OFFICE OF THE CHILD ADVOCATE ANNUAL REPORT

July 1, 2018 to June 30, 2019

Safety and security don't just happen, they are the result of collective consensus and public investment.

We owe our children, the most vulnerable citizens in our society, a life free of violence and fear." Nelson Mandela

STATUTORY DUTIES OF THE OFFICE OF THE CHILD ADVOCATE

- Advocate on behalf of children in Connecticut
- Periodically review facilities in which juveniles are placed
- Review the circumstances of the death of any child due to unexpected or unexplained causes
- Periodically review the procedures of state agencies
- Evaluate the delivery of services provided to children
- Take all possible action necessary to secure the legal, civil, and special rights of children
- Review the needs of children in foster care and/or permanent care facilities
- Review the needs of children with special health care needs
- Engage in legislative advocacy and make policy recommendations
- Review and investigate complaints regarding services provided to children

A MESSAGE FROM THE CHILD ADVOCATE, SARAH HEALY EAGAN, JD

The Office of the Child Advocate ("OCA") was created by the state legislature in 1995 after the tragic death of an infant in state care. The child's death made clear to legislators that an independent agency with authority to investigate and report information to the public was necessary to ensure the well-being of children and to ensure transparency for state-funded services to Connecticut's most vulnerable citizens.

The OCA uses its resources to focus on children who are most at risk in our society: children who have been abused or neglected, children with profound disabilities who are dependent on critical supports, including children enrolled in Connecticut schools and children in institutional facilities. These children and their families often need the most help to ensure their needs are met and their rights protected.

Systems of care for children with complex needs or who are at risk of harm have improved over time, but for the most vulnerable there is always need for continued reform and transparency. OCA staff strongly support the office's mission to pull back the curtain on how the needs of vulnerable children are met, always striving to emphasize the humanity of each child, the goals and concerns of their families and loved ones, and the common bonds we all share to ensure that children are safe and well, with equal opportunity to survive and thrive.

As the Child Advocate, I am so grateful for the hard work of so many people in this state who are dedicated to protecting and supporting children, or who advocate for their own children and the children in their communities. The mission of the OCA must be to shine a light on children who, despite our collective efforts, still need the most help. We support public policies that promote the inherent dignity and worth of every child and their inalienable human rights, without regard to their race, ethnicity, disability, or immigration status. We have made so many strides as a state, as a community. However, OCA continues to find that concerns regarding lack of access to appropriate mental health, developmental support, or special education services persistently and disproportionately affect children of color, and our collective work must urgently address this injustice.

I am privileged to lead the Office of the Child Advocate, honored to work with its staff and our colleagues across the state, humbled to be able to offer help and support for families, and committed to another year of advocating for our state's children.

Sarah Healy Eagan

RESPONDING TO CITIZEN CONCERNS: CALLS FROM THE COMMUNITY

For the time period July 1, 2018 through June 30, 2019, the OCA responded to approximately 500 concerns regarding the provision of state and state-funded services to vulnerable children. The OCA hears from 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 in need of help. 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 seeks to be responsive to the concerns of everyone reaching out with a question or concern by providing guidance about how to effectively navigate the state's often complex service systems. In the most complex or urgent cases, OCA will undertake 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. Frequent 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 mental health treatment needs or developmental disabilities;
- Safety or permanency concerns for children who have experienced abuse/neglect;
- School safety concerns, including children experiencing bullying, abuse/neglect by school staff, or inappropriate discipline;
- Children with unmet needs housed in both the juvenile and adult correctional systems.

The OCA interacts regularly with the staff and executive administrations of several state agencies and government officials including 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.

CHILD FATALITY REVIEW & PREVENTION

As outlined in Connecticut General Statute § 46a-13l(c), the OCA and the state's Child Fatality Review Panel (CFRP) are 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 address patterns of risk to children, improve coordination of services to children and their families, and strengthen fatality prevention strategies.

The CFRP is comprised of professionals from multiple disciplines, and 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 meets monthly at the Office of the Chief Medical Examiner (OCME).

2018 Unexpected Unexplained Deaths of Children

From January 1, 2018 to December 31, 2018, 69 child fatality cases were reported to the OCA by OCME for purpose of an autopsy for an unexpected/untimely death of a child. Of those child fatality cases, 57 deaths were from unintentional or intentional injuries and 12 deaths were determined to be from natural causes (including SIDS, Asthma, and other medical complications).

