THE OFFICE OF THE CHILD ADVOCATE

ANNUAL REPORT

JUNE 30, 2016 to JULY 1, 2017

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

OVERVIEW & AUTHORITY

The Office of the Child Advocate ("OCA") was established in 1995 after the tragic death of an infant in state care. The child's death made clear that an independent agency with the power to investigate and issue public reports was necessary to ensure the well-being of children and provide transparency to government services otherwise shielded from public view by confidentiality laws and institutionalized practices intended to protect the privacy of children and families. The OCA continues to utilize its unique statutory and independent authority to investigate and evaluate state-funded and state-operated programs and services for children, identify areas in need of attention, and make recommendations to protect the rights of Connecticut's children. Committed to education and workforce development, the OCA proudly serves as a learning environment for students. This past year the OCA hosted interns from the University of Connecticut graduate Schools of Social Work and Law, Boston University and Smith College. In addition, the OCA staff members are frequently asked to speak to students at area universities and colleges, as well as various professional associations and community groups.

The OCA has 7 full time employees and an operating budget of approximately $650,000. The OCA staff is comprised of the Child Advocate—Sarah Eagan; a nurse; a social worker; a clinical social worker; a staff attorney; and two human services specialists. The OCA is staffed to ensure a multidisciplinary approach to meeting its broad statutory mandates.

In February 2017, the OCA was relocated to 18-20 Trinity Street, Hartford, with all staff contributing to a smooth transition with minimal disruption to the agency's work. The OCA strives to meet its responsibilities to the children and residents of the state and remains a tenacious and reliable voice for children.

RESPONDING TO CITIZEN CONCERNS
OCA OMBUDSMAN ACTIVITIES

Between July 1, 2016 and June 30, 2017, the OCA responded to approximately 500 formal inquiries regarding the provision of state and state-funded services to children. The OCA receives questions, concerns, and complaints from parents (58% of intakes) and other relatives (16%), providers of health/mental health services, educators, foster parents, attorneys, legislators, and employees of state agencies, and often from youth who are in need of services.

All calls to the OCA are confidential. The OCA provides callers with information on the responsibilities of state agencies serving children and families, and offers guidance to callers on how to effectively navigate sometimes overwhelmingly complex systems. Issues brought to the attention of the OCA through citizen calls this past year continued to be extremely variable and frequently involved concerns regarding access to needed services for a child and/or the quality of services being provided. The most commonly reported areas of concern involved child welfare practice, special education, mental health treatment needs, and supports and services to children with developmental disabilities and special health care needs. Beyond providing information, referral and coaching, the OCA staff determined it necessary to intervene directly on behalf of approximately 40% of the children referred through its ombudsman activities. Most of those child/youth cases involved significant issues with child/family treatment planning around complex mental health needs, developmental disabilities and social issues necessitating the services of multiple state agencies.

The OCA interacts regularly with the staff and executive administrations of the Department of Children and Families, Department of Developmental Services, Department of Social Services, Department of Mental Health and Addiction Services, Department of Correction, Department of Education, Department of Public Health, Office of the Chief Public Defender, Office of the Chief Medical Examiner, Judicial Branch-Court Support Services Division, as well as the CT General Assembly. The OCA continues to work collaboratively with local education authorities, private sector health and human service providers and other advocates across the state, examining the effectiveness of the current service delivery systems, identifying gaps and needs in services, and advocating for changes and improvements as needed.

