OFFICE OF THE CHILD ADVOCATE

2021-2022 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 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. 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 agencies and advocacy organizations to understand and respond to the needs of young children at risk for maltreatment, educational needs of children with disabilities, and the pandemic's impact on children's mental health. OCA has provided individual advocacy to hundreds of children and families who have struggled to access necessary services during the past year.

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.

OCA Director and Staff

Sarah Healy Eagan, JD, Child Advocate

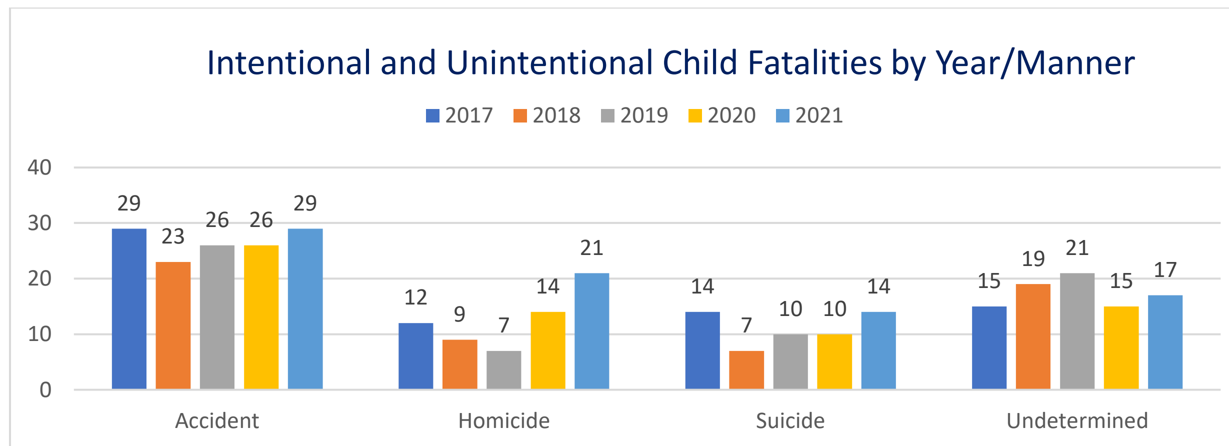
Virginia Brown, JD, Staff Attorney
Brendan Burke, MSW, Assistant Child Advocate
Maria Cruz, Ed.D., Assistant Child Advocate
Julie McKenna, Human Services Advocate
Lucinda Orellano, Human Services Advocate
Heather Panciera, Assistant Child Advocate
Faith Vos Winkel, MSW, Assistant Child Advocate (retired)
Mickey Kramer, RN/MSN, Associate Child Advocate (retired)

CHILD FATALITY REVIEW JANUARY 1, 2021 TO DECEMBER 31, 2021

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 publish patterns of risk to children, and inform fatality prevention strategies. The CFRP is composed 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 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, 2021, to December 31, 2021, 81 child fatalities were determined to be from either Accidents, Homicides, Suicides or Undetermined.



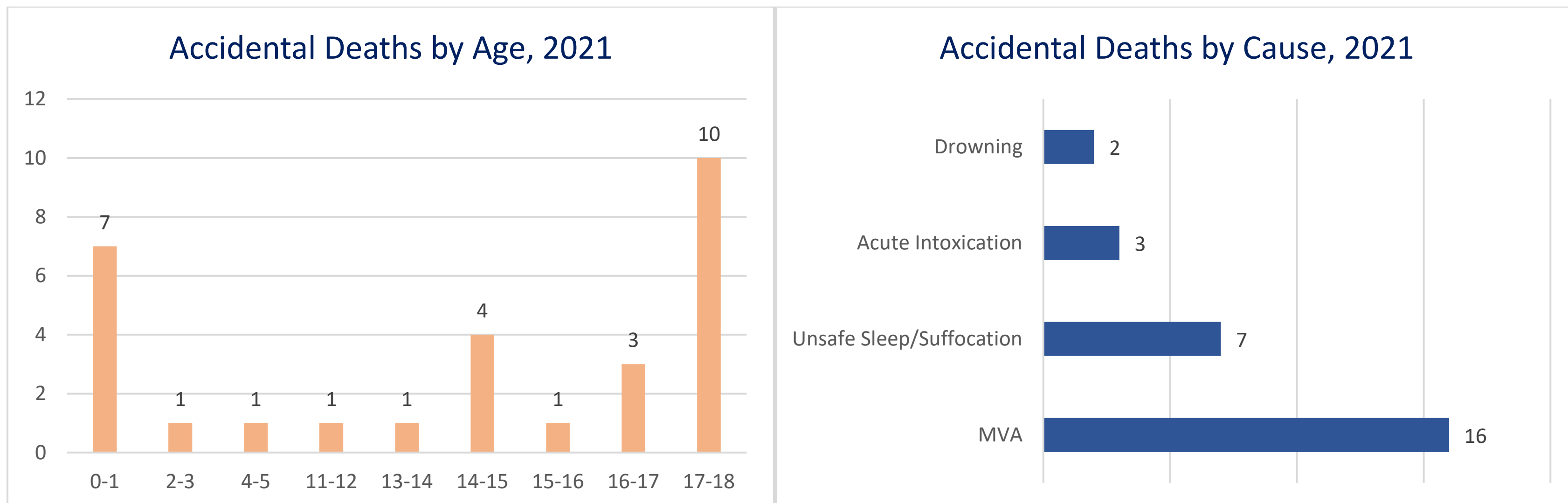
Accidental Deaths of Children (29 Total)

