OFFICE OF THE CHILD ADVOCATE

2020-21 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 is to ensure that publicly funded services for children are effective and accountable to the citizens and families of Connecticut. Throughout the fiscal year, OCA conducted individual and systemic investigations on behalf of children. However, as the public health emergency of COVID-19 persisted, OCA continued to shift resources to respond to the needs of children and families profoundly affected by the ongoing pandemic.

OCA utilized its List Serve to provide regular public updates regarding supports for children and children's legal rights to colleagues and families across the state. OCA convened and/or participated in multiple working groups with state and local partners to address the needs of young children at risk for maltreatment, educational needs of children with disabilities, and addressing the pandemic's impact on children's mental health. OCA has provided individual advocacy to children and families who have struggled to access necessary supports during the pandemic.

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 death of any child due to unexplained causes.
Take all possible action necessary to secure the legal and civil rights of children.
Review the needs of children in foster care.
Periodically review facilities in which juveniles are placed.
Publish biennially a comprehensive report regarding conditions of confinement for incarcerated youth.
Publish an annual report regarding the activities of the OCA.

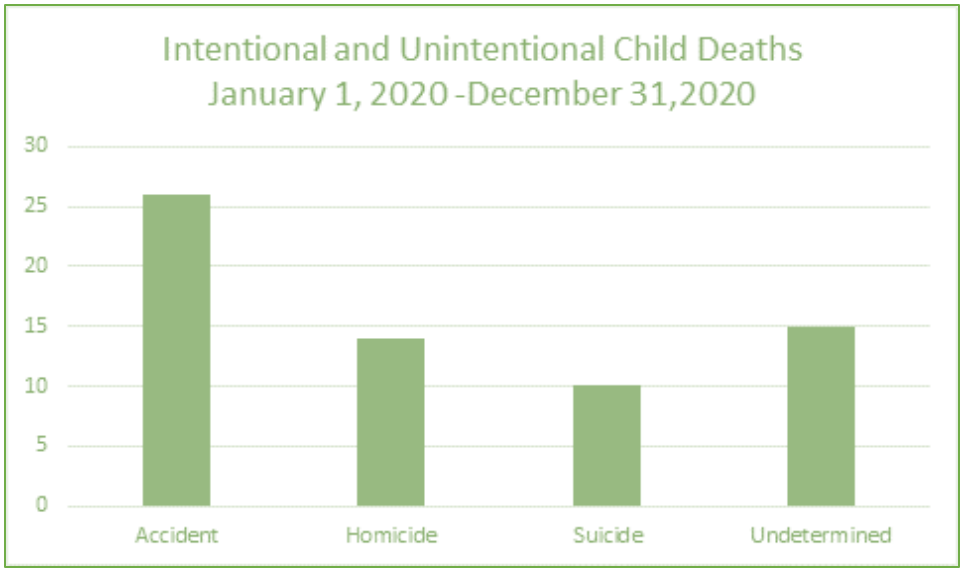
Office of the Child Advocate Staff

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

CHILD FATALITY REIVEW JANUARY 1, 2020 TO DECEMBER 31, 2020

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 minimize preventable child deaths, identify and address patterns of risk to children, improve coordination of services to children and their families, and inform fatality prevention strategies. The CFRP is comprised of state and community partners 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, which is 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 across the United States.



Recently, the National CFRP has developed a Child Dynamic Analysis and Statistics Hub (Child DASH), which will further support Connecticut's child fatality prevention efforts, and facilitate greater data-sharing amongst prevention stakeholders.

OCME reports unexpected and untimely deaths of children to the OCA. From January 1, 2020 to December 31, 2020, ***97 child fatality cases*** were reported to the OCA by OCME. Children from Connecticut who die unexpectedly outside of Connecticut may not be reported to OCME, but where known are included in OCA's fatality data summaries.

Of those child fatality cases, the OCME determined that ***65 deaths were from unintentional or intentional injuries and 32 deaths were determined to be from natural causes*** (including conditions such as: pneumonia, meningitis, complications from special health care needs, asthma, epilepsy, diabetes, and congenital heart issues).

