CHILD FATALITY INVESTIGATION FINDINGS & RECOMMENDATIONS

FEBRUARY 2024

STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE
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INTRODUCTION AND METHODOLOGY

The Office of the Child Advocate is issuing this Fatality Investigation Findings & Recommendations Report ("Findings 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. Marcello's mother had outstanding warrants for violation of probation, issued by the court shortly after Marcello's birth, brought forth by the Judicial Branch, Court Support Services Division (JB-CSSD), which were served at the time of Marcello's death. OCA's investigation 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.

In accordance with OCA's statutory obligations and authority, OCA undertook a broader review of child protection and adult probation system issues implicated by findings in this Report, focusing on the efficacy of existing policy and quality assurance frameworks to ensure child safety. As Ms. Polino is criminally charged in connection with Marcello's death, information regarding relevant aspects of her criminal history, treatment, and involvement with DCF are contained in public databases and documents.[4] OCA reviewed additional

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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.

[4] Information contained in this report regarding the results of substance use testing is also contained in criminal records related to Ms. Polino.

records from state and local agencies and interviewed stakeholders/professionals to complete this fatality review.

OCA's Methodology for Marcello's Fatality Investigation included:

1. A review of DCF records regarding Marcello and his family.
2. A review of JB-CSSD records regarding Marcello's mother and father.
3. A review of relevant state agency policies, practice manuals, and data.
4. A review of Marcello's birth/hospital records.
5. Review of police records and warrants for arrest of Marcello's mother.
6. Review of treatment records pertaining to Marcello's mother.
7. Interviews with medical professionals, substance use treatment providers, and state agency representatives.
8. Consultation with medical professionals, including experts in pediatric emergency medicine and neonatology.

OCA shared multiple drafts of this Report with the agencies identified herein. Agency responses are summarized and included at the conclusion of the OCA's Findings and Recommendations.[5] OCA also shared a draft of this Report with the State's Attorney for the Judicial District of New Haven, and with the Office of the Chief Medical Examiner. OCA acknowledges the constructive dialogue and cooperation of all state and local agencies with this review, and notes that each agency has committed to ongoing work to address systemic issues identified herein.

CASE FINDINGS- CIRCUMSTANCES PRECEDING THE DEATH OF 10-MONTH-OLD MARCELLO MEADOWS

Ms. Polino's criminal history in Connecticut dates to 2013 and includes charges for larceny, criminal impersonation, drug possession with intent to sell, violation of probation, failure to appear, and identity theft.

2019 THROUGH JULY 2022. Ms. Polino's first child was born substance exposed. Ms. Polino was involved with Adult Probation.

2019

In early 2019 Marcello's sibling was born. A report was made to DCF at the time of the child's birth due to Ms. Polino's history of substance misuse. The report was not accepted for investigation due to Ms. Polino only testing positive for methadone at the birth and information provided that Ms. Polino was engaged in treatment. A toxicology report finalized 12 days after the baby's birth revealed the baby was positive at birth for nonprescribed opioids. There is no record the hospital made a follow up report to DCF with the results of this toxicology screen.

Ms. Polino was arrested in 2019 for larceny and unauthorized credit card charges. In April 2019, as a condition of her release on criminal charges, including violation of probation, Ms. Polino was court-ordered to attend substance use treatment. She participated in medication assisted treatment and outpatient services.

In September 2019 she was sentenced to three years' probation. She admitted stealing for the purpose of securing heroin, and she was directed by probation staff to continue with treatment and cooperate with a

[5] An initial draft of this report was provided to JB-CSSD, DCF, and provider agencies on January 12, 2024 and revisions/responses were submitted through February 15, 2024.

mental health evaluation. Her risk score (based on a screen used by Probation to assess an individual's risks and needs) was "medium."[6] Ms. Polino had uneven participation in services over the next three years, marked by partial attendance at services and periodic relapses into opioid misuse.

2021

In 2021 Ms. Polino was again sentenced to three years' probation for identification theft and credit card theft. In November 2021 she reported to probation that she had recently had a baby though OCA could locate no medical or vital records to corroborate that assertion. During phone and office contacts with her probation officer, Ms. Polino repeatedly stated that she was happy at home with her newborn and toddler. Probation visits with Ms. Polino were conducted virtually or in the probation office.

2022

In early 2022, probation records reflect concerns about Ms. Polino's substance use, and she was re-classified as in need of "high" supervision. Despite applicable agency policies regarding individuals in need of "high supervision," no home visits were conducted. No assessment was done of the impact of Ms. Polino's substance use on the safety of her "two" children, and no reports were made to DCF.

Probation staff again directed Ms. Polino to participate in outpatient treatment/therapy. She completed an intake with a local provider in March 2022 and was recommended for individual psychotherapy. Ms. Polino participated in four therapy sessions and three urine screens (no information is in the treatment record as to whether toxicology screens were supervised or unsupervised), and she was discharged successfully in June 2022. Probation records show that staff conducted substance use tests in February, which were negative for illicit substances, and in July, the results of that test was not documented.

On July 20, 2022, at eight months pregnant, Ms. Polino was arrested again for larceny and risk of injury to a child after being caught shoplifting with her three-year-old child 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 where Ms. Polino's probation terms emanated from, Bridgeport and Norwalk, and such warrants were issued on September 14, 2022, and September 20, 2022, respectively. The Bridgeport warrant was served on the date of issuance when Ms. Polino was arrested for larceny 6th degree, to which she subsequently was sentenced for an unconditional discharge (unsupervised). Therefore, on September 20, 2022, Ms. Polino had the three new charges pending in court and the unserved Norwalk violation of probation warrants.

A review of JB-CSSD probation records, police reports, and discussions with JB-CSSD administrators revealed the following concerns regarding case documentation, supervision, and follow up:

1. Contrary to agency expectations, after Ms. Polino was reclassified, in 2022, to high supervision there were not any home visits. All visits were conducted virtually or in the probation office.
2. No DCF reports were made despite documented concerns about Ms. Polino's Fentanyl use and her report of caring for a newborn and toddler. JB-CSSD has a new policy (February 2023) that requires a report to DCF of emergent and non-emergent safety concerns if an adult under supervision tests positive for Fentanyl and has a child in their care.
3. There was no information in the JB-CSSD record documenting the results of Ms. Polino's July 2022 urine screen and was not found following OCA's request for the information.

[6] JB-CSSD uses the Level of Service Inventory-Revised (LSI-R), which is "a standardized actuarial instrument that contains 54 items and produces a summary risk score that can be categorized into five risk levels." Lowenkamp, C.; Bechtel, K. The Predictive Validity of the LSI-R on a sample of Offenders Drawn from the Records of the Iowa Department of Corrections Data Management System, Federal Probation—Journal of Correctional Philosophy and Practice (Vol. 71, Number 3).

4. Probation did not make regular efforts to serve Ms. Polino's outstanding warrants. Follow up activity was expected and should have been reflected in the case notes.

JB-CSSD reported they are currently in meetings with DCF to improve and standardize inter-agency communication on shared cases. They reported they are open to changes in policy regarding probation officer's engagement, support, and supervision of adults with young children. OCA recommends attention to risk/need assessments that can help determine the impact of individual's risks and needs not only on the public but on vulnerable household members. Referrals and supports should be provided accordingly.

JULY 20, 2022 - AUGUST 10, 2022

Following Ms. Polino's July 20th arrest for larceny and risk of injury to a child, JB-CSSD staff had no further contact with her until after Marcello's death.

DCF opened an investigation in July 2022 due to Ms. Polino's arrest for larceny and risk of injury. She denied to DCF stealing items and denied substance abuse or mental health concerns.

AUGUST 10, 2022 - SEPTEMBER 1, 2022. Marcello was born substance exposed. He was diagnosed with Neonatal Opioid Withdrawal Syndrome and Failure to Thrive.

On August 10, 2022, Marcello was born. Records indicate Ms. Polino participated in only one prenatal care appointment. A report was made to DCF by the hospital because Ms. Polino tested positive for cocaine on August 3 and August 9.[7] It was later learned that Ms. Polino had also tested positive for Fentanyl.[8] Marcello remained in the hospital for several days due to opioid withdrawal symptoms. Hospital records indicate that Marcello was struggling with "jitters," weight loss, and was hypertonic. He was diagnosed with Neonatal Opioid Withdrawal Syndrome and Failure to Thrive. He was put on a nasogastric tube to help address marked weight loss after birth.

DCF did not conduct adequate background checks and assessments on Marcello's parents.

