THE OFFICE OF THE CHILD ADVOCATE

ANNUAL REPORT

JUNE 30, 2014 to JULY 1, 2015

- ✓ *Evaluate the delivery of services to children through state agencies or state-funded entities;*
- ✓ *Periodically review the procedures of state agencies and recommend revisions;*
- ✓ *Review and investigate complaints regarding services provided by state agencies or state-funded entities;*
- ✓ *Advocate on behalf of a child and take all possible action necessary to secure the legal, civil, and special rights of children, including legislative advocacy, making policy recommendations, and legal action;*
- ✓ *Periodically review facilities and procedures of facilities in which juveniles are placed and make recommendations for changes in policies and procedures;*
- ✓ *Periodically review the needs of children with special health care needs in foster care or permanent care facilities and make recommendations for changes in policies and procedures;*
- ✓ *Review the circumstances of the death of any child due to unexpected or unexplained causes.*

OVERVIEW AND AUTHORITY

The Office of the Child Advocate (OCA) was established in 1995 after the tragic death of an infant in state care. The child's death catalyzed the legislature to create an independent agency with the power to investigate and issue public reports to ensure the well-being of children and provide transparency to government services for vulnerable children. The OCA continues to utilize its unique statutory and independent authority to investigate and evaluate state-funded and state-operated programs and services for children, identify areas in need of attention, and make recommendations to protect the rights of Connecticut's children. Committed to education and workforce development, the OCA proudly serves as a learning environment for students. This past year OCA hosted interns from the University of Connecticut graduate Schools of Social Work and Law, Suffolk University Law School, undergraduate students from the University of Saint Joseph and Goodwin College. In addition, OCA staff members are frequently asked to guest lecture at state universities and colleges on a variety of topics involving children.

Fiscal Year 2015 (FY14) has been a very busy year for the OCA, and despite its small number of staff (6 FTEs) and operating budget of $643,848, the OCA has continued to diligently strive to meet its responsibilities to the children and residents of the state.

RESPONDING TO CITIZEN CONCERNS

Between July 1, 2014 and June 30, 2015, the OCA responded to over 400 inquiries regarding the provision of state and state-funded services to children. OCA receives questions, concerns, and complaints from parents and other relatives of children in need, community service providers, attorneys, juvenile and criminal justice professionals, legislators, and employees of state agencies, and from youth who themselves are in need of services. All calls to the OCA are maintained as confidential. OCA employees provide callers with information on the responsibilities of state agencies serving children and families, and our intake coordinators coach callers on how to effectively navigate sometimes overwhelmingly complex systems. Issues brought to the attention of the OCA through citizen calls this past year include concerns regarding child welfare services, special education, mental health, legal representation, supports and services to children with developmental disabilities and special health care needs, juvenile justice, criminal justice, and social services available to children and families.

Beyond providing information, referral and coaching, OCA staff determined it necessary to intervene directly on behalf of approximately 57% of the children referred through its ombudsman activities. Most of those child/youth cases involved significant concerns with treatment planning around complex mental health needs, developmental disabilities and social issues transcending the services of multiple state agencies. As reported in previous years, child-specific case review and advocacy was provided to many more children and youth encountered during OCA's facility-based work in state funded or state-operated treatment and correctional settings. It is OCA's unique access to information about child-funded services that allows for comprehensive inspection of service access, availability and quality across all state-funded systems that serve children. The OCA uses this knowledge and authority to inform both child-specific case planning as well as system-wide practice and policy

initiatives. Information yielded through OCA's child specific investigations is shared with oversight entities including Executive branch agency leaders, the Governor's office, the Legislature, Judicial branch officials, and the public.

OCA's staff interacts regularly with the staff and executive administrations of the Department of Children and Families, Department of Developmental Services, Department of Social Services, Department of Mental Health and Addiction Services, Department of Correction, Department of Education, Department of Public Health, Office of the Chief Public Defender, Office of the Chief Medical Examiner, Judicial Branch-Court Support Services Division, and Judicial Branch-Probate Courts and Probate Administration. OCA continues to work collaboratively with private sector health and human service providers and other advocates across the state, examining the effectiveness of the current service delivery systems, identifying gaps and needs in services, and advocating for changes and improvements as needed. In August 2014, the OCA and several other divisions of the Office of Governmental Accountability implemented a sophisticated new case management system which will permit more efficiencies to support OCA's mandated review of publicly funded services to children and will enable more strategic analysis of the office's ombudsman activities.

