OFFICE OF THE CHILD ADVOCATE

Annual Report

July 1, 2010 to June 30, 2011

Dear Friends of Connecticut's Children,

I offer this annual report to you as an overview of the activities of the Office of the Child Advocate (OCA) for the state fiscal year July 1, 2010 to June 30, 2011. As in previous years, my office remains very busy responding to citizen concerns regarding children, as well as maintaining our continued focus on systemic policy reforms. We endeavor to bring the issues facing children to the forefront by working collaboratively with other stakeholders, task forces, working groups, policy groups, and legislative groups. The OCA continues to respond to hundreds of calls from citizens about their concerns for children. As the ombudsman for Connecticut's children, it is critical that our office keep lines of communication open with all communities so we have a keen understanding of the problems and issues facing children and their families.

This year also brought OCA and eight other watchdog agencies under one administrative umbrella called the Office of Governmental Accountability (PA 11-48). I assure you that OCA maintains its statutory independence along with all of the authority associated with that independence. The most important change will be a newly constituted Child Advocate Advisory Committee. I would like to take this opportunity to thank the current OCA Advisory Committee members for their commitment to the values and mission of the Office of the Child Advocate and their dedication to the children of Connecticut.

Too many children in Connecticut struggle with issues related to extreme poverty, impacting their lives in dramatic ways. Too many of our educational systems continue to struggle to bridge the disparity gap. Children in our state, as with children all over the country, are at risk for substance use, eating disorders, dating related and other forms of violence, bullying, and other health complications.

We can and must do better. In closing, I would like to thank all of our incredible partners who work so diligently despite tremendous resource challenges. We do make a difference in the lives of children and families. The OCA looks forward to our continued partnerships as we move forward during these unpredictable times.

Sincerely,

RESPONDING TO CITIZEN CONCERNS

During FY 2010-2011, the Office of the Child Advocate (OCA) responded to more than 1,200 citizen requests for assistance regarding specific children, investigated concerns and advocated on behalf of more than 400 individual children receiving state funded services, conducted or participated in more than 1,400 child case reviews involving over 1,500 contacts with other state agencies. In addition, the OCA reviewed over 4,000 "significant events/critical incidents" reported by state operated or state funded child caring facilities to the Department of Children and Families-resulting in numerous requests by the OCA for meetings with DCF central administration to discuss troubling data and incidents and urge needed action. Because of OCA's broad authority regarding access to information, including subpoena authority, OCA is often the only entity with access to such comprehensive information. The OCA has used this knowledge and authority to inform and assist other oversight entities including the Governor, the Legislature and the Judicial branch.

PUBLIC POLICY INITIATIVES

As the independent voice for children, we have participated on multiple task forces and committees focused on understanding and addressing the challenges facing children and their families in our state today including, but not limited to, the impact of the recession on children, domestic violence, racial disparity, children's mental health, and suicide awareness and prevention. OCA led prevention efforts on safe sleep, suicide prevention, bullying and injury prevention and continued to provide vigorous advocacy for children with disabilities and special health care needs across public service systems and has contributed numerous recommendations for systems reform across multiple state agencies. In addition, the OCA continued to spearhead efforts to focus attention on the importance of more effective transition planning for young adults leaving DCF care.

I am pleased to report that the OCA was an active participant and provided leadership to Governor Dannel Malloy's transition team "Children's Services Working Group." The OCA, in partnership with Connecticut Voices for Children, the Center for Children's Advocacy, Commission on Children, NAMI, the Juvenile Justice Alliance and other children's advocacy organizations, developed an action plan and roadmap to prioritize the well being of children and families. Priorities included coordinating and integrating public systems and policies, instituting benchmarks and accountability measures, maximizing funding opportunities and revitalizing Connecticut's workforce and economy. The OCA has continued to advocate for Connecticut's children who are placed out of state.

The OCA collaborated with DCF and other advocacy organizations to assess the needs of the children and determine what services and programs need to be implemented in Connecticut in order to bring the children back to Connecticut. DCF's new leadership has committed to dramatically reducing the number of children sent out of state and developing needed resources to serve our children within Connecticut.

LEGISLATIVE ADVOCACY

OCA's legislative advocacy is driven and shaped by the information received through our facility investigations, advocacy on behalf of individual children, trends in concerns reported by citizens, legal involvement, fatality investigations and data. The Child Advocate and OCA staff meet regularly with legislators and policymakers to provide information, respond to their concerns and questions about the provision of state or state funded services to children and develop joint proposals which will improve the safety, well being and permanency of Connecticut's children. During the past year, the General Assembly unanimously passed legislation which will result in sweeping reforms to better protect Connecticut's children while they are in school. The proposals stemmed from the lengthy and exhaustive investigation conducted by the OCA and the Office of the Attorney General.

