CONNECTICUT
Child Advocate

OFFICE OF THE CHILD ADVOCATE

2023-2024 ANNUAL REPORT

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

The mission of the Office of the Child Advocate (OCA) is to ensure that publicly funded agencies that serve children are accountable to the citizens and families of Connecticut and effectively care for the most vulnerable children. During the last fiscal year, OCA responded to individual complaints and requests for advocacy from individuals and families across the state. OCA investigated complaints that raised systemic concerns regarding the state-funded provision of care to children. OCA reviewed preventable child fatalities and issued public reports with recommendations to prevent child injury and death. OCA testified on dozens of legislative proposals seeking to advance the legal and human rights of children. OCA talked with families, advocates, and service providers throughout the state to better understand and respond to the needs of young children at risk for maltreatment, the educational needs of children with disabilities, and solutions to support children's mental health.

OCA Statutory Responsibilities

- Investigate complaints regarding services provided to children.
- Evaluate the delivery of services provided to children.
- Advocate on behalf of children in Connecticut.
- Review the circumstances of the unexpected or unexplained death of any child.
- 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.
- Publish biennially a comprehensive report regarding conditions of confinement for incarcerated youth.
- Publish an annual report regarding the activities of the OCA.

Current OCA Director and Staff

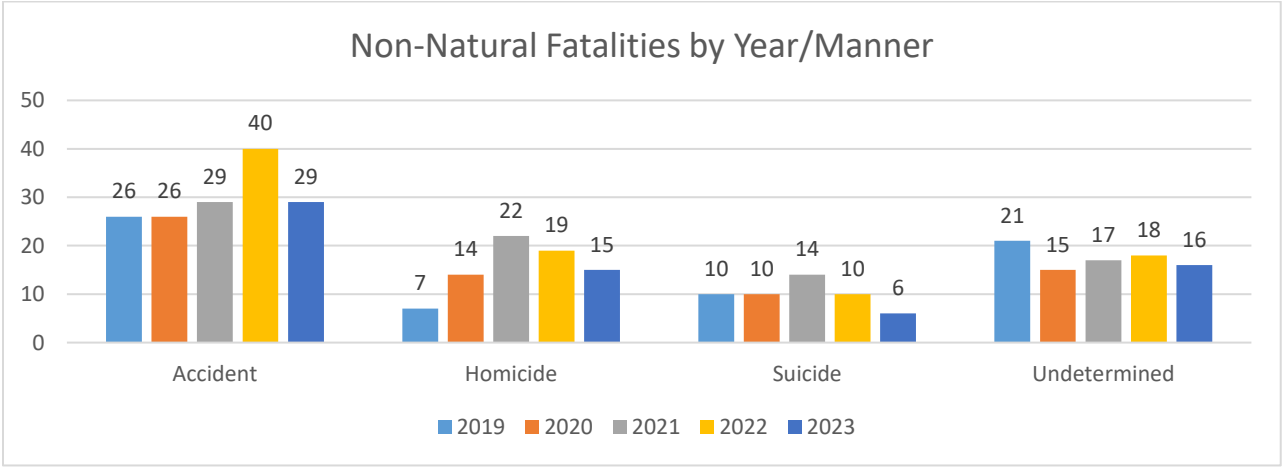
Sarah Healy Eagan, JD, Child Advocate
Christina D. Ghio, JD, CWLS, Associate Child Advocate
Virginia Brown, JD, Staff Attorney
Brendan Burke, MSW, Assistant Child Advocate
Julie McKenna, Human Services Advocate
Lucinda Orellano, Human Services Advocate
Heather Panciera, Assistant Child Advocate
Liz Stitler, LPC, Assistant Child Advocate

CHILD FATALITY REVIEW, JANUARY 1, 2023, TO DECEMBER 31, 2023

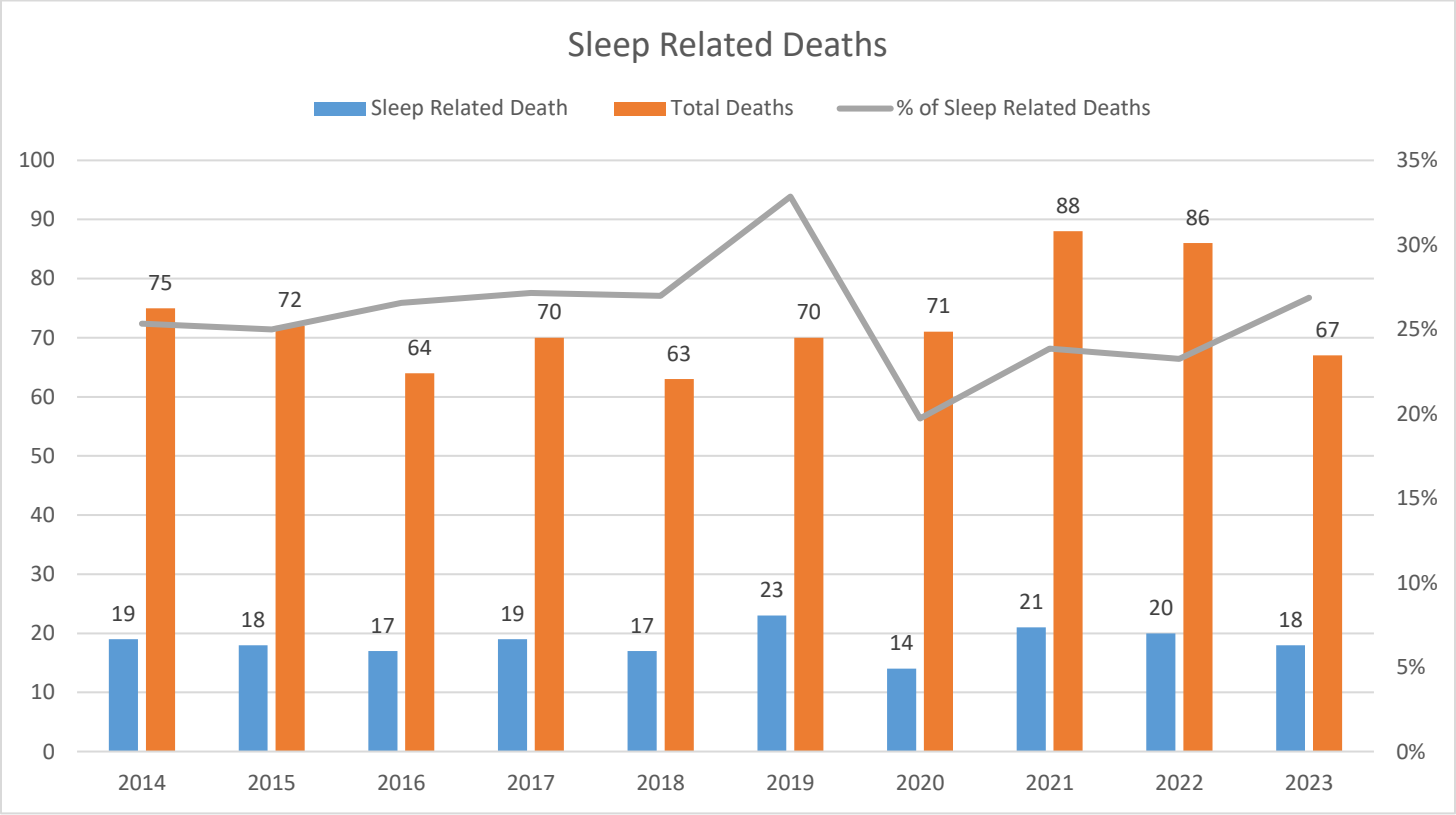
The Child Fatality Review Panel (CFRP) is statutorily tasked with reviewing the circumstances of the death of any child from unexpected or unexplained causes. The purpose of the state's fatality review process is to identify and report on patterns of risk to children and inform fatality prevention strategies. The CFRP is comprised of state and community agencies from multiple disciplines (medical, mental health, law enforcement, legal). The CFRP is currently co-chaired by State Child Advocate Sarah Eagan and Dr. Kirsten Bechtel, an emergency-room pediatrician at Yale New Haven Hospital. The CFRP is staffed by OCA with support from the Office of the Chief Medical Examiner (OCME).