DCF conducted state and local police checks on Ms. Polino and Marcello's father. These checks showed Ms. Polino's prior arrests for shoplifting, larceny, and possession. DCF did not obtain records from JB-CSSD and were unaware of Ms. Polino's prior risk/need assessments or mandated conditions.

DCF interviewed Marcello's father, and like Ms. Polino, he denied any mental health or substance use concerns as to him and Marcello's mother. The state police checks completed by DCF document that Marcello's father had arrests dating back to 2007 for risk of injury to a child, assault, and robbery. In 2021 he was arrested for carrying a dangerous weapon and assaulting a public safety officer. The record does not reflect that DCF staff discussed this history with him during this assessment. DCF did not obtain records from JB-CSSD as to the father's history with adult probation, what needs and risks were identified, and what services were provided. The DCF investigations protocol documents an inaccurate finding on the DCF background check on Marcello's father,[9] which would have shown that he had his own history with DCF due to concerns about his substance abuse.

DCF investigation records document that "no concerns were assessed for [Marcello's father] during the course of the investigation." The record states that DCF did ask Marcello's father to schedule a "toxicology screen." DCF staff identified him as the central sober caregiver in Marcello's Safety Plan.

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[7] Arrest warrant application pertaining to A. Polino, signed September 15, 2023.
[8] Id.
[9] It's not clear why assigned staff did not locate the father's prior DCF records. It is standard practice to look up all household members in the DCF system.

DCF Created a Safety Plan for Marcello and he was discharged home to his parents' care.

Given concerns about Ms. Polino's substance use and the need to determine a discharge plan for Marcello from the hospital, DCF created a Safety Plan with the family. DCF policy[10] provides that where a safety factor is identified, such as a non-accidental injury to a child by a caregiver, or parental substance abuse that impairs the ability of the caregiver to safely meet the needs of a child, DCF staff must work with the family and providers to "identify strategies and interventions that can be implemented immediately to safeguard the children and mitigate the safety factor(s)." The interventions must be documented in the DCF-2180, "Safety Plan," and reviewed with a Social Work Supervisor, and "when appropriate," the Program Manager.

DCF policy states that where "no interventions are available that can provide appropriate protection for the children, removal shall be actively pursued."

DCF quality assurance reviews in recent years have persistently found practice concerns related to safety planning, in particular a lack of effective supervision and ongoing monitoring of safety plans, and failure to update safety plans when new information arises. Inadequate safety planning and monitoring was identified as an area needing improvement in multiple fatality and near-fatality reviews conducted by DCF and/or OCA.

DCF administration issued updated guidance to agency staff in August 2022, providing:

- <u>The safety plan [must] clearly outline what the [protective] actions and activities are, who is responsible for undertaking them, and under what conditions they will take place</u>. It is designed to control threats to the child's safety using the least intrusive means possible. … The intervention/activities that are implemented must be planned realistically so that they are feasible and sustainable for the family, with clear timeframes for the plan that are agreed upon by the family and documented in the safety plan.
- <u>A Safety Plan or Family Arrangement should not exceed 30 days</u>. Under extenuating circumstances, if social work staff plan to extend the time period beyond 30 days, a managerial consult shall be held to determine if the Safety Plan or Family Arrangement should continue and/or whether a legal or RRG consult is needed.
- <u>All Safety Plans that remain in effect for 45 days require Office Director review and approval</u>. Note: A case cannot be closed when there is an active safety plan.
- <u>A detailed plan for monitoring a Safety Plan</u> is a critical component of the safety planning process.
- <u>As circumstances change, safety plans require updates based on these changes</u>. A timeframe for review is included within the plan.
- <u>Frequent and ongoing contact with the family, including parents and children, as well as team members who are included in the Safety Plan</u> is essential to assessing whether the Safety Plan is working and whether adjustments to the plan are needed that further promotes child safety.
- <u>Making unannounced visits to the home</u> helps to ensure the family is abiding by the terms of the safety plan and helps to identify whether additional supports are necessary.
- <u>Frequency of in-home visitation will be discussed in supervision</u> and dependent on case circumstances and child vulnerability.
- <u>The family's Safety Plan will be discussed in supervision every other week</u> throughout its duration to assess whether the plan is working, potential modifications needed to the plan, parent's adherence to the plan, and whether the safety factors have successfully been mitigated and there is no longer a need for the plan.
- <u>Legal consults should be considered by the managers for all cases</u> transferring from intake to in-home cases with an active Safety Plan or Family Arrangement.

[10] DCF Policy 22-2-2 (revised Feb. 2021).

The DCF Safety Plan developed for Marcello (just days before the new DCF guidance was disseminated), as summarized in the DCF electronic case record, required:

> Mother will not be left alone unsupervised while caring for the newborn child. Mother will continue to actively engage in treatment [with methadone provider]. Mother will utilize father, family, friends, and other natural supports to supervise her. DCF will do home visits twice per week.

The Safety Plan was thereafter extended to include Marcello's three-year-old sibling. Documentation regarding the Safety Plan does not specify how Ms. Polino would parent a newborn and three-year-old child with total supervision. She and Marcello's father maintained a household separate from relatives and the father worked outside the home. DCF records also do not include adequate assessment of family members identified as sober supervisors. The DCF records provided to OCA during this investigation did not contain a copy of the August 2022 Safety Plan. Upon second request by OCA, DCF sent an image of an amended Safety Plan, dated December 2022. The amended Plan appears not to have been maintained in the DCF case file. The original August 2022 Safety Plan was never produced.

Marcello was subsequently discharged to Ms. Polino's care with the terms of the DCF Safety Plan in place. There was no documentation in the DCF record regarding who would be responsible for Fentanyl testing of Ms. Polino.

Contrary to DCF's newly clarified expectations issued shortly after Marcello's discharge from the hospital, there is no documentation that the family's Safety Plan was reviewed by a DCF supervisor every two weeks, there was minimal documentation in the record regarding how the Safety Plan was being monitored, and the Safety Plan was eventually lifted without documented discussion.

Ms. Polino agreed to treatment services with Family Based Recovery

Ms. Polino agreed to any service needed to keep her family intact.

DCF recommended an intensive in-home service, Family Based Recovery (FBR), in addition to Ms. Polino continuing with out-patient Medication Assisted Treatment (MAT- methadone provider). FBR provides in-home clinical and therapeutic supports, up to three times each week, and the model includes a family engagement service as well as parenting supports. Marcello was identified as the "index child" for FBR treatment purposes. FBR is a treatment model developed at Yale University and has been a DCF-contracted service for over a decade.

DCF records accurately note that at the time they referred Ms. Polino, the assigned FBR provider <u>had no procedures in place to test for Fentanyl use</u>[11]. The FBR model includes use of in-home rapid urine-screens administered multiple times per week to facilitate treatment and relapse safety planning. However, there has been no federally approved rapid urine test for Fentanyl.[12] While the DCF record noted that the assigned FBR provider was not testing for Fentanyl, the DCF Safety Plan did not address the need to secure drug testing by other means.

DCF records reflect appropriate referrals were made for multiple family and child-specific supports, including FBR, a visiting nurse, a Birth to Three evaluation, and the NICU Grad program—a comprehensive

[11] In March 2022 FBR, per agreement with DCF, suspended use of unapproved rapid tests for Fentanyl. The FBR Model Developer distributed statewide memo to providers effective in April 2022 outlining expectations for periodic lab testing for clients with opioid use disorder. Records indicate that the FBR provider serving Marcello and his family did not lab test Ms. Polino until December 2022.

[12] There is a new CLIA-waived rapid urine test as of November 2023. OCA is in discussions with stakeholders regarding implications for provider testing and service delivery in Connecticut.

multidisciplinary medical and developmental follow-up program designed specifically for infants and young children at risk for medical and/or developmental difficulties due to conditions faced in the newborn period. There is however no documentation of follow up in the DCF record regarding most of these services. OCA was informed by the Office of Early Childhood that Birth to Three has no record of a referral being made for Marcello. Notably, Marcello's diagnosis of Neonatal Opioid Withdrawal Syndrome would have resulted in automatic acceptance for evaluation by the state's Birth to Three program. There is no follow up in the DCF record regarding Marcello's referral to or engagement with the NICU Grad program. OCA was informed by Yale that no one brought Marcello to the NICU Grad program, and despite multiple outreach attempts by the program, the family never responded.

OCA finds that procedurally, the DCF investigation was commenced and finalized timely, utilized agency structured decision-making tools, and included regular staff supervision contacts per agency requirements.

SEPTEMBER 2022. DCF substantiated neglect and transferred the case to the DCF In-home Services Unit. No neglect petition was filed with Juvenile Court.