CHILD FATALITY REVIEW and PREVENTION INITIATIVES

Pursuant to C.G.S. 46a-13l(c), the OCA and Child Fatality Review Panel (CFRP) are tasked with reviewing the circumstances of the death of any child due to unexpected or unexplained causes in order to facilitate the development of prevention strategies, to address identified trends and patterns of risk, and to improve coordination of services to children and families in the state. The CFRP is comprised of multi-disciplinary professionals, and is currently co-chaired by the Child Advocate and an emergency-room pediatrician. The CFRP meets monthly at the Office of the Chief Medical Examiner (OCME). The OCA and CFRP continue to review the unexplained and unexpected deaths of all children in Connecticut and other cases sent to OCA by the OCME.

During the period of this annual report, **133** child fatality cases were reported to the OCA.

<u>73 Natural Child Deaths</u>: These child deaths primarily consisted of heart complications, cancer, children who are medically complex, medical complications from prematurity, and other acute illness. One natural case was classified Sudden Unexplained Infant Death (SUID). There were no child deaths classified as SIDS.

<u>21 Undetermined Child Deaths</u>: An undetermined death is a category used by the Office of the Chief Medical Examiner when upon the completion of an autopsy there are no findings of accident, disease, trauma, or obvious injury. Twenty of these deaths were infants (under one-year), and one child was 2 years old. Many of these babies were in sleep environments other than their crib such as an adult bed, chair or couch. Some babies had potentially harmful items in their sleeping environment such as blankets, pillows, wedges, and stuffed animals.

18 Accidental Child Deaths: This was the lowest number of children to die from accidents in over a decade. Four accidental deaths were infants who died from positional asphyxia (lay-over by an adult or sibling or suffocation), 2 children under the age of three died as a result of a car crash, 1 two-year old child was rolled over in a driveway, 2 children under the age of 10 were also passengers in cars, 2 teens died from a drug overdose, 1 youth drowned, 1 youth died from injuries in a boating accident, 1 youth died from injuries riding an ATV, 1 teen was a pedestrian hit by a car, 1 toddler died in a fire, and 1 child died from choking. The only teen driver killed in CT in 2014 did not have a driver's license and this youth was the only person in the car at the time of the fatal crash.

15 Child Homicides: Eight of the child homicides during the 2014-15 fiscal year were children under 3 years of age (4 boys and 4 girls). These 8 infants and toddlers sustained injuries associated with fatal child abuse (blunt force trauma and abusive head trauma), hyperthermia, choking, stabbing, and intentional drug overdose. Seven other homicides were teens 15-17 years of age (6 boys and 1 girl). Five of these teens died from injuries associated with gunshot wounds and two teen were stabbed to death.

6 Child Suicides: The youth that died from suicide were teens between the ages of 14-17: 4 girls and 2 boys. Five of the youth died from asphyxia from hanging, and one youth died from a gunshot wound.

The OCA, in consultation with the CFRP, published the following child fatality reports during this reporting period:

- Child Fatality Report: Infants and Toddlers July 31, 2014
  http://www.ct.gov/oca/lib/oca/final_oca_infant_toddler_fatality_report.pdf
- Shooting at Sandy Hook Elementary School (November 21, 2014)
  http://www.ct.gov/oca/lib/oca/sandyhook11212014.pdf
- Public Health Alert, Youth Suicide Prevention May 7, 2015
  http://www.ct.gov/oca/lib/oca/suicide_prevention_alert_final.pdf

OCA is a participant on the following committees, taskforce, and working groups focused on prevention efforts for child at risk of intentional and unintentional injuries/fatalities.

Suicide Prevention Initiatives
- American Foundation for Suicide Prevention Board
- Statewide Suicide Advisory Board
- Safe School Climate Coalition

Infant and Toddler Initiatives
- Maternal Child Health Coalition, Improving Birth Outcomes

- Children's Prevention Partnership
- Substance Exposed Infants Work Group
- Abusive Head Trauma Prevention Working Group
- Child Abuse Prevention/Safe Sleep Coalition

Youth & Teen Safety Initiatives

- Department of Motor Vehicles Commissioner's Advisory Committee
- CT Teen Driving Safety Partnership
- Trafficking of Persons Council
- Domestic Minor Sex Trafficking Committee
- Drug Endangered Children's Task Force

Other Prevention Efforts

- Board Member, National Center for the Review and Prevention of Child Deaths
- Governor's Task Force on Justice for Abused Children
- CT Violent Death Registry Advisory Board
- CT Academy of Science and Engineering– Family Violence Study Committee
- Multidisciplinary Team and Children's Advocacy Center Work Group