A death ruled accidental is when there is little evidence or no evidence that the injury occurred from intent to harm. Over the last 5 years in CT, the accidental death rate for children has remained constant (range of 23-29/year). Children under 1 (24%) and children 16-18 years old (45%) make up a majority of this group, with very specific causes for accidental deaths. The racial/ethnic breakdown identified for these children were: White (59%), Hispanic (24%), and Black (17%).

In 2021, there were 7 deaths of children under age 1. Five of the 7 deaths were from accidental causes due to an unsafe sleep environment, identified as positional asphyxia, which is the insufficient intake of oxygen when breathing, most frequently the result of a compromised airway due to co-sleeping in adult sleep space.

Older adolescents (16-18) were most likely to experience an accidental death from a motor vehicle accident (MVA) (9), drowning (2), or overdose (2). Of the 9 children that lost their lives from a motor vehicle accident in 2021, 89% had a positive toxicological screen for marijuana and/or alcohol upon autopsy and 89% were male (positive toxicology screen for marijuana does not necessarily indicate that victim was under the influence at time of death as this substance can stay in one's system up to 30 days).

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.



Homicides (21 Total)

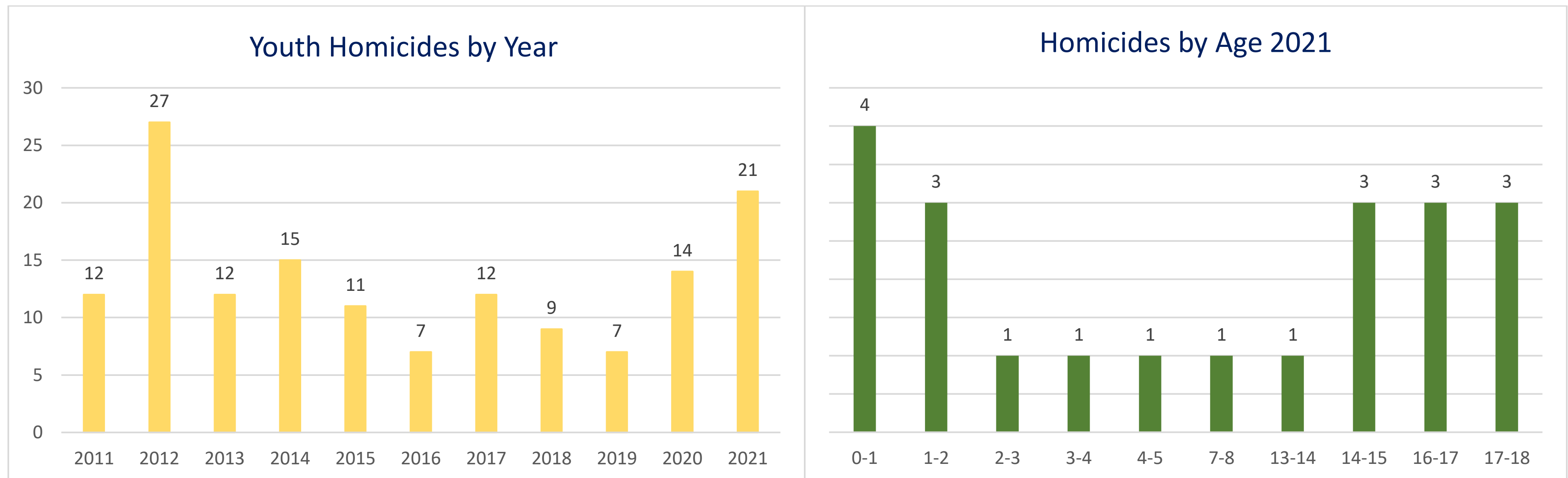
A death ruled a homicide is a death that was caused by the act of another, typically an intentional act. Most homicides of children in CT for 2021 were a result of gun violence (9) and Fentanyl intoxication (6). The Homicide count was up 50% from 2020 (14), and 200% since 2019 (7).

