OFFICE OF THE CHILD ADVOCATE

ANNUAL EVALUATION BY OCA ADVISORY COMMITTEE

165 Capitol Avenue, Ground Floor

(860) 566-2106

1-800-994-0939

www.ct.gov/oca

OCA Director and Staff

Sarah Healy Eagan, JD, Child Advocate
Christina D. Ghio, JD, CWLS, Associate Child Advocate
Virginia Brown, JD, Staff Attorney
Heather Panciera, Assistant Child Advocate
Brendan Burke, MSW, Assistant Child Advocate
Maria Cruz, Ed.D., Assistant Child Advocate (retired)
Julie McKenna, Human Services Advocate
Lucinda Orellano, Human Services Advocate
Faith Vos Winkel, MSW, Assistant Child Advocate (retired, temporary worker)

Summary of Advisory Committee Evaluation

Section 46a-13r of the Connecticut General Statutes establishes the role and responsibilities of the Advisory Committee to the Office of the Child Advocate, whose members are appointed by the Senate and House leadership of both parties, and the Governor. A key role of this Committee is to provide an annual evaluation of the effectiveness of the Office of the Child Advocate (OCA).

Part 1 of this Annual Evaluation sets out the critical and unique responsibilities of the OCA, and the role of this Advisory Committee. Part 2 summarizes OCA's activities since June 2022 through 2023. In Part 3 is this Committee's written evaluation of the OCA's effectiveness. We unanimously conclude OCA's performance has been stellar, particularly given its current staff resources, and make two recommendations to further enhance the effectiveness of this essential Office in our state government:

a) To provide funding for two additional position within OCA – one devoted to the time-intensive and mandated task of reviewing the facilities and procedures of all places in which juveniles are placed by an agency or department and preparing an in-depth report on the conditions of confinement for the Committee on Children and the other to focus on child injury/fatality prevention and related systems investigations; and

b) To amend state law to conform OCA governance to that of other state government accountability offices in Connecticut to assure its independence, as required by Section 46a-13k(b) of the General Statutes.

PART 1 - Responsibilities of the Office of the Child Advocate and its Advisory Committee

OCA's Creation and Mission. The Office of the Child Advocate (OCA) was created in 1995 (Public Act 95-242) to serve as an independent voice for children rather than an administrator of programs. It was subsequently placed within the Office of Governmental Accountability (OGA) and, in 2016, its administrative functions transitioned to the Department of Administrative Services' SMART units

The OCA monitors and evaluates public and private agencies that are charged with the protection of children, and reviews state agency policies and procedures to ensure they protect children's rights

and promote their best interest. Committed to ensuring that *all* children receive the care and supports that they need, OCA continues to shine light on the needs and circumstances of Connecticut's children, working constantly to bring about identified, necessary changes for children and families. 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, distribution to relevant legislative committees, and through the OCA website (www.ct.gov/oca/).

OCA's Statutory Responsibilities. Over these past nearly 30 years, the General Assembly has tasked OCA with an increasing number of duties and responsibilities as set out in Sections 46a-13*l* of the General Statutes. Its duties are expansive, spanning investigation and advocacy on behalf of an individual child and providing training and technical assistance to attorneys representing children to identifying broader systemic problems in Connecticut's child-serving state agencies and state-funded entities, then recommending necessary changes to address identified deficiencies and improve child welfare policy.

Because this Committee is charged with evaluating OCA's effectiveness, we set out in full its thirteen specific duties and responsibilities as mandated by the General Assembly in Sections 46a-13*l* (a) of the General Statutes:

> "The Child Advocate shall:
>
> (1) Evaluate the delivery of services to children by state agencies and those entities that provide services to children through funds provided by the state;
>
> (2) Review periodically the procedures established by any state agency providing services to children to carry out the provisions of sections 46a-13k to 46a-13p, inclusive, with a view toward the rights of the children and recommend revisions to such procedures;
>
> (3) Review complaints of persons concerning the actions of any state or municipal agency providing services to children and of any entity that provides services to children through funds provided by the state, make appropriate referrals and investigate those where the Child Advocate determines that a child or family may be in need of assistance from the Child Advocate or that a systemic issue in the state's provision of services to children is raised by the complaint;
>
> (4) Pursuant to an investigation, provide assistance to a child or family who the Child Advocate determines is in need of such assistance including, but not limited to, advocating with an agency, provider or others on behalf of the best interests of the child;
>
> (5) Periodically review the facilities and procedures of any and all institutions or residences, public or private, where a juvenile has been placed by any agency or department;
>
> (6) Recommend changes in state policies concerning children including changes in the system of providing juvenile justice, child care, foster care and treatment;