Unintentional/Accidental Deaths of Children (26)

Motor Vehicle — Passenger (8)
Ages-All Teens
Gender-5 male, 3 females
Race-All White
Two crashes involved multiple teen deaths.

Motor Vehicle Pedestrian (4)
Ages-Between 4 and 15 years
Gender-3 male, 1 female
Race/Ethnicity-3 White, 1 Hispanic/White

Motor Vehicle — Driver (1)
Age-Teen
Gender-Male
Race-White

Motor Vehicle Roll-over (1)
Age-Toddler
Gender-male
Race-White

Firearm Fatality (1)
Age- 17
Gender-male
Race-White

Drowning Fatalities (1)
Age-Teen
Gender-Male
Race-Black

Positional Asphyxia (2)
Ages-Infants less than 45 days old.
Gender-1 male, 1 female
Race-1-Black, 1 White

Overdose (5)
Ages-3 Teens, 2 Infants
Gender-3 males, 2 females
Race-4 White, 1 Black

Fire/Burns (2)
Ages- 9, 16
Gender-males
Race/Ethnicity-White and Hispanic/White

Other (1)
Age- (infant)
Gender-male
Race/Ethnicity-Hispanic/White

Intentional/Homicide (14)

Ten children were killed by a parent/family member.
Five (5) of those children were killed by their mothers, two (2) siblings were killed by their father who subsequently died by suicide, two (2) were killed by a cousin (one child resided in CT but was visiting out of state when he was killed), and one (1) was killed by a sibling.

Age- These children ranged in age from one (1) day to 15 years old.
Race/Ethnicity- 3 White, 3 Hispanic/White, 1 Black, 1 Hispanic/Black, and 2 Other.

Four additional homicides were teen boys.
Age- Three (3) boys were 16 years-old, one (1) boy was 14-years-old.
Race/Ethnicity- Three (3) boys were Hispanic/White and (1) was Black.
Investigative reports indicate that all of the teens knew their assailant(s).

Intentional/Suicide (10)

Ages- Four (4) children were 12-14 years old, six (6) were 15-17 years old.

Race/Ethnicity-7 White, 1 Black 1 Hispanic/White, and 1 Other

Gender-6 boys & 4 girls

Undetermined (15)

Of the 15 Undetermined deaths, 13 were infants. <u>All</u> of the infants had a modifiable risk factor in their sleep environment. This is often referred to as with unsafe sleep environment. It includes the position of the infant: i.e. infant is placed prone (on their stomach) or on their side, or placed to sleep in heavy clothing, or with pillows, blankets or other items in the infant's sleep areas. Unsafe sleep environment also includes an infant sleeping with one or more adults or other children in the same sleep space. Of the 13 infant deaths, 8 deaths occurred in an adult bed or other sleep surface (couch/sibling's bed). Each family had a crib/bassinette/pack-n-play for the baby, but it was not where the infant was sleeping at the time of death.

(11) infants were less than 6 months-old
(2) infants were over 6-8 months-old

The other (2) Undetermined deaths were a 17-month-old and a 12-year-old.

Gender – 11 boys and 4 girls

Race/Ethnicity: (7) White, (4) Black, (4) Hispanic/White

Gun Violence 2001-2020 (139)

In Connecticut, between January 1, 2001, and December 31, 2020, **139 children** died from injuries as a result of a firearm.

- 108 of those children died from homicides (78%).
- 5 were suicides child deaths (18%)
- 3 were determined to be accidents/unintentional
- 3 were classified by as undetermined

Age of victims

41 children were between Birth and 14 years old.
20 of these children were from the mass murder at Sandy Hook Elementary School.
98 (70%) of the children were 15 through 17 years-old.

Race/Ethnicity of victims.

White=62 (45%) Black=58 (41%) Hispanic=17 (12%)

Gender of victims.