Gun violence deaths most commonly impacted non-white adolescent males. Most of these incidents (78%) occurred in CT's largest cities. Of all homicide victims, 76% of the children were Black or Hispanic. Most victims were positive for marijuana upon autopsy (89%). OCA strongly supports youth gun violence prevention efforts and the development of a new state taskforce dedicated to this public health priority. OCA will continue to provide data and qualitative information to gun violence prevention partners to assist with collective efforts to eliminate these deaths.

New Development in Cause of Death for Young Children

Fentanyl intoxication for young children is a new development in child fatalities. Six children, ranging from less than a month old to age 2, were deemed to have died due to Fentanyl intoxication, a cause not previously documented within this age group in CT. Work continues to understand the pathology of this outcome, with very few reports of children's established direct exposure to Fentanyl or discovery of Fentanyl in the environment upon scene investigation.

OCA is working with the Office of the Chief Medical Examiner, health care providers, and other stakeholders to urgently understand and respond to the concerns of Fentanyl toxicity in young children.

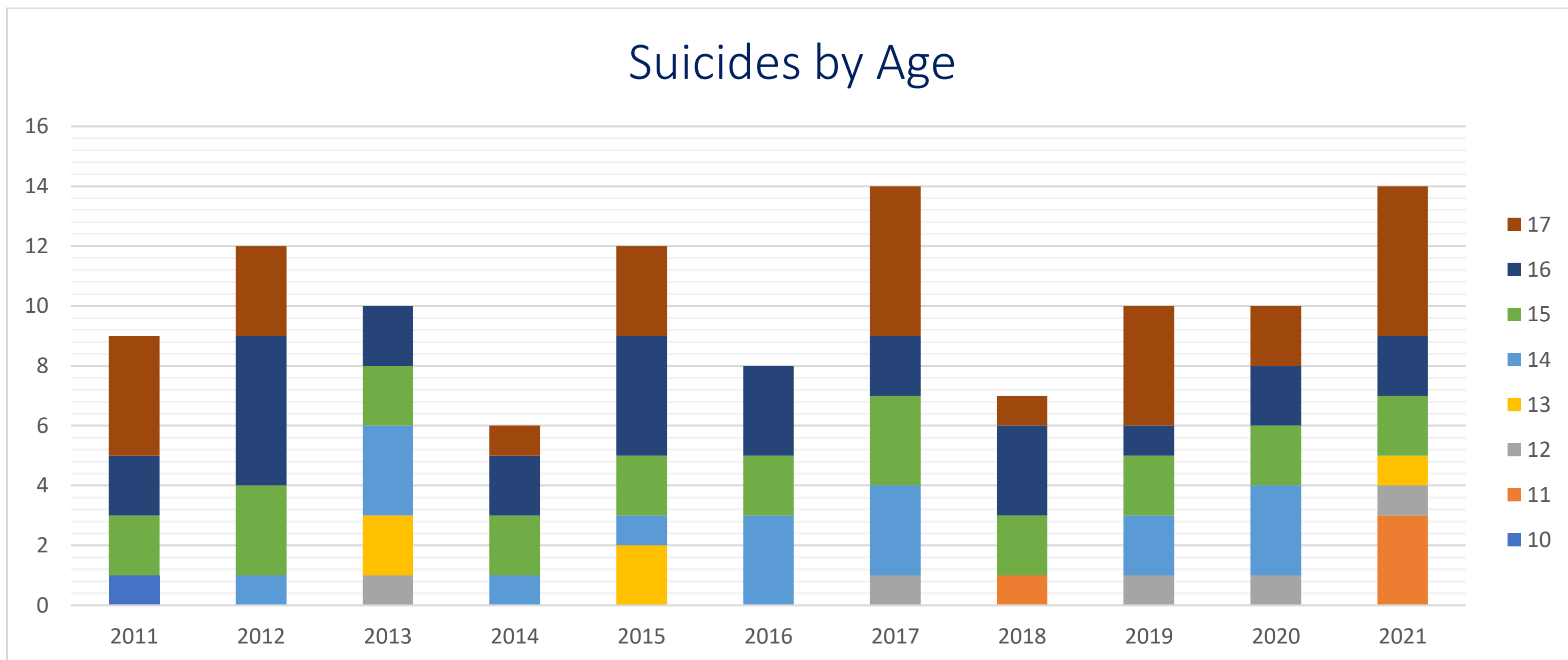


Suicides (14 Total)