(7) Take 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;

(8) Provide training and technical assistance to attorneys representing children and guardians ad litem appointed by the Superior Court;

(9) Periodically review the number of special needs children in any foster care or permanent care facility and recommend changes in the policies and procedures for the placement of such children;

(10) Serve or designate a person to serve as a member of the child fatality review panel established in subsection (b) of this section;

(11) Take appropriate steps to advise the public of the services of the Office of the Child Advocate, the purpose of the office and procedures to contact the office;

(12) Prepare an in-depth report on conditions of confinement, including, but not limited to, compliance with section 46a-152, regarding children twenty-one years of age or younger who are held in secure detention or correctional confinement in any facility operated by a state agency. Such report shall be submitted, in accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to children not later than March 1, 2017, and every two years thereafter; and

(13) Present to the advisory committee, established pursuant to section 46a-13r at least three times each year, a report on the goals of and projects undertaken by the Office of the Child Advocate, within available appropriations, that are consistent with the responsibilities of the Child Advocate."

Child Advocate's Responsibility in Child Fatalities. As noted above, the Child Advocate is a member (and co-chair) of the Child Fatality Review Panel, established by Sections 46a-13*l* (b)-(h) of the General Statutes and charged with reviewing "the circumstances of the death of a child placed in out-of-home care or whose death was due to unexpected or unexplained causes 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." To enable this review, the Child Advocate staffs the fatality review when a child dies due to unexpected or unexplained causes to identify trends and patterns of risk, facilitate development of prevention strategies, and improve the coordination of services for children and families in the state. The Child Advocate also is required each year, by Section 46a-13s of the General Statutes, to submit a report "regarding the causes and rates of child fatalities in the state" to the Committees on Children and Education.

OCA's Tools. Recognizing OCA's unique and critical role in our state government, the General Assembly granted this Office, through Sections 46a-13m through 46a-13o of the General Statutes, critical legal tools to assure that it has access to all the information it needs to investigate and monitor the work of child-serving state agencies and state-funded entities, including the right to inspect and copy otherwise confidential documents and records, to issue subpoenas and seek judicial

enforcement of them if needed, and to intervene in or commence legal action on behalf of any child in any proceeding in any forum. Further, in Section 46a-13n(b) of the General Statutes, the General Assembly afforded whistleblower protection to any employee of a state or municipal agency or publicly funded entity "who in good faith makes a complaint to the Child Advocate or cooperates with the Office of the Child Advocate in an investigation"

Role of OCA Advisory Committee. Section 46a-13r of the General Statutes establishes the Advisory Committee to the Office of the Child Advocate and defines its membership and its responsibilities. The Advisory Committee is required to meet at least three times per year to review the goals and projects undertaken by the Office of the Child Advocate. The Committee is further charged to conduct this annual evaluation of the effectiveness of the Office of the Child Advocate and, upon any vacancy in the Office of the Child Advocate, to prepare a list of the three to five most outstanding candidates, ranked in the order of committee preference, for the Governor to use in appointment, as directed by Section 46a-13k of the General Statutes. Over the past year, members of the Advisory Committee met with Child Advocate Sarah Eagan and Associate Child Advocate Christina Ghio nine times to review the activities, administration, and investigations of the OCA. The Committee was also provided with copies of OCA reports and alerts.