Boys=111 (80%) Girls=28 (20%)

Child Safety Public Health Alerts—Co-developed by OCA with funding support from the CT Children's Alliance

Summer Flyer Spanish (ct.gov) --Drowning Prevention
Summer Flyer (ct.gov) --Drowning Prevention
Sleep Flyer 2020 (ct.gov)--The Safest Place for Your Baby

Suicide Public Health Alert _CT (ct.gov)— Children's Mental Health
ScaldBurnFlyer-4.pdf (ct.gov)-Burn Prevention Safety

Child Fatality Review Panel (CFRP) Membership

Ex-Officio Government Members

Office of the Child Advocate-Sarah Healy Eagan, JD
Office of the Chief States Attorney-Brett Salafia, JD
Office of the Chief Medical Examiner-Gregory Vincent, MD
Emergency Services & Public Protection-Cpt. Seth Mancini, JD
Department of Children and Families-Ken Mysogland, MSW
Department of Public Health- Angela Jimenez, MPA

CFRP Appointments

University of CT Medical Center-Ted Rosenkrantz, MD
CT Coalition Against Domestic Violence-Tonya Johnson, MPA
CT Children's Medical Center- Michael Soltis, MD

Legislative Appointments

Governor Kirsten Bechtel-MD-Yale New Haven Hospital
Majority Leader of the Senate- Andrea Barton Reeves, JD
Minority Leader of Senate-Thomas C. Michalski, Jr. LCSW
Minority Leader of the House- Steven Rogers, MD: CCMC
Speaker of the House-Pina Violano, PhD.
Majority Leader of the House-Vacant
President Pro Tempore-Law Enforcement, Vacant

Ten Year Overview	Accident	Undetermined	Suicide	Homicide
2011	34	16	9	13
2012	33	18	12	27
2013	35	17	10	12
2014	18	21	6	15
2015	30	19	12	11
2016	30	19	8	7
2017	29	15	15	12
2018	23	19	7	8
2019	25	21	10	7
2020	26	15	10	14
Total	283	180	99	126

FACILITY OVERSIGHT

The OCA staff visit and otherwise maintain contact with children and youth in publicly operated or regulated settings including, but not limited to, hospitals, residential treatment programs, juvenile detention, correctional institutions, and schools. OCA's facility oversight efforts are determined by a) concerns reported to the Office, b) vulnerability of children and youth served by the program and c) legislative mandates.

OCA MONITORING OF CONDITIONS OF CONFINEMENT FOR DETAINED and INCARCERATED YOUTH

Conn. Gen. Stat. § 46a-13*l*(12) requires the OCA to 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, providing detailed findings and multiple recommendations for system improvement, focused on ending solitary confinement for youth and increasing youth's access to educational, rehabilitation and mental health treatment services. In October 2019, the U.S. Department of Justice Civil Division (DOJ) announced an investigation into conditions for minor boys confined at the DOC-run Manson Youth Institution. The DOJ investigation is pending, and the DOC continues to address conditions of confinement for incarcerated minor youth.

In November 2020, OCA published a follow up report which also included a review of conditions for youth age 18-21 incarcerated in two DOC-run facilities: MYI and York Correctional Institution (https://portal.ct.gov/-/media/OCA/OCA-Recent-Publications/OCA-Report-MYIYCI-Nov-2020.pdf). While there were some improvements for minor youth, OCA continues to find deficiencies regarding youth access to mental health, rehabilitative and educational programming. Foundationally, OCA finds that Black children continue to be disproportionately incarcerated in adult prisons.

In December 2020, the DOC presented an Action Plan to the state's Juvenile Justice Policy and Oversight Committee, outlining its effort to improve conditions for boys at MYI, and focused on increasing access to education, enhancing mental health services, and enhancing staffing to support additional programming. The DOC Corrective Action Plan can be found here: https://portal.ct.gov/OCA/Reports-and-Investigations/System-Investigations/Links-to-System-and-Facility-Investigations.

OCA staff are continuously monitoring conditions of confinement for incarcerated youth, collecting key data and meeting with youth, staff, and agency administrators at the DOC and Judicial Branch's Court Support Services Division.