A death is ruled a suicide when the injury to oneself is done with the intent to die. In 2021, 14 children ages 11 through 17 took their own lives, with the mean age of 15.3 years old, and gender being equally distributed (7M, 7F). 71% of the children identified as white. More children under the age of 13 died by suicide in 2021 than have previously been recorded. The increased number of younger children in Connecticut who have died by suicide is also part of a national trend. Across the country, suicide is now the second leading cause of preventable death in children starting at age 10.

Suicide rates over the last 5 years have fluctuated, with 2021 reflecting an increase of 40% from the last 2 previous annual counts, and a 100% increase from 2018 totals.

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

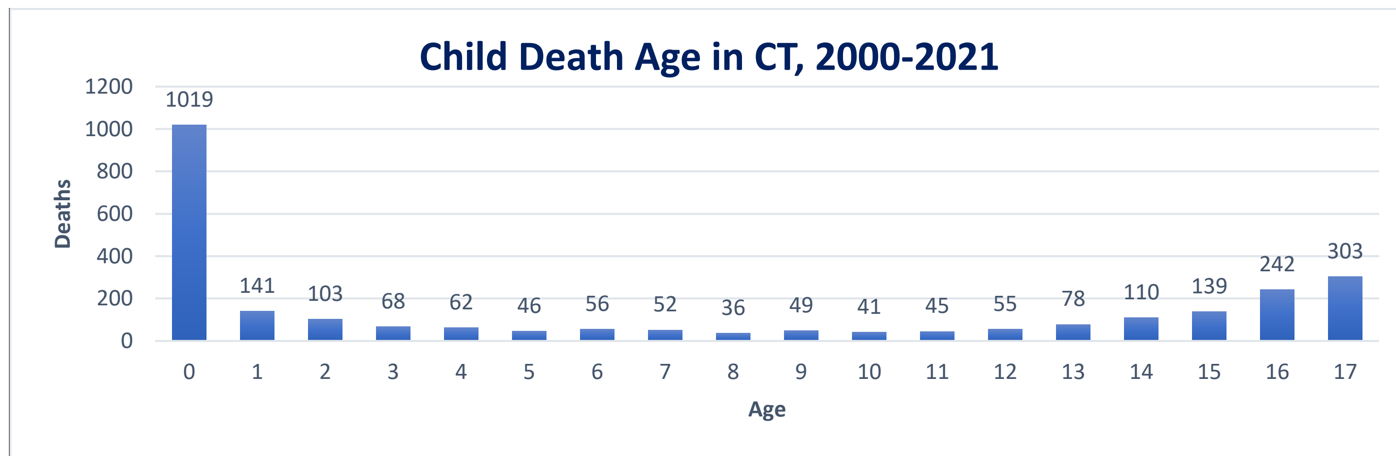


Undetermined (17 Total)

A death is ruled Undetermined when there is no sufficient degree of medical certainty to determine the cause of death. With these 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, therefore the death is ruled as Undetermined. These cases, *typically involving infants*, have gone through a very 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 2021, 94% of the Undetermined deaths were children less than 7 months old, with a mean age of 3 months old at the time of death. **81% of children who died in this category had documented modifiable risk factor/s in their sleep environment**.