CHILD FATALITY REVIEW & PREVENTION

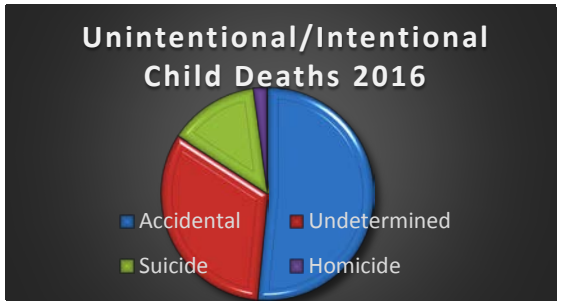
As outlined in Connecticut General Statute § 46a-13l(c), the OCA and Child Fatality Review Panel (CFRP) are tasked with reviewing the circumstances of the death of any child due to unexpected or unexplained causes. These unexpected-unexplained deaths fall primarily into four categories: (1) accident ;(2) homicide; (3) suicide; and (4) undetermined. Below is a brief explanation of those categories and a summary of the cause of death for children in those categories.

The purpose of the fatality review process is to identify and address trends and patterns of risk to children, to improve coordination of services to children and their families, and to facilitate the development of prevention strategies. The CFRP is comprised of multi-disciplinary professionals, and is currently co-chaired by the Child Advocate (Sarah Eagan) and Dr. Kirsten Bechtel, an emergency-room pediatrician at Yale New Haven Hospital. The CFRP meets monthly at the Office of the Chief Medical Examiner (OCME). The OCA and CFRP continue to review the unexplained and unexpected deaths of all children who reside in Connecticut or die in our state. The OCA and CFRP also review other cases of natural deaths of children that have come to the attention of the OCME.

From January 1, 2016 to December 31, 2016, 145 child fatality cases were reported to the OCA by OCME. Of those child fatality cases, 81 deaths were determined to be from natural causes and 64 deaths were from unintentional or intentional injures. Over 40% of the children whose death was determined to be from natural causes came to the attention of the OCME for cremation purposes only. Those child deaths were frequently due to heart complications, cancer, extreme medical complexity, prematurity, medical complications, and other acute illnesses.

Notably, infant deaths from a variety of causes, including accidents, homicide or undetermined, account for *over a third* of all unintentional and intentional fatal injuries. The deaths of infants in sleep-related circumstances is the second leading cause of accidental death in the state.

2016 Unintentional and Intentional Injuries



30 Accidental Child Deaths: While accidental deaths of children in Connecticut continued to trend downward during the past decade, accidental death remains the leading cause of preventable death for children in the state.

- Motor vehicle related deaths are still the leading cause of accidental death for children. 12 children died in motor vehicle related fatalities, 6 were passengers, 4 were drivers and 2 were pedestrians.

- There were 6 accidental deaths of infants who died from positional asphyxia (lay-over by an adult or sibling or suffocation).There were 4 deaths from accidental drowning, 2 deaths from drug overdoses, 2 deaths from house fires, and 4 deaths from various forms of accidental traumas.

19 Undetermined Child Deaths: An undetermined death is a category used by the OCME where upon the completion of an autopsy there are no clear findings of accident, disease, trauma, or injury.

- 13 of the 19 child deaths that were classified as undetermined were infants (under 1-year), 3 were toddlers.
- Many of the 13 infant deaths had an associated concern about the infant's sleep environment, such as a concern that the child was sleeping in an adult bed, chair or couch, or the infant was found to have harmful items in his or her sleeping environment such as blankets, pillows, wedges, and stuffed animals. As reported under the accidental death heading, 6 infants died from positional asphyxia, which is also associated with the infants' sleep environment, meaning that an infant death occurring in the presence of unsafe sleep environmental factors remains the leading cause of preventable infant death in the state.
- The remaining 3 undetermined cases were children between the ages of 9-16.

8 Youth Suicides:

- All of the youth who died from suicide were teenagers between the ages of 14-16.
- 4 boys and 4 girls.
- 6 of the youth died from asphyxia by hanging, 1 youth died from a gunshot wound and 1 youth died from blunt force trauma.

7 Child Homicides:

- 3 homicide victims were infants, 2 boys and 1 girl. 2 of the infants sustained blunt traumatic injuries consistent with fatal child abuse, and 1 infant died from acute diphenhydramine intoxication (Benadryl).
- 3 child victims of homicide were between the ages of 4-11. Those 3 children died from carbon monoxide poisoning, homicidal asphyxia and neglect.
- 1 teenager died by homicide (gunshot wound).

Five Year Child Fatality Report

In December 2016, the OCA, in consultation with the CFRP, published a child fatality report which provided analysis of child death trends from 2011-2015. The report also provided a series of recommendations to support and strengthen child death prevention efforts in our state as well as an overview of 15 years of child death review in Connecticut. Over the 5 year period, **367** children died from unintentional and intentional injuries in Connecticut. The vast majority of those children were *under the age of 1*. Infants younger than 12 months of age had the highest risk for premature death, more so than at any other time during childhood and adolescence. The OCA Five Year Fatality Report can be found at:
www.ct.gov/oca/lib/oca/Final_Five_Year_Fatality_Report_2011-2015.pdf

Child Fatality Review-Public Health Alert:

In response to several highly publicized deaths of young children who died from diphenhydramine (aka Benadryl) toxicity, the OCA and CFRP issued a Public Health Alert: When is Benadryl Safe to Use With Children?
The alert can be found at: http://www.ct.gov/oca/lib/oca/Benadryl_Public_Health_Alert.pdf.

The OCA is recognized nationally as a leader in child fatality review. Publications and investigative reports generated by the OCA have been distributed broadly and have garnered national attention. In addition to its investigatory work and publications, the OCA actively participates on several committees, taskforces, and working groups focused on prevention efforts for child at risk of intentional and unintentional injuries/fatalities.

Committees, Task Forces, Working Groups

Suicide Prevention Initiatives
American Foundation for Suicide Prevention Board of Directors
Statewide Suicide Advisory Board

Infant and Toddler Initiatives
Maternal Child Health Coalition, Improving Birth Outcomes
Every Woman, CT
Prevention Partnership for Children
Substance Exposed Infants Work Group
Abusive Head Trauma Prevention Working Group
Child Abuse Prevention

Youth & Teen Safety Initiatives
Department of Motor Vehicles Commissioner's Advisory Committee
CT Teen Driving Safety Partnership
Trafficking of Persons Council
Domestic Minor Sex Trafficking Committee

Other Prevention Efforts
Governor's Task Force on Justice for Abused Children
CT Violent Death Registry Advisory Board
Domestic Violence Fatality Review

Child Fatality Review Panel Membership

Ex-Officio Government Members
Attorney Sarah Eagan: Office of the Child Advocate
Attorney Anne Mahoney/Brett Salafia: Office of the Chief States Attorney
Dr. Susan Williams/Dr. Gregory Vincent: Office of the Chief Medical Examiner
Lt. Seth Mancini, JD: Department of Emergency Services & Public Protection
Ken Mysogland, MSW: Department of Children and Families
Margie Hudson, RN: Department of Public Health

Legislative Appointment & Appointing Authority
Dr. Kirsten Bechtel: Yale New Haven Hospital, (Governor)
Attorney Andrea Barton Reeves, (Majority Leader of the Senate)
Thomas C. Michalski, Jr. LCSW, (Minority Leader of Senate)
Dr. Steven Rogers: CT Children's Medical Center, (Minority Leader of the House)
Dr. Regina Wilson, (Majority Leader of the House)
Dr. Pina Violano, Yale Injury Prevention (Speaker of the House)
Law Enforcement, Vacant (President Pro Tempore)

CFRP Appointments
Dr. Ted Rosenkrantz: University of CT Medical Center
Tonya Johnson, MPA: CT Coalition Against Domestic Violence
Dr. Michael Soltis: CT Children's Medical Center

FACILITY BASED INVESTIGATIONS & ADVOCACY ACTIVITIES

The OCA's statutory responsibilities include evaluating the efficacy of publicly funded child-serving facilities and programs. The OCA staff visit children and youth wherever they are being served. The OCA's unique access allows us to get a true sense of the experience of the child within the facility or program. The OCA is the only entity with statutory authority to enter such programs, meet with children and youth, and access child-specific information from programs and facilities. In addition, the OCA responds to any reported concerns regarding the safety and well-being of children in state-funded, state-licensed or state-operated settings. In 2016, the OCA activities included the following:

- Continued monitoring and advocacy regarding conditions and outcomes of confinement for incarcerated youth in both the juvenile and adult correctional systems. The OCA has examined aspects of facility safety, facilities' use of restrictive measures, and access to needed mental health and other therapeutic and rehabilitative services across state-funded systems.
- The OCA met with/advocated on behalf of more than 100 youth in state-run or state-licensed facilities and programs to address a range of issues affecting youth residing or confined in more than 7 facilities.
- The OCA contributed extensively to the work of the state's Juvenile Justice Policy and Oversight Committee ("JJPOC") as that body sought to make findings and recommendations regarding juvenile and adult criminal justice reforms necessary to improve rehabilitative and public safety outcomes. Findings and recommendations of the JJPOC Incarceration sub-group, which recommendations reference the contribution of the OCA, can be found here: https://www.cga.ct.gov/app/tfs/20141215_Juvenile%20Justice%20Policy%20and%20Oversight%20Committee/20170120/2017%20JJPOC%20Recommendations%20final%20%201-17-17.pdf, pages 10-13.

SYSTEMIC INVESTIGATIONS & ADVOCACY

Ensuring School Enrollment for Vulnerable Children

In April 2016, the OCA undertook a review of school districts' school registration requirements in response to concerns raised with the OCA regarding onerous criteria that made school enrollment difficult for certain at-risk or vulnerable children. Specifically, the OCA was concerned about access to school for homeless youth, undocumented children, and children involved with the Department of Children of Families (DCF). The OCA sampled 18 different school districts' registration criteria to compare requirements and found than many school districts were utilizing criteria that the U.S. Department of Justice found potentially unlawful and that may have the impact of discouraging enrollment of undocumented and/or homeless youth in public school. The OCA discussed the relevant issues and remedies to the findings with stakeholders from the State Department of Education, which Department pledged to address the concerns with local school districts. The published memo can be found on the OCA website at: MEMO: OCA Review of Districts' School Registration Requirement (August 2016).

Preventing Suspension of Young Children from School

In September 2016, in response to an alarming number of reported school suspensions for children under the age of 7, the OCA, in partnership with the Center for Children's Advocacy, published an issue brief sharing information about the practice of exclusionary discipline for very young children, the resulting harms to vulnerable young students, and suggested solutions to better support children and their teachers. The OCA continues to work

with state and local partners regarding solutions to improve outcomes for young children in schools who have experienced significant trauma, the most likely group of children to be suspended. The suspension issue brief can be found at: http://www.ct.gov/oca/lib/oca/SuspensionYoungChildren_OCA_CCA_2016.pdf

Investigation—Critical Injuries to Baby Dylan C. in Foster Care

In October 2016, the OCA published an investigative report detailing the circumstances leading to the critical injuries and near death of one year old Dylan C. from child abuse and neglect while in the care of the Department of Children and Families in 2015. The report makes recommendations for change to ensure that no child completely dependent on the state for his or her care will languish in similar deprivation or experience such abuse. The OCA assisted with the development of P.A. 17-92 which codifies several of the recommendations from the OCA's report. The full report can be found at: http://www.ct.gov/oca/lib/oca/OCA Investigative Report Dylan C. pdf

Investigation—Education for Young Children with Disabilities

Also in October 2016, the OCA published an investigative report detailing education service delivery for preschool age children with disabilities entering New Britain public schools. In its investigation, the OCA identified an alarming number of children with significant developmental delays who received services inconsistent with best practices and/or state guidelines. The report contained a number of strategies and recommendations to ensure that the District improved IDEA Compliance and educational services delivery for children entering from birth to three or otherwise in need of special education services. Following the investigation but prior to issuance of the OCA's report, the District took steps to address the issues identified by the OCA. The full report can be found at: Investigative Report: Education Service Delivery for Preschool Age Children with Disabilities Entering New Britain Public Schools (October 27, 2016)

Investigation—Hartford Public Schools' Compliance With Mandated Reporting of Child Abuse and Neglect

In February 2017, the OCA published an investigatory report concerning compliance of Hartford Public Schools ("HPS") with state laws regarding mandated reporting of child abuse and neglect. The investigation identified deficiencies in HPS's mandated reporting policies, procedures and practices. The report contained a number of strategies and recommendations to ensure that HPS was adequately protecting children from potential abuse/neglect, many of which have begun to be implemented by HPS. The OCA continues to work closely with state and local officials to implement strategies that will improve children's safety in the school environment. The full report can be found at: Investigative Report Regarding Compliance of Hartford Public Schools with State Laws Regarding Mandated Reporting of Child Abuse and Neglect

PUBLIC POLICY & LEGISLATIVE ADVOCACY

Legislative Advocacy

In addition to our continued commitment to responding to legislators' requests for assistance in understanding the special and often complex needs of children, and providing reliable information about the efficacy of publicly funded child serving systems, the OCA submitted legislative testimony on multiple proposed bills during the 2017 session. The OCA testified in support of improving services and supports for children with developmental disabilities, mandated reporting of suspected child abuse and/or neglect, juvenile justice system improvements, strengthening child welfare quality oversight, and protecting the rights of children related to educational issues. The OCA presented lawmakers with recommendations from its report on *Dylan C.* to improve the safety net for abused and neglected children in foster care. Such recommendations were codified by the legislature in Public Act No. 17-92, which Act requires DCF to report to the Juvenile Court regarding the safety and appropriateness of a child's placement in foster care, any treatment/developmental/education needs the child has and a timeframe for ensuring those needs are met.

Policy Advocacy—Improving Outcomes for Children with Developmental Disabilities

The OCA has been an active member of the legislative multi-stakeholder working group established under Public Act No. 16-142 *AN ACT CONCERNING RECOMMENDATIONS FOR SERVICES PROVIDED TO CHILDREN AND YOUNG ADULTS WITH DEVELOPMENTAL DISABILITIES,* which work-group is directed to examine and report on the adequacy and efficacy of the state's continuum of services for children and youth with complex developmental disabilities. The OCA frequently speaks to and advocates on behalf of families who have children with complex developmental support needs that are not capably met in our current health care system. Many of those families are in crisis, and some children have been forced to stay in emergency rooms for weeks on end as they await appropriate and safe care. The OCA has been working closely with public health partners and legislators to examine these crises and propose urgent reforms to ensure that no child and family lacks access to badly needed care and a safe environment.

The Office of the Child Advocate's mission includes providing education and training to stakeholders and the public regarding issues affecting children's welfare. Through our growing listserv, the OCA continues to disseminate policy updates, disability rights' advisories, and tips for caregivers regarding issues frequently brought to the OCA. The OCA regularly facilitates or participates in trainings in local communities both for professionals and caregivers. Trainings included workshops for lawyers representing abused and neglected children, children with developmental disabilities, suicide prevention, special education, and training to community partners on the responsibilities of the OCA.

COMMUNITY PARTNERSHIPS, COMMITTEES, TASKFORCES, & WORKING GROUPS

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

OCA maintains an active role on:

- CT Behavioral Health Partnership Oversight Council ("BHPOC") and BHPOC subcommittee on Quality Access
- Juvenile Justice Oversight and Policy Council
- PA 16-142 MAPOC Subcommittee on Children with ID/DD
- Commission on Racial and Ethnic Disparity in the Criminal Justice System
- CT Juvenile Justice Alliance Advisory Committee
- Alliance for Children's Mental Health
- Children's Committee Results Based Accountability Report Card Working Group
- CT Interagency Restraint & Seclusion Prevention Steering Committee
- Children Exposed to Family Violence Task Force