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

UPDATE ***Special Act No. 19-16, An Act Concerning the Licensure of the Albert J. Solnit Children's Center.*** Following publication of OCA's fatality and facility investigation report into the death by suicide of 16-year-old Destiny G. at the state-run Solnit Center, a treatment setting for children, which report found numerous deficiencies in the oversight structure for the Center, the legislature passed legislation requiring an examination of the license-exempt status of the facility and a follow-up report from DCF. The OCA participated in a multi-agency working group led by DCF, that ultimately recommended the legislature require the Solnit Center to be subject to outside licensure by the Department of Public Health.

In 2021, the legislature passed Public Act 21-02, creating a requirement for the Solnit programs to be licensed by the Department of Public Health. OCA continues to engage in monitoring activities, including periodic review of quality management reports specific to the Solnit Center programs.

UPDATE ***Special Act No. 19-19: An Act Concerning the Provision of Certain Information Pertaining to Congregate Care Facilities Licensed or Administered by the Department of Children and Families.*** In 2019, also following the OCA's fatality/facility investigation report regarding the Solnit Center, the Legislature passed Special Act No. 19-19 requiring DCF, in consultation with the OCA and providers of DCF licensed congregate care facilities, to develop a framework for publishing material information about the quality and safety of state-licensed treatment facilities for children, including information about the monitoring and inspection of such facilities and the health, safety, treatment and discharge outcomes concerning children receiving services at such facilities. While the COVID-19 pandemic slowed down the implementation of this requirement, the OCA continues to work with DCF to co-lead a public-private working-group that is moving this work forward. DCF has recently launched a new internal IT project to begin implementation of the Special Act's requirements.

OCA OMBUDSMAN & SYSTEMIC ADVOCACY DURING THE COVID PANDEMIC

For the time period July 1, 2020 through June 30, 2021, the OCA responded to nearly 250 individual and systemic complaints regarding the provision of state and state-funded services to vulnerable children. OCA also re-opened approximately a dozen cases for new inquiries and closed almost 450 existing cases during this period. The OCA is contacted by family members, providers of health/mental health services, school personnel, foster parents, attorneys, legislators, and employees of state agencies, as well as youth who are seeking assistance. Calls from the community impact the direction of OCA investigations as we work to ensure that we are responding effectively to the needs of children and families.

The OCA provides all callers with guidance about how to navigate the state's often complex service systems. In the most urgent cases, OCA undertakes additional investigation and advocacy efforts, including record reviews, program visits, and advocacy with both state and local agencies to ensure the needs of children are appropriately met.

Due to continued widespread effects of the COVID-19 pandemic, this time period proved exceptionally challenging to families in Connecticut and to the systems that serve them. Systems including school districts, courts, health care providers, home visitation services, and child welfare workers all found their ability to contact and meaningfully engage children and families dramatically restricted. OCA endeavors to help mitigate the effects of these restrictions on children and families and assist service systems to evolve in their capacity to meet the needs of children and families.
Issues addressed or investigated by the OCA this year included:

- Lack of access to appropriate special education and related services for children with disabilities.
- Unmet needs of children with significant mental health treatment needs or developmental disabilities.
- Safety or permanency concerns for children who have experienced abuse/neglect.
- Youth with unmet needs involved in the justice system.

Virtual interaction has continued regularly throughout the pandemic 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, Office of the Chief Public Defender, Office of the Chief Medical Examiner, Judicial Branch-Court Support Services Division, as well as the CT General Assembly.

EDUCATIONAL ADVOCACY

Many of the citizen complaints received by the OCA involve educational concerns. Educational complaints come from families, clinicians, school staff, advocates, and legislators. All complaints received by the OCA are confidential and reviewed by staff during regularly scheduled intake meetings. The OCA has limited resources to investigate individual complaints but attempts to accept as many requests as possible for systemic review.

Educational investigatory activities are conducted in accordance with the OCA's statutory duty to "[t]ake all possible action including, but not limited to, conducting programs of public education, undertaking legislative advocacy and making proposals for systemic reform and formal legal action, in order to secure and ensure the legal, civil and special rights of children who reside in this state." *See* Conn. Gen. Stat. § 46a-13l. Those activities include: (i) child specific educational programming reviews; (ii) systemic educational programming reviews/investigations and (iii) systemic educational reviews/investigations. Some of those investigatory activities result in the OCA issuing an Investigatory Report; Issue/Policy Brief and /or Letter of Concern, which are provided to the Connecticut State Department of Education for further investigation and corrective action.

CHILD SPECIFIC EDUCATIONAL PROGRAMMING REVIEWS

During the 2020-2021 fiscal year, child-specific reviews included many issues impacting children receiving special education and related services in numerous school districts across the state. 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 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.

SYSTEMIC EDUCATIONAL INVESTIGATIONS AND ADVOCACY

Child-specific educational reviews continue to lead to larger and more extensive systemic educational reviews and/or investigations. During this reporting year, the OCA conducted systemic reviews/investigations of the Vernon, Meriden, and Waterbury Public School Districts, all arising from Child-Specific Educational Programming Reviews.

Birth to Three Transition—Inadequate Services.

The Vernon Public Schools Review centered specifically on children transitioning to the district from the state's Birth to Three support program and led to the OCA issuing a Letter of Concern to the District along with the State Department of Education for follow-up activities consistent with the SDE's IDEA

compliance oversite responsibilities. SDE addressed OCA's findings with the school district to ensure revised District protocols were in place to support individualized educational planning for children.

Children with Disabilities: Denial of Modifications and Support.

The Meriden Public Schools Investigation has focused on children who, during a period of elevated COVID-19 cases in the region, were not permitted to receive in-person instruction due to their inability to tolerate wearing a mask and other behaviors related to their disability. That investigation was recently completed, and findings have been shared with the State Department of Education. OCA provided individual advocacy to children and families to ensure they were provided with accommodations needed to access their education.

Children with Disabilities: Schools' Reliance on Police Response.

The Waterbury Public Schools Investigation focused on Pre-K through Grade 8 schools' reliance on police to respond to the behavioral crises of young children. OCA found that during a six-month period of time in the 2018-19 school year, these Waterbury public schools called police almost 200 times, resulting in 36 arrests of children, including 9 arrests of children age 11 and under. Most children subject to police calls were children with disabilities. OCA made several recommendations to improve supports and services to students and educators and divert children from police response. OCA reviewed the report's findings and recommendations with the local school district, the Waterbury Mayor, and the State Department of Education. OCA also responded to questions from the U.S. Department of Justice's Education Division regarding its investigation and anticipated local/state corrective action. In response to OCA's investigative report, the State Department of Education and the school district developed a Corrective Action Plan, which can be found on OCA's website here: https://portal.ct.gov/-/media/OCA/OCA-Recent-Publications/WPS-Progress-Update.pdf.

Sexual Abuse Prevention in Schools

Additionally systemic educational reviews/investigations conducted by the OCA addressed Adult Sexual Misconduct in the Education Setting; Compliance with State Mandatory Reporting Laws; Title IX; Student Abuse and Staff Hiring Practices. During 2020-2021, the OCA completed its investigation into Stonington Public Schools, which involved allegations of sexual harassment of children, and published its completed Report, along with a set of recommendations to the local school district and the State Department of Education.

OCA has investigations underway into a district's sexual abuse prevention practices, and local school districts' policies and practices to support safe school transportation for students with disabilities. Both investigations were paused due to the COVID-19 pandemic but are expected to be completed by December of 2021.

ADVOCACY ON BEHALF OF CHILDREN WITH DEVELOPMENTAL DISABILITIES

A number of calls to the OCA involve concerns about the unmet needs of children and families living with developmental disabilities and frequently co-occurring special health care or behavioral health challenges. Expressed concerns may be specific to child and family safety, adequacy of special education services being provided, or lack of access and availability to critically needed in-home or community-based services.

The COVID-19 pandemic caused pervasive lack of access to in-person treatment and support services resulting in disrupted routines for children dependent on structure and consistency and families stranded. In addition, the pandemic-forced rapid conversion to remote or hybrid learning models that left many children with complex learning needs without access to traditional educational services for an extended period.

While Connecticut's investment over the past several years in systems of care has resulted in positive outcomes, children with developmental disabilities are still too frequently underserved. This has become increasingly evident during the current pandemic as many high need children have been unable to access critical special education and behavioral support programming, and families continue to struggle without access to respite. Prior to and throughout the past months of COVID-19, OCA has continued efforts to work with legislative leaders, advocates, families and state agency partners to highlight the unique needs of children with disabilities, particularly those with the highest support needs.

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 regarding allegedly unmet needs of children for services, permanency, or protection. The OCA meets often 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, facility quality improvement reports, and other systemic issues affecting children and youth.

CHILDREN'S MENTAL HEALTH ADVOCACY AND ACTIVITIES

The OCA works with a variety of callers, including social workers, hospital staff, and families, to address individual and systemic concerns regarding child/children's access to appropriate and timely mental health services. Over the last year, OCA has met frequently with legislators and executive branch agency leaders, as well as community providers and hospital administrators, to discuss strategies to improve families' access to needed treatment and related services. Stakeholders have been particularly alarmed at the high number of children boarding in state Emergency Departments, and the proportion of children identified with acute mental health treatment needs. OCA continues to meet with legislators and state agency leaders and OPM to discuss investments that must be made to strengthen community-based mental health services and provide relief and support to community-based providers striving to meet the urgent needs of children and families in their communities. Much work remains to ensure that underserved children, including children of color and children in lower income communities, and children who are justice-involved have ready access to mental health supports. The upcoming legislative session will provide a critical opportunity to oversee efforts to fill gaps in our mental health system and invest dollars where they are most needed to bolster community-based supports.

LEGISLATIVE ADVOCACY ACTIVITIES

Legislative advocacy is an important function of the OCA. OCA strives to build strong relationships with legislative colleagues and continues to serve as an independent resource to the legislature on a wide variety of topics pertaining to or potentially impacting children and families. OCA monitors legislative bill proposals and provides testimony where appropriate. This past session, OCA provided testimony on more than three dozen bills covering topics such as child fatality prevention measures, expanded access to children's mental health services, improving special education and related services for children with disabilities, and ending the school to prison pipeline for young children.

TRAININGS

This past year OCA staff 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.

COMMITTEES-TASK FORCES-COUNCILS

Critical to the work of the OCA are the efforts on a systemic level to keep children safe. Some of that work is accomplished by active and ongoing participation in a variety of statewide efforts.

PREVENTION	INFANT & TODDLER	EDUCATION	CHILDREN'S HEALTH & WELL-BEING	TEEN/ADOLESCENT SAFETY	JUVENILE JUSTICE
Prevent Child Abuse America-CT Chapter	Maternal Child Health Coalition	Civil Rights Advocacy Coalition	Behavioral Health Partnership Oversight Council	Suicide Advisory Board	Juvenile Justice Policy and Oversight Committee (JJPOC)
CT Violent Death Registry Advisory Board	Every Woman CT	School Safety Collaborative	Child/Adolescent Quality, Access & Policy Committee	Commissioner's Advisory Committee (DMV)	Incarceration subcommittee (JJPOC)
Domestic Violence Fatality Review Task Force	Substance Exposed Infants Work Group	COVID-19 Educational Advocacy Coalition	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	Home Visiting Consortium	Social Emotional Collaborative	Autism Spectrum Disorder Advisory Council DDS Children's Services Committee Meeting	Trafficking of Persons Council	Raise the Age to 12 Subcommittee (JJPOC)
DCF Family First Initiative	DPH-State Health Improvement Plan	U.S. Attorneys' Disability/Educational Rights Coalition Meetings	North Central Care Coordination Collaborative	Domestic Minor Sex Trafficking Committee	