Highlighting the Importance of A Safe Sleeping Environment For Infants

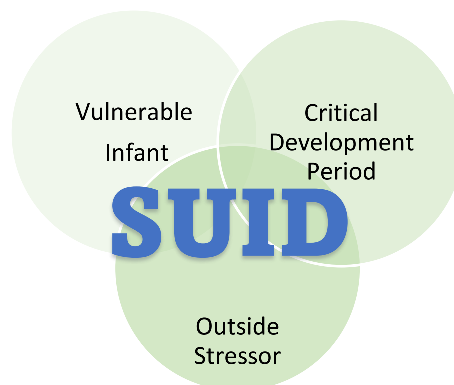


Of the non-natural deaths of children in CT since 2000, 38.5% occurred before the child's their first birthday. As indicated above, many of these infants were determined to have been in an unsafe sleep environment at the time of their death. Data continues to support that children who sleep in an environment free of environmental risk factors are less likely to experience a tragic outcome. Over half of the deaths associated with an unsafe sleep environment occurred when the child was between 2 and 5 months old.

Understanding Sudden Unexplained Infant Death and Sudden Infant Death
Sudden unexpected infant death (SUID) is a term used to describe the sudden and unexpected death of a baby less than 1 year old in which the cause was not obvious before investigation. These deaths often happen during sleep or in the baby's sleep area.
Sudden unexpected infant deaths include sudden infant death syndrome (SIDS), accidental suffocation in a sleeping environment, and other deaths from unknown causes.
Different practices in investigating and reporting SUID can affect the ability to reliably monitor SUID trends and risk factors at the state and national level.

www.cdc.gov/sids/about/index.htm

The triple risk model proposes that SUID occurs when an infant with intrinsic vulnerability (often manifested by impaired arousal, cardiorespiratory, and/or autonomic responses) undergoes an exogenous trigger event (e.g., exposure to an unsafe sleeping environment) during a critical developmental period. The American Academy of Pediatrics recommends a safe sleep environment to reduce the risk of all sleep-related deaths. OCA continues to work with partners across the state including the Connecticut Hospital Association, the American Academy of Pediatrics, and service providers so that we can ensure caregivers understand the need for a safe sleep environment and are supported in their infant care efforts.



AAP Recommendations to reduce the risk of sleep-related death:

- ✓ Back to sleep for every sleep.
- ✓ Use a firm, flat, non-inclined sleep surface to reduce the risk of suffocation or wedging/entrapment.
- ✓ Feeding of human milk is recommended because it is associated with a reduced risk of SUID.
- ✓ It is recommended that infants sleep in the parents' room, close to the parents' bed, but on a separate surface designed for infants, ideally for at least the first 6 months.
- ✓ Keep soft objects, such as pillows, pillow-like toys, quilts, comforters, mattress toppers, fur-like materials, away from the infant's sleep area.
- ✓ Offering a pacifier at naptime and bedtime is recommended to reduce the risk of SUID.
- ✓ Avoid smoke and nicotine exposure during pregnancy and after birth.
- ✓ Avoid alcohol, marijuana, opioids, and illicit drug use during pregnancy and after birth.

- ✓ Avoid overheating and head covering in infants.
- ✓ It is recommended that pregnant people obtain regular prenatal care.
- ✓ It is recommended that infants be immunized in accordance with guidelines from the AAP and CDC.
- ✓ Do not use home cardiorespiratory monitors as a strategy to reduce the risk of SUID.
- ✓ Supervised, awake tummy time is recommended to facilitate development and to minimize the risk of positional plagiocephaly
- ✓ It is essential that physicians, nonphysician clinicians, hospital staff, and childcare providers endorse and model safe infant sleep guidelines from the beginning of pregnancy.
- ✓ It is advised that media and manufacturers follow safe sleep guidelines in their messaging and advertising to promote safe sleep practices as the social norm.
- ✓ Continue the NICHD "Safe to Sleep" campaign, focusing on ways to reduce the risk of all sleep-related deaths. Pediatricians and other maternal and child health providers can serve as key promoters of the campaign messages.
- ✓ Avoid the use of commercial devices that are inconsistent with safe sleep recommendations.
- ✓ There is no evidence to recommend swaddling as a strategy to reduce the risk of SUID.