Ms. Polino was substantiated by DCF for physical neglect, and the family's case was transferred to the DCF in-home services unit for supervision and case management. No legal consult occurred, and no neglect petition was filed with the Juvenile Court, as such filings are discretionary by statute.[13] Currently DCF has over 1700 cases open in "In-home services." These are cases where DCF has substantiated child abuse or neglect and/or identified ongoing risk or safety concerns and kept the case open for administrative supervision and case management. Data shows that in approximately half of the cases currently open with DCF in In-home Services, DCF also filed a petition with the Juvenile Court seeking a legal adjudication of neglect and accompanying court orders. This means that in the remaining 800-850 cases currently open with DCF In-home Services, there is no Juvenile Court involvement, and DCF manages risk and safety concerns without judicial involvement or oversight. DCF policy provides that when a parent is noncompliant with the DCF case plan requirements, DCF staff in consultation with the agency attorney/s will determine whether a neglect petition should be filed with the Court.[14] If concerns of abuse/neglect and parental capacity are not resolved and a safety concern develops that cannot be reasonably resolved by a Safety Plan and there is an imminent risk to the child, DCF will invoke a 96 hour "hold" or file for an Order of Temporary Custody, and remove the child, placing the child with a relative caregiver or a non-relative foster care provider.

Only about ten percent of accepted reports to DCF are transferred to the agency's In-home Services unit, indicating that cases like Marcello's and Kaylee's, those that are transferred for continued supervision by DCF, are most often the highest risk cases that the agency manages.

Marcello was identified by DCF as a "High-Risk Newborn." Contact directives from the DCF Supervisor were not followed.

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[13] Connecticut General Statute Section 46b-129 "a) Any selectman, town manager, or town, city or borough welfare department, any probation officer, or the Commissioner of Social Services, the Commissioner of Children and Families or any child-caring institution or agency approved by the Commissioner of Children and Families, a child or such child's representative or attorney or a foster parent of a child, having information that a child or youth is neglected, uncared for or abused <u>may</u> file with the Superior Court that has venue over such matter a verified petition plainly stating such facts as bring the child or youth within the jurisdiction of the court as neglected, uncared for or abused within the meaning of section 46b-120, the name, date of birth, sex and residence of the child or youth, the name and residence of such child's parents or guardian, and praying for appropriate action by the court in conformity with the provisions of this chapter."

[14] DCF Policy Section 23-2.

DCF transferred the case from its investigations unit to the In-home Services Unit and identified Marcello as a High-Risk Newborn per agency policy.[15] The DCF Risk Assessment tool did not accurately document Marcello's medical complexity, Failure to Thrive diagnosis, or prenatal exposure to substances.

The assigned DCF worker was directed by the supervisor to conduct twice weekly home visits with Marcello and his sibling for the next month, and to ensure that visits included family member/s identified in the Safety Plan. Despite the supervisory directive for twice weekly visits, records show no home visit by the assigned worker for the next three weeks, and no follow-up visit for another three weeks after that. The record also indicates that the caseworker was directed to "maintain minimally twice a month contact with all providers working with the family" (FBR, Probation, visiting nurse, methadone provider), though these contacts either did not regularly occur or were not consistently documented in the case record.

No testing of Ms. Polino for Fentanyl.

Ms. Polino was not lab tested for Fentanyl during September. The FBR updates sent to DCF each month included information that Fentanyl was <u>not being tested</u>. Concurrently, Ms. Polino's methadone provider did not test her either given the provider's insurance-driven policy of testing every 90 days.

Ms. Polino was arrested in September 2022 by Branford police for shoplifting. Marcello's father was noted in the police report to be waiting outside in the vehicle for mother to exit the store. No children were present.

OCTOBER 2022. No unannounced visits by DCF to monitor the Safety Plan as recommended by agency guidance. No testing of Ms. Polino for Fentanyl.

DCF conducted twice monthly announced home visits to see Marcello and his parents and conducted internal case supervision. However, despite the August 2022 agency guidelines regarding safety plans, case records include no documented discussion as to the need for unannounced visits.

DCF counseled Ms. Polino to resolve her outstanding charges and warrants. The assigned caseworker told Ms. Polino that she had contacted Adult Probation and was told that Ms. Polino should turn herself in to local police. The DCF record does not contain a contact entry related to Adult Probation, and JB-CSSD records contain no documentation of any contact from DCF. The DCF narrative entry related to the home visit where this information was relayed does reference two specific probation officers that the assigned worker spoke with.

Ms. Polino was not lab tested for Fentanyl during October. FBR records provided to DCF continued to note that the provider was not testing for Fentanyl.

The DCF supervisor entry for the month of October contains no reference to the Safety Plan put in place in August. There is no record of a Safety Plan review every two weeks per agency requirements, and there was no program supervisor review or office director review of the Plan which, if still in place, had extended well beyond the agency's 30-day limit for Safety Plans.

OCTOBER 24, 2022. DCF Fentanyl guidance issued.

DCF distributed an all-staff email memo which included information that Fentanyl-related poisoning had increased within the previous year and that early detection of Fentanyl use was essential in ensuring child safety. The memo noted: "any person using or handling Fentanyl in the home is a safety concern. Assessment of safety shall include child vulnerability based on development and age, with children under the age of five being the highest risk."

[15] DCF Policy Section 21-11.

The Guidance also provided that "Effective immediately, an emergency Substance Use Regional Resource Group (RRG-an internal consultation) request, … shall be completed for any case in which active Fentanyl use is alleged, suspected, or confirmed by the parent's admission, as a Safety Plan is being developed."

NOVEMBER 2022. Visits with family continue by DCF and FBR. Assessment of parent-child interaction positive. No documentation regarding DCF Safety Plan. No lab testing of Ms. Polino for Fentanyl.

DCF and FBR continued to make regular visits to the family, and records document positive interaction between Ms. Polino and her children, and engagement by Ms. Polino with her treatment services.

DCF talked to Ms. Polino regarding her arrest in September for shoplifting, during which Marcello's father was also present. Ms. Polino denied any criminal conduct and stated she was arrested only for an outstanding warrant, information contradicted by the police record.

Ms. Polino was not lab tested for Fentanyl during November. During a home visit, the DCF worker spoke to Marcello's father about the results of DCF's revised accurate background check, which revealed he had a previous history with DCF due to concerns of his heroin, cocaine, and PCP use, and that his eldest child had been removed from his care as a result. Marcello's father denied any current substance misuse and stated that he had recently completed a drug screen for his new job. Despite being an identified sober caregiver in the Safety Plan and DCF's request for the information, he did not produce a record of this screen. There is no indication the Safety Plan was amended (if it was still active) or resurrected.

DECEMBER 2022. Ms. Polino's first lab tests since the Safety Plan was put in place were positive for Fentanyl. Internal case review conducted.

In December, DCF conducted announced home visits with the family at Ms. Polino's relative's home, where Ms. Polino was frequently staying due to transportation issues. Marcello's father was reportedly working third shift at his job and was not present for most visits with DCF due to being asleep in the family's home. Visits reflect positive assessment of the home and the interactions between Ms. Polino and her children.

Records reflect that as of December 2022, due to the change in policies, FBR began submitting Ms. Polino's urine samples for lab testing to assess for Fentanyl use. This was the first lab testing conducted since Marcello was discharged home from the hospital and the DCF Safety Plan put into place. Ms. Polino's urine screens were positive for Fentanyl, with two consecutive positive results on December 14 and December 21. Ms. Polino denied knowingly using Fentanyl and told DCF she had a one-time use of cocaine on December 10. A toxicology expert at Yale New Haven Hospital consulted by OCA during this review stated that Fentanyl is generally detectable in urine screens for only 48 to 72 hours post use.

In accordance with the latest agency guidelines, DCF conducted an internal review of the case with participation from a DCF legal counsel and an internal substance use consultant (RRG). Records indicate staff was directed to update Marcello's Safety Plan to identify the father and maternal relatives as sober caregivers. Marcello's father still had not complied with DCF's request for a toxicology screen. He was noted to be working 12-hour days and Ms. Polino reportedly continued to reside in the home with him and the children, with unclear supervision by maternal relatives. DCF did not conduct a new SDM safety assessment which would be expected given the creation of a revised Safety Plan. While the agency's revised guidance regarding Fentanyl cases and safety planning included consideration of more frequent and unannounced home visits and possible removal of the individual using Fentanyl from the home,[16] these strategies were not employed in

[16] DCF's staff guidance regarding safety planning reads: "The Department does not have the legal authority to require a household member to move out of the home as a condition of the safety plan. A family may choose to have a household member leave the home as part of the safety plan, but any such step may only be initiated voluntarily by the family, or through a legal action by the Department."

this case and there is no documentation they were considered. The case appeared to be managed with the assumption that Ms. Polino was not deliberately using Fentanyl.

