OFFICE OF THE CHILD ADVOCATE

CHILD FATALITY INVESTIGATION EXECUTIVE SUMMARY—THE DEATH OF MARCELLO M. FROM FENTANYL INTOXICATION- FEBRUARY 2024

The Office of the Child Advocate is issuing a Fatality Investigation Findings & Recommendations Report following the death by homicide of 10-month-old Marcello Meadows on June 28th, 2023, from Fentanyl, Xylazine, and cocaine intoxication.

> The statutory purpose of fatality and critical incident review in Connecticut is to inform statewide child injury prevention efforts. According to the National Center for Fatality Review and Prevention a child fatality must be understood as a "sentinel event that should catalyze action."[1]

Since 2020 in Connecticut, there have been more than 40 fatalities and near fatalities of children under the age of 5 from Fentanyl/opioid intoxication, with many children surviving due to the documented administration of Naloxone by first responders.[2] Marcello is the 11th young child to die from opioid ingestion. Notably, Connecticut has persistently been in the top ten of all states for adult opioid overdoses per 100,000 adults,[3] and public health responses must include specific attention to the needs of caregivers with opioid use disorder and their children.

Marcello's family had an open child abuse/neglect case with the Department of Children and Families (DCF) until three weeks before his death. His mother had outstanding warrants for violation of probation, issued by the court shortly after Marcello's birth, which were served at the time of Marcello's death. OCA examined events preceding Marcello's death including 1) DCF policies and practice regarding safety planning in "in-home cases" like Marcello's; 2) JB-CSSD policies for supervision of adult probationers and individuals under supervision who are using Fentanyl and caring for children; and 3) provision of services to Marcello's mother by DCF and JB-CSSD.

OCA found that though agencies involved with this family provided supervision and referrals to community-based treatment, they did not comply with all their respective policies and procedures regarding risk and safety management. Although OCA supports treatment focused family preservation efforts whenever safe and feasible, OCA finds that agencies' policies and processes for assessing and managing risk and safety in the context of caregiver substance misuse require further improvement with concurrent quality improvement activities.

Of particular note, OCA finds that DCF's practice with "in-home cases" like Marcello's (cases that are open with DCF but where the child remains at home) requires urgent attention. This is the third

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[1] Child Death Review Process as outlined by the National Cener for Fatality Review and Prevention. Found on the web at: https://ncfrp.org/cdr/cdr-process/ (last accessed January 8, 2024).

[2] OCA review of Exceptional Circumstance notifications drafted and disseminated by DCF based on reports to DCF of suspected abuse/neglect.

[3] Centers for Disease Control and Prevention SUDORS Dashboard: Fatal Overdose Data (updated December 26, 2023) available at: https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html (last accessed February 16, 2024); see also 2021 Opioid Overdose Death Rates and All Drug Overdose Death Rates per 100,000 Population (Age-Adjusted), Source: KFF.org Health facts.

fatality report that OCA has published in the last year regarding the death by homicide of a child under active or recent DCF supervision (two of the children died from Fentanyl intoxication).[4] DCF is making numerous efforts to strengthen practice. However case reviews and DCF systems data continue to show persistent deficiencies in safety planning and case management. Available data shows a marked decline in DCF's risk and safety assessment and case supervision over the last two years. OCA's full report makes several recommendations for the agency's and policymakers' consideration and OCA and DCF remain in regular discussion about these dynamic challenges.

OCA shared drafts of this Report with the agencies and accepted feedback. Responses are summarized and/or included at the conclusion of the Full Report (Attached). OCA acknowledges the constructive dialogue and cooperation of all state and local agencies with this review, and notes that each agency is committed to ongoing work to address systemic issues identified herein.

NOTE: Ms. Polino is criminally charged in connection with Marcello's death, and information regarding relevant aspects of her criminal history, treatment, and involvement with DCF are contained in public databases and documents.[5] OCA reviewed additional records from state and local agencies and interviewed stakeholders/professionals to complete this fatality review.