CT Child Fatality Data

Eight- year Overview	2011	2012	2013	2014	2015	2016	2017	2018	Total
Accident	**34**	**33**	**35**	**18**	**30**	**30**	**29**	**23**	**232**
Undetermined	**16**	**18**	**17**	**21**	**19**	**19**	**15**	**19**	**144**
Homicide	**13**	**27**	**12**	**15**	**11**	**7**	**12**	**8**	**105**
Suicide	**9**	**12**	**10**	**6**	**12**	**8**	**14**	**7**	**78**

2018 Data

Twenty-Three Accidental (Unintentional) Child Deaths (23)

Key Points

- *Accidental deaths of children in Connecticut continue to trend downward.*
- *Drowning is the leading cause of preventable death for children age 1 to 4.*

- 6 children died from accidental drowning.
  - 5 children died in pools; 1 child died in a lake.
  - 4/6 children were black, consistent with year to year trends indicating that children of color in Connecticut drown more often that white children.

- 5 infants died from positional asphyxia
  - lay-over by an adult or sibling; or
  - accidental suffocation due to unsafe sleep environment

- 4 children died in motor vehicle related fatalities:
  - 2 teen drivers;
  - 1 passenger;
  - 1 child died in a roll-over.

- 4 teens died from drug overdoses;

- 4 children died from various forms of accidental causes including, choking, falls, and hyperthermia.

2018: Nineteen Undetermined (Unintentional) Child Deaths (19)

An undetermined death is a category used by the OCME where upon the completion of an autopsy there are no definitive findings of accident, disease, trauma, or injury.

Key Points

- *The largest cohort of children that died in this category were infants who were found in unsafe sleep environments.*
- *More than half of the infants who died were children of color. Most of these infants were Black, and they accounted for more than 40 % of the infants who died in unsafe sleep environments. The disproportionate death of Black infants in Connecticut mirrors national child fatality data, necessitating that public health professionals urgently address issues of racial disparities in health outcomes for pregnant and parenting women and their children.*

- 16 of the 19 undetermined deaths were infants found in an unsafe sleep environment, such as 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, 5 other infants died from positional asphyxia, also a result of the infants' unsafe sleep environment, bringing the total number of infants whose deaths coincided with or were caused by unsafe sleep environments to 21.

- 3 other Undetermined child deaths were from other causes.

2018: Seven Youth Suicides (7)

Key Points

- *Suicide has risen to be the second leading cause of death nationwide for children age 10 and above.*
- *Historically, most children who died from suicide were white, but children of color are increasingly represented in this child fatality group.*

- All of the children who died from suicide were between the ages of 11-17, with a median age of 16;
- 4 children were boys and 3 were girls. Six of the children died from asphyxia by hanging.

2018: Eight Homicides (8)

Key Point

- *The 4 children who died from gun violence were all Black males, with an age range of 12 to 17 years old.*

- 1 homicide victim was an infant who died from child abuse;
- 3 children died from stab wounds;
- 2 children were between 10-12 years old;
- 5 homicide victims were teens (ages 15-17).

CHILD FATALITY PREVENTION COMMITTEES, TASK FORCES & WORKING GROUPS

Infant and Toddler Initiatives

- Maternal Child Health Coalition
- Every Woman, CT
- Substance Exposed Infants Work Group
- Home Visiting Consortium

Youth & Teen Safey

- Department of Motor Vehicles Commissioner's Advisory Committee
- CT Teen Driving Safety Partnership
- Trafficking of Persons Council
- Domestic Minor Sex Trafficking Committee
- Suicide Advisory Board

Prevention Initiatives

- Prevent Child Abuse America-CT Chapter
- Governor's Task Force on Justice for Abused Children
- CT Violent Death Registry Advisory Board
- Domestic Violence Fatality Review Task Froce

CHILD FATALITY REVIEW PANEL MEMBERSHIP

Ex-Officio Government Members

- Office of the Child Advocate
  Sarah Healy Eagan, JD
- Office of the Chief States Attorney
  Anne Mahoney, JD
- Office of the Chief Medical Examiner
  Dr. Gregory Vincent
- Department of Emergency Services & Public Protection
  Lt. Seth Mancini, JD
- Department of Children and Families
  Ken Mysogland, MSW
- Department of Public Health
  Amy Mirizzi, MPA

Legislative Appointment & Appointing Authority

- Governor
  Dr. Kirsten Bechtel 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
  Dr. Steven Rogers: CT Children's Medical Center
- Majority Leader of the House
  Dr. Regina Wilson
- Speaker of the House
  Dr. Pina Violano Yale Injury Prevention
- President Pro Tempore
  Law Enforcement, Vacant

CFRP Appointments

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

OCA FACILITY AND FATALITY INVESTIGATIONS

The OCA staff visit children in publicly operated and regulated settings including, but not limited to, hospitals, residential treatment programs, detention, correctional institutions and schools. OCA's governing statute authorizes its staff to meet with children, assess the safety and appropriateness of their environment, interview program staff and administration and review program and child-specific records thus allowing for a full review of the efficacy of state-funded services provided. 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, within available resources.

OCA Report -- Solnit Center's Psychiatric Residential Treatment Facility and the Death of Destiny G.