From the DCF record:

> Recommendations
> -Mom will continue with FBR and methadone maintenance.
> -SW will review the safety plan with Dad, RELATIVE, & RELATIVE
> -SW will discuss with Mom obtaining test strips for drugs if there is future use.
> -SW will discuss with family and Mom obtaining a NARCAN kit from a pharmacy.
> -SW will provide Mom with the phone number for Never Use Alone is 800-484-3731.
> -Mom would benefit from attending 12 step meetings to establish and maintain a sober support system.

Contrary to agency directives, there was no documented plan for how the Safety Plan would be monitored. There was no documentation regarding how visits would be conducted (frequency or announced/unannounced). And DCF records indicate that no home visit was conducted by DCF to see Marcello, his sister, or speak to relatives (individuals relied upon for Marcello's safety) for another 21 days. The record contains no documented outreach to Marcello's father though he was the caregiver relied on by DCF to ensure Marcello's safety. There is also no documentation that relative/s relied on to be sober caregiving supports were assessed as to their own substance abuse histories and protective capacity. FBR did not obtain permission to share the results of Ms. Polino's tests with her methadone provider and therefore that provider did not know of the recent positive test results.

JANUARY 2023. DCF continued case supervision. Ms. Polino continued engagement with home-based treatment services. Two unsupervised urine screens negative for Fentanyl, one of which was "not completed" by the lab.

DCF continued to conduct announced visits twice per month with Ms. Polino and her children at the home of maternal relatives. DCF records indicate that Ms. Polino did not give clear answers as to her residency. Ms. Polino continued to participate in FBR and methadone maintenance.

Ms. Polino's methadone provider administered a drug screen on January 27, 2023, which was negative for Fentanyl. The provider reported to OCA that screens are not supervised unless there is a concern for use. At that time, the methadone provider remained unaware of concerns regarding Ms. Polino's Fentanyl use. FBR conducted two screens that were sent for lab testing, one of which was not completed due to lack of adequate patient identification on the sample. The second test was negative for Fentanyl. Neither urine screen was documented as supervised.

FEBRUARY 2023. DCF Safety Plan lifted, not clear when.

A note in the DCF record in February indicates that the Safety Plan had ended. A "sober plan" was signed by FBR, with maternal relative/s, and Marcello's father identified as caregivers should Ms. Polino relapse again. The FBR record does not include documentation of contact with Marcello's father.

DCF records outline the "criteria for a successful DCF closure" of Ms. Polino's case:

- Compliance with programs (FBR & Methadone maintenance provider);
- Children being current with their medical and dental care needs;
- Mother`s warrants resolved;
- Father providing a rule-out urine screen.

One lab test was done in February, and it came back "inconclusive" for Fentanyl as the lab identified "interference," which meant that there was a drug/chemical present which interfered with the test, resulting in the lab being unable to provide a quantitative value regarding Fentanyl.

MARCH 2023. Ms. Polino tested positive for Fentanyl on two occasions.

Ms. Polino continued to participate in treatment with FBR and her methadone provider. DCF records reflect the caseworker attempted contact with the methadone provider, with no success.

Ms. Polino's lab tests came back positive for Fentanyl on March 24, 2023, and again on March 31, 2023. The DCF record does not reflect timely documentation of these results. There is no documentation that DCF reinstated or revisited the Safety Plan. Despite agency guidance regarding safety planning and Fentanyl cases, there is no documented discussion in the record of the positive screens until a supervisor's note in mid-April.

APRIL 2023. Ms. Polino tested positive for Fentanyl again. No documentation of a DCF safety plan or legal consult.

Ms. Polino reported to DCF that both of her March tests were positive for Fentanyl because she had put a prescribed Fentanyl patch on a family member. DCF records indicate that the assigned worker spoke with an in-house substance abuse consultant (RRG), and a determination was made that no legal consult was necessary. There is no documented discussion of the legitimacy of the Fentanyl patch explanation, and there is no effort to confirm the explanation. A toxicology expert consulted by OCA during this fatality review stated that it was "doubtful" that handling a Fentanyl patch would result in a positive test in the person applying it as the drug delivery devices are meant to release the Fentanyl very slowly, and that it would be "EXTREMELY unlikely for that person to test positive again 7 days later, given the short half-life (3-7 hours) of Fentanyl."[17] Additionally, lab tests, maintained in the FBR file, showed that the amount of Fentanyl in Ms. Polino's samples *increased* from the first lab test to the second, further indicating that use was likely intentional and ongoing. Despite the positive Fentanyl tests in March, the DCF record states that Ms. Polino had "successfully completed [her treatment program]."

Records from Ms. Polino's methadone provider, not obtained by DCF or FBR staff, indicated Ms. Polino had missed clinic sessions on multiple occasions in mid-April.

DCF record states:

> Update:
> Mother continues to work with FBR on a voluntary basis. She successfully completed the program. FBR reported mother is consistent, engaged, communicates, utilizes the services, has a great connection with the kids, meets their needs and has good family support. Mother had 2 positive Fentanyl screens last month. She tested negative this month. Mother reported she tested positive due to administering a Fentanyl patch to her RELATIVE when she was discharged from the hospital ….
>
> FBR has not made any closing recommendations. SW has spoken with FBR regarding their discharge summary to include recommendations.
>
> SW spoke with [internal DCF consultant] who did not feel it was necessary to have a legal consult or Fentanyl consult.
>
> Recommendation was made to keep the case open 1 more month before closing to continue to assess. Mother continues to work with FBR.

[17] Correspondence to OCA from Dr. Carl Baum, professor of pediatrics and emergency medicine at Yale.

DCF conducted two announced home visits in April. One of the visits included the agency's first contact with Marcello's father since November 2022. He again stated he would follow through with a drug screen, originally requested 9 months prior.

Ms. Polino tested positive for Fentanyl again from a screen administered on April 19. Ms. Polino reported to DCF that she ingested a CBD gummy given to her by Marcello's father, and that the gummy must have been "laced." The FBR record states that a plan was made with Ms. Polino to temporarily increase her sessions to three times a week, ensure that she only uses over-the-counter pain relievers and prescribed substances, and that she utilizes her sober caregiver plan. The FBR record states that the "DCF worker was contacted with client and this plan communicated to her." There is no documentation in the DCF record of this call, or that the information was immediately discussed with a DCF supervisor, and a decision made about how to ensure Marcello's safety. There is no discussion of the reasonableness of the proffered explanation, or that this was the third Fentanyl test in a month (March and April) that Ms. Polino attributed to unwitting exposure. DCF did conduct a new SDM safety assessment in April but found no safety factors and did not document the positive Fentanyl tests. With DCF identifying no safety factors, there was no documented consideration for the need for a revised Safety Plan or legal consultation.

MAY 2023. Ms. Polino's screens were negative for Fentanyl. Provider and DCF begin to prepare the case for closure.

DCF conducted an announced home visit with Ms. Polino and her children at maternal relatives' home. FBR was also present. Ms. Polino discussed with DCF her positive screen and reiterated that she took a "CBD gummy" due to pain from a minor injury. She denied using substances and acknowledged that taking the gummy was not good judgment. DCF documented the positive feedback from FBR and recorded that "there are no parenting concerns", a consistent assessment throughout their involvement. DCF verbally confirmed that Ms. Polino had a Naloxone kit at home in case of accidental overdose.

DCF reiterated that it needed to see Ms. Polino's home and that Marcello's father must comply with a drug screen prior to DCF closing its case.

DCF supervisory conference notes later that month document that Ms. Polino had two negative lab tests in May. There is no documentation in the treatment record as to whether these tests were supervised or unsupervised. FBR recommended stepping down Ms. Polino's services to once a week. Ms. Polino reported participating in a support group for mothers in recovery, which was not verified by any provider or DCF. Her warrants remained pending. The DCF record reflects no communication with Adult Probation or law enforcement, and no coordination regarding resolving Ms. Polino's outstanding warrants.

DCF was able to speak with Ms. Polino's methadone provider for the first time who reported that Ms. Polino was compliant with methadone maintenance and had tested negative for Fentanyl. A total of one drug test was done in 2023 by the methadone provider prior to Marcello's death.

DCF contacted the children's pediatrician and confirmed they were up to date medically and had no outstanding concerns.

