State of Vermont

Vulnerable Adult Fatality Review Team

2017 Report

VAFRT Annual Report

Dedication

This report is dedicated to Jackie Majoras, formerly the Vermont Long-Term Care Ombudsman. The Vermont Vulnerable Adult Review Team (hereafter Team), would not exist save for her determination and perseverance.

The Team, in turn, dedicates its work to Vermont's vulnerable adults, their families and loved-ones. It is our hope that by studying fatalities among vulnerable adults, the Team will generate insights and recommendations, increase awareness, and improve the delivery of services that will benefit vulnerable adults and all Vermonters. We are privileged to devote our time to this effort.

Introduction

The Vermont General Assembly enacted legislation establishing the Team within the Office of the Attorney General, in May 2016. (The law is codified at 33 V.S.A. § 6961, *et seq.*).

Fatality review teams are interdisciplinary bodies that bring together public and private sectors with a shared interest in the health and welfare of various vulnerable populations (examples include victims of domestic violence, child abuse, and elder abuse). Fatality review teams study untimely deaths to ask the following questions: How did this happen? How can we do better? What kinds of interventions might have produced a different outcome?

For more than a decade, Vermont has benefited from the work of fatality review teams focusing on domestic violence and child abuse. With the addition of this Team, Vermont again leads the way in becoming one of only five states with a fatality review team focused on vulnerable adults or the elderly.

This is the Team's first Annual Report to the Legislature.

Team Activities

The Team began its work on September 27, 2016, with an inaugural meeting to discuss our legislative authority and mission. The original membership of the Team included:

- Shawna Agel, Adult Protective Services
- Shelia Aubin, Visiting Nurses and Hospice for Vermont
- Chris Bell, Office of Public Health Preparedness
- Michelle Carter, Office of the State Long-Term Care Ombudsman
- Andre Courcelle, Department of Aging & Independent Living
- Jeff Tieman, Vermont Association of Hospitals and Health Systems
- Nietra Panagoulis, Victim Advocate, Chittenden SAO
- Dr. Michael LaMantia, UVMMC
- Ed Paquin, Disability Rights Vermont

- Laura Pelosi, Vermont Health Care Association
- AJ Ruben, Disability Rights Vermont
- Steven Monde, Office of the Attorney General
- Lauri McGivern, Office of the Chief Medical Examiner
- Capt. Daniel Trudeau, Vermont State Police
- Roy Gerstenberger, Department of Aging & Independent Living.

In 2017, the Team's efforts focused primarily on foundational matters. We drafted and approved general protocols to guide our work; developed policies and procedures for case intake, screening, and review; and formed sub-committees to assist with the preparation of cases for presentation. (The protocols, formalized over four meetings from December 2016 through July 2017, can be found in the Appendix to this Report).

Preparations for the Team's inaugural substantive review of cases began in July 2017. The Team selected three cases for it's initial review, all of which involved hypothermia as a cause or contributing cause of death. Two of the deaths occurred in private homes, and one in a residential facility. After assembling the relevant documents, conducting interviews, and with the support of local law enforcement and family members, the cases were presented to the full Team on October 31, 2017.

There were three primary takeaways from the review. First, preventing hypothermia-related deaths among vulnerable adults is first and foremost a local, community issue. Consistent public messaging and service announcements educating Vermonters on the effects of hypothermia, and the need for community members to check-in on their vulnerable neighbors during the coldest months, is a low-cost, high-impact measure that can save lives.

Based on its case studies, the Team drafted a model press release for distribution to facilities and area agencies. Notices of this type are fairly common in the late fall, but there is no coordinating entity responsible for targeted distribution and follow up. The Team's primary recommendation is that the State designate an agency with responsibility for coordinating private and public messaging regarding cold-weather danger and tasked with making sure that messaging is delivered where it is needed most – in our local communities. The Team will work with the Vermont Department of Health to assist in getting the message out to Vermonters regarding the dangers associated with cold weather and prevention strategies to stay warm.

Second, in two of the deaths reviewed, the vulnerable adults died with heating oil in the tank, but the heating was turned off, likely to save money. This was, to say the least, disheartening. The recommendation here, as above, is for education and the coordinated delivery of information to ensure that elderly and vulnerable Vermonter's living alone in our communities are aware of heating assistance programs and know how to take advantage of them. Partnering with area heating suppliers to get the message out early in the season by including information on resources and dangers of cold weather in billing statements is another low-cost, high-impact measure.