Current OCA Advisory Committee Members (and their appointing authorities) are:

Rudolph Brooks (House Speaker)
Jennifer Collins, JD (House Minority Leader)
Edwin Colon, JD (House Majority Leader)
Shelley Geballe, JD, MPH (Senate President Pro Tempore)
Amanda Meeson (Senate Minority Leader)
Jeanne Milstein (Office of the Governor)

PART 2: Summary of OCA Activities – June 2022 through 2023

A full recounting of the many activities and accomplishments over this period by the Office of the Child Advocate can be found in its Annual Report for 2022-2023. What follows is a brief summary to illustrate the breadth of the work done by OCA's small staff of eight (one of the eight positions is currently vacant) and highlight ways its recommendations to address shortcomings it identified in our child-serving agencies were embraced by the General Assembly and incorporated into state law.

Ombudsman Activities

Between July 1, 2022 through June 30, 2023, the OCA responded to 360 individual and systemic complaints regarding the provision of state-funded services to vulnerable children. These inquiries and concerns came from family members, health and mental health care providers, school personnel, foster parents, attorneys, legislators, employees of public agencies, and youth seeking assistance for themselves.

In most case intakes, OCA provided information and guidance on how to effectively navigate our state's often complex service systems. When the concerns presented were more complex concerns about the unmet needs of vulnerable children, OCA's investigation and advocacy efforts included review of case records, site visits to programs, and communications with state and community-based agencies to assess whether the needs of children were being appropriately assessed and addressed.

Frequent issues addressed or investigated by the OCA over this period included:

- Children with disabilities experiencing a lack of access to appropriate special education and related services in the least restrictive environment.
- Children on discharge delay (i.e., "stuck") in hospital emergency departments or hospitals because of problems accessing the levels of care recommended by their providers (including in-patient care, psychiatric residential treatment facilities, foster care, or community-based services).
- Children who became justice-involved while waiting for needed mental health services.
- Safety and/or permanency concerns for children who have experienced abuse/neglect and are in foster care.
- Children and older youth in the justice system who are struggling to find a place to live that has a consistent and caring adult and necessary supports.
- For children with intellectual and developmental disabilities, the lack of timely and available services
- Children experiencing bullying and harassment.

Child Fatality Prevention & Child Safety

Child Fatality Review Panel. OCA co-chaired and staffed the state's Child Fatality Review Panel (CFRP). This multi-disciplinary panel met monthly to review the unexpected and unexplained deaths of Connecticut children as reported to the Office of the Chief Medical Examiner (OCME).

From January 1, 2022, to December 31, 2022, 87 child fatalities were determined to be Accidents, Homicides, Suicides or Undetermined. Over this period, OCA published multiple investigative reports:

- In February 2023, OCA's investigative report focused on the death by fentanyl intoxication of 1 year old Kaylee, examining her family's involvement with the Department of Children and Families (DCF) and how such a death could have been prevented. OCA made numerous recommendations for child fatality prevention, including having several state agencies evaluate and report to the legislature regarding the current service array for caregivers with substance use disorder and their children, as well as specific recommendations to improve service delivery and enhance safety planning for impacted children. The Connecticut General Assembly, in Public Act 23-97, enacted several of OCA's recommendations into state law.

- In July 2023, OCA and Dr. Kirsten Bechtel, a Yale Emergency Department pediatrician, prepared and published the Infant and Toddler Fatality Report, which examined deaths of Connecticut children under age 3 between January 2019 and August 2022. OCA reviewed data from multiple state agencies regarding the children's or families' receipt of benefits, services, and/or supervision prior to, or at the time of, the child's death. The Report included numerous recommendations for policy changes necessary to curb these fatalities and OCA has been meeting with state agency administrators and policymakers as well as other stakeholders to advance recommendations made in this Report.

- In October 2023, the OCA's investigative report examined the death by homicide of 2-year-old Liam Rivera that resulted from child abuse. Liam was under the supervision of DCF and the Juvenile Court at the time of his death. The OCA report made numerous recommendations for administrative improvements at DCF, for enhanced judicial oversight of DCF cases involving young children, and statutory changes to increase accountability for child safety and improve the delivery of legal services to children in child protection proceedings. OCA has submitted legislative proposals arising from these recommendations.

- In October 2023, OCA published its annual Child Fatality report that included an overview of preventable child fatalities during 2022 and identified patterns of risk to children.