In Connecticut all deaths reviewed by the CFRP are entered by OCA into the National Fatality Review–Case Reporting System, a secure, web-based, standardized case reporting tool. Connecticut is one of 47 states that participates in the national electronic child death review case reporting system. This centralized data collection system helps identify trends and patterns of child fatality in Connecticut and across the country, informing prevention efforts in Connecticut and throughout the United States. The National CFRP has developed a Child Dynamic Analysis and Statistics Hub (Child DASH), which supports Connecticut's child fatality prevention efforts, and facilitates greater data-sharing amongst prevention stakeholders.

OCME reports unexpected and untimely deaths of children to the OCA. From January 1, 2023, to December 31, 2023, 67 child fatalities were determined to be Accidents, Homicides, Suicides, or Undetermined. 2023 marked a significant decrease in preventable deaths of children, about 23% less than the 2 years prior.



Although there is variance year to year in total child deaths, CT persistently continues to see infants die from unsafe and modifiable sleep related causes, with numbers fluctuating from 17 to 23 infant deaths each year (a future kindergarten class of children). Over the last decade, over a quarter (25.6%) of the children that have died in CT from non-natural or unexpected causes had a sleep environment that was not consistent with safe sleep recommendations published by the American Academy of Pediatrics. These deaths are classified by the Medical Examiner as either Undetermined or Accidental manners of death.



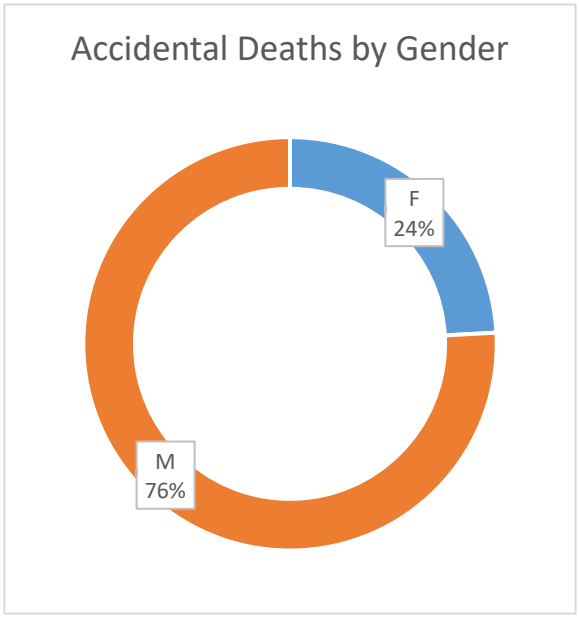
ACCIDENTAL DEATHS OF CHILDREN (29 TOTAL)

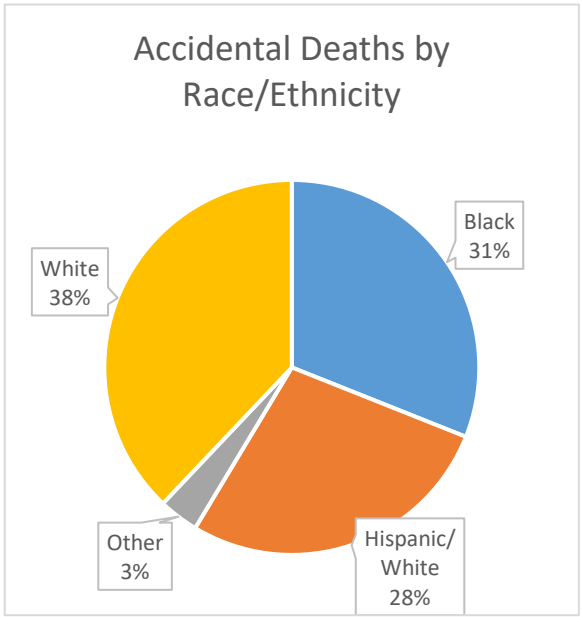
A death is ruled accidental when there is little or no evidence that the injury occurred from intent to harm. The accidental death rate for children in 2023 decreased 28% from the year prior. Children aged 13 to 17 years old (51.7%) make up a majority of this group, with motor vehicle crashes the primary cause of these accidental deaths.

In 2023, there were 5 deaths of children under age 1 classified as Accidents due to positional asphyxia, which is the insufficient intake of oxygen when breathing, most frequently the result of a compromised airway due to co-sleeping in an adult sleep space.

Older adolescents were most likely to experience an accidental death from a motor vehicle crash, with 15 such deaths occurring in 2023. Five children died due to accidental drowning in 2023. The OCA/CFRP is engaged in a pilot program with the National Center for Fatality Review and Prevention (NCFRP) to support enhanced surveillance of drowning which will inform future data collection efforts specific to drowning deaths.

For motor vehicle related accidents that resulted in a fatality, only on 1 occasion was the minor the driver of the vehicle. For the passengers, 5 were less than five years old, while the remaining 7 were older than 14. OCA regularly shares and discusses data and trends regarding the accidental deaths of children with injury prevention partners around the state and country to help inform public health prevention strategies.





Accidental Deaths

Average Age: 9.4
Median Age: 6.5

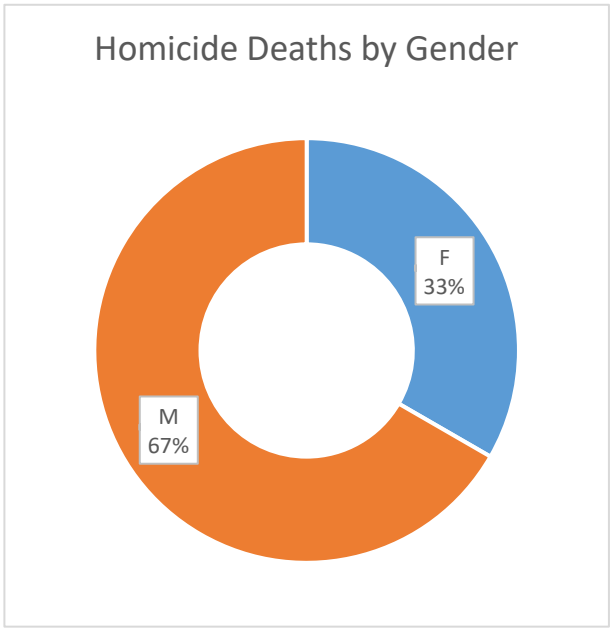
Cause

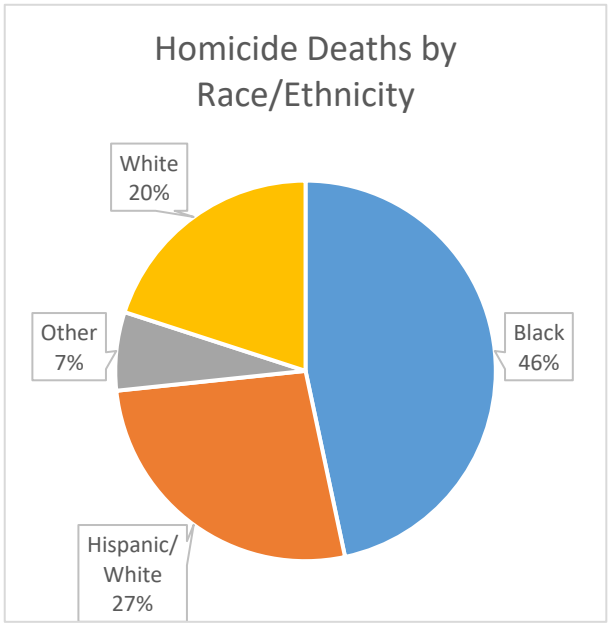
Motor Vehicle (Driver): 1
Motor Vehicle (Passenger): 12
Motor Vehicle (Pedestrian): 2
Drowning: 5
Positional Asphyxia/Overlay: 5
Acute Intoxication: 1
Smoke Inhalation: 1
Choking: 1
Fall: 1