Third, the cases reviewed confronted the Team with the truth that sometimes, even when everything is done correctly, messaging has been delivered and supports are in place, untimely deaths related to hypothermia still occur. Although frustrating, these facts allowed the Team to glimpse, and truly appreciate, the Vermont character traits that make our vulnerable adults and elderly so treasured. We are flinty, frugal, proud and self-reliant. Vermonters tend to age in their homes in the communities where they have made their lives. This is as it should be, and we appreciate the importance of State programs that make this possible. The interventions we recommend here are small, and do not seek to change the way Vermonter's live their lives. Rather our aim is simply to remind Vermonter's that we have to look out for our neighbors, friends, and families to provide a local safety net that will help the elderly and vulnerable remain in their homes and our lives.

Moving forward, the Team has identified several cases for review in the next year. We found focusing on a specific issue, such as hypothermia in the vulnerable population, gave us a better understanding of the problem and identified several obstacles Vermonters may face during the cold weather months. We will continue to focus on specific issues as we move forward and address any additional fatality review requests.

In summary, the Team made great progress in its first year, which includes the development of policies and procedures to guide our fatality reviews. In addition, we performed three full case reviews and, in the process, identified interventions that may prevent another hypothermia death. We also consulted with other fatality review teams in the state and in future years hope to conduct joint reviews on cases that meet each review team's criteria.

The members of the Team are dedicated to our mission and are grateful for the opportunity to assist in attempting to improve the lives and deaths of our vulnerable population.

Respectfully submitted,

Steven J. Monde, Chair

Lauri McGivern, Vice-Chair

State of Vermont
Vulnerable Adult Fatality Review Team
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Appendix 1

Policies and Procedures

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ATTORNEY GENERAL

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Vermont Vulnerable Adult Fatality Review Team

General Protocols

I. Purpose and Membership

A. The Vermont General Assembly enacted legislation establishing the Vulnerable Adult Fatality Review Team ("VAFR Team") within the Office of the Attorney General in May 2016. (See 33 V.S.A. § 6961, *et. seq.*). The Team was created for the following purposes:

1. to examine select cases of abuse- and neglect-related fatalities and preventable deaths of vulnerable adults in Vermont;

2. to identify system gaps and risk factors associated with those deaths;

3. to educate the public, service providers, and policymakers about abuse- and neglect-related fatalities and preventable deaths of vulnerable adults and strategies for intervention; and

4. to recommend legislation, rules, policies, procedures, practices, training, and coordination of services to promote interagency collaboration and prevent future abuse- and neglect-related fatalities.

B. The VAFR Team is comprised of the following statutory members or designees:

1. the Attorney General;

2. the Commissioner of Disabilities, Aging, and Independent Living;

3. the Commissioner of Public Safety;

4. the Chief Medical Examiner;

5. the Assistant Director for Adult Protective Services in the Department of Disabilities, Aging, and Independent Living;

6. the Adult Services Division Director in the Department of Disabilities, Aging, and Independent Living;

7. the Director of the Vermont Office of Emergency Medical Services and Injury Prevention;

8. the State Long-Term Care Ombudsman;

9. a representative of victim services, appointed by the Executive Director of the Vermont Center for Crime Victim Services;

10. the Director of the Center on Aging at the University of Vermont, or a gerontologist or geriatrician appointed by the Director;

11. the Director of Disability Rights Vermont or designee;

12. a hospital representative, appointed by the Vermont Association of Hospitals and Health Systems;

13. a long-term care facility representative, appointed by the Vermont Health Care Association; and

14. a home health agency representative, appointed jointly by the Vermont Association of Home Health Agencies and designated home health agencies that are not members of the Vermont Association of Home Health Agencies.

C. Statutory members of the VAFR Team shall serve a two-year term. Vacancies shall be filled in the same manner as the original appointment. Replacement members shall serve for the remainder of the unexpired term.

D. The VAFR Team shall annually select a chair and vice chair from among its members. The vice chair shall also serve as secretary.

E. VAFR Team members agree to endeavor to attend all meetings of the Team. When attendance is not possible, a member may select an alternate to attend in his or her place.

F. The VAFR Team dedicates its work to Vermont's vulnerable adults and their families whose lives have been affected by abuse, neglect and other circumstances resulting in preventable deaths. It is our hope that by studying fatalities among vulnerable adults, the Team will generate insights and recommendations, increase awareness and improve the delivery of services that will benefit all Vermonters.

II. Confidentiality of All Meetings, Proceedings and Records

A. The VAFR Team shall meet at least once in each calendar quarter and as many times thereafter as reasonably necessary to carry out its duties. The Team's meetings are confidential and exempt from the Vermont Open Meetings Law, pursuant to 33 V.S.A. § 6964(c).