Summary of Findings and Recommendations

- Marcello's mother, Alexandra Polino, had a long history of involvement with the criminal justice system, and had been on probation for several years prior to Marcello's birth. Records reflect persistent concerns about opioid misuse.
- Marcello's older sibling was born in 2019 and tested positive for illicit opioids; complete information was not reported to DCF by the hospital and no case was opened.
- Due to ongoing concerns about Ms. Polino's substance misuse, in 2022 probation staff assessed Ms. Polino as in need of high supervision and referred her for community services. Ms. Polino completed services and was discharged successfully. Contrary to agency policies, probation staff did not conduct a home visit as part of its supervision, and the need for a DCF report was not assessed.
- On July 20, 2022, Ms. Polino was arrested for larceny and risk of injury to a child after being caught shoplifting with her three-year-old present. A DCF report was made by police and accepted for investigation. Ms. Polino was deemed by probation staff to be in violation of the conditions of her probation and applications for violation of probation warrants were submitted to the courts. Warrants issued in September 2022.
- Following Ms. Polino's July 20th arrest JB-CSSD staff had no further contact with her until after Marcello's death and did not conduct agency-required activities to serve the outstanding warrants.
- August 2022, Marcello was born, exposed to cocaine and opioids. He was diagnosed with Neonatal Opioid Withdrawal Syndrome (NOWS) and Failure to Thrive. A report to DCF was

[4] Liam Rivera: OCA Fatality Report 2023 and baby Kaylee: OCA Fatality Report 2023.
[5] Information contained in this report regarding the results of substance use testing is also contained in criminal records related to Ms. Polino.

made by the hospital and a Safety Plan was created by DCF to ensure his and his three-year-old sibling's safety and engage their mother in treatment.

- DCF did not conduct adequate background checks and assessments on Marcello's parents: probation records were not obtained regarding either parent. The father's DCF history (due to substance misuse) was not identified or reviewed by DCF staff until several months into the case. Marcello's father never completed the toxicology screen required by DCF. Nonetheless he was identified early on as the "sober caregiver" in the DCF Safety Plan.
- Though DCF staff utilized an initial Safety Plan to keep the family together, staff did not follow multiple DCF expectations for supervision and monitoring of the Plan.
- DCF staff made an appropriate referral for in-home substance abuse treatment services. However, the DCF contracted treatment service, Family Based Recovery, did not comply with policies regarding drug testing and discharge. DCF likewise did not ensure regular, random, or supervised Fentanyl testing as part of Marcello's Safety Plan.
- Ms. Polino participated in methadone treatment. Records do not reflect coordination between providers and DCF regarding Fentanyl testing or safety planning.
- Visits by DCF to Ms. Polino's household met the agency standard for frequency (minimum two times per month), and were conducted in person per agency policy. Contrary to agency policy, records do not reflect an assessment of the need for unannounced visits as part of the Safety Plan.
- During scheduled visits to see Ms. Polino, frequently at a relative's home, FBR treatment providers and DCF observed Marcello and his sibling to be doing well. Marcello's father however was not seen or interviewed for several months while the case was pending and the actual residence of Ms. Polino and the children remained unverified.
- Between August and December 2022, no lab testing for Fentanyl was conducted. Once lab testing commenced, Ms. Polino tested positive multiple times, including three times in March and April 2023, after which she denied knowingly using illicit substances. No DCF Safety Plan was renewed as required by policy, despite staff being aware of the positive tests.
- In May 2023, two drug screens were conducted by FBR, and results were negative. There is no documentation that the screens were supervised as required by provider policy.
- No Fentanyl testing was conducted in June. The June 2023 record from the FBR provider inaccurately documented that Ms. Polino had met criteria for successful discharge and did not note her recent positive tests. (FBR policies require the client to produce twelve consecutive negative screens prior to "successful" discharge.)
- On June 7, 2023 DCF closed its case citing Ms. Polino's successful completion of treatment.
- On June 27, 2023, Ms. Polino's methadone provider requested a welfare check on Ms. Polino as she had not been seen or heard from since June 6, and she usually came in weekly. Police completed a welfare check at 2:32 P.M., and the record notes no vehicle in the driveway and no movement inside the home.
- On June 28, 2023, Marcello was found deceased in Ms. Polino's relatives' home, where Ms. Polino and the children were apparently residing. Toxicology tests ordered by the Office of the Chief Medical Examiner (OCME) confirmed Marcello had ingested Fentanyl, cocaine, and Xylazine.