- In December 2023, the OCA co-led a Child Fatality Prevention Summit to review best practices, research, and innovations from around the country related to preventing serious child injury and death. The Summit was attended by members of the Child Fatality Review Panel, stakeholders from throughout Connecticut, state agency leaders, and legislators. The Summit concluded with multiple actionable recommendations and next steps to prevent child fatalities. The OCA submitted legislative proposals for the 2024 Session to further support the safety and wellbeing of these highly vulnerable children.

In sum, these investigations have informed OCA's recommended strategies for prevention of child fatalities. In addition to this investigatory work and related legislative advocacy, OCA staff participated on multiple committees, taskforces, and working groups – national as well as local - focused on prevention efforts for children at risk of intentional and unintentional injuries/fatalities.

Investigation and Oversight of Facilities in Which Children and Youth are Placed

Sections 46a-13*l* (5), (12) of the General Statutes require the Child Advocate to: "Periodically review the facilities and procedures of any and all institutions or residences, public or private, where a juvenile has been placed by any agency or government" and also "Prepare an in-depth report on conditions of confinement, including, but not limited to, compliance with section 46a-152, regarding children twenty-one years of age or younger who are held in secure detention or correctional confinement in any facility operated by a state agency."

To accomplish these tasks, OCA staff visited children and youth in both public and privately operated settings including, but not limited to, hospitals, residential treatment programs, detention, correctional facilities and classrooms in both public and private schools. Further, during the past year:

- OCA participated in the state's Juvenile Justice Policy and Oversight Committee (JJPOC) and worked with members of its Incarceration Subcommittee to draft recommendations for an improved re-entry framework for incarcerated children returning to their communities. The General Assembly codified these recommendations in Public Act 23-188.

- In September 2023, OCA published an investigative report and public testimony regarding the care being provided to children in DCF-licensed Short-Term Assessment and Respite placements (STAR homes) after there were published reports of abuse/neglect in one of these homes. OCA's report, reviewed during a legislative public hearing, contained numerous recommendations to

enhance care for children in STAR homes. OCA continues to meet with legislators to review opportunities for system improvement to support these vulnerable girls and boys, all of whom have histories of child abuse or neglect and/or serious mental health treatment needs.

- In November 2023, OCA published an investigative report examining the circumstances leading to a critical incident involving a minor child and a young adult in a state-licensed group home for individuals with intellectual and other developmental disabilities. OCA's report identified system-wide issues regarding the adequacy of oversight and resources to support safe and high-quality care in these settings. OCA made several recommendations for system improvement, and the Departments of Social Services (DSS) and Developmental Services (DDS) committed to various changes to improve quality oversight as well as critical injury/incident review and follow up. OCA is developing legislative proposals to implement additional recommendations from this report, including the creation of a transparent and accountable framework for the state's compliance with the mandated safety and quality of care assurances that Connecticut made to the federal government in its Medicaid Home and Community Based Waiver application.

- OCA staff continued to monitor conditions of confinement for incarcerated youth aged 15 to 22, meeting with youth, staff, and agency administrators at the Department of Correction and the Judicial Branch's Court Support Services Division (CSSD). OCA is preparing an updated investigative report for early 2024 that will include information regarding youths' access to necessary services and include a focus on conditions of confinement for older youth aged 18 to 21 who are living in highly restrictive settings.

Educational Advocacy

All the OCA's systemic educational reviews and investigations that resulted in the issuance of a formal OCA Report, Letter of Findings and/or Program Concern are available on OCA's website. OCA anticipates completing additional investigative reports by early/mid 2024. In addition:

- OCA assisted multiple families in accessing disability support services, summer programming, early intervention services, and services delivered in the least restrictive environment.

- OCA conducted systemic reviews/investigations of multiple public-school districts and privately-run (but publicly funded) programs that provide special education instruction. Investigations addressed issues concerning: the use of restraint and seclusion on students; educational administration and programming; the quality of education in a particular state-approved private special education program; compliance with Title IX; and Title VI language-based discrimination. Multiple school districts have initiated systemic changes to their Title IX compliance frameworks because of OCA's reviews.

- OCA's previous investigative reports about adult sexual misconduct against children in schools included a recommendation that Connecticut create a Title IX technical assistance committee and toolkit to support school districts' compliance with federal anti-discrimination and sexual abuse prevention laws. In 2023, the legislature codified this recommendation into state law through Public Act 23-66.

- OCA advocated, along with other stakeholders, for changes in state law to strengthen transparency in the special education services being provided to children. Public Act 23-150 now requires the State Department of Education to publish summaries of the complaints it receives about special education services and the corrective actions the Department has required of school districts with regard to their provision of special education services.

- OCA continued to monitor school-based arrests and sanctions for young children, including programs' reliance on restraint and seclusion to manage children with disabilities.

- OCA participated in multiple committees and working groups to address systemic educational concerns affecting children throughout Connecticut, including: the U.S. Attorneys' Disability/Education Working Group; JJPOC's Working Groups on Education and on Suspension and Expulsion; the CSDE Special Populations Roundtable and its Title IX Compliance Toolkit Working Group; the CT Language Access & Equity Strategic Partnership Workgroup; and CT School Climate Standards and Bullying Complaint Form Subcommittee.

Child Welfare Advocacy

The OCA responded to individual complaints about children who are involved with DCF, providing advice to callers and following up with DCF regarding the alleged unmet needs of these children for services, permanency, or protection. It also met regularly with the DCF Executive Team to review issues of mutual concern including: child fatalities and critical incidents involving children recently involved with or under the care/supervision of DCF; DCF's quality assurance data; and other systemic issues affecting children and youth.

Committees &Taskforces

Integral to OCA's systemic advocacy efforts is its staff's participation in multiple taskforces and working groups:

PREVENTION	INFANT & TODDLER	EDUCATION	CHILDREN'S HEALTH & WELL-BEING	TEEN/ADOLESCENT SAFETY	JUVENILE JUSTICE
Prevent Child Abuse America-CT Chapter	Maternal Child Health Coalition	CT School Climate Standard and Bullying Complaint Form Subcommittee	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	CT Language Access/Equity Strategic Partnership Workgroup	DDS Children's Services Committee Meeting	Commissioner's Advisory Committee (DMV)	Incarceration subcommittee (JJPOC)
Domestic Violence Fatality Review Task Force	Substance Exposed Pregnancy Initiative of CT (SEPI-CT)	Title IX Compliance Toolkit Workgroup	Children's Behavioral Health Plan Implementation Advisory Board	CT Teen Driving Safety Partnership	Governor's Task Force on Justice for Abused Children

Interagency Restraint & Seclusion Prevention Partnership	Alcohol/Drug Policy Council	School Discipline Collaborative	Autism Spectrum Disorder Advisory Council	Trafficking of Persons Council	JJPOC Incarceration Subcommittee
Alcohol and Drug Policy Council		U.S. Attorneys' Disability/Educational Rights Coalition Meetings	Child Support Guidelines Commission	Regionalized Human Trafficking Recovery Taskforce	JJPOC Education Workgroup/Suspension and Expulsion Workgroup

Training

As noted earlier, state law imposes some responsibility on OCA for the training of others who might represent and/or provide services to our state's most vulnerable children. This past year OCA provided multiple trainings to health care professionals, social service providers, legal professionals, educators and student groups on topics ranging from child death prevention strategies, the representation of vulnerable child populations, and cross-agency multidisciplinary advocacy.

PART 3: The Findings and Recommendations of the OCA Advisory Committee

The OCA Advisory Committee's evaluation is based on what it has learned about OCA's activities through nine meetings with the Child Advocate and Associate Child Advocate, e-mails to our group, its published investigation and other reports, OCA's 2022-2023 Annual Report, as well as other communications with OCA and persons outside OCA who work with it.

Based on this body of information, the Committee unanimously concludes as follows:

- The Office of the Child Advocate has accomplished far more than one could ever expect given the mismatch between the breadth of OCA's *unique* statutory responsibilities and the resources the state has provided for staff to accomplish this work.

- The Child Advocate and Associate Child Advocate are highly experienced and well respected among the child-serving community. They work extremely hard to prioritize staff workloads and the focus of OCA's work so the challenges posing the greatest danger to our state's most vulnerable children get requisite and immediate attention.

