THE OFFICE OF THE CHILD ADVOCATE

ANNUAL REPORT

JUNE 30, 2017 to JULY 1, 2018

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.

The statuary duties and responsibilities of the OCA include:

- Evaluating 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.

The OCA has 7 full-time employees and an operating budget of approximately $630,000. The OCA staff is multidisciplinary, comprised of legal, health, mental health, social work and human service specialists. OCA is 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, Smith College and Boston 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.

RESPONDING TO CITIZEN CONCERNS: OCA OMBUDSMAN ACTIVITIES

Between July 1, 2017 and June 30, 2018, 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 and other family members, 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.

The OCA provides information and advises callers in how to navigate often complex service systems. The OCA also assists families by reviewing records, communicating with state and community-based agencies and advocating to ensure the needs of children are addressed. Frequent issues addressed or investigated by the OCA this year included: concerns regarding children served by DCF; unmet needs of children with complex mental health needs; lack of access to appropriate special education services for children with disabilities; acute and chronic lack of access to adequate services for children with developmental disabilities, who often have co-occurring mental health disorders or special health care needs; and concerns about children who are bullied or inappropriately disciplined in schools.

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, 2017 to December 31, 2017, 154 child fatality cases were reported to the OCA by OCME. Of those child fatality cases, 84 deaths were determined to be from natural causes and 70 deaths were from unintentional or intentional injuries. Over 50% 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 leading cause of accidental death in the state, for the first time surpassing motor vehicle related fatalities.

7 year Overview	2011	2012	2013	2014	2015	2016	2017	Total
Accident	34	33	35	18	30	30	29	209
Undetermined	16	17	17	21	19	19	15	124
Homicide	13	27	12	15	11	7	12	97
Suicide	9	12	10	6	12	8	14	71

2017 UNINTENTIONAL AND INTENTIONAL INJURIES

29 Accidental (Unintentional) 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.

- 8 infants died from positional asphyxia (lay-over by an adult or sibling or suffocation, unsafe sleeping)- the leading cause of accidental deaths of children in CT. These infant deaths, coupled with the category of undetermined infant fatalities (15), **surpassed all other manners of death for children**.
- 7 children died in motor vehicle related fatalities; 5 were passengers, of which 4 teens, 1 was a sole teen driver and 1 was a toddler pedestrian/roll-over. For the first time in over twenty years, motor vehicle related deaths was not the leading cause of death of children.
- 6 children died from accidental drowning-5 in open bodies of water (pools-ponds-ocean) and 1 infant drowning in a bucket.
- 8 children died from various forms of accidental causes including drug overdose, choking, house fire, accidental hanging, falls, and other trauma.

15 Undetermined (Unintentional) 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.

- 15 child deaths were classified as undetermined; all were infants.
- Most of these 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, 8 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.

14 Youth Suicides:

- 2017 youth suicide deaths was significantly increased from 2016. 14 youth died by suicide in 2017 as compared to 8 deaths in 2016.
- All of the youth who died from suicide were teenagers between the ages of 12-17.
- 8 were boys and 6 were girls.
- 9 of the 14 youth died from asphyxia by hanging.
- 12 of the 14 youth were white.

12 Child/Youth Homicides:

- 2017 homicide deaths of children/youth also saw an increase over 2016. 12 children/youth died by homicide in 2017 as compared to 8 in 2016.
- 5 homicide victims were infants and toddlers, all were boys.
- 6 homicide victims were teens (ages 14-17), 5 were boys.
- 1 child victim of homicide was 9 years old.

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.

FATALITY INVESTIGATION

In December 2017, OCA released an investigative report into the circumstances surrounding the homicide death of Matthew Tirado, a 17 year old youth with autism and intellectual disability. http://www.ct.gov/oca/lib/oca/MT_final_12_12_2017.pdf. The investigation found that multiple publicly funded systems failed in their responsibilities to protect this highly vulnerable youth and that all systems needed to improve their ability to serve children with developmental disabilities. Multiple systemic reforms are underway following the release of the OCA report and a subsequent legislative hearing, including the following:

- PA 18-71 requires DCF, in collaboration with the Offices of Early Childhood, Developmental Services and Social Services to develop investigation, assessment and case-planning procedures that are responsive to the needs of children with intellectual and developmental disabilities. A report on this work is due to the legislature by February 1, 2019.
- The State Department of Education (SDE) has convened a working group focused on chronic absenteeism and children with disabilities. OCA is an active participant, along with other stakeholders.
- The Connecticut Judicial Branch changed court rules to ensure that no child protection case is closed early without a demonstration that closing the case serves the best interests of the children. The Branch also sought additional training for judges regarding child protection cases that involve children with developmental disabilities.
- The Public Defenders' Office committed to offering training for lawyers on representing children with disabilities.

In follow up to a significant finding of the MT fatality investigation, OCA initiated a review of 6 school districts to examine whether there were other children who were permanently removed from school for the stated purpose of homeschooling and where the family had histories with DCF due to concerns of child abuse or neglect—OCA found that dozens of children in the six sampled districts lived in families that had been investigated multiple times by DCF; that Connecticut, unlike most states, has no law regulating the permanent withdrawal of children from school; and that after a child is withdrawn from school to be homeschooled there is no follow up. OCA issued a public report in April 2018, and after a public hearing, legislators committed to learning more about the issue and examining the need for a safety net for high-risk children. The report can be found here: http://www.ct.gov/oca/lib/oca/OCA.Memo.Homeschooling.4.25.2018.pdf

In November 2017, OCA convened an initial meeting between DCF, DDS and OCA to discuss cross-agency workforce development needs, specifically related to building state agency competency regarding risk and vulnerability assessment of children with developmental disabilities. The interagency group has expanded to include the Departments of Social Service, Education, and Early Childhood, with the University of CT Center for Excellence in Developmental Disabilities and UCONN's Institute for Collaboration on Health, Intervention, and Policy providing research and academic support.

In response to reports of several infant deaths in day care settings, the OCA is completing a review of individual infant death circumstances as well as the state's regulatory framework designed to protect young children in day care settings. A public report is pending.

- In addition to its investigatory work and publications, OCA actively participates on several committees, taskforces, and working groups, local and national, focused on prevention efforts for child at risk of intentional and unintentional injuries/fatalities.

COMMITTEES, TASK FORCES & WORKING GROUPS

Suicide Prevention Initiatives
Statewide Suicide Advisory Board

Infant and Toddler Initiatives
Maternal Child Health Coalition
Every Woman, CT
Prevent Child Abuse America, CT Chapter
Substance Exposed Infants Work Group
Abusive Head Trauma 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.

During the past year, the OCA facility oversight activities included the following:

- OCA continues to assess and monitor conditions of confinement and treatment for children and youth in the state's juvenile/youth correctional and adult correctional facilities, as well as the state hospitals, for the purpose of supporting and guiding practice improvement and reform.
- OCA staff have been investigating conditions of confinement for incarcerated youth confined by multiple agencies, with a report expected in late 2018.
- OCA continues as an active member of the legislative Juvenile Justice Policy and Oversight Council (JJPOC).
- As part of OCA's facility investigation work, OCA staff meet with dozens of youth with complex needs served in state funded/operated facilities and worked to identify and address youth's unmet needs.
- OCA has continued to monitor the care and treatment provided youth at the DMHAS operated CT Valley Hospital Young Adult Unit. Pursuant to concerns identified through contacts with specific youth, OCA initiated multiple stakeholder meetings inclusive of state agency administrators, mental health professionals and mental health advocates, focused on the needs of older youth with extremely complex mental health disorders and ensuring accountability for high quality care and treatment.

CHILDREN WITH DISABILITIES

OCA continues to examine the state's continuum of services for children with complex developmental disabilities and advocate for needed systems development and enhancement. This work includes examination of both access to and quality of special education services, critically needed home and community services and intensive treatment programs. OCA continues active participation on the Developmental Disabilities working group established through P.A. 16-142 and was a lead contributor to reports offering findings and recommendations to improve access to critically needed services, reduce emergency department and hospital stays, and strengthen family support. Those reports can be found at: https://**www.cga.ct.gov/med**

OCA continues its collaboration with the CT Interagency Restraint and Seclusion Prevention Initiative. The group has expanded to include more than 10 state agencies, private sector providers, education professionals, as well as increased voice of persons with lived experience. Funding constraints precluded a statewide conference in 2017, but the group continues to meet monthly to share information and updates on practice reforms across service systems. A statewide conference is planned for the fall 2018.

OCA has been an active participant on the Hartford Public Schools Monitoring Advisory Group, established in response to OCA's 2017 investigatory report detailing serious deficiencies in the district's compliance with mandated reporting of suspected child abuse and neglect. The OCA investigation found that children with disabilities were particularly vulnerable. Hartford Public Schools have additionally engaged with outside experts to assist them in improving educational services to children with developmental disabilities.

In November 2017 OCA published an issue brief detailing concerns regarding school districts' utilization of homebound instruction, disproportionately affecting children with disabilities. Under federal law, homebound instruction is considered the most restrictive setting and permissible under limited circumstances. OCA's review of 17 sampled districts, over a two year period, found more than 500 students each year, many with disabilities, were placed on homebound status for at least part of the year, for medical and non-medical reasons. Many students remained on homebound status for several months or even longer. The State Department of Education has committed to working with OCA and other stakeholders to ensure children are educated in the least restrictive environment appropriate to their needs. Report can be found here: http://www.ct.gov/oca/lib/oca/OCA_homebound_issue_brief_nov_2017.pdf

YOUNG CHILDREN

In February 2018, the OCA in partnership with the Center for Children's Advocacy and the Child Health and Development Institute of Connecticut, Inc. published a policy brief *Setting Young children Up for Success: Decreasing Suspension by Investing in Social and Emotional Development*. The goal of this policy brief is to provide best practice strategies, including local examples of effective models that will decrease the number of young children excluded from school through recommendations that will also improve children's social-emotional development and capacity to learn. http://www.ct.gov/oca/lib/oca/Setting_Young_Children_Up_for_Success_Policy_Brief_Feb_2018.pdf

LEGISLATIVE ADVOCACY

OCA continues to serve as a resource to legislators contemplating matters related to child safety and well-being across all child serving systems, responding to their requests for information and assistance as well as actively participating on multiple legislative working groups. During the 2018 legislative session provided testimony on more than 2 dozen bills pertaining to juvenile justice, child welfare, education and children with disabilities. OCA investigatory reporting and testimony contributed to the passage of PA 18-31, involving sweeping juvenile justice reforms across multiple systems.

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.

PARTNERSHIPS

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 a variety of task forces and work groups

- CT Behavioral Health Partnership Oversight Council ("BHPOC") and BHPOC subcommittee on Quality Access for Children
- Juvenile Justice Oversight and Policy Council
- PA 16-142 MAPOC Subcommittee on Children with D/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
- Autism Spectrum Disorder Advisory Council

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