Child Fatality Review Panel Membership

- Sarah Eagan: Office of the Child Advocate
- Anne Mahoney/Brett Salafia: Office of the Chief States Attorney
- James Gill/Susan Williams: Office of the Chief Medical Examiner
- Seth Mancini: Department of Emergency Services & Public Protection
- Barbara Claire/Michael Schultz: Department of Children and Families
- Margie Hudson/Okeke, Chinedu: Department of Public Health
- Ted Rosenkrantz: University of CT Medical Center
- Tonya Johnson: CT Coalition Against Domestic Violence
- Michael Soltis: CT Children's Medical Center
- Kirsten Bechtel: Yale New Haven Hospital, Governor's appointment
- Jack Reed: Willimantic Police Department, Senate Pro Tempore appointment
- Alexandra Dufresne: Center for Children's Advocacy, Majority Leader of the Senate appointment
- Christopher Lyddy: Trauma Solutions, Minority Leader of Senate appointment
- Steven Rogers: CT Children's Medical Center, Minority Leader of the House appointment
- Majority Leader of the House: Vacant
- Speaker of the House appointment: Vacant

FACILITY BASED INVESTIGATIONS & ADVOCACY ACTIVITIES

DEPARTMENT OF CORRECTION (DOC)

While we are not alone in monitoring the conditions of care and confinement for adolescents in the adult correctional system, only OCA has the type of access to these youth that allows for a thorough examination of their experience when incarcerated. OCA's work within the adult correctional system began in 2005 following the suicide of a 16 year old boy at the DOC's Manson Youth Institution (MYI). At that time MYI housed more than 700 boys ages 14-20, both sentenced and pre-sentenced. CT has seen a significant decrease in the number of teenagers admitted to the adult prisons since the state legislature raised the age of juvenile jurisdiction from 16 to 18, fully effective July 1, 2012.

The population of youth in custody of the DOC, while fewer in number, are typically pre-sentenced and have extraordinary behavioral health, educational, and social needs. Despite a more youth-focused approach to corrections over the past several years, widely reported outcomes for youth who have experienced incarceration continue to be bleak with high rates of recidivism.

Manson Youth Institution (MYI) and York Correctional Institution (YCI)

The OCA continues to have a regular presence at both MYI and YCI, the two primary DOC facilities used for adolescents. OCA continues to monitor the conditions of confinement, including access to quality programming provided to the youth in custody. The OCA works closely with the DOC facility leadership and staff to discuss how youth can receive developmentally appropriate care and treatment in order to ensure their safety and well-being while incarcerated, as well as help to increase the chance of successful reintegration efforts back into the community. Over the past year, the OCA has witnessed fewer disciplinary infractions, improvement in participation in school, and administration's commitment to creating an environment that is more developmentally appropriate for the youth. In addition, the OCA meets regularly with DOC executive leadership to discuss progress within the facilities, as well as to advocate for additional resources and interagency collaborations needed to better serve this complex population.

An important collaborative initiative with the DOC involves OCA participating in a working group convened to examine existing DOC policies and procedures and offer recommendations to DOC administration for changes in policy that reflect current knowledge and best practices regarding youth in custody. At the invitation and encouragement of the facility wardens, the working group is co-led by OCA and UConn Correctional Managed Health Care. This past year Manson Youth created a housing program specifically for the youth population under the age of 18. OCA in collaboration with UCONN has been administering an interview tool developed by the multidisciplinary team, creating a framework to measure how the changes have affected the youth, what improvements have been made, and what areas still need intensive attention. Successful community reintegration upon discharge continues to be a critical area of concern with responsibility shared by multiple systems. OCA is committed to continued work with the DOC and others on behalf of these vulnerable youths.

DEPARTMENT OF CHILDREN AND FAMILIES

The OCA is the only independent state entity that has unfettered access to child-specific information regarding youth in state-run and state-licensed facilities. During the report period, OCA responded to numerous complaints regarding conditions in multiple child-serving institutions, alleging inadequate treatment planning and care for children with disabilities. The OCA conducted facility site visits where needed, issued records requests and participated in numerous quality assurance and review discussions to address findings and make recommendations for improved care to institutionalized children. The OCA conducted an extensive investigation into conditions within the Connecticut Juvenile Training School and Pueblo, catalyzed by a number of complaints received from state-agency employees knowledgeable about conditions in the facilities. The OCA met with state agency leadership and other policy-makers regarding OCA's findings and recommendations to ensure youth committed to the state for delinquent offenses receive the most appropriate care and rehabilitative treatment. The OCA offered public testimony to the legislature on several occasions during the 2015 session to inform lawmakers and the public regarding our relevant findings and recommendations.