B. Likewise, the VAFR Team's proceedings and records are confidential and exempt from public inspection and inspection under the Vermont Public Records Act and shall not be released, pursuant to 33 V.S.A. § 6964(a). The term "records" includes oral and written communications of any kind whether obtained or generated by the VAFR Team. Moreover, the Team's records and information related to its proceedings are not subject to subpoena or discovery, and are not admissible in any civil or criminal proceeding, subject to the independent-source exception set forth in 33 V.S.A. § 6964(a).

C. The VAFR Team shall not use information, records, or data that it obtains of generates for purposes other than those described in its enacting statute (33 V.S.A. § 6961 *et. seq.*).

D. VAFR Team members and any person invited to appear before or to assist the Team in its work shall execute a sworn confidentiality agreement that he or she will not reveal any information, records, discussions or opinions disclosed in connection with the Team's proceedings. The VAFR Team chair shall obtain and maintain these confidentiality agreements.

E. Information, records, or data obtained or generated by the VAFR Team shall be destroyed when the VAFR Team determines that they are no longer necessary for its work.

F. Notwithstanding the confidentiality and non-disclosure provisions relating to the VAFR Team's proceedings and records, the Team's conclusions and recommendations may be disclosed at the Team's discretion, and as necessary to fulfill its annual reporting requirement, but any information disclosed shall not identify or allow for the identification of any person or entity.

III. Authority to Obtain Information and Records

A. In any case subject to the VAFR Team's review, upon written request of the Chair, any person possessing information and records that are necessary and relevant to the Team's review shall provide the Team with the requested information and records as soon as practicable. However, the VAFR Team shall not have access to the proceedings, reports and records of peer review committees as defined in 26 V.S.A. § 1441. Persons disclosing or providing information or records upon the Team's request are not criminally or civilly liable for disclosing or providing information or records in compliance with this section. 33 V.S.A. § 6964.

IV. Annual Reporting Requirement

A. The VAFR Team shall prepare and submit an annual report to the General Assembly on or before January 15 each year. The Team membership shall approve the form and content of the annual report. The chair and vice-chair are responsible for ensuring its timely preparation and submission.

B. The annual report shall:

1. summarize the Team's activities for the preceding year;

2. identify any changes to the Team's procedures;

3. identify system gaps and risk factors associated with deaths reviewed by the Team;

4. recommend changes in statute, rule, policy, procedure, practice, training, or coordination of services that would decrease the number of preventable deaths in Vermont's vulnerable adult population; and

5. assess the effectiveness of the Team's activities.

C. The annual report may be made available to the public. The Team may also issue periodic reports to the public describing its work, conclusions and recommendations, subject to the limitations described in 33 V.S.A. § 6964.

IV. Policies and Procedures

A. Statutory Mandates

1. The Team shall develop and implement policies to ensure that it uses uniform procedures to review the deaths of vulnerable adults in Vermont.

2. The Team may review the death of any person who meets the definition of a vulnerable adult in 33 V.S.A. § 6902(14) and:

   a. who was the subject of an adult protective services investigation; or

   b. whose death came under the jurisdiction of, or was investigated by, the Office of the Chief Medical Examiner.

3. The Team shall not initiate the review of the death of a vulnerable adult until the conclusion of any active adult protective services or law enforcement investigation, criminal prosecution, or civil action.

4. The review shall not impose unreasonable burdens on health care providers for production of information, records, or other materials. The Team shall first seek to obtain information, records, and other materials from State agencies or that were generated in the course of an investigation by the Adult Protective Services Division, the Office of the Chief Medical Examiner, or law enforcement.

5. The Team shall establish criteria for selecting specific fatalities for review to ensure the analysis of fatalities occurring in both institutional and home- and community-based settings.

B. Executive Committee

1. A VAFR Team Executive Committee is established consisting of the chair, vice-chair and at least one additional member appointed by the full Team membership.

2. The Executive Committee is responsible, as described further below, for the in-take and screening of cases for potential review, and the organization and coordination of the Team's full case reviews. The Executive Committee shall also draft additional protocols and policies for the Team's review and approval, as necessary.

C. Case Referrals, Intake and Screening

1. Referrals

a. A VAFR Team member or any other person, agency or organization may refer a potential case to the Team for review. The Executive Committee will receive and maintain a log of all case referrals.

b. To ensure uniform in-take procedures, the Executive Committee will draft and use a standard referral form. The form will contain a notice of the Team's confidentiality provisions and state that the Team's records, including referrals, are not subject to subpoena, discovery or introduction into evidence in a civil or criminal action. The form will be distributed to Team members and available to the public in hard copy and on the Office of the Attorney General's web page.

c. Telephone or oral referrals may be made to any member of the Team, who will reduce the referral to writing, and forward to the Executive Committee. Referrals may also be made anonymously.

d. All referrals, regardless of the source, or method of communication, shall be recorded in writing and should include the following information:

- The source of, and date on which, the referral was made to the Team. (Source information is not required for anonymous referrals);
- The decedent's name and, if known, date of birth, or other identifying information;
- The date and location of the fatality;
- A description of the circumstances of the decedent's death including, where relevant, any alleged history of abuse or neglect;
- The names, addresses, phone numbers of other people having information regarding the death;
- Whether the fatality was investigated;

- A brief statement explaining why the referrer would like the case reviewed;
- Any other information that would aid the Team in understanding the history and circumstances of the fatality.