Destiny G. was a sixteen (16) year old girl who died by suicide at the Albert J. Solnit Center a day before she was scheduled to be discharged to a foster home. Destiny was eight (8) months pregnant at the time of her death and her unborn child died as well. OCA investigated circumstances leading to Destiny's death in this state-run and license-exempt facility. OCA's public report addressed numerous deficiencies in the care and treatment of children at Solnit, and OCA offered multiple recommendations to improve the safety and quality of care at Solnit and increase transparency and accountability for state dollars invested in the treatment of highly vulnerable children. OCA's report can be found here: https://www.ct.gov/oca/lib/oca/OCA.SolnitS.Leg.Report.9.26.2018.pdf

In September 2018, the OCA presented its findings and recommendations at a legislative public hearing.

- **Legislative Reforms**. In response to the OCA report and testimony from DCF as well as the Departments of Social Services and Public Health, the legislature passed **Special Act No. 19-16** requiring DCF, in consultation with the Commissioners of Social Services and Public Health and the Child Advocate to submit a report by the end of 2019 with recommendations to end the license-exempt status of Solnit and move forward with oversight from the Department of Public Health. DCF, under the leadership of newly appointed Commissioner Vannessa Dorantes, has committed to improving the quality and transparency of the state operated psychiatric hospital and PRTFs.

  The legislature also passed **Special Act 19-19**, requiring DCF to develop a framework for publishing critical 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.

  The OCA is working closely with DCF and other stakeholders to further the goals outlined in these new state laws.

OCA Report -- Conditions of Confinement for Incarcerated Youth

In January 2019, at the direction of the legislature, the OCA published an investigative report regarding conditions of confinement for youth detained or incarcerated in the juvenile and adult criminal justice systems, examining suicidal behavior, restraint and seclusion, adequacy of programming and education, family engagement and child abuse/neglect.

OCA's chief finding was that children of color are disproportionately incarcerated in Connecticut's state-run facilities, disproportionality which cannot be explained by differences in delinquent behavior across racial and ethnic groups. OCA also found that the deeper youth go into the justice system (i.e. incarceration in the adult correctional system), the less likely they are to receive adequate support necessary to help address their unmet needs, change their behaviors and successfully discharge them back to the community.

- **Legislative Reforms**. OCA's findings and recommendations were presented to the state's Juvenile Justice Policy and Oversight Committee as well as the legislature and served as the foundation for statutory reforms passed during the 2019 legislative session, which include new requirements that state agencies ensure delivery of and accountability for best practices and adequate services to support the rehabilitation and treatment of confined youth, including addressing the persistent practice of solitary confinement. The state is also currently working with national experts to examine alternative and more effective methods for treating youth charged with serious offenses.
- The OCA's report can be found at: https://www.ct.gov/oca/lib/oca/v4/Conditions_of_Confinement_final_January_2019.pdf

OCA Report -- Fatality Review Investigative Report: The Deaths of Nine Children in Unlicensed and Licensed Day Care Settings

In December 2018, the OCA published an investigative report concerning the death of nine (9) children in licensed day care settings over an 18 month period from 2016 to 2017. At the request of the General Assembly's Committee on Children, the OCA conducted a review of the general practices of the Office of Early Childhood ("OEC") with respect to the review, suspension and license revocation of child care programs. The OCA found that the majority of children who died were being served in unlicensed and unregulated (illegal) child care settings, and that the state needed to take additional steps to 1) increase families' access to affordable and high quality child care for infants and toddlers, and 2) strengthen regulation for all licensed child care programs to ensure best practices for infant care and improved attention to safe sleep practices for babies. The OCA worked closely with the OEC and its then-Commissioner, David Wilkinson, to finalize the report's recommendations. The OEC continues to strengthen its framework for ensuring public access to high quality infant care and the state has committed additional funding to support this effort.

The full report can be found at: https://www.ct.gov/oca/lib/oca/Office_of_the_Child_Advocate_Report_on_Child_Care_Fatalities.pdf

COMMITTEES, TASK FORCES & WORKING GROUPS

EDUCATION

- SDE committee on Chronic Absenteeism
- SDE School Safety Collaborative
- Hartford Public Schools, Monitoring Advisory Group

MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/CHILDREN WITH SPECIAL HEALTH CARE NEEDS

- Behavioral Health Partnership Oversight Council
- BHPOC Child/Adolescent Quality, Access & Policy Committee
- Children's Behavioral Health Plan Implementation Advisory Board on Monday
- MAPOC Developmental Disabilities Work Group
- North Central Care Coordination Collaborative
- Interagency Restraint/Seclusion Prevention Partnership

JUVENILE/CRIMINAL JUSTICE

- Juvenile Justice Policy and Oversight Committee (JJPOC)
- JJPOC Incarceration subcommittee

OCA STAFF

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

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