https://doi.org/10.1542/peds.2022-057990

Child Fatality Review and Panel (CFRP) Membership

Name	Affiliation	Appointing Authority
Sarah Eagan, JD Co-Chair	Office of the Child Advocate	Ex-Officio
Kirsten Bechtel, MD Co-Chair	Pediatrician- Yale New Haven Hospital	Governor (Pediatrician)
Tonya Johnson, MPA	CT Coalition Against Domestic Violence	CFRP (Domestic Violence Rep)
TJ Michalski, LCSW	The Village of Families and Children	Senate Minority Leader (SW Professional)
Steven Rogers, MD	Injury Prevention- CT Children's Medical Center	House Minority Leader (Injury Prevention)
Brett Salafia, JD	Office of the Chief States Attorney	Ex-Officio
Gregory Vincent, MD	Office of the Chief Medical Examiner	Ex-Officio
Pina Violano, PhD	Community Health	Sec of the State (Community Service Rep)
Ken Mysogland, MSW	Department of Children and Families	Ex-Officio
Michael Soltis, MD	Pediatrician- CT Children's Medical Center	CFRP (Pediatrician)
Angela Jimenez, MPA	Department of Public Health	Ex-Officio
Andrea Barton Reeves, JD	Paid Family and Med Leave	Senate Minority Leader (Attorney)
Ted Rosenkrantz, MD	UCONN Health Center	CFRP (Neonatologist)
Sgt. Christine Jeltema	CT State Police	Ex-Officio
Elizabeth Corley, Psy. D.	Clifford Beers	Maj Leader House of Reps (Psychologist)

Child Fatality Investigation

In March 2022, the OCA published investigative findings and recommendations regarding the death of Alexander Medina (Alex), a 17-year-old boy who was committed to DCF custody at the time of his death in October 2019. Alex died from injuries sustained from a motor vehicle crash allegedly caused by his foster father, Mr. James Bailey, a licensed DCF foster care provider and a previous licensed community provider for the Department of Developmental Services (DDS). Mr. Bailey was allegedly intoxicated at the scene of the motor vehicle crash and has been criminally charged with multiple offenses related to Alex's death. OCA found that there were several concerns raised or investigated over the years by DDS and then DCF regarding Mr. Bailey's drinking and capacity to safely care for children or vulnerable adults. OCA determined that these concerns were, collectively, inadequately investigated and followed up on, and that essential information regarding Mr. Bailey's ability to provide safe care was not thoroughly communicated between state and local agencies.

OCA made several recommendations to DCF and DDS to improve and standardize the way state agencies maintain, obtain, and share records and information regarding licensed caregivers and prospective licensed caregivers for vulnerable populations. Both agencies reported to OCA that they are working to strengthen inter-agency communication and problem solving. DDS also reported it would explore adding additional detail and records to its licensing information management system and review what the agency considers when a provider is being re-licensed by the agency. DDS stated it would explore memorializing its interagency communication with DCF regarding license checks through policies, procedures, or Memoranda of Agreements to clearly outline how material information will be shared across agencies. OCA will continue to review progress on this matter with the state agencies.

FACILITY OVERSIGHT

The OCA staff 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

Conn. Gen. Stat. § 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, issuing detailed findings and recommendations for system improvement. OCA's report included emphasis on youth in solitary confinement and youth's lack of access to appropriate education, rehabilitation, and mental health treatment services in the adult system. Following the publication of OCA's report, the U.S. Department of Justice Civil Division (DOJ) announced its own investigation into conditions for minor boys confined at the Department of Correction-run Manson Youth Institution (MYI). The DOJ investigation concluded in December 2022, finding conditions at MYI, including use of solitary confinement,

violated minor boys' constitutional rights to adequate care, treatment, and education. The DOJ and the State of Connecticut are in settlement negotiations to address these constitutional violations.

OCA staff continue to monitor conditions of confinement for incarcerated youth, meeting with youth, staff, and agency administrators at the DOC and Judicial Branch's Court Support Services Division. OCA is preparing an updated investigative report for early 2023. This report will include information regarding youth's access to necessary services and will add a focus on discharge planning and community reintegration.

> *OCA talked to youth about obtaining his GED, as this was his priority. We have reached out to the school administration regarding the status of his credits, GED prep and if he can take the tests before he is discharged and if not to see they can connect him to a community provider prior to discharge to assist.*

OCA's ONGOING SYSTEMIC ACTIVITIES TO ENSURE SAFE AND EFFECTIVE FACILITY-BASED CARE

Licensing of the state-run Solnit Center for Children. In 2018, the OCA published a 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. Following publication of the OCA's report and an accompanying public hearing, the legislature required state agency stakeholders to review Solnit's license-exempt status and make recommendations for reform. 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 (DPH). OCA continues to engage in monitoring activities, including periodic review of quality management reports specific to the Solnit Center programs. DPH has reported to OCA that progress is being made towards licensure of the Solnit programs

Creation of a Public Database Regarding Safety and Quality of State-Licensed Facilities for Children. In 2019, following the OCA's fatality/facility investigation report regarding the Solnit Center, the Legislature passed Special Act 19-19 requiring DCF, in consultation with the OCA and providers of DCF licensed congregate care facilities, to develop a framework for publishing 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 for children receiving services at such facilities. OCA participated in a follow-up working group with DCF and private providers to help develop this database. In 2022, DCF launched phase one of the public-facing database, for the first time including public information on licensing inspections and corrective actions required of agency-licensed programs for children. Work remains to ensure comprehensive information regarding the quality of these programs is available to consumers and the public.

OCA OMBUDSMAN & SYSTEMIC ADVOCACY DURING THE COVID PANDEMIC

Between July 1, 2021, through June 30, 2022, the OCA responded to over 300 individual and systemic complaints regarding the provision of state-funded services to vulnerable children. The OCA is frequently 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 about how to navigate the state's often complex service systems. In the most urgent cases and where the individual complaint raises a systemic concern, 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.

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

- Lack of access to appropriate special education and related services for children with disabilities in the least restrictive environment.
- Children on discharge delay in hospitals who cannot access necessary care in the community.
- Safety or permanency concerns for children who have experienced abuse/neglect.
- Children and older youth in the justice system who are struggling to find a place to live with a consistent and caring adult and necessary supports
- Lack of timely and available services for children with intellectual and developmental disabilities.
- Children experiencing bullying and harassment.

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, Judicial Branch-Court Support Services Division, as well as the CT General Assembly.

OCA received a concern for an 8-year-old boy who had been hospitalized due to significant aggressive and self-injurious behavior. Discharge planning for the child was challenging due to his complex needs, his age, and his mother's ability to maintain him safely without significant caregiving support. OCA facilitated communication among the providers, public agencies, and the family to help create a plan to meet the child's needs. Ultimately the child was discharged to his family, with intensive in-home treatment services that support the child as well as build the mother's capacity to aid in his recovery from early childhood trauma.

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's multidisciplinary staff during weekly intake meetings. 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; Issue/Policy Brief and /or Letter of Concern, which are also provided to the Connecticut State Department of Education for further investigation and corrective action, where applicable. OCA also 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.

Child Specific Educational Programming Reviews

During the 2021-2022 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.

Systemic Educational Investigations And Advocacy

During this reporting year, the OCA completed systemic reviews/investigations of the West Hartford, Meriden, New London, Thomaston, and Hartford Public Schools. 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 its website. **The OCA has pending reviews regarding the adequate provision of early childhood special education supports in various public schools.**

- Disproportionate Discipline and School Based Arrests of Younger Children of Color: The West Hartford Public Schools Review focused on the disproportionate suspension and arrest of children of color and children with disabilities age 12 and younger in West Hartford Public Schools. *OCA met with District administrators several times, culminating in the issuance of a public Findings Letter and a commitment from the school district to reduce reliance on police and exclusionary discipline through adherence to a data-driven Multi-Tiered System of Support.*

- Children with Disabilities: Denial of Modifications and Support: The Meriden Public Schools Investigation 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. OCA's investigation followed multiple complaints that certain children with developmental disabilities were being denied in-person education. OCA also reviewed whether the District was providing early childhood education supports to children with disabilities in the least restrictive environment as required by federal law. In addition to publishing a final report during this past year, the OCA submitted multiple individual and systemic complaints to the State Department of Education (SDE). *The SDE resolved some of the individual complaints in favor of students, requiring compensatory education for those children. The SDE also required the District to commit to a Corrective Action plan to ensure young children with disabilities receive services in the least restrictive environment.*

- Sexual Abuse Prevention in Schools: Additional systemic educational reviews/investigations conducted by the OCA addressed Adult Sexual Misconduct in the education setting; compliance with state mandatory reporting laws and Federal Title IX obligations; student abuse and staff hiring practices. During 2021-2022, the OCA completed its investigation into New London Public Schools, which involved allegations of sexual abuse of children, and published its completed report, along with a set of recommendations to the local school district, the State Department of Education and the Legislature. *The OCA met with District and City officials on numerous occasions to discuss OCA's findings and recommendations, and the District developed a comprehensive remedial action plan to address concerns regarding Adult Sexual Misconduct.*