D. Case Screening

1. After receipt of a referral, the Executive Committee may screen the potential case to determine whether it falls within the Team's statutory jurisdiction and is otherwise appropriate for the Team's review. Screening shall be recorded in writing and conducted according to the following criteria:

a. Determination of Jurisdiction

i. The Team's jurisdiction is a function of two inquiries. First, the Executive Committee will determine whether the decedent was a "vulnerable adult" under the Vermont statutes.

ii. Second, if decedent was a vulnerable adult, the Executive Committee will determine whether the decedent was ever the subject of an Adult Protective Services investigation; or whether the decedent's death came under the jurisdiction, or was the subject, of investigation by the Office of the Chief Medical Examiner.

b. Determination of On-Going Investigation or Legal Action

i. If the Executive Committee finds that the Team's jurisdiction is appropriate, it will proceed to determine whether the decedent's death is under APS or law enforcement investigation, or the subject of a criminal prosecution or civil action.

ii. If the decedent's death is under investigation or the subject of on-going legal action, the Executive Committee will not refer the matter to the full Team. However, the case will be maintained in a possible review file and the Executive Committee will make follow-up inquiries at six-month intervals to determine the status of the case. The Executive Committee will also endeavor to gather public records relating to the matter and preserve them in the possible review file.

2. **Forwarding Screened Cases to the Team**

a. If the Team's jurisdiction is appropriate, and there are no on-going law enforcement investigations or legal actions, the Executive Committee shall record the fatality on a list which will be forwarded to the Team in advance of its next scheduled meeting for potential selection for a full case

review. At that time, the Executive Committee will also provide a recommendation regarding selection of the case for a full review. The Team is under no obligation to conduct a full review of any case.

b. The Executive Committee's recommendation will include an analysis of whether a full review is consistent with and is likely to advance the Team's statutory purposes. Specifically, the recommendation will note whether a full review will

- identify systems gaps and risk factors associated with abuse and neglect-related fatalities;
- offer opportunities to educate the public, service providers and policymakers; and
- result in policy and other recommendations to coordinate services, promote interagency collaboration and develop strategies for intervention.

c. The Executive Committee may group together cases that represent similar patterns and recommend a single review of the grouped cases.

d. The Executive Committee will also maintain a record of previous full case reviews, including information on the location of the fatalities reviewed. The Team will review this data prior to selecting a new case for full review to ensure the review of fatalities occurring in institutional, home- and community-based settings.

E. Full Case Review

1. Selection of Cases

a. The VAFR Team membership will select cases for full review from the Executive Committee's list of potential cases. The Team is under no obligation to review any particular case and is not required to review a specific number of cases in any year.

2. Case Groups

a. Following selection of a case for full review, a Case Group shall be formed consisting of at least one member of the executive committee and at least one individual from the VAFR Team membership.

b. Each case will be unique and present different requirements for full review. Some cases may be presented to the Team membership based solely on file reviews, while others may involve conducting interviews and the presentation of testimony. Consequently, case preparation

procedures will vary. Generally, however, the Case Group will be responsible for the following:

- Developing a plan to ensure a thorough and productive case review that includes, where appropriate, the voices and experience of the decedent and his or her family;
- Collecting and reviewing the Executive Committee's in-take and screening forms;
- Identifying, collecting and reviewing all relevant documents and case-related materials. (The Case Group may request the Chair to issue a formal request for the production of documents to third parties, pursuant to 33 V.S.A. § 6964);
- Interviewing referral sources and other individuals with relevant knowledge, including care givers, first-responders, investigators, state and private agency actors and, with the assistance of a victim advocate, family members, among others;
- Identifying and securing the participation of witnesses where testimony is deemed necessary and appropriate;
- Drafting a chronology of the case to guide the Team's full review;
- Drafting a set of defining questions and issues that will be the focus of the Team membership's full case review;
- Distribute materials, including the chronology and defining questions to all Team members at least two weeks prior to the date on which the case will be presented to the Team for full review[1];
- Presenting the case to the Team membership; and
- Drafting a closing memo when the full review is completed.

c. The Case Group will report its activities and progