family engagement programming and interventions are in place to meet the needs of these youth.

OCA engages in multiple activities to closely monitor development and implementation of such programming. Activities throughout 2019-2020, prior to the COVID-19 pandemic, included reviewing records of youth, conducting frequent site visits, attending meetings, and interviewing staff and youth.

DEPARTMENT OF CORRECTION: MANSON YOUTH INSTITUTION and YORK CORRECTIONAL INSTITUTION

After the publication of OCA's initial report on conditions of confinement in January 2019, the DOC made efforts to decrease its reliance on prolonged highly restrictive housing for the youth in its custody. Facility administration also made efforts to improve access to age-appropriate activities for minor youth. OCA's continued monitoring did note some improvement during 2019. However, we continue to find that youth incarcerated in the adult correctional system experience significant isolation and lack of access to comprehensive programming and mental health treatment. These concerns have been compounded by conditions during the COVID-19 pandemic.

OCA SYSTEMIC ACTIVITIES RELATED TO ENSURING SAFE AND EFFECTIVE FACILITY-BASED CARE FOR CHILDREN AND YOUTH

- *Special Act No. 19-16, An Act Concerning the Licensure of the Albert J. Solnit Children's Center*

Special Act 19-16 calls for a process to license the DCF-run Solnit Center, a psychiatric treatment facility for children. The Act was passed following an OCA investigation into the circumstances leading to the death of Destiny G., a 16 year old girl who died by suicide at the Solnit Center in June 2018, the day before her scheduled discharge into foster care. Destiny was eight months pregnant at the time of her death (her unborn child also died). OCA found that the Department of Public Health and the Department of Social Services, pursuant to federal Medicaid laws, had investigated and reviewed a series of recent suicide attempts at Solnit in the months preceding Destiny's death, and the agencies had found serious care and treatment deficiencies affecting the safety of children. Though corrective action was required, deficiencies persisted. In part due to the lack of an outside state licensing requirement for Solnit, DPH and DSS's deficiency findings and corrective action plans were not published prior to Destiny's death.

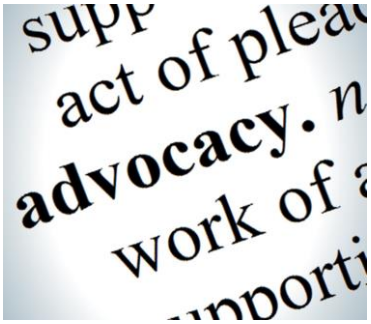
Following passage of Special Act 19-16, OCA participated in a working group convened by DCF to develop recommendations for the legislature to end the facility's license-exempt status. The working group report, fully supporting licensure by the DPH, was submitted by the DCF Commissioner to the Children's Committee of the state legislature in January 2020. The 2020 legislative session halted in March due to the COVID-19 pandemic, thus OCA will continue to advocate for licensure of Solnit by DPH in the upcoming legislative session.

- *Special Act No. 19-19: An Act Concerning the Provision of Certain Information Pertaining to Congregate Care Facilities Licensed or Administered by the Department of Children and Families*

During the 2019 legislative session, OCA successfully advocated for increased transparency and accountability for services provided by congregate care settings serving vulnerable youth. Special Act No. 19-19 requires DCF, in consultation with the OCA and providers of DCF licensed congregate care facilities, to develop a framework for publishing information about the quality and safety of

state-licensed treatment facilities for children, including information about the monitoring and inspection of such facilities and the health, safety, treatment and discharge outcomes concerning children receiving services at such facilities. A working group was formed in August 2019 to begin this important work designed to promote child safety and treatment efficacy through transparency and accountability. A draft report was developed in partnership with the DCF Commissioner prior to the COVID-19 pandemic. OCA intends to pursue the furtherance of this important safety measure.

OMBUDSMAN & CHILD SPECIFIC ADVOCACY



For the time period July 1, 2019 through June 30, 2020, the OCA responded to approximately 300 complaints regarding the provision of state and state-funded services to vulnerable children. The OCA hears from family members, providers of health/mental health services, school personnel, foster parents, attorneys, legislators, and employees of state agencies, as well as youth who are seeking assistance. Calls from the community impact the direction of OCA investigations as we work to ensure that we are responding effectively to the needs of children and families.