ADVOCATING FOR REFORMS AND IMPROVING SERVICES TO CHILDREN AND FAMILIES

I am pleased to report this past year the OCA has enjoyed a highly respectful and valued relationship with the Department of Children and Families executive leadership team. The OCA has been an active participant on Commissioner Katz's DCF Transition Team, as well as the DCF Riverview Implementation Team, providing information and insights gleaned from OCA's unique access and extensive child welfare and children's mental health oversight experience. The Department has articulated a vision and plan for long overdue, sweeping reforms.

Implementation has begun, but practice remains inconsistent and infrastructure is uneven and underdeveloped. While we are cautiously optimistic, the children and families of the state must experience the changes. It is critical that the OCA continue to vigilantly monitor the implementation of these reforms, and continue to advocate for change wherever and whenever necessary. Today, there are still too many children who continue to have unmet needs, who are languishing in hospitals and other restrictive settings, who are in need of foster care, who are without an adoptive family, who remain in out of state facilities and whose transition to adulthood is inadequately planned or supported. Additionally, we remain concerned about critically needed reforms with the newly combined Riverview Hospital/CCP and during the last fiscal year, have increased our monitoring in those facilities because of persistent problems with over reliance on restrictive measures, inaccurate data reporting and unreliable quality assurance.

OCA has continued to investigate concerns regarding the safety and quality of care for children placed by the state outside of their families in foster care and congregate care facilities. We continue to review conditions of confinement for youth in state custody and advocate for improvement. OCA also advocates on behalf of many individual children and youth, as well as for broader systemic reforms focused on promoting children's best interest and ensuring quality. OCA also continues to review all unexpected and unexplained child fatalities via the Child Fatality Review Panel (CFRP), providing information about health and fatality risks to children offering an opportunity to examine the effectiveness of state agencies and community programs.

2011 CHILD FATALITY SUMMARY July 1, 2010 to June 30, 2011

Connecticut General Statutes §46-13k established the state's CFRP to review the circumstances surrounding all unexplained or unexpected child deaths. The statutory authority for the CFRP is embedded in the Office of the Child Advocate (OCA) statute. The CFRP reviews a child's death to determine whether there were contributing risk factors that could be impacted by systemic interventions. Identified risk factors are then incorporated into proposed prevention initiatives designed to decrease the incidence of such deaths. As outlined in statute, the goal of the child fatality review process is to "facilitate development of prevention strategies to address identified trends and patterns of risk and to improve coordination of services for children and families in the state". During this period of time the CFRP reviewed 133 child fatality cases.

Accidental Deaths

Twenty-nine children died from accident related injuries; 18 were related to motor vehicle accidents. Of those motor vehicle related fatalities 7 were passengers. Tragically, in one crash 4 teenagers were killed. There were also three 17 year old passengers killed in separate crashes, all of the drivers of those crashes were 18 year-old drivers. Additionally, 7 pedestrians were killed, 4 on streets, 2 while riding bikes, and one child was on a skateboard. The other motor vehicle related fatalities were 3 drives 2 were 16 and one was 15, they were all the sole occupants in their vehicles. Also, during this reporting period, 5 children died as a result of drowning; 4 of those children were under the age of three, the other child was 10 years old. The remaining 6 child deaths from accidents were a combination of overdose, falls, ATV, and asphyxia.

Undetermined Deaths

Fifteen child fatalities accounted for an Undetermined manner of death. Of those 13 were infants.

Homicide Deaths

Ten children died from homicide; 6 were teenagers, 3 were infants, and one was an 8 year-old that died in an arson fire. Of the teenager homicides 4 were boys and 3 were girls. All 3 infants were boys, and the fire fatality was also a boy.

Suicide Deaths

Five children died from suicide; 4 were teenage boys and 1was a teenage girl.

Natural Deaths

The CFRP reviewed 72 natural child deaths, of which 3 were from Sudden Infant Death Syndrome (SIDS). The CFRP also reviewed the deaths of two children that were from other jurisdictions, but died in our state.

OCA Participation in Systemic Initiatives & Partnerships

* Child Poverty and Prevention Council
* Youth Suicide Advisory Board
* Behavioral Heath Partnership Oversight Council
* Speaker's Task Force on Domestic Violence
* DDS Children's Services Committee
* Interagency Suicide Prevention Network
* Domestic Violence Fatality Review
* Family Support Council
* Teen Driving Working Group
* Keeping Infants Safe and Secure Committee
* Statewide Injury Planning Group
* Children of Incarcerate Parents Steering Committee
* Differential Response Steering Committee
* DCF Provider Academy Advisory Board
* Keep the Promise Coalition Children's Committee
* CT Medicaid Care Management Oversight Counsel
* Executive Implementation Team
* Commission of Racial and Ethnic Disparity in the Criminal Justice System
* Juvenile Justice Alliance Steering Committee

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