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

The OCA continues its advocacy efforts to promote seamless transitions for hundreds of youth each year from child-serving health, mental health, educational, and developmental services to the corresponding adult systems of care and support. Young adults have unique needs that require developmentally focused services and supports. In addition, OCA has continued to monitor the conditions of care and treatment provided to some of Connecticut's most vulnerable and complex young people hospitalized at the DMHAS operated CT Valley Hospital. OCA has participated in some young adults' treatment planning meetings, and worked with community providers and other advocates to ensure that young adults have access to treatment and resources to allow them to be successful as they transition to community placements.

Connecticut Valley Hospital: Young Adult Unit and the Whiting Forensic Division

Over the previous two years, in response to OCA's reported concerns of overreliance on restrictive measures, quality of care, length of stay, and poor unit environmental conditions, DMHAS officials developed a program improvement plan to more effectively meet the needs of the young adult inpatients. Transition to community settings remains a challenge for some of the most vulnerable and complex young adults. OCA will continue to provide needed independent oversight and work to engage other stakeholders in advocating for an appropriate and accessible continuum of services for this vulnerable and underserved population.

OTHER SYSTEMIC INVESTIGATIONS

In September 2014, OCA co-sponsored the second annual statewide educational forum with the CT Interagency Restraint and Seclusion Prevention Initiative at Central Connecticut State University. The forum brought together national experts, consumers, and almost 500 participants to review strategies to prevent restraint and seclusion of children and adults.

In February 2015 OCA published an investigative report regarding the pervasive and inappropriate reliance on harmful restraint and seclusion interventions with young children who have disabilities. The investigation focused on elementary school age children who were subjected to repeated restraint and closed-door seclusion in their school programs. The report included a number of strategies and recommendations to prevent restraint and seclusion of children. The full report can be found at: http://ct.gov/oca/lib/oca/SECLUSION_AND_RESTRAINT_IN_CT_SCHOOLS_Final_Report.pdf

PUBLIC POLICY and LEGISLATIVE ADVOCACY

OCA submitted legislative testimony on over 25 matters during the 2015 session, providing legislators with expertise, experience and recommendations regarding diverse matters affecting children, including: reducing restraint and seclusion, preventing child fatalities, improving outcomes for the juvenile justice system, and increasing access to health services for children. The Office of the Child Advocate's mission includes providing education and training to stakeholders and the public regarding issues affecting children's welfare. OCA established a listserv during the previous fiscal year and has disseminated monthly newsletters, policy updates, disability rights advisories, and tips for caregivers regarding issues frequently brought to the OCA. Newsletters are also available via the OCA's website, and they provide brief updates on OCA's ongoing fatality review reports, community outreach and professional education programs. OCA regularly facilitates or participates in trainings in the community both for professionals and caregivers. Trainings included workshops for lawyers representing abused and neglected children, suicide prevention, special education, and training to community partners on the responsibilities of the OCA.

COMMUNITY PARTNERSHIPS, COMMITTEES, TASKFORCES, AND WORKING GROUPS

OCA meets regularly with policy-makers, human service professionals and law makers regarding strategies to improve access to critical support services for children and their families. OCA participates in numerous state taskforces and working groups for the purpose of advocating for system reform to better meet the needs of children.

OCA maintains an active role on:

- Office of Governmental Accountability Commission
- Family Support Council
- CT Behavioral Health Partnership Oversight Council and BHPOC subcommittee on Quality Access
- Department of Developmental Services Children's Services Committee
- Department of Children and Families /Judicial Branch Juvenile Justice Joint Strategic Plan Executive Implementation Team
- Commission on Racial and Ethnic Disparity in the Criminal Justice System
- CT Juvenile Justice Alliance Advisory Committee
- CT Keep the Promise Coalition/Children's Committee
- Children's Committee Results Based Accountability Report Card Working Group
- CT Interagency Restraint & Seclusion Prevention Steering Committee
- Children Exposed to Family Violence Task Force

OCA Advisory Committee

- *Senate Pro Tempore appointment: Shelley Geballe*
- *Speaker of the House appointment: Rudolph Brooks*
- *Majority Leader of the Senate appointment: Joel Rudikoff*
- *Minority Leader of Senate appointment: Catherine Cook*
- *Minority Leader of the House appointment: John Fenton*
- *Governor's appointment: Jeanne Milstein*
- *Majority Leader of the House: Vacant*

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