The OCA seeks to be responsive to community concerns by providing guidance about how to effectively navigate the state's often complex service systems. In the most urgent cases, OCA undertakes additional investigation and advocacy efforts, including record reviews, program visits, and advocacy with both state and local agencies to ensure the needs of children are appropriately met. Frequent issues addressed or investigated by the OCA this year included:

Individual Advocacy

Lisa (pseudonym) is a 10-year-old adopted child who was diagnosed with a significant learning disability by the age of 3. She was placed in the foster care system at birth, and experienced many hardships at home, school and in the community. After several criminal charges were brought forth against Lisa, OCA was contacted for assistance given her significant history and challenges navigating multiple systems including the local school district, DDS and DCF. OCA identified subsequent issues including the child's frequent hospital ER visits and in-patient stays; the child's refusal to attend school; and the family's ability to safely maintain her in the home. OCA's role in this case involved persistent advocacy to address the urgency of interrupting the child's cycle of trauma which included repeated hospitalizations, unaddressed mental and behavioral health needs, and the lack of stability in her adoptive placement. The OCA also completed a comprehensive review of the child's educational record and actively participated in several school meetings. In an effort to build a stronger partnership between the stakeholders and ultimately address the child's gaps in services and unmet needs, the OCA convened and facilitated individual and joint meetings across the systems involved including the family, school district, DDS, DCF, attorneys and hospital providers.

♣Lack of access to appropriate special education and related services for children with disabilities.

♣Unmet needs of children with significant mental health treatment needs or developmental disabilities.

♣Safety or permanency concerns for children who have experienced abuse/neglect.

♣School safety concerns, including children experiencing bullying, abuse/neglect by school staff, or inappropriate discipline.

♣Youth with unmet needs involved in both the juvenile and adult correctional systems.

The OCA interacts regularly with the staff and executive administrations of several state agencies and government officials including the Departments of: Children and Families, Developmental Services, Social Services, Mental Health and Addiction Services, Correction, Education, Public Health, Office of the Chief Public Defender, Office of the Chief Medical

Examiner, Judicial Branch-Court Support Services Division, as well as the CT General Assembly.

EDUCATION

In conjunction with its statutory duty to "[t]ake all possible action including, but not limited to, conducting programs of public education, undertaking legislative advocacy and making proposals for systemic reform and formal legal action, in order to secure and ensure the legal, civil and special rights of children who reside in this state," See Conn. Gen. Stat. § 46a-13l, the OCA conducts child-specific educational reviews and systemic educational reviews/investigations.

During the 2019-2020 fiscal year, child-specific reviews included many issues impacting children receiving special education and related services in numerous school districts across the state. OCA assisted families in accessing disability support services, summer programming, early intervention services, relief from bullying, and services in the least restrictive environment.

During the course of its reviews, the OCA has participated in PPT meetings, resolutions sessions and early stages of dispute resolution as advocates for students in cases in which a public school district's policies, procedures and/or practices were not in conformance with state and/or federal law or best practices.

Child-specific educational reviews have led to larger and more extensive systemic education reviews and/or investigations in several districts, including investigations of (i) the Waterbury Public School District and police intervention for students' mental health issues and (ii) the Fairfield Public School District and the transportation of children with disabilities. The Waterbury report was released in September of 2020 and the Fairfield report will be released later this calendar year.

Systemic educational reviews/investigations currently being conducted by the OCA also include investigations related to the alleged sexual abuse of children in various public schools. Those investigations, which were paused due to the pandemic, are scheduled to be concluded in 2020. The issues addressed in those investigations include: Adult Sexual Misconduct in the Education Setting; Mandatory Reporting; Title IX and Staff Hiring Practices.

Child Program Review

Amy (pseudonym) was struggling in kindergarten both academically and socially. On one occasion, the district called 911 because Amy became dysregulated in the classroom. She was then suspended. Amy had never been evaluated for eligibility for special education and related services. The family came to the OCA for assistance.

In response, the OCA conducted a child-specific educational programming review, spoke to the family and district administrators and participated in the PPT process. The district agreed to follow OCA's recommendations, including that Amy be evaluated immediately for eligibility for special education and related services, all necessary assessments/evaluations be conducted and that measures be put into place to support Amy's social and emotional well-being.

The district also reviewed its policies for exclusionary discipline and practices for calling 911 for mental health situations.

During the COVID-19 Pandemic, the OCA increased its efforts to advocate for vulnerable students and addressed additional issues related to school closures, including access to remote learning; extension of transition services for students aging out of special education services and social emotional well-being of students, through advocacy, support to families and participation in several educational advocacy community groups.

CHILD SAFETY AND PERMANENCY

One of the essential functions of the OCA is to promote safety, permanency, and well-being for children and their families who are at risk or involved with the child welfare system. The OCA responded to a significant number of reports of young children in foster care with a complex permanency plan. OCA advocated with stakeholders to facilitate adequate planning to reunify or place children with their families or relative caregivers, and to ensure the provision of appropriate mental health, physical and developmental support services to meet the needs of the child and their caregiver.

OCA also advocates on behalf of children and families who are struggling to coordinate behavioral health care services for vulnerable children including those with learning disabilities and/or mental illness and complex trauma. OCA provides support to the family and to advocates for appropriate service delivery within a system that providers and families too often find to be fragmented and siloed. OCA continues to address barriers to care including the lack of qualified behavioral health programs and providers that are unevenly scattered across the state and the lack of access to adequate health care coverage for some children and families.

FAMILY FIRST PREVENTION SERVICES ACT

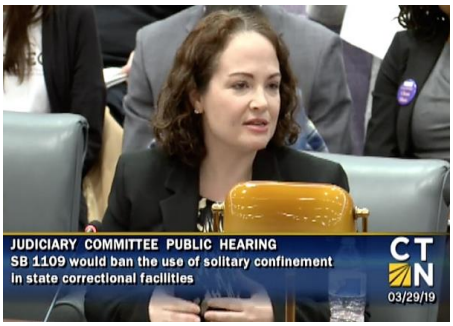
The federal Family First Prevention Services Act ("Family First") was passed and signed into law (P.L. 115-123) as part of the bipartisan budget act on February 9, 2018. In November 2019, Connecticut, led by DCF as the state's lead for Title IV-E programs, embarked on a highly inclusive planning process to re-imagine and develop a plan to re-structure child welfare services. Among other things, the Family First legislation requires states to commit to evidence-based child welfare prevention services in order to access critical federal IV-E funds. Multiple workgroups were promptly established with rigorous meeting schedules, and OCA was an active participant throughout this effort. COVID-19 has paused this important work, but OCA is looking forward to resuming full participation in the future.

CHILDREN WITH DEVELOPMENTAL DISABILITIES

A significant number of calls to the OCA involve concerns about the unmet needs of children and families living with complex developmental disability and frequently co-occurring special health care or behavioral health challenges. Expressed concerns may be specific to child and family safety, adequacy of special education services being provided, or lack of access and availability to critically needed in-home or community-based services. While Connecticut's investment over the past several years in systems of care has resulted in positive outcomes, children with complex developmental disabilities are still too frequently underserved. This has become increasingly evident during the current pandemic as many high need children have been unable to access critical special education and behavioral support programming, and families continue to struggle without access to respite. Prior to and

throughout the past months of COVID-19, OCA has continued efforts to work with legislative leaders, advocates, families and state agency partners to highlight the unique needs of children with disabilities, particularly those with the highest support needs. OCA continues to examine the availability, accessibility and efficacy of services across multiple public and private agencies.