JUNE 2023. Fentanyl testing was not able to be completed. DCF and FBR closed their cases with the family.

Ms. Polino's June lab test was not completed due to insufficient identification from the provider.

DCF closed its case with the family. June 7, 2023, and the record states:

> Ms. Polino maintained her sobriety from August 2022 through December 2022 but had a one-time relapse on cocaine. Although she tested positive for Fentanyl, she denied using it. Ms. Polino regained sobriety in January 2023, and maintained through March 2023, when she again tested positive. She reported she administered a prescribed Fentanyl patch to a family member and subsequently tested positive. Ms. Polino again tested positive for Fentanyl at the beginning of April 2023 after taking an alleged contaminated CBD gummy for pain sustained from spraining her ankle. Ms. Polino admitted this was not good judgement or decision making and stated, she will not put herself in that type of situation again. Ms. Polino is now rendering negative urine screens since the end of April 2023. Despite these setbacks, FBR and MAAS have reported, Ms. Polino has been able to reflect and identify that removing herself from unstable environments has been beneficial to her. She has shown progress in strengthening and increasing her coping skills, increasing communication, and managing her stress and anxiety. They describe her as motivated, engaged, and utilizing treatment appropriately and as intended.

On June 15, 2023, FBR closed its case with the family stating that Ms. Polino had completed the program requirements. OCA notes that per the FBR model for a client to "successfully graduate from FBR and meet goals," the client must, among other requirements, "provide 12 consecutive negative screens prior to discharge."[18] The FBR discharge summary makes no reference to Ms. Polino's positive Fentanyl tests, and based on the model criteria, she did not meet the treatment goals of the program.

On June 27, 2023, the 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. Toxicology tests ordered by the Office of the Chief Medical Examiner (OCME) confirmed Marcello had ingested Fentanyl, cocaine, and Xylazine. OCME reported that "the levels [Marcello] tested positive for regarding each substance were 'very high'…. Given the size and age of the decedent, … any trace amount of any of these substances could cause death."[19]

Post death investigation found evidence of opioid use in the home. The warrant for Ms. Polino's arrest documented that police 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. Police search and lab testing also documented Ziplock bags that tested positive for Fentanyl, Xylazine, caffeine, and cocaine.

DCF took custody of Marcello's sibling, and Marcello's father admitted to DCF his own recent substance use.

On June 30, 2023, an anonymous report was made to DCF alleging that Ms. Polino was using another child's urine to pass her drug testing.

<u>Treatment services were not effectively delivered or coordinated.</u>

Treatment services to Ms. Polino and Marcello/sibling were not effective in numerous ways:

- At the time of Marcello's discharge from the hospital, there was no clear plan by FBR and DCF to test Ms. Polino for Fentanyl use despite her documented history and recent use of Fentanyl. Lab testing did not begin until December, almost four months after Marcello was discharged home; testing was not conducted with adequate frequency to permit timely safety planning.

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[18] Inside the FBR Box, FBR Treatment Manual, FBR Model Development and Operations, Yale Child Study Cener, Revised July 2023.

[19] Police Arrest Warrant Application, signed September 2023, paragraphs 63 through 65.

- Urine screens facilitated by FBR were not consistently supervised due to a non-same gender clinician being assigned.[20]
- Despite multiple lab tests resulting in lack of result due to administrative error (presumably by FBR) these tests were not timely repeated.
- Although Ms. Polino tested positive for Fentanyl on multiple occasions between December and April 2023, FBR treaters credited her explanations that all tests reflected inadvertent exposure, did not challenge the plausibility or implications of these explanations, and did not adequately safety plan in accordance with program expectations which considers all positive results as indications of use regardless of client explanation.
- FBR staff met with Ms. Polino frequently, though there was turnover of clinical and other support staff from the FBR team during the case.
- There was no documented effort to obtain releases and share information and coordinate care with Ms. Polino's methadone provider, who remained unaware of Ms. Polino's positive Fentanyl tests.
- In the wake of Ms. Polino's positive screens in March and April, testing by FBR continued to be infrequent, and FBR discharge records document that Ms. Polino met the treatment goals of the program despite program expectations for 12 negative toxicology screens.

OCA met with the treating FBR provider. Feedback was that FBR service delivery in this case was likely affected by staff turnover during the treatment episode, and that service delivery in general is affected by workforce recruitment and retention challenges, including the lack of contractual funding for a full time FBR supervisor. Providers expressed support for the model but described the work, which requires home-based care to very high need individuals and families across a large catchment area as "grueling."

OCA also met with the model developer at Yale, who committed to various "opportunities to strengthen the [FBR] model," including 1) incorporating a safety checklist to be created at case intake and updated every 90 days that would address safe sleep for infants, safe substance storage, and access to/use of Naloxone; 2) enhancing communication to ensure that collateral contacts are engaged regularly; and 3) revising their family engagement guide to be more explicit on how to engage siblings and co-parents.

OCA makes the following findings regarding the methadone services provided to Ms. Polino:

- Services were provided without coordination or communication with Ms. Polino's in-home substance abuse treatment provider (FBR), and without ongoing communication with DCF.
- Toxicology screens were infrequently conducted, with typically more than 90 days in between testing. Ms. Polino was tested upon intake and two weeks later, than testing lapsed for 162 days following. After that screen in January 2023, Ms. Polino was not tested again prior to the death of Marcello.
- There were no documented efforts to obtain releases of information and coordinate care with FBR; as a result, the methadone provider was unaware of Ms. Polino's continued Fentanyl use.
- The provider offered Naloxone on a regular basis, which was declined repeatedly by Ms. Polino.
- The provider offered a peer group service to Ms. Polino, which was also declined.

[20] Per the FBR model, unsupervised screens are completed when a same-gender staff member is not available. Ms. Polino had two clinicians (one male, one female) assigned to her case that administered drug screens. A male clinician was assigned from 8/29/22-1/17/23.

<u>Several DCF policies and directives relevant to children's safety were not followed by assigned staff.</u>

When examining agency activities preceding a child fatality, a central part of OCA's review is whether the agency has applicable policies and guidance in place and whether those directives were followed. In this case, and similar to findings from OCA's previous reports on the death of baby Kaylee from Fentanyl intoxication and Liam Rivera from child abuse, OCA found that DCF does have relevant policies and guidance regarding assessment, safety planning, and supervision, but agency records do not support that those expectations were consistently followed. Specifically, records show:

- <u>Regular visits to Ms. Polino and her children did occur (DCF Policy 20-1-1)</u>. DCF staff had regular interaction with Ms. Polino and her children and observed/documented positive engagement and care of the children.
- <u>Internal case supervision occurred regularly (DCF Practice Guide 2-3-2)</u>. The DCF caseworker and supervisor met regularly to discuss the case and review Ms. Polino's progress in treatment.
- <u>Appropriate service referrals were made (DCF Policy 23-2)</u>. The family was connected to home and community-based substance abuse treatment services.
- <u>There was inaccurate and/or lack of background-checking of caregivers and family resources (DCF Policy 22-2-2)</u>. Marcello's father's DCF history was not ascertained by staff for several months after Marcello went home from the hospital, and concerns regarding his history of substance misuse was inadequately addressed. Upon apparent establishment of a new household, relative resources and household members were not background checked at all despite DCF's safety plan that relied on relatives to supervise Ms. Polino's care of Marcello and his sibling.
- <u>Failure to adequately monitor and update the Safety Plan. (DCF August 2022 Memorandum: Safety Planning Guidance; DCF Policy 21-7)</u>. Case documentation lacked specific information as to how the Safety Plan for Marcello and his sibling was being monitored; the safety planning relied on the unrealistic expectation that Ms. Polino would never be unsupervised with her newborn or 3-year-old child; no unannounced visits were used to monitor adherence to the Safety Plan; there was no specific plan for regular Fentanyl testing; no resolution to the safety plan was documented; the Safety Plan was not revisited after Ms. Polino's multiple positive Fentanyl screens in March and April 2023;
- <u>Inadequate case documentation and supervision (DCF Policy 8-2)</u>. The DCF case record does not reflect timely notification and response to multiple drug screens indicating Fentanyl use

by Ms. Polino; supervisory notes do not consistently reflect timely responses to these events, nor discussion as to the necessity of safety planning; directives for engagement with Marcello's father and the need for him to complete a drug screen remained unresolved at the time of case closure; directives that Ms. Polino resolve her outstanding arrest warrants prior to case closure remained unresolved. Supervisory notes lack explanation for why a legal consult was not sought after multiple positive Fentanyl results in March and April.