HOMICIDES (15 TOTAL)

A death ruled a homicide is a death that was caused by the act of another, typically an intentional act. Most homicides of CT children in 2023 were the result of violence, either by firearm (7) or stabbing (1). In 40% of the homicide deaths, the perpetrator was identified as the caregiver of the child that died. Children of color were overrepresented in homicides, with 4 out of 5 victims being non-White, non-Hispanic. OCA strongly supports youth gun violence prevention efforts. OCA will continue to provide data and qualitative information to gun violence prevention partners to assist with collective efforts to eliminate these deaths.

- **UPDATE: Fentanyl intoxication continues to pose a risk for young children.** In 2023, two more children died of Fentanyl intoxication, bringing the total number of very young children in CT who have died from Fentanyl intoxication to 11 since 2020. Additionally, in 2023 there were 10 incidents reported to DCF due to suspicion of a child younger than 3 having ingested opioids due to abuse/neglect by a caregiver. First responders and/or health care professionals frequently administered Naloxone to these children, and they survived the ingestions. Even a trace amount of Fentanyl can be fatal to a young child if ingested. The OCA is co-chairing the newly established Accidental Ingestion Workgroup to ensure effective and easily accessible treatment options for caregivers with young children, expand naloxone distribution/training efforts, and build on safe storage messaging and intervention efforts.



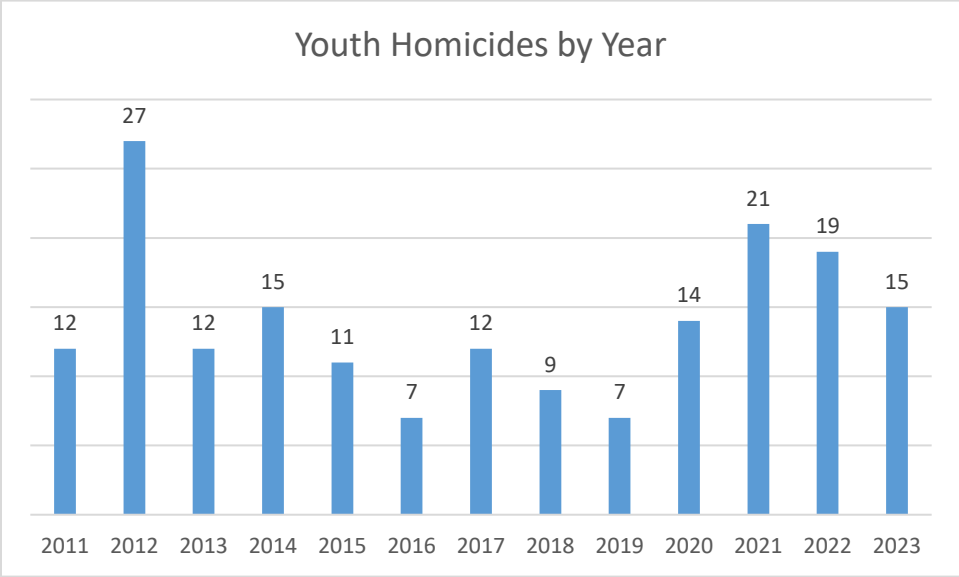


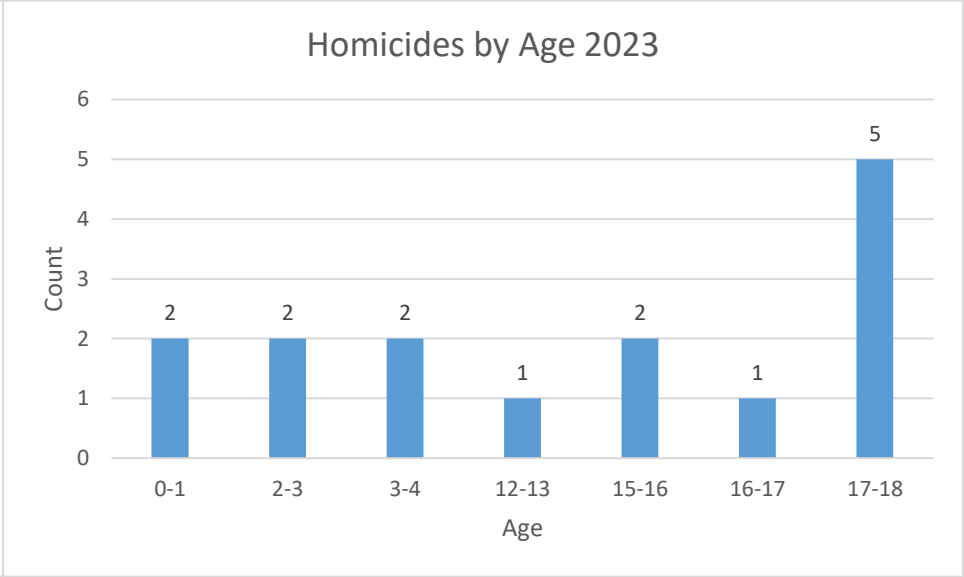
Homicide Deaths

Average Age: 10.7
Median Age: 12.9

Cause
Gun violence: 7
Stabbing: 1
Fentanyl Intoxication: 2
Other child abuse: 2
Drowning: 1
Domestic Violence related: 2

Caregiver perpetrator: 6

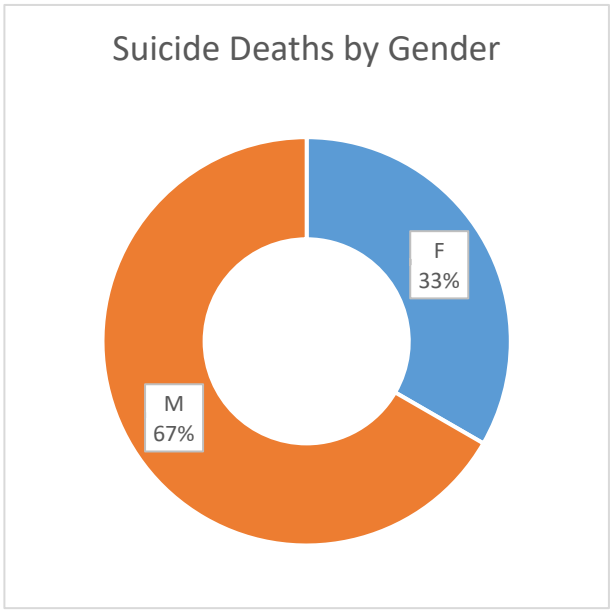


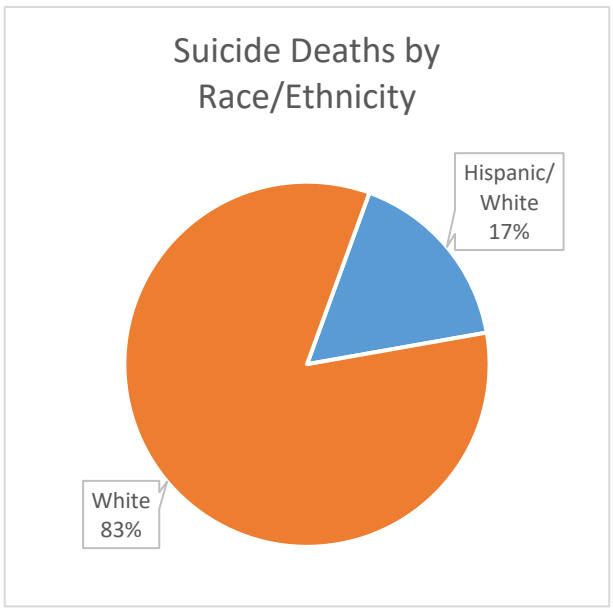


SUICIDES (6 TOTAL)

A death is ruled a suicide when the injury done to oneself is done with the intent to die. In recent years across the country, suicide has been the second leading cause of preventable death in children starting at age 10. Data presented by the Connecticut Department of Public Health consistently reflects that more than 15 children per day in CT seek treatment from a hospital emergency department for suicidal ideation or a suicide attempt.

The OCA participates in several working groups and stakeholder meetings aimed at suicide prevention and improving the children's mental health system.



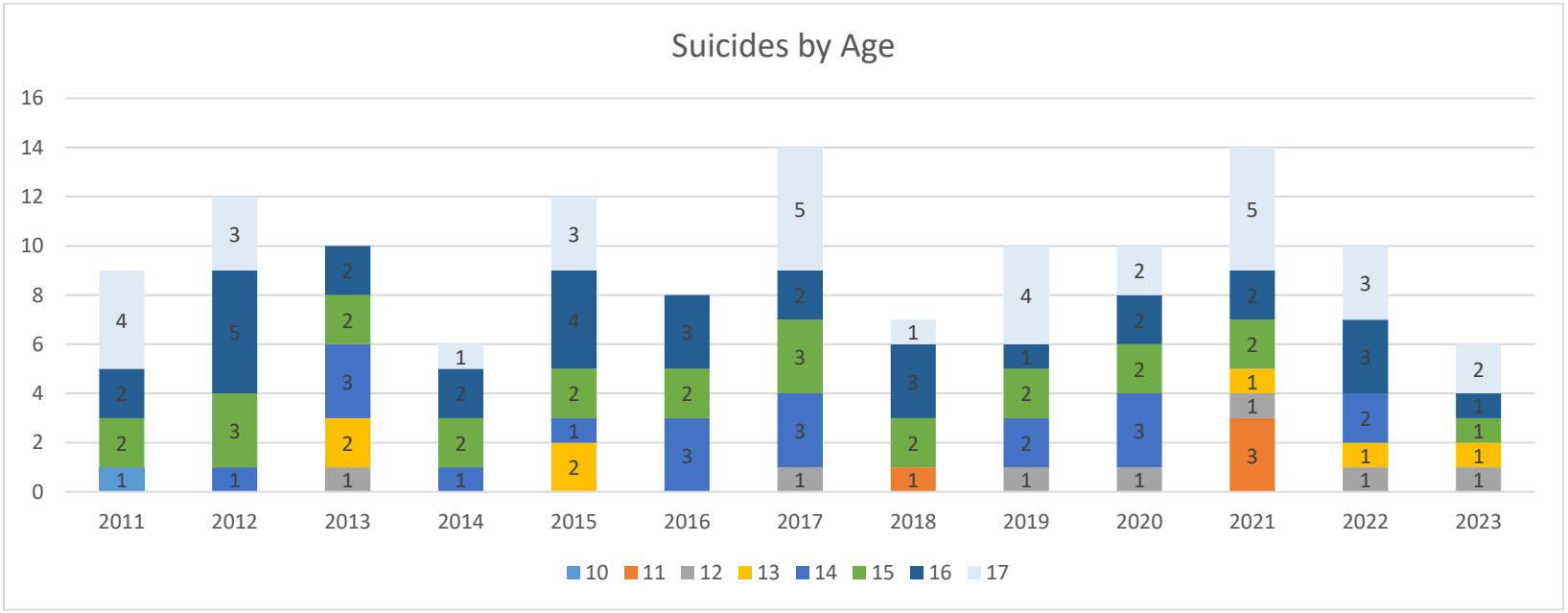


Suicide Deaths

Average Age: 15.4
Median Age: 16

Cause
Hanging/Asphyxia: 2
Gun shot wound: 3
Blunt Force Trauma: 1

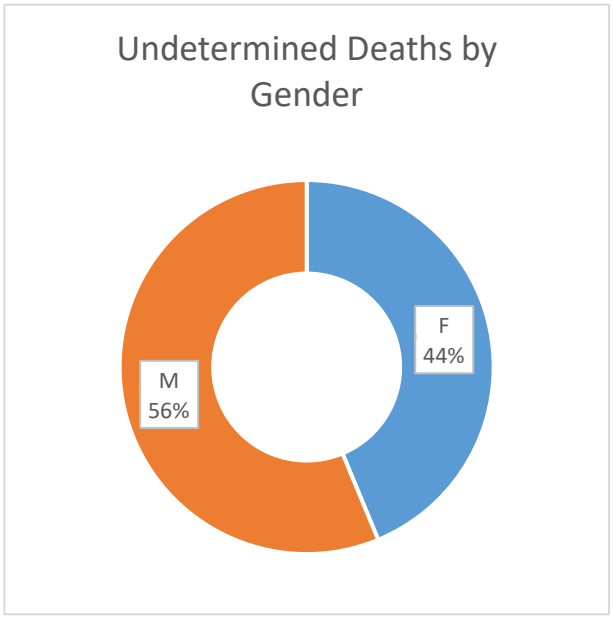
By season
Summer: 1
Fall: 3
Winter: 2

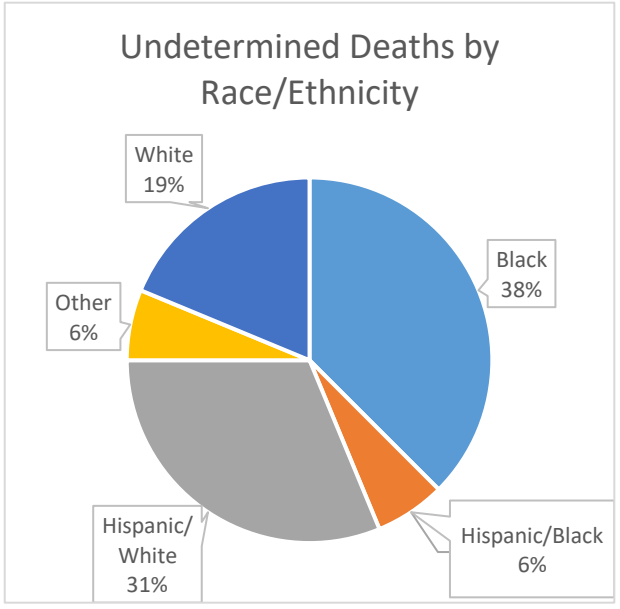


UNDETERMINED (16 TOTAL)

A death is ruled Undetermined when there is no sufficient degree of medical certainty to determine the cause of death. With Undetermined deaths, there is no sign of natural disease and there is no obvious injury such as you find in a Homicide or Suicide or Accident. These cases, *typically involving infants*, have gone through a rigorous examination by the Office of the Chief Medical Examiner. Most often case review identifies modifiable risk factors in the infant's sleep environment, such as the baby being in an adult sized bed, in an adult sized bed with other children, in their own sleep environment but with blankets, pillows, etc. These risk factors are typically referred to collectively as an "unsafe sleep environment." "Unsafe sleep environment" also includes the position of the infant: i.e., infant is placed prone (on their stomach) or on their side. Unlike Accidental deaths where unsafe sleep conditions are definitively established, autopsy and scene investigation may identify unsafe sleep risk factors such as those listed above, but positional asphyxia or lay-over is not conclusively determined.