- Post death investigation found evidence of opioid use in the home. Police search and lab testing found glassine bags/wax folds in the trash can of the main bedroom where she slept with the children, with laboratory testing identifying cocaine on certain items and Ziplock bags that tested positive for Fentanyl, Xylazine, caffeine, and cocaine.

Probation Findings Summary

- In discussion with OCA, and consistent with findings regarding the death by homicide of 2-year-old Liam Rivera (which included a review of Probation supervision of Liam's father), JB-CSSD acknowledged that Probation staff did not adhere to various agency supervision policies: staff did not follow policies pertaining to case documentation, home visits for high risk cases, or activities to serve Ms. Polino with the outstanding warrants.

DCF Findings Summary

- DCF staff adhered to certain agency policies and guidelines. The frequency of visitation and internal case supervision met minimum agency standards, and community services were provided. However, staff did not comply with various agency expectations for safety planning and case supervision.
- DCF closed its case with Marcello's family in June 2023 despite Ms. Polino having tested positive for Fentanyl on multiple occasions, and without conducting a meaningful assessment of Marcello's father.
- The case record reveals no initial plan for reliable Fentanyl testing of either parent as part of Marcello's safety plan, a lack of timely documentation and agency response to positive Fentanyl screens rendered by Ms. Polino, and inadequate safety planning.

Treatment Findings Summary

- Treatment records show that the mother's in-home treatment provider did not adhere to the treatment model's (Family Based Recovery) requirements regarding drug testing, interagency communication, and discharge documentation. The quality of services was affected by staff turnover and inadequate supervision.
- While Ms. Polino also received services from a Medication Assistance Treatment provider, there was no coordinated communication between the two treatment providers and DCF.

Recommendations

1. Though JB-CSSD has numerous quality assurance reports regarding various aspects of pretrial and probation supervision, the agency should ensure consistent real-time audits of high supervision cases to determine systemic fidelity to agency expectations
    - JB-CSSD is implementing this central audit system.
2. Quality assurance protocols by the Family Based Recovery model developer should be revised to strengthen audit protocols across provider sites to ensure fidelity to the model expectations, with additional resources from DCF to support quality assurance, staff recruitment and retention and high-quality service delivery.

- The Family Based Recovery model developer has committed to various revisions in agency practice, including enhanced safety assessment. Dialogue with OCA continues.

3. Further operational improvements to DCF's safety planning in caregiver substance abuse cases is indicated, including: 1) greater specificity in the plans regarding how a safety factor is being mitigated; 2) a clear plan for service delivery and frequent drug testing; 3) documentation in the safety plan of the DCF monitoring and visitation plan; 4) a documented communication plan with service providers; and **perhaps most importantly 5) a targeted agency quality assurance plan** that includes a dynamic methodology for review of safety plans and related supervision.
    - DCF is working with consultants to enhance its internal CQI framework; OCA and DCF remain in active dialogue regarding these challenges.
4. Policymakers should work with DCF to address factors contributing to inconsistent practice, including staffing challenges, the impact of widespread virtual work, and community service gaps, so that monitored plan for improvement can be established.
5. State statute should be amended to strengthen the role of the DCF Statewide Advisory Committee (SAC) to enhance membership, align the SAC's duties with federal requirements,[6] and include a focus on DCF's resources, safety practice, child and family outcomes.
6. The state's Alcohol Drug Policy Council should develop best practices for safety planning in the context of parental substance misuse. The ADPC should also examine the adequacy of available treatment options and related services for caregivers with substance use disorder and their children, with specific attention to barriers to treatment for caregivers with children.[7]
7. State agencies should promote public health messaging regarding the safe use of Naloxone with infants and young children.

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[6] Sections 106(c)(4)(A)(i) and (ii) of the Child Abuse Prevention and Treatment Act (CAPTA).

[7] Public Act 23-97 required coordination amongst multiple state agencies (DCF, DSS, DMHAS, OEC) to evaluate and provide recommendations regarding programs for caregivers with substance use disorder. The agencies are also charged with reporting to the legislature for the 2024 session "areas where additional substance use disorder treatment services are needed." The agencies' report to the legislature should help launch the continuing work of the ADPC.