- Failure to conduct collateral contacts and obtain regular information from Adult Probation, the methadone provider, the pediatrician, or the Yale NICU-Grad program. (DCF Policy 21-1-1). Notably, the record reflects a lack of collateral contact or coordination with Judicial Branch Court Support Services Division despite Ms. Polino's lengthy probation history and her outstanding arrest warrants.

The practice in Marcello's case by the assigned staff also indicates that more training may be needed to educate agency staff regarding the modes of treatment and testing to address Fentanyl use.

No Human Resource Investigation Undertaken by DCF with Regard to Marcello's Death

DCF reported to OCA that it did not initiate a human resource/labor investigation into practice in Marcello's case. It also did not implement any formal or informal disciplinary counseling or documented corrective action for any staff member involved in Marcello's case.

While OCA takes no position as to whether and what discipline or counselling may be warranted in this matter, as outlined above numerous agency policies and directives regarding case assessment and safety planning were not followed and a plan for follow up, professional development, and/or accountability is warranted.

DISCUSSION: SYSTEM FINDINGS AND RECOMMENDATIONS

I. DEPARTMENT OF CHILDREN AND FAMILIES

OCA references and repeats findings and recommendations from our recently issued investigative report regarding the death by homicide of 2-year-old Liam Rivera, a child under DCF and Juvenile Court supervision at the time of his death. We recognize the significant complexity and challenge of child protection work, particularly in cases involving significant risk factors for child maltreatment and/or immediate safety concerns. In Marcello's case, it is clear that staff assigned to work with this family, both from DCF and the FBR team, were engaged with Ms. Polino and meeting with her and her children regularly to support a positive case outcome. However, overall the case practice regarding initial and ongoing safety assessment and monitoring did not adhere to agency expectations and failed to timely and effectively address the urgent safety concern presented by Ms. Polino's active Fentanyl use. Additionally, while DCF has relevant and fairly recent memoranda regarding management of safety and cases involving Fentanyl use, OCA finds that they were not followed here and that further efforts are needed to improve Safety Plans and operationalize a consistent approach to case management and supervision in these high-risk cases. Cross-agency work with DMHAS and community providers will be needed to integrate safety planning for children in a treatment and harm-reduction framework.

Continued Need to Improve DCF Safety Planning for Children

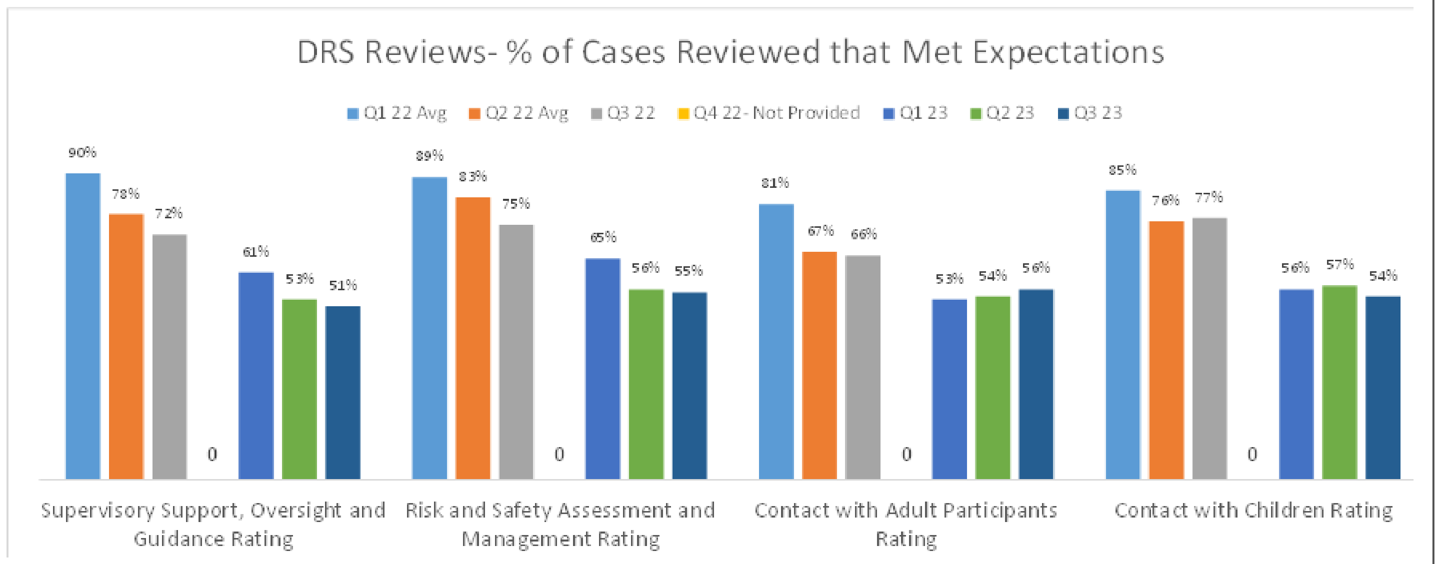
Multiple OCA fatality/near-fatality reviews and DCF systems data have confirmed inconsistent practice in "In-home" cases like Marcello's. Agency data shows persistent concerns in critical practice areas such as staff contact with children and case participants, case supervision, and the monitoring of Safety Plans. Relevant available data is described below.

DCF's Differential Response System (DRS) case review process is used to examine the quality of DCF's intake (investigation) practice. The DRS case reviews have been completed for multiple years, including being done in conjunction with the *Juan F.* Court Monitor's staff prior to the conclusion of their work and the 2022 exit from the Court-ordered Consent Decree. The reviews are now completed monthly by DCF's Case Practice Review Unit. The Unit completes 82 DRS case reviews per month. Using the review tool, the reviewer collects information about multiple components of the work which are grouped into sections.

Certain areas of performance have sustained performance:

1. **Information Collected and Documented in the Protocol,**
2. **Services to Family to Protect Children in the Home and Prevent Removal, and**
3. **Timeliness of Commencement.**

However, data shows decline over the last 2 years in the key practice areas below related to supervision, assessment, and contact with case participants, <u>with approximately half of cases rated as not meeting expectations.</u>



The **Child and Family Services Reviews (CFSR)** are a federal-state framework designed to ensure that quality services are provided to children and families by state child welfare systems. These reviews include strengths and challenges in state agency practices pertaining to Safety, Permanency and Well-being. The federal tool—the Onsite Review Instrument and Instructions (OSRI)-- is used to review both foster care and in-home services cases.

- CT ranked in the bottom half of all states at the conclusion of the 2015-18 Federal CFSR.
- DCF completed a mandatory Performance Improvement Plan in 2021.
- DCF continues to use the Federal tool to evaluate performance in advance of the next Federal CFSR (2022-26).
- **The following measures relate to children's safety and wellbeing and indicate a significant recent decline in CT performance.** The number of case reviews range from 55-112 cases reviewed per item. Data reported in the Annual Progress and Services Report is retrospective.

Data from https://portal.ct.gov/DCF/Data-Connect/Federal-Reports

Data Regarding In-home Service Cases, DCF QA tool.

DCF has not yet produced a data report regarding its qualitative analysis of practice in "In-home cases" cases, a review process launched by DCF in April 2023 that looks at least 50 cases a month across the DCF offices, some with safety plans, some without. DCF did provide OCA with a narrative summary of reviews conducted between April and June 2023 which found that practice related to safety assessment, visitation, and case supervision, were identified as "needing improvement." DCF recently reported to OCA that resource constraints have delayed the production of the next round of case review findings.

