

THE DIGEST OF ADMINISTRATIVE REPORTS TO THE GOVERNOR
Fiscal Year 2020-2021

Office of the Child Advocate/Office of Governmental Accountability

Agency Head: Sarah Eagan, Child Advocate
Deputy Head: Mickey Kramer, Associate Child Advocate
Established: 1995
Statutory Authority: C.G.S. § 46a-13K, et seq.
Central Office: 165 Capitol Avenue
Number of Employees: Seven (7)
Recurring Operating Expenses: \$776,953 (OCA/CHILD FATALITY REVIEW)

Effective 7/1/2016, the administrative functions of the divisions of the Office of Governmental Accountability were transitioned to the Department of Administrative Services SMART unit. Designated as a division of the OGA, the OCA maintains its independence and statutory authority/responsibilities. The OCA relocated into the renovated state office building at 165 Capitol Avenue in March 2021.

MISSION

The Office of the Child Advocate (OCA) speaks for Connecticut's children. The OCA was created in 1995 to be an independent voice for children rather than an administrator of programs. OCA's mission is to oversee the care and protection of Connecticut's children and to advocate for their well-being. OCA is committed to ensuring that all children receive the care and supports that they need.

STATUTORY RESPONSIBILITIES

The statutory responsibilities include: evaluating the procedures for and the delivery of state-funded services to children, investigating inquiries or complaints about services for children, recommending changes in state policy, conducting programs of public education, legislative advocacy and proposing systemic reform, reviewing conditions and procedures of all public and private facilities where children are placed, providing training and technical assistance to children's attorneys, initiating or intervening in court cases on behalf of children, serving on the Child Fatality Review Panel (CFRP) and conducting a fatality review on the circumstances of the death of a child due to unexpected or unexplained causes in order to facilitate development of prevention strategies to address identified trends and patterns of risk and to improve coordination of services for children and families in the state.

PUBLIC SERVICE

OCA continues to shine the light on the needs and circumstances of children in Connecticut and works to bring about necessary change for children and families. OCA helps children/youth, families, community members, health, human service and education professionals and others by educating and informing them about available services and supports, reviewing individual cases, advocating for children at risk and addressing public policy issues impacting the well-being of children. Specific reviews and investigations assist the OCA in identifying systemic issues and such investigations often shape OCA's public policy and legislative advocacy. OCA shares its public investigative reports, public health alerts, issue briefs and other relevant educational information through a listserv as well as the OCA website (www.ct.gov/oca/).

ACHIEVEMENTS/IMPROVEMENTS FOR FISCAL YEAR 2020-2021

OMBUDSMAN ACTIVITIES

For the time period July 1, 2020 through June 30, 2021, the OCA responded to approximately 300 reports of concern regarding the provision of state and state-funded services to children. The OCA receives questions, concerns, and complaints from parents and other family members, providers of health/mental health services, educators, foster parents, attorneys, legislators, and employees of state agencies, and often from youth who are in need of services. OCA ombudsman activity regularly informs our systemic reviews/investigations as well as both administrative and legislative advocacy efforts.

The COVID 19 pandemic has had a particularly harsh impact on the state's most vulnerable children-leaving many without access to meaningful education, therapeutic supports and services and community engagement. OCA is committed to ensuring that the needs of these children and their families receive critical attention in the months ahead as CT works to recover.

The OCA seeks to be responsive to the concerns of everyone reaching out with a question, concern or problem by providing information and guidance in how to effectively navigate the state's often complex service systems. In the most complex cases involving concerns about unmet needs of vulnerable children, OCA's investigation and advocacy efforts will include record reviews, program visits, and communication with state and community-based agencies to ensure the needs of children are appropriately assessed and addressed. Frequent issues, all exacerbated by the continued pandemic, addressed or investigated by the OCA this year included:

- Concerns regarding consistent and reliable access to education
- Lack of access to appropriate special education services for children with disabilities
- Safety and well-being concerns for children who have experienced abuse/neglect
- Lack of access to needed intensive mental health treatment, including inpatient and intensive outpatient and home-based services
- Lack of access to adequate home, community and intensive out of home treatment services for children with complex developmental disabilities, who often have co-occurring mental health disorders or special health care needs.

CHILD FATALITY PREVENTION/CHILD SAFETY

OCA continues to co-chair and staff the state Child Fatality Review Panel (CFRP), meeting monthly with a multi-disciplinary panel to review unexpected and unexplained deaths of CT's children reported to the Office of the Chief Medical Examiner (OCME) and develop strategies for fatality prevention.

From January 1, 2020 to December 31, 2020, **97** 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, **65** deaths were from unintentional or intentional injuries and **32** deaths were determined to be from natural causes (including conditions such as: pneumonia, meningitis, complications from special health care needs, asthma, epilepsy, diabetes, and congenital heart issues. While the number of CT children/youth dying by suicide has remained the same as last year, this past year of the COVID pandemic has seen a dramatic increase in emergency room visits and inpatient admissions for youth experiencing suicidal ideation or attempts. Homicide deaths during this reporting period doubled

from the previous year; violence across the life span has increased during the pandemic and children/youth were impacted as well.

Children of color continue to 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).

During the past year, OCA, in collaboration with a variety of state partners, published multiple Child Safety Public Health Alerts:

- [Summer Flyer Spanish \(ct.gov\) --Drowning Prevention](#)
- [Summer Flyer \(ct.gov\) --Drowning Prevention](#)
- [Sleep Flyer 2020 \(ct.gov\)--The Safest Place for Your Baby](#)
- [SUICIDE Public Health Alert 2020 CT \(ct.gov\)—Concern for Children’s Mental Health](#)
- [ScaldBurnFlyer-4.pdf \(ct.gov\)-Burn Prevention Safety](#)

OCA continues its work with active participation/leadership on a wide variety of child fatality prevention initiatives, both local and national, focused on public awareness and public policy.

FACILITY OVERSIGHT AND INVESTIGATION

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 sustained COVID-19 pandemic continues to have a 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. In-person visitation remains limited. Some youth have endured prolonged isolation. In addition, many youth have had limited access to meaningful education for the past several months. 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. This past year, OCA has resumed site visits adhering to facilities’ public health protocols.

OCA MONITORING OF CONDITIONS OF CONFINEMENT FOR DETAINED/INCARCERATED YOUTH

Conn. Gen. Stat. § 46a-13/(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 report in January 2019, providing detailed findings and multiple recommendations for system improvement. Monitoring of the conditions of confinement for youth housed within the DOC as well as CSSD detention programs has continued throughout this year, including a gradual return to in-person facility visits.

In November 2020, OCA published a follow up report which included a review of conditions for the population of DOC incarcerated youth age 15-21. (<https://portal.ct.gov/-/media/OCA/OCA-Recent-Publications/OCA-Report-MYTYCI-Nov-2020.pdf>) OCA's report resulted in a DOC Action plan to improve conditions for youth in its facility for adolescent males, Manson Youth Institution. DOC Corrective Action Plan can be found here: <https://portal.ct.gov/OCA/Reports-and-Investigations/System-Investigations/Links-to-System-and-Facility-Investigations>.

OTHER SYSTEMIC INVESTIGATIONS

In response to multiple concerns reported to this office, the OCA published an investigative report regarding Waterbury Public Schools' utilization of 911 and local police response to address the behavioral health and mental health crises of children in Prekindergarten through 8th Grade. <https://portal.ct.gov/-/media/OCA/OCA-Recent-Publications/OCA-Report--Final-Waterbury-Report-September-1-2020.pdf>. OCA's report resulted in corrective action plans by the school district and the State Department of Education that OCA will continue to monitor at the state level. <https://portal.ct.gov/-/media/OCA/OCA-Recent-Publications/WPS-Progress-Update.pdf>.

In response to publicly reported concerns, the OCA published an investigative report addressing allegations that Stonington Public Schools failed to adequately prevent or respond to reports of child sexual harassment/abuse in the school community. OCA's report, which contains the District's Action Plan, can be found here: <https://portal.ct.gov/-/media/OCA/OCA-Recent-Publications/OCASTONINGTONFINALREPORT51321.pdf>.

In response to a family complaint, the OCA conducted a data-driven investigation of Vernon Public Schools' provision of individualized educational services to young children with disabilities transitioning from the State's Birth to Three Program to the public school system. OCA published a Letter of Concern (<https://portal.ct.gov/-/media/OCA/OCA-Recent-Publications/05042021-OCA-Letter-Vernon-Public-Schools.pdf>) and continues to follow up on systemic concerns with the State Department of Education.

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

- ***UPDATE Special Act No. 19-16, [An Act Concerning the Licensure of the Albert J. Solnit Children's Center].*** OCA has continued to engage in monitoring and periodic review of quality management reports specific to the Solnit Center programs.

NEW. P.A. 21-02 established a requirement for the Solnit programs to be licensed by the Department of Public Health, a recommendation initially arising from an investigative report published by the OCA regarding the death of a child at the Solnit Center in 2018.

- ***UPDATE 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*** 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 critical 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. OCA continues to help facilitate a public-private working-group to support implementation of this statutory requirement.

OCA TRAININGS IN THE COMMUNITY

OCA staff are frequently called upon to participate in a variety of educational forums. This past year OCA staff provided virtual 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.

Respectfully submitted,
Sarah Eagan, Esq.,
Child Advocate