LEGISLATIVE ACTIVITIES



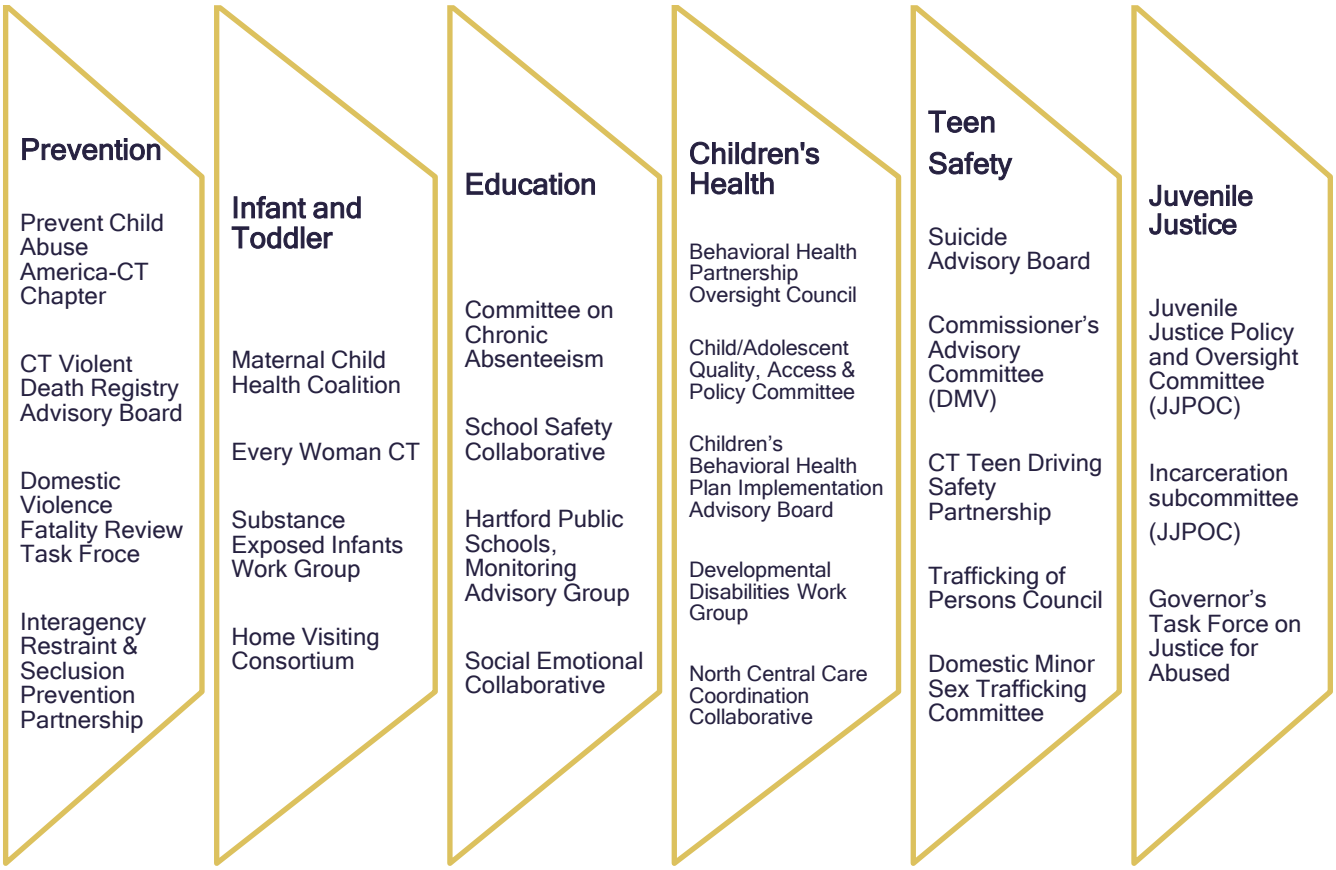
Legislative advocacy is an important function of the OCA. OCA strives to build strong relationships with legislative colleagues and continues to serve as an independent resource to the legislature on a wide variety of topics pertaining to or potentially impacting children and families. OCA is also an active participant in child-focused legislative committee work. OCA monitors legislative bill proposals and provides testimony where appropriate. This past session, which was unfortunately interrupted by the COVID-19 pandemic, OCA provided testimony on several proposed bills, including but not limited to, bills promoting child safety on school transportation vehicles, training to prevent youth suicide, and requiring licensure by DPH of the state's children's psychiatric hospital. OCA frequently partners with state agencies, other advocates and stakeholders in the development of bills, optimizing the potential for adoption of effective public policy on behalf of the state's children.

TRAININGS

OCA staff are frequently called upon to participate in a variety of educational forums. This past year OCA staff provided training to health care professionals, social service providers, legal professionals, educators and student groups on topics ranging from child death prevention strategies, representation of vulnerable child populations, and cross-agency multidisciplinary advocacy.

COMMITTEES-TASK FORCES-COUNCILS

Critical to the work of the OCA are partnerships....



OCA STAFF

Sarah Healy Eagan, Child Advocate
Mickey Kramer, Associate Child Advocate
Virginia Brown, Staff Attorney
Valerie Lilley, Assistant Child Advocate
Heather Panciera, Assistant Child Advocate
Faith Vos Winkel, Assistant Child Advocate
Julie McKenna, Human Services Advocate
Lucinda Orellano, Human Services Advocate

OFFICE OF THE CHILD ADVOCATE

18-20 Trinity Street Hartford, CT 06106
(860) 566-2106
1-800-994-0939
www.ct.gov/oca