Recommendations

1. **Improved safety planning and differentiated practice for young children and cases involving illicit substance abuse needed—quality assurance must be the highest priority.**
   - Frequent and reliable quality assurance protocols pertaining to safety planning and service delivery must be the highest executive priority. DCF's quality assurance tools regarding Safety Plans should reflect the most recent agency expectations and a targeted quality assurance methodology should be implemented to assess fidelity to revised agency policies regarding safety planning and case supervision.[21] To the extent resources are constraining the timeliness and frequency of quality assurance data and executive reviews, this should be immediately resolved.
   - DCF should revise its High-Risk Newborn Policy to address need for improved safety planning and service delivery.
   - DCF should evaluate its data and practice regarding use of unannounced visits to assess and monitor safety concerns in the home. Data reviewed by OCA reflects that even following agency memorandum regarding the utility of unannounced visits in cases with Safety Plans, a very small percentage of visits conducted in "In-home cases" are unannounced, unchanged since 2019.
   - DCF memorandum regarding Fentanyl cases and Safety Planning need to be incorporated into relevant agency policies.
   - DCF policy should be revised to ensure that Safety Plans pertaining to caregiver substance misuse specify:
     - The plan for and frequency of drug testing and who will be responsible for the testing, ensuring at least weekly testing and considering the need for random testing.
     - Ensuring drug testing includes synthetic opioids and Xylazine.
     - How information will be shared among providers and DCF. Safety plans should include the expectation of releases being signed to ensure appropriate and timely communication is occurring between providers.
     - Specific identification of supports and sober caregivers. These individuals should be assessed for their own protective capacities relative to the needs of the children.
     - A need-risk based visitation plan, inclusive of unannounced home visits must be written into the Safety Plan or case plan.
     - Any other information regarding how the Safety Plan will be monitored, reviewed, and reassessed.
   - DCF should require its contracted substance use treatment providers to ensure frequent (at least weekly) testing for clients with illicit substance misuse who are actively caregiving, inclusive of reliable Fentanyl testing. DCF and providers should establish a consensus understanding regarding the duration that Fentanyl would be identified in one's system through testing and revisit as needed, based on clinical studies.
   - DCF risk and safety assessment tools (Structured Decision-Making tools) should be updated to reflect Fentanyl's impact on child safety.

[21] DCF's current qualitative tool for initial safety planning dates to 2021 and does not specifically incorporate subsequently issued modified agency expectations regarding safety planning and Fentanyl use cases.

- Heightened supervisory review should be utilized in all cases involving Fentanyl, Safety Plans, and/or open cases with children under the age of three.
- Supervisory checklists should be developed to assist with consistent practice in cases involving Safety Plans, High Risk Newborns, and children birth to three years old, and the checklists should be included as part of the quality assurance tools.
- Safety Plan forms are not currently embedded in the DCF electronic case record. This should be changed immediately, if possible.
- Regular analysis should be conducted regarding the available service array for families with young children to identify areas of the state where families may have unmet needs for mental health and substance abuse treatment, parenting support, childcare, or other services. Budget proposals should follow to address service gaps for highly vulnerable children and caregivers. For example, Connecticut's Child First program, one of the only in-home clinical services for parents with young children, has lost significant capacity in recent years due to diminished funding.

2. The State should review the impact of telework and workforce trends on DCF case practice, staff retention and supervision, as well as progress towards implementation of a new information management system.

Current collective bargaining agreement/s[22] permit DCF staff, including the bargaining class that Marcello's caseworker and case supervisor are part of, to telework 80% of the time, although home visits have continued to be conducted in person per DCF policy. It is essential to examine how teleworking at DCF impacts the critical functions of the agency, including engagement with children and families and providers as well as recruitment and retention of staff, professional development, and supervision—and whether DCF can meet its mandates with a largely virtual workforce.

In November 2023, DCF reported to OCA and the state Child Fatality Review Panel that it is facing a workforce "crisis" regarding recruitment and retention of qualified staff. DCF estimated that its workforce turnover rate was between twenty and thirty percent and given the complexities of the cases that DCF now opens and maintains supervision on, there are real concerns of staff "burnout." While the state must continue to offer its workforce flexibility as a hiring incentive, overuse of telework in this field may have the paradoxical effect of leaving workers less supported as they take on the challenges of front-line child safety work.

- Given fluctuations in the human services/child welfare workforce, it will be imperative for the state to ensure a full and well supervised staff at DCF. Regular public reporting regarding agency capacity, including workforce retention and recruitment and caseload capacity should be instituted to inform stakeholders and policymakers' investments and supports of agency hiring.

- The state should revisit telework awards to ensure that state agency workers responsible for engagement and service delivery to vulnerable families are adequately supported and supervised in the execution of their job responsibilities, while maintaining flexibility necessary for recruitment and retention of qualified staff. Internal DCF performance data should be used to demonstrate the need for revisions to the agency telework awards.

3. Progress Monitoring Recommended for State Child Welfare Work

DCF is charged with one of the most challenging and vital state responsibilities, namely ensuring the safety and wellbeing of abused and neglected children through the provision of case management and service delivery to children and families. OCA continues to recommend the creation of a transparent and accountable framework for the state's child welfare work, inclusive of DCF's child fatality/near-fatality review findings and

[22] https://portal.ct.gov/-/media/OPM/OLR/Notices/Telework-Award122721.pdf

recommendations (for which DCF has an internal case review process). Such a framework is critically important in the wake of the state's exit from class-action driven federal court oversight almost two years ago.

- OCA recommends that state law be amended to strengthen the role of the DCF Statewide Advisory Committee (SAC), enhance membership, align the SAC's duties with federal requirements for state Citizen Review Panels,[23] and include a specific focus on DCF's resources, safety practice, child and family outcomes, and the quality and availability of services to support children and families. Consideration of additional or alternative oversight measures may also be undertaken. Specific reports by DCF to the SAC, including qualitative data regarding child safety, should be required by statute.

- State law should be amended to require DCF to affirmatively report information regarding child fatalities and near fatalities consistent with the federal CAPTA provisions. Federal guidance regarding the CAPTA requirements includes:

> States must develop procedures for the release of information including, but not limited to: the cause of and circumstances regarding the fatality or near fatality; the age and gender of the child; information describing any previous reports or child abuse or neglect investigations that are pertinent to the child abuse or neglect that led to the fatality or near fatality; the result of any such investigations; and the services provided by and actions of the State on behalf of the child that are pertinent to the child abuse or neglect that led to the fatality or near fatality.[24]

4. Enhanced wrap around treatment and support for caregivers with substance use disorder are needed.

OCA supports the provision of family centered treatment and medication assisted treatment to caregivers with substance use disorder as interventions that can support child safety and preserve families where concerns of abuse and neglect have been substantiated. As outlined in this fatality review, OCA found gaps or deficiencies in the provision of services to Marcello and his family, including both of his parents and his sibling. Specifically, the review raised questions regarding the adequacy of care coordination amongst providers, adequate protocols for toxicology testing and safety planning where a caregiver is using illicit substances, including Fentanyl, and the appropriate duration of intensive services and DCF supervision. For example, the FBR model contract calls for up to an 12-month intervention (with an opportunity to extend an additional 6 months if warranted), however, program data shows that families are served on average for only about six months. Outcome data shows that 1/3 of referred families complete treatment goals.

Given the numbers of children living in families affected by substance use disorder, including but not limited to opioid use disorder, and the challenges caregivers may have in accessing traditional outpatient services, the state should examine the current service array available to caregivers and their children, inclusive of access points, capacity, and outcomes.

- Family Based Recovery's quality assurance protocols should be strengthened to ensure fidelity to the model expectations, with quality assurance resources from DCF; funding should be enhanced to permit hiring of a full time supervisor for each FBR site to support recruitment and retention of qualified staff. The model developer should ensure provider sites have a common approach to drug testing (frequency, supervision, use of lab testing/rapid urines), inclusive of a common understanding of drug test results.

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

[24] Child Abuse Prevention and Treatment Act (CAPTA), as amended (42 U.S.C. 5106a et seq.) Section 106. DCF receives the federal CAPTA funding. https://www.cga.ct.gov/2020/rpt/pdf/2020-R-0223.pdf

- The state's Alcohol Drug Policy Council should examine and publish best practices for child protection in the context of parental substance misuse. The ADPC should also examine the adequacy and effectiveness 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. Public Act 23-97 requires 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.
- State agencies should expand strategies to more broadly disseminate Naloxone, to destigmatize use of Naloxone and promote public health messaging regarding the safe use of Naloxone with infants and young children.

II. JUDICIAL BRANCH- COURT SUPPORT SERVICES DIVISION

OCA and JB-CSSD met during the pendency of this investigation to review aspects of Ms. Polino's cases with Adult Probation. JB-CSSD and OCA had also recently met to discuss findings from OCA's investigation into Liam Rivera's death (Liam's father was under Adult Probation supervision at the time of Liam's death by homicide) and JB-CSSD's quality assurance framework for ensuring consistent supervision practice. JB-CSSD officials acknowledged that in both Liam's father's case and Ms. Polino's case several agency policies regarding probation supervision were not followed. With regard to Ms. Polino, the record was not adequately maintained, no home visits were done despite Ms. Polino being classified as in need of "high supervision" for a time, and no reports were made to DCF despite concerns of parental substance misuse and information that Ms. Polino was allegedly parenting two young children prior to Marcello's birth. Finally, JB-CSSD noted that assigned probation staff did not take required steps to ensure Ms. Polino was served with her multiple outstanding Norwalk violation of probation warrants after such warrants were issued by the court on September 20, 2022.