In 2023, 94% of the Undetermined deaths were children less than 10 months old, with **87.5% of children having documented modifiable risk factor/s in their sleep environment**.





Undetermined Deaths*

Average Age: 3.8 months
Median Age: 3.3 months

Modifiable Sleep Environment Factor
Co-sleeping: 8
Adult sized mattress: 7
Cluttered sleep environment: 5

*A 16-year-old was also labeled as "Undetermined" however, not included in the above analysis given it is such an outlier.

Infant and Toddler Fatality Report

In July 2023, the Office of the Child Advocate and Dr. Kirsten Bechtel published the Infant and Toddler Fatality Report, which examined deaths of children under age 3 who died between January 2019 and August 2022. OCA reviewed data from several state agencies regarding children or families' receipt of benefits, services, or supervision prior to or at the time of the child's death.

Brief findings from Infant and Toddler Fatality Report

1. There were 97 children younger than 3 years old who died from non-Natural causes between January 1, 2019, and August 8, 2022, in Connecticut. Eighty-five of these children were younger than 12 months old, and the median age of a child at the time of death was 3 months old with a mean age of 5.5 months.

2. Unsafe sleep-related deaths remain the leading factor in preventable deaths of infants in Connecticut. Despite multi-agency efforts to reduce infant fatalities associated with unsafe sleep environments, Connecticut has seen no decline in such deaths over the last 10 years.

3. Children who died were disproportionately male (63%), and more than 50% of children were identified as Black, Hispanic, or both, consistent with national findings regarding Sudden Unexpected Infant Death (SUID) rates.

4. A review of state agency data shows:

- 81% of children who died were Medicaid enrolled but only approximately 50% received Women, Infants, and Children (WIC) Nutrition program benefits.
- 12.5% children/families received benefits or services from the Office of Early Childhood (OEC) within six months of the child's death.
- 7% of birth mothers were involved with a Department of Mental Health and Addiction Services (DMHAS) referred or licensed service within 6 months prior to the child's death.
- 13% of birth mothers had involvement with the Judicial Branch- Court Support Services Division (JB-CSSD).
- 26% of children lived in families that had a case open with the Department of Children and Families (DCF) at the time of death or a case open within the previous 12 months.

5. 83 of the child fatalities were investigated by DCF. Of those, 30 investigations (36.2%) led to a substantiation of a caregiver for Physical Neglect, Physical Abuse, and/or Medical Neglect.

6. Fentanyl intoxication in young children is a new development in child fatalities. 8 of the 97 (8.2%) children, ranging from 4 weeks old to 27 months old, died due to Fentanyl intoxication, a cause not previously documented within this age group in Connecticut.

Infant/Toddler Fatality Summit

In December of 2023, the Child Fatality Review Panel hosted a virtual summit to discuss the findings of the Infant and Toddler Fatality Report and had several national experts present their findings and research regarding infant/toddler fatalities, including:

- From epidemiology to etiology: using case review to inform biological mechanisms of SIDS/SUID;
- Community partnerships to reduce infant deaths from unsafe sleep;
- The impact of the opioid crisis on infants and toddlers; and
- Colorado Moms initiative: take-home naloxone for birthing parents and newborns.

During monthly meetings of the CFRP efforts continue to follow up on recommendations from the report/summit, including: strengthening the state's Safe Sleep public health campaign, strengthening of investments in early childhood supports and services, and promoting Fentanyl injury prevention.

The Child Fatality Review Panel has been in ongoing consultation with the Department of Public Health to develop an Infant Mortality Review Panel, as statutorily established, in CT. This panel will complement current child fatality review systems in CT in reviewing deaths of children less than age 1 and provide valuable resources in education and prevention efforts. The CFRP and IMR will be scheduling an Infant/Toddler Fatality Summit in the winter of 2024.

Fatality Report- Liam R.

In October of 2023, OCA released an investigative report examining the circumstances preceding the death by homicide of 2-year-old Liam Rivera on or about December 28, 2023, in Stamford, Connecticut. Liam had an open child protection case with DCF and the Superior Court for Juvenile Matters at the time of his death (he was under court-ordered Protective Supervision), and his father was on Adult Probation supervision by the Judicial Branch Court Support Services Division (JB-CSSD) due to a previous child abuse charge. Liam had an attorney and Guardian ad Litem appointed by the Office of the Chief Public Defender (OCPD) to represent him in the child protection case.

OCA's fatality investigation found agency staff at DCF and JB-CSSD did not comply with all relevant policies designed to ensure the safety of children and victims. OCA found that the appointed lawyer for Liam did not comply with statutory or contractual performance expectations for lawyers who represent children. OCA reviewed the adequacy of quality assurance structures across agencies. OCA issued several recommendations for systemic improvement including 1) improvement to DCF's case practice in "in-home" cases like Liam's, 2) the need to evaluate the impact of telework on DCF case practice, 3) the need to strengthen certain policies and quality assurance protocols at JB-CSSD to enhance supervision in cases where a child is a victim, 4) development of a legislative working group to consider structural

improvements to ensure reliable legal representation for children in child protection proceedings, and 5) strengthening the membership and oversight activities of the DCF Statewide Advisory Committee.

DCF, JB-CSSD, and the OCPD were cooperative with OCA's investigation. JB-CSSD met with OCA throughout this review, provided findings from its internal review, and took several remedial actions during the pendency of the investigation. DCF administrators and/or staff met with OCA on multiple occasions and shared with OCA a list of initiatives that it is undertaking to improve agency performance. The OCPD committed to ongoing work to strengthen legal services for children, including enhancing payment for assigned counsel to attrack and retain qualified lawyers and hiring social workers to support advocacy on behalf of represented children. OCA and the agencies worked cooperatively to pass reform legislation that implemented many of the recommendations from Liam's fatality review.

Fatality Report—Marcello M.

In February 2024, OCA released an investigative report examining the circumstances preceding the June 2023 death by homicide of 10 month old Marcello Meadows from Fentanyl and Xylazine intoxication. Marcello's family had an open child abuse/neglect case with the Department of Children and Families (DCF) until three weeks before his death. His mother had outstanding warrants for violation of probation, issued by the court shortly after Marcello's birth, which were served at the time of Marcello's death.

OCA found that though DCF and JB-CSSD provided supervision and referrals to community-based treatment, they did not comply with all applicable policies and procedures regarding risk and safety management, and there were areas of practice where more quality assurance activities were warranted. OCA also found deficiencies in the provision of clinical services to Marcello and his mother by a community provider. All state and local agencies were cooperative with OCA's investigation. JB-CSSD continues to implement recommendations from OCA fatality reports and enhance quality assurance activities, including creating a central audit system for certain supervision activities. DCF administrators meet regularly with OCA to review enhancements to its safety work with families and its quality improvement framework. OCA and DCF worked cooperatively to create the Ingestion Prevention working group described above.

Young Adult Fatalities Ad-Hoc Review

The OCA, in consultation with CFRP, conducted an Ad-Hoc review of young adults, ages 18-21, who died unexpectedly from January 1, 2018 through September 30, 2022 in CT. These findings were shared with colleagues and may have policy/practice implications for those working with this population.

Findings from Data

- 409 individuals aged 18 to 21 year olds died from preventable causes (Accidents, Homicides, or Suicides). 3 out of 4 individuals were male, and 2 out of 3 were White.
- Accidents (62%) were identified as the most common manner of death, with suicides (17%) and homicides (17%) accounting for the remainder.
- The leading cause of death was overdose, with 27% (n= 111) of 18 to 21 year olds dying from this cause. A majority of these individuals were found to have Fentanyl in their system upon autopsy.
- As age increased in this group, fatality rates also increased, with 21-year-olds accounting for nearly twice as many fatalities as 18-year-olds. This was most evident in rates of accidental deaths, with 21-year-olds nearly 2.25 times more likely to die by accidental means than 18 year olds.
- The most common age to suffer death by suicide was 19 years old, and they accounted for 36.7% of all suicides in this sample.
- CT State Department of Education was able to find educational histories on 287 of the young adults. Of this group, 62% graduated, 7% died while enrolled, 7% moved and there was no information as to their continuing education, and 5% transferred to a GED program.
- 43% of the individuals had prior involvement with DCF. Approximately one-third of individuals had been committed to DCF guardianship at some point during their childhood.
- 27 young adults had individual or family cases open with DCF at the time of the individual's death. Of the other 143 with previous DCF involvement, their involvement with DCF ended an average of 5.3 years (median of 3.5 years) prior to their death.
- Judicial Branch Court Support Services Divisions reported involvement with 36% of the group at some given time, not necessarily at the time of death.
- 25% of the individuals had both CSSD and DCF involvement during their lifetime.

Implications from Data

- Fatality data is consistent with research findings that correlate significant adverse childhood experiences, including child maltreatment and juvenile incarceration, with poor health and morbidity outcomes.
- Given leading manner/causes of death are overdose and suicide, data has significant implications for children's mental health initiatives, including ensuring access to suicide and substance use screening and early intervention.
- Fatality prevention strategies include improving services to support high need families, ensuring timely access to health/mental health/substance use treatment services for children and their caregivers, improving permanency and developmental outcomes for youth involved with the child welfare system, increasing access to housing supports for young adults, and ensuring that state agencies have coordinated strategies to support late adolescents/emerging adults.

Child Fatality Review and Panel (CFRP) Membership

Ex Officio Members	
Office of the Chief State's Attorney:	*Brett Salfia, Esq.*
Office of the Child Advocate:	*Sarah Healy Eagan, J.D. (Co-Chair)*
Office of the Chief Medical Examiner:	*Gregory Vincent, M.D.*
Emergency Services and Public Protection**:**	*Samantha Haynes*
Department of Children and Families:	*Susan Hamilton, MSW, J.D.*
Department of Public Health:	*Jody Terranova, DO, MPA*
Statutorily Appointed Members	
Pediatrician (by Governor):	*Kirsten Bechtel, M.D. (Co-Chair)*
Community Service Representative (by Speaker of the House):	*Pina Violano, Ph.D*
Social Work Professional (by Senate Minority Leader):	*Thomas C. Michalski, Jr. LCSW*
Injury Prevention (by House Minority Leader):	*Steven Rogers, M.D.*
Attorney: (by Senate Minority Leader)	*vacant*
Psychologist:	*Elizabeth Corley, Psy D.*
Law Enforcement:	*Sgt. Ivys Arroyo*
Appointed by CFRP Membership	
Neonatologist:	*Ted Rosenkrantz, M.D*
Intimate Partner Violence Professional:	*Megan Scanlon*
Pediatrician**:**	*Michael Soltis, M.D.*

FACILITY OVERSIGHT

The OCA staff, within available resources, may visit 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 facility oversight priorities are determined by a) concerns reported to the Office, b) the vulnerability of children and youth served by the program, and c) legislative mandates.

OCA MONITORING OF CONDITIONS OF CONFINEMENT FOR DETAINED AND INCARCERATED YOUTH

Connecticut General Statutes § 46a-13*l* was amended in 2016 to require the OCA issue a biennial 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, which included detailed findings and recommendations for system improvement. OCA's report found that certain youth were held in solitary confinement and many youths in the adult correctional system lacked access to appropriate education, rehabilitation, and mental health treatment services. Following the publication of OCA's report, the U.S. Department of Justice Civil Division (DOJ) launched its own investigation into conditions for minor boys confined at the Manson Youth Institution (MYI), run by the Department of Correction. The DOJ investigation concluded in December 2022, finding conditions at MYI violated minor boys' constitutional rights to adequate care, treatment, and education. The DOJ recently finalized a settlement agreement with the Department of Correction, requiring sweeping reforms to how the agency treats, houses, rehabilitates, and educates minor boys.

During the last year, OCA participated in the state's Juvenile Justice Police and Oversight Committee, and OCA is working with members of the Committee to improve re-entry services for incarcerated youth, increase access to gender responsive programming, and ensure oversight and accountability for state agencies serving incarcerated children.

OCA staff continue to monitor conditions of confinement for incarcerated youth aged 15 to 22, meeting with youth, staff, and agency administrators at the DOC and JB-CSSD. OCA's updated report on conditions of confinement for youth aged 15 to 22 in DOC facilities will be published in the Fall of 2024. This report will include information regarding conditions for 18- to 21-year-olds in restrictive housing settings.

During the course of OCA's investigative activities, OCA met a youth who presented with significant unmet mental health treatment needs. Upon review of the boy's records, OCA learned that he had been committed to the guardianship of DCF due to concerns of child abuse or neglect and was diagnosed with a serious mental illness. He was initially placed in a state-licensed youth shelter where he allegedly engaged in an altercation with another youth, resulting in criminal charges and his subsequent incarceration. When OCA met with the youth, he had been in the prison for many months, was not leaving his cell to attend school and

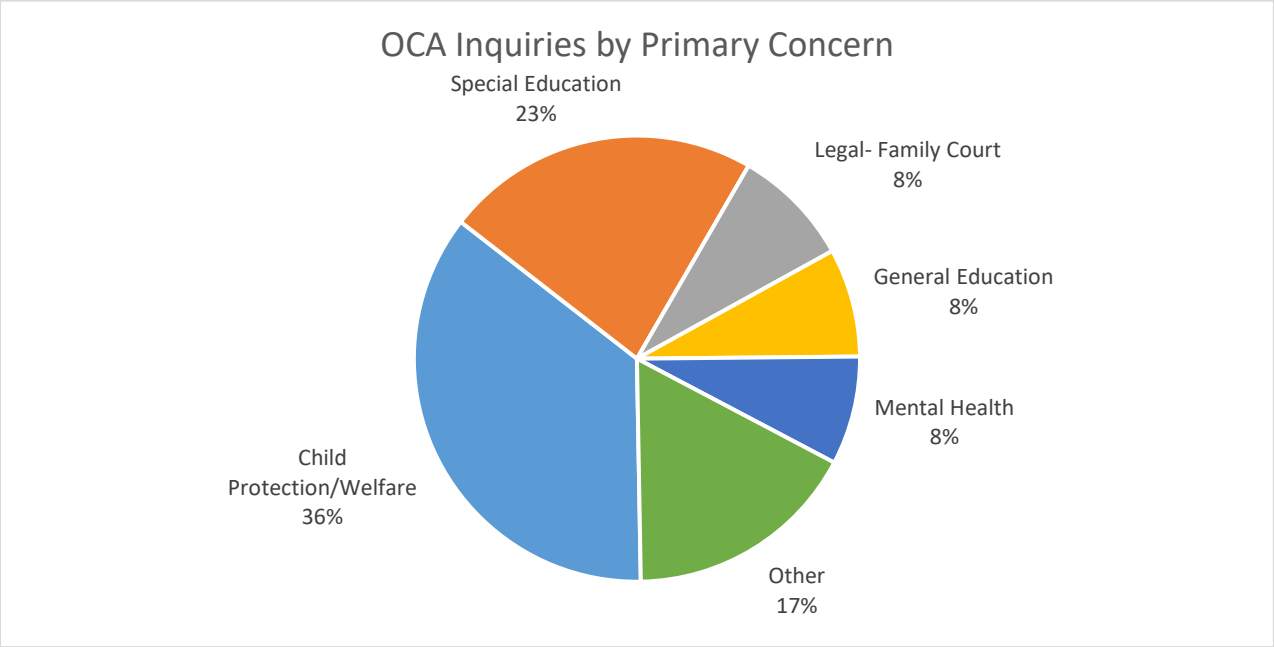
presented as in need of significant mental health interventions. OCA worked with the youth's state-appointed lawyer and advocated for the youth's transfer to a treatment setting for children.

OCA OMBUDSMAN & SYSTEMIC ADVOCACY

Between July 1, 2023, through June 30, 2024, the OCA responded to **nearly 400** individual and systemic complaints regarding the provision of state-funded services to children. The OCA is contacted by family members, providers of health/mental health services, school personnel, foster parents, attorneys, legislators, and employees of public agencies, as well as youth who are seeking assistance. The OCA provides all callers with guidance on how to navigate the state's service systems. In the most urgent cases and where the individual complaint raises a systemic concern, OCA undertakes additional investigation and advocacy efforts, which may include record reviews, program visits, and advocacy with both state and local agencies to ensure the needs of children are appropriately met.

Issues addressed and/or investigated by the OCA this year included:

- Safety or permanency concerns for children who have experienced abuse/neglect.
- Lack of access to appropriate special education and related services for children with disabilities in the least restrictive environment.
- Lack of timely and available mental health treatment services across the continuum, from outpatient to in-home to residential treatment.
- Children on discharge delay in hospital emergency departments or hospitals who could not access recommended levels of care, including in-patient, psychiatric residential treatment facilities, foster care, or community-based services.
- Children awaiting appropriate mental health services and/or foster care, who become justice involved while waiting.
- Lack of timely and available services for children with intellectual and developmental disabilities.
- Children experiencing bullying and harassment.



In its efforts to address systems issues arising from these concerns, OCA meets 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, Early Childhood, Mental Health and Addiction Services, Correction, Education, Public Health, and the Office of the Chief Public Defender, Office of the Chief Medical Examiner, the Judicial Branch Court Support Services Division, as well as the CT General Assembly.

EDUCATIONAL ADVOCACY

Many of the community complaints received by the OCA involve educational concerns. All complaints received by the OCA are kept confidential and reviewed by OCA staff regularly. The OCA is authorized to investigate individual complaints that raise a concern of a systemic problem. Some of OCA's investigation activities result in the OCA issuing an Investigatory Report, an Issue/Policy Brief, and /or a Letter of Concern, which are also provided to the Connecticut State Department of Education for further investigation and corrective action, where applicable. OCA encourages local school districts to develop remedial action plans wherever possible to address system concerns uncovered during the review. Where a local district provides a remedial action plan, OCA includes this plan on its website.

INDIVIDUAL EDUCATIONAL PROGRAMMING REVIEWS

During the 2023-2024 fiscal year, the OCA assisted families in accessing disability support services, summer programming, early intervention services, and delivery of services in the least restrictive environment. During its reviews, the OCA participated in Planning and Placement Team (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. In matters concerning children who were denied a free appropriate public education ("FAPE") that could not be resolved, the OCA filed administrative complaints with the Connecticut State Department of Education ("CSDE").

> *The OCA received an intake complaint from a family with concerns about a young student in the second grade who was receiving special education and related services in her public school district. In accordance with her IEP, the student relied on hands-on materials, hand-under-hand assistance in most areas, physical prompts, and manipulative objects to meet goals and objectives. The IEP also required a multi-sensory integrated approach. She also required related services. Despite those needs, when the student was hospitalized, the district only offered to provide virtual tutoring for the student's educational programming. The OCA's review concluded that it was not possible to implement her IEP via virtual tutoring in a way that would allow her to participate in the general education curriculum or make progress toward meeting the goals and objectives in her IEP, as is legally required. Given the student's high level of need, she could not make progress without those related services. In addition, while hospitalized for well over one month, she received no educational services during that time, and the district did not recommend any compensatory educational services. The OCA filed a complaint on the child and family's behalf with the State Department of Education, which resolved the matter in the child's favor and ordered corrective action.*

SYSTEMIC EDUCATIONAL REVIEWS/INVESTIGATIONS AND ADVOCACY

During this reporting year, the OCA conducted systemic reviews/investigations of multiple public-school districts and privately run publicly funded programs that provide special education instruction. Investigations addressed issues concerning educational administration and programming, Title IX compliance, Title VI language-based discrimination, and exclusionary discipline and disproportionate impact on children of color. All the OCA's systemic educational reviews/investigations resulting in the issuance of a formal OCA Report, Letter of Findings, and/or Program Concern are available on the OCA website.

The OCA, in partnership with Disability Rights of Connecticut (DRCT), concluded a two-year investigation into High Road Schools, private-equity owned group of eight state-approved private special education programs (APSEPS). In conducting this investigation, OCA and DRCT examined the programming provided to students with disabilities placed by their home school district to receive their special

education services at High Road schools and the state and local oversight of such programming. OCA and DRCT concluded that many of the students at High Road Schools were underserved both in terms of educational planning and service delivery. The investigation revealed widespread student disengagement and chronic absenteeism across High Road locations, failure to adequately assess and support students' educational needs through individualized service delivery, alarming deficiencies in the number of certified special education teachers and other credentialed educational staff working with children and systemic failure to ensure and/or document that staff had undergone employment checks and criminal and child welfare background checks. In addition, OCA/DRCT investigation revealed significant deficiencies with respect to the oversight and monitoring by CSDE and the LEAs of services to these students—disproportionately low-income children of color. Additionally, the investigators identified systemic violations of Title II of the ADA, Section 504 of the Rehabilitation Act, and the Individuals with Disabilities Education Act. Based on the deficiencies identified during its investigation and lack of LEA oversight, the OCA and DRCT filed a joint complaint with the Department of Justice against four Districts included in its investigation.

The OCA, in partnership with DRCT, also began an investigation into certain private special education facilities located outside of Connecticut where Connecticut students are receiving special education and related services. Its investigation is primarily focused on educational programming and service delivery and LEA and CSDE oversight and monitoring. This investigation is expected to conclude in late 2024.

ADVOCACY FOR CHILDREN WITH UNMET MENTAL HEALTH TREATMENT AND DISABILITY SUPPORT NEEDS

Many calls to the OCA involve the unmet needs of children with mental health disorders or developmental disabilities. Expressed concerns may be specific to child and family safety, lack of treatment options, the adequacy of special education services being provided, or lack of access to in-home or community-based services. OCA frequently advocates for children with unmet mental health needs to assist the family with obtaining mental health services at the appropriate level of care.

OCA received a concern from a provider regarding a child with acute mental health needs who was in need of out of home therapeutic treatment. The child had been adopted through DCF and was experiencing significant behavioral challenges related to her disabilities including Intellectual Disability, Autism, and Reactive Attachment Disorder. She experienced multiple hospital admissions and unsuccessful discharges. Because the child's mental health needs could not be met with services available in the community, OCA advocated for the child to receive treatment in a therapeutic residential setting and this was ultimately obtained. In addition, OCA identified that the child's adoption was not approved as a subsidized adoption, though it appeared that it should have been. Without a subsidized adoption, the child was not covered by

HUSKY insurance. OCA provided guidance to the parent to seek review of the adoption decision and DCF modified the adoption to be a subsidized adoption, allowing the family to apply for and obtain HUSKY.

In 2023, OCA worked to support the state's new Transforming Children's Behavioral Health Policy and Planning Committee (TCB), which will evaluate the children's mental health services delivery system, establish strategic and measurable goals, and make annual recommendations to the legislature to support improved access to services for children and families. The TCB is codified in Public Act 23-90. The statute specifically requires the TCB to address the needs of chronically underserved children such as children who are justice-involved and children with developmental disabilities. OCA continues to participate in the TCB and advocate for a continuum of care for all children with mental health needs.

OCA is frequently contacted regarding children with intellectual disability and/or Autism. OCA has identified this group of children as particularly vulnerable and in need of access to a continuum of care and treatment services.

OCA received a citizen complaint regarding the planned closure of a DDS-licensed group home. Three children were placed in the group home at the time. All of them had intellectual disability, Autism, and significant behavioral health needs. All were committed to DCF. The provider could no longer operate the group home and DDS no longer wanted to license the group home, but the children still needed round the clock level of care. There was no other existing treatment setting in the community to which the children could be moved. Over the course of months, OCA advocated for DCF to license the children's group home, keep the staff, and avoid disrupting the children. Ultimately, DCF agreed to license the group home and identified a provider to take over the group home. Unfortunately, despite best efforts by many involved, the children still experienced disruption and loss of staff with whom the children had relationships, in large part due to lack of adequate resources.

OCA continues to be concerned about the lack of services available for children with intellectual and developmental disabilities, from community-based services to group home levels of care. OCA testified to the legislature regarding the unmet needs of children with intellectual and developmental disabilities, including children with Autism, and the efforts needed to ensure services are available to all children who need them across Connecticut. OCA continues to meet with DCF and DDS to advocate for the state to develop development of a continuum of care that can meet the needs of children and young adults with intellectual and developmental disabilities.

In November 2023, the OCA published an investigative report examining circumstances preceding and following a serious incident in a DDS licensed group home (Community Living Arrangement) that involved a minor youth who was committed to DCF and a young adult woman who is a DDS client. The matter was originally brought to the OCA by a first responder due to concerns of supervision of the individuals in the group home. OCA's report included an examination of the state's framework for ensuring safe and high quality care for intellectually/developmentally disabled children and adults in DDS licensed CLAs. OCA found that while progress has been made by DDS and DSS towards addressing concerns about client safety in community group homes previously identified by the Inspector

General for the U.S. Department of Health and Human Services, serious concerns remain regarding resources and oversight to support individuals with intellectual and developmental disabilities in these settings. OCA's report also found deficiencies with DCF's case planning and care for the minor child involved in the incident, and the quality of legal representation for the minor child. DDS, the Department of Social Services, DCF, and the Office of the Chief Public Defender provided feedback and response to the findings and recommendations. DDS and DSS shared new plans and new staff that will work to address incidents involving Medicaid beneficiaries in DDS licensed settings.

CHILD WELFARE ADVOCACY AND ACTIVITIES

The OCA responds to individual complaints about children involved with DCF, providing advice to callers and following up with DCF administrators regarding allegedly unmet needs of children for services, permanency, or protection. The OCA meets regularly with the DCF Executive Team to review child fatality/critical incidents involving children recently involved with or under the care/supervision of DCF, quality assurance data regarding OCA's child protection activities, foster care, and other systemic issues affecting children and youth. OCA reviews DCF systems data regarding core practice areas: safety, permanency, and wellbeing.

> *OCA was contacted by a government official concerned about two boys who were involved in the juvenile justice system and had identified mental health needs, one of whom had been deemed not competent by the court. The caller reported concern about conditions the children were living in, the parent's ability to meet the needs of her children, and the need for services for the family. DCF was already involved with the family. OCA contacted DCF to advocate for services to meet the complex needs of the parent and family. Over time, despite DCF's efforts to keep the family together with support and services, most of the children were removed from the parent's care. One of the children was seven years old, non-verbal and intellectually disabled with significant medical needs, including the use of a G-tube for feeding. Upon removal, she was brought to the emergency room to address concerns related to the G-tube. When she was ready for discharge, DCF did not have a placement available for her. She was socially admitted to the hospital in March, where she remained until July when a foster home was located for her. Throughout her hospitalization, OCA advocated for speedy identification of an appropriate foster home, family visitation in the hospital, infusion of services to engage and support the child during hospitalization, and educational services. After the school district proposed tutoring, which would be provided virtually, OCA filed a complaint with the State Department of Education due to the inadequacy of the educational services being provided to the child. The State Department of Education found that the district failed to provide the child with Free Appropriate Public Education and has required that the district take corrective actions.*

In September 2023, the OCA published an investigative report on conditions for children in state-licensed shelters, called STAR homes. The STAR homes maintain temporary custody of children who have been abused and neglected and cannot remain with their families. OCA found that many children in the STAR homes have significant child welfare histories and unmet mental health treatment needs. OCA

advocated with policymakers for increased oversight of the STAR homes as well as improved resources to meet the permanency and treatment needs of the children. In early 2024, DCF announced several changes to improve services and supports for children in shelter care, and to increase treatment options for children. OCA continues to work with legislators, DCF, and policymakers to address recommendations contained in the OCA's 2023 report.

In 2024, OCA worked cooperatively with DCF to draft and pass new legislation that will strengthen membership and oversight activities of the DCF Statewide Advisory Committee and improve transparency and accountability for the state's child welfare system. OCA is working with the Office of the Chief Public Defender to improve delivery of legal services to children in child protection proceedings. The OCPD recently announced its intention to hire twenty social workers to support the legal representation of children in child protection proceedings.

COMMITTEES-TASK FORCES-COUNCILS

OCA participates in multiple taskforces and working groups as part of our systemic advocacy efforts.

PREVENTION	INFANT & TODDLER	EDUCATION	CHILDREN'S HEALTH & WELL-BEING	TEEN/ADOLESCENT SAFETY	JUVENILE JUSTICE
Accidental Ingestion Workgroup	Maternal Child Health Coalition	CT Language Access/Equity Strategic Partnership Workgroup	Transforming Children's Behavioral Health Planning and Policy Committee	Suicide Advisory Board	Juvenile Justice Policy and Oversight Committee (JJPOC)
National Child Fatality Review Case Reporting System	CT Perinatal Quality Collaborative	Title IX Compliance Toolkit Workgroup	Children's Behavioral Health Plan Implementation Advisory Board	Commissioner's Advisory Committee (DMV)	Incarceration subcommittee (JJPOC)
Interagency Restraint Prevention Partnership	Substance Exposed Pregnancy Initiative of CT (SEPI-CT)	School Discipline Collaborative	Autism Spectrum Disorder Advisory Council	CT Teen Driving Safety Partnership	Education Workgroup (JJPOC)
Alcohol and Drug Policy Council	Alcohol/Drug Policy Council	U.S. Attorneys' Disability/Educational Rights Coalition Meetings	Child Support Guidelines Commission	Trafficking of Persons Council	Suspension and Expulsion Workgroup (JJPOC)
Statewide Epidemiological Outcomes Workgroup	OEC Quarterly Meetings	CT School Climate Standards and Bullying Complaint Form Subcommittee	Finding Words Trainer/Advisor	Regionalized Human Trafficking Recovery Taskforce	
		CSDE Special Populations Roundtable	Governor's Task Force on Justice for Abused Children		
		Gender/Transgender in Education Working Group			

TRAININGS

This past year OCA provided several trainings 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.