As pleased as we are with OCA's work, the Committee is very concerned that OCA – with its unique and expansive investigatory authority and responsibility in our state – has only eight staff and that OCA's governance structure does not adequately protect its independence. We wish to draw these two issues to the attention of those with authority to address our concerns, as follows:

1. The need for additional staff. When OCA was established in 1995, there were two other independent entities providing some oversight over the services and care being provided to the state's children and youth by state, local, and publicly-funded agencies.

> ***The General Assembly's Office of Program Review and Investigations.*** This Office was established in 1972 to provide the General Assembly with the capacity to conduct "an examination of programs administered by state departments and agencies to ascertain whether such programs are effective, continue to serve their intended purposes, [and] are conducted in an efficient manner." Its fulltime professional staff conducted "investigations

to assist the General Assembly in the proper discharge of its duties," researched and analyzed agency practices and policies, and reviewed state programs for "efficiency, effectiveness, compliance, and recommended changes as needed." (https://www.cga.ct.gov/pri/index.asp)

Indeed, between 1977 and 2016, the PRI Office produced eighteen deeply researched reports about our state's children and youth. These included eight reports about the Department of Children and Families and the children and youth it serves (1978, 1990, 1995, 1999, 2007, 2009, 2013, 2016), as well as reports on child day care (1981, 1995), the Birth to Three Program (1995), educational services for blind and visually impaired children (2000), youth substance use (1996), psychiatric hospitalization services for children and adolescents (1986), juvenile justice (1977, 1988) and more. (www.cga.ct.gov/pri/studies.asp#children).

This Office was abolished in 2017.

Federal court oversight. The federal Court Monitor in the *Juan F* class action litigation (was brought in 1989) was tasked with monitoring compliance with the terms of a Consent Decree that DCF signed in 1991 and then with monitoring progress toward Exit Plan benchmarks. The Court Monitor's quarterly reports tracked DCF's compliance with several dozen child welfare outcome measures (https://portal.ct.gov/DCF/Positive-Outcomes-for-Children/Outcome-Measures-for-Children). These reports provided independent insight into and accountability for the care provided to our state's abused and neglected children.

This oversight ended in 2022 when the federal court determined that DCF had met and sustained compliance with the remaining outcome measures.

Now, with no federal court monitor tracking the quality of DCF's care for our state's most vulnerable children and no Office of Program Review and Investigations to provide the General Assembly with its independent assessment of the performance of state child-serving agencies, it is OCA *alone* tasked with such independent monitoring. That OCA – with its unique and expansive investigatory authority and responsibility among all state-funded agencies - has only eight staff positions is of grave concern to this Committee.

Committee's Recommendation. We recommend that additional funding be provided to OCA for – at the least, in this year's budget revisions – two full-time positions devoted to facilities' inspections and to child injury/fatality prevention and related systems investigations.

2. The need for a governance structure that fully protects OCA's investigatory independence. The demise of PR&I and the end of federal court monitoring make OCA's oversight and accountability work even more critical. What other entity in our state government now provides members of our General Assembly with *independent* insight into how well our child-serving state agencies and state-funded agencies are going their jobs?

When our General Assembly established the OCA, it explicitly recognized the importance of assuring OCA's independence, as Section 46a-13k(b) of the General Statutes states: "Notwithstanding any other provision of the general statutes, the Child Advocate shall act independently of any state department in the performance of the advocate's duties." Yet, unlike Connecticut's other state government accountability offices (Freedom of Information, Ethics,

Elections), OCA only has a bi-partisan Advisory *Committee* with limited authority to ensure that the mission and work of the OCA not only can operate independently but also is viewed as operating independently.

Committee's Recommendation. We recommend that a structural change be made to the governance of the OCA to better assure its independence and autonomy. Specifically, we urge the Connecticut General Assembly to prioritize legislation that will ensure OCA's ability to operate independently by establishing a bi-partisan Advisory *Board* with authority to both evaluate the Child Advocate's performance and also to remove, appoint, and re-appoint the Child Advocate.

Respectfully submitted by the Members of the OCA Advisory Committee

Rudolph Brooks
Jennifer Collins, JD
Edwin Colon, JD
Shelley Geballe, JD, MPH
Amanda Meeson
Jeanne Milstein

February 27, 2024