- Discriminatory Enrollment and Registration Practices: The Thomaston Public Schools Review centered on discriminatory enrollment and registration practices that were "potentially unlawful and may have the impact of discouraging enrollment of undocumented or homeless youth in public school" and led to the OCA issuing a Findings Letter to the District and the SDE, requesting that the District take corrective action to address the identified issues and that SDE monitor that corrective action consistent with SDE's oversite responsibilities. *Due to the lack of response by the District to OCA's letter, the OCA took the additional measure of filing a formal complaint with the U.S. Department of Education Civil Rights Office (OCR). That complaint is currently under investigation by the OCR.*

- Lack of Parent Counseling & Training & Paraeducator Training: The Hartford Public Schools Review focused on children with complex disabilities who were not offered parent counseling and training as a related service and the lack of appropriate paraeducator training and accountability. *In response to the OCA's findings the District conducted additional fact-finding and recently committed to a comprehensive corrective action plan addressing the concerns raised by the OCA.*

ADVOCACY ON BEHALF OF CHILDREN WITH DEVELOPMENTAL DISABILITIES

Many calls to the OCA involve the unmet needs of children with developmental disabilities. 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.

While Connecticut's investment over the past several years in systems of care has resulted in positive outcomes, ***children with developmental disabilities remain too frequently underserved***. 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. OCA advocated for the development of additional oversight structures to help ensure a consumer and data-driven public framework for improvement of our health care system as it promotes and treats children's mental health. The state must establish strategic and measurable goals to ensure that chronically underserved children can access necessary care wherever they live and regardless of disability type.

The OCA received a community concern about a 13-year-old boy with Autism stuck in an inpatient unit, lacking access to community supports and services for him and his guardian. OCA met with hospital staff, mental health system administrators, providers, and the family to help construct a discharge plan for the child, with close attention to needed in-home supports, weekend help, transportation, and an appropriate school program.

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. In the wake of the end of *Juan F.*, a federal court consent decree and federal court monitoring of DCF, OCA is creating its own framework for reviewing DCF systems data regarding core practice areas: safety, permanency, and wellbeing.

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 children's access to appropriate and timely mental health services. OCA meets regularly with community providers, family advocates, and state agency administrators to problem-solve individual and systemic issues.

The past legislative session saw significant investments made into the children's mental health system. However, much work remains to ensure that underserved children, including Black and Hispanic children, children in lower income communities, children with developmental disabilities, and children who are justice-involved have timely access to community supports. OCA supports the Legislature's decision to create a Behavioral Health Policy and Oversight Committee, which has membership and funding to help analyze children and families' access to services and will report out regarding the efficacy of our mental health care system for children.

The OCA received a report of a young boy in state custody with developmental and psychiatric disabilities. He was cycling in and out of hospital emergency departments without access to necessary care and no connection to a consistent and nurturing caregiver. OCA participated in regular treatment plan meetings for this child, met with state administrators, and continues to advocate for access to the most appropriate setting for this child. OCA is meeting with stakeholders regularly to discuss issues surrounding acute mental health and family support needs for very young children and their caregivers. System design changes, including improved access to in-home services, weekend and overnight supports, including respite, and access to prosocial services for children and families are desperately needed to support these children in the least restrictive environment.

LEGISLATIVE ADVOCACY ACTIVITIES

OCA monitors legislative bill proposals and provides testimony where appropriate. OCA develops legislative proposals corresponding to systemic findings and recommendations from OCA's investigative reports.

This past session, OCA provided testimony on more than three dozen bills covering topics such as child fatality prevention, oversight of the children's mental health system, preventing and responding to Adult Sexual Misconduct in schools, and improving conditions of confinement for incarcerated children. OCA appreciates the legislature's investments in children's mental health, development of a new behavioral health policy/oversight council, sexual abuse prevention reforms, and protections for incarcerated individuals.

- OCA STATUTORY CHANGES: The OCA sought and obtained changes to the Office of the Child Advocate's own statutory framework to 1) extend whistleblower protections for those that make complaints to this office; 2) ensure timely delivery of records to the OCA; and 3) re-establish the OCA advisory committee to ensure independent evaluation and review of the Office's effectiveness.

- OCA IS A NEW MEMBER OF THE STATE'S ALCOHOL DRUG AND POLICY COUNCIL. OCA sought and obtained a change in state law to become a member of the state's Alcohol Drug and Policy Committee. The OCA will work to ensure that critical issues affecting children are considered by this policy-making group.

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
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	

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.