JB-CSSD has provided OCA with information regarding the action steps the agency has/is undertaking to address system improvement, including revision of several agency policies, enhancement of quality assurance reports, and updated memorandum and training for staff.

OCA noted in our report regarding Liam Rivera's death that JB-CSSD has numerous policy requirements for supervision by pre-trial/probation staff. The agency has several quality management reports to help administer and review supervision practices and outcomes, including 1) timeliness of needs/risk assessments; 2) contact (with probationer) standards; 3) referrals for treatment; 4) case plan timeliness; and 5) violations/re-arrests. The agency supervisors, and at times, regional and central administrators, review the quality of casework to identify areas of strength and areas needing improvement.

During Liam's fatality investigation, JB-CSSD reported to OCA that they are making several revisions to agency policies, including clarifying expectations for quality assurance reports, and providing training and guidance to staff to address deficiencies and areas for improvement identified during OCA and JB-CSSD's concurrent reviews. Such changes include, but are not limited to:

1. Clarifying frequency for review of quality assurance reports;
2. Addressing policy to enhance supervisory oversight of case management practices by probation officers and ensuring that regional management staff review reports measuring compliance with performance standards.

OCA acknowledges that there are many quality management reports used by JB-CSSD supervisory, regional, and administrative staff. OCA finds that additional improvements may be needed to ensure consistent supervision of individuals on pretrial and probation status.

Recommendations

- Adult probation officers should be trained to assess and engage with caregivers under supervision regarding behaviors that create risk to household members, including children, such as untreated serious mental illness or illicit drug use. While JB-CSSD staff are trained as mandated reporters, additional guidance is needed to support engagement, risk assessment, and effective service delivery for caregivers with serious treatment needs. Probation staff should receive pre- and in-service training regarding assessing household safety and the need for a possible DCF report when an individual under supervision is a caregiver of young children and engaged in high-risk behaviors to the public *or* household members.
- Acknowledging JB-CSSD's commitment to enhancing case supervision and practice compliance review at the regional level, OCA recommends that JB-CSSD have a centralized methodology for auditing case supervision (both pretrial and probation), to determine the fidelity of practice with agency policies.
- OCA recommends that JB-CSSD develop clear protocols with DCF for information-sharing between agencies when cases overlap.
- JB-CSSD should audit practices regarding service delivery, safety planning, and DCF referrals in cases involving individuals using Fentanyl.
- JB-CSSD should continue to work with state public health partners to maximize distribution of Naloxone and ensure its staff receive relevant training regarding availability and safe use of Naloxone with adults and children.

AGENCY RESPONSES

JB-CSSD

JB-CSSD indicated that it has created a centralized policy audit unit and the first audit of an adult probation policy, Warrant Service and Arrest Process, that is scheduled to begin in the near future.

Family Based Recovery- Model Development and Operations

The Family Based Recovery Model Developer has shared with the OCA developments in their practice as a result of consultations regarding the review of this case, including enhanced documentation to ensure a complete capture of communication between FBR and DCF, the creation and implementation of a Safety Check List, and revising practice guidance to provide greater clarity on including siblings of the index child and other family members into treatment. Follow up was conducted with providers to ensure that that teams are skilled at including family members when appropriate, addressing safety concerns with clients and making attempts to engage collateral contacts.

DCF- written response provided February 5, 2024.

In the aftermath of the June 28, 2023, passing of a 10-month-old, DCF commenced an internal Continuous Quality Improvement (CQI) review of this family's case as the Department had ended its involvement with the family on June 8, 2023.

The purpose of the CQI process is to review and evaluate the Department's work leading up to the incident and identify areas where there are opportunities for case practice and/or systems improvements. As a proud member of

the National Partnership for Child Safety (NPCS), DCF employs this framework and these processes to understand the inherently complex nature of the work and the factors that influence decision-making during cases where a fatality or near fatality has occurred. It also provides a safe and supportive environment for our social work staff to process, share information and learn from critical incidents to prevent additional tragedies. This framework is foundational to our ABCD Child Safety Practice Model and Safe and Sound culture established for our employees.

Continuous Quality Improvement remains a tenet of the Department's core values, as evidenced by the March 2022 court decision to end the Juan F. Consent Decree and remove that aspect of federal oversight of the Department's practice. CTDCF worked closely with the Court Monitor's Office for over 30 years to ensure that an effective CQI infrastructure was developed to identify, analyze, and refine practice to improve outcomes for children and families. Since the termination of federal oversight under the Consent Decree, and in keeping with a commitment to excellence in child welfare practice, the Department contracted with Chapin Hall, an independent policy center at the University of Chicago, to complete a comprehensive overview of the Bureau of Strategic Planning and its functions to build upon the existing performance management system and propose recommendations to create a holistic CQI Practice Model. As previously noted, this engagement began in January of 2023.

As a result of our CQI reviews and processes, including the review in this case, we have identified system improvement opportunities as well as areas of best practice that have continued to be addressed and reinforced over the past six months. Those areas of best practice include, but are not limited to, the use of a strength-based approach to our work, supervisory support and oversight, fentanyl triage meetings, Structured Decision Making (SDM) safety assessments, multidisciplinary consultation teams, engaging with providers, and onboarding and training of new staff, including shadowing opportunities, to assist in retaining a qualified workforce and reduce turnover.

More specifically, the Department remains focused on the following practice and systemic areas for continuous improvement:

1. <u>Assessing child safety in families where substance misuse and particularly fentanyl is present</u>

    - We have trained all social work staff on how to administer the UNCOPE screening tool to determine the impact of substance use on child safety and well-being and to assess parental functioning to meet the needs of their children. The UNCOPE is comprised of six questions and provides a quick and simple way of identifying risk for substance use concerns when not already clearly identified as a problem. The tool can be used to screen for alcohol and/or other drugs in adults.
    - Staff have also been trained on the use of Motivational Interviewing, which is an evidence-based approach to engagement that can assist in gathering additional information to inform our assessments and improve service delivery.
    - Full training occurred with all area office social work, legal and administrative staff on the topic **"Enhanced Safety Guidance for Cases Involving Fentanyl and Substance Use".** This training covered the final fentanyl protocol, the agency's substance use practice guide, screening and testing and a refresher on substance use and misuse in general.
    - Work will continue with thought partners and subject matter experts, including the Alcohol and Drug Policy Council, the Department of Mental Health and Addiction Services, the federal Substance Abuse and Mental Health Services Administration, to develop best practice in child protection when parental/caregiver substance use is present.
    - Educational literature and brochures were distributed to each of the offices labeled "keeping you safe and your families safe". This was education on Fentanyl and resources to support our staff and our families in prevention and treatment.

- The Department is also initiating training for our staff on Naloxone and distributing this to all DCF offices along with reviewing and updating policy and procedures related to its use.

2. Accessing/Enhancing Fentanyl testing

- Partnerships will continue with the adult substance use community to address challenges with and developments related to Fentanyl testing.
- The state has received technical assistance from the Opioid Response Network regarding this issue, including training on the Role of Substance Use Disorders & Management in the Family Unit.
- Providers now have an FDA CLIA waived rapid screening test for Fentanyl. The goal is to have all providers begin using this in February.
- Family Based Recovery (FBR) is now testing for Fentanyl. The Department will continue to review the protocols, expectations and best practices regarding testing and revise/update FBR and other provider contracts as needed.

3. Including all providers in teaming

- DCF will continue to engage with non-contracted programs such as Methadone Programs and Probation to include them in the DCF teaming process and in meetings with other providers involved with the family. This will ensure all entities involved with a family have coordinated communication and sharing of information.
- DCF and JB-CSSD have been meeting to discuss barriers to information sharing, many statutorily set, and determine ways to ensure better communication between agencies.

4. Addressing provider staff turnover

- Connecticut continues to experience a workforce shortage and the Department will continue to strategize with the provider community to develop solutions. Challenges existed with staffing in the FBR provider network, and turnover occurred specifically with members of the FBR team working with this family leaving those directly involved newer to their roles.

5. Engaging Fathers

- The Department has hired a Fatherhood Engagement Coordinator to establish best case practice standards regarding fatherhood engagement and to promote more comprehensive assessments of fathers as an integral component of case planning.

The Department acknowledges the OCA's observations regarding this case and our shared focus on continuous quality improvement for all agencies and partners who comprise the child welfare system. While the Department may have a different perspective on some of the OCA's findings and conclusions, we are reviewing the recommendations and remain committed to collaborating with the OCA, our sister agencies and other system partners to support and improve the safety and well-being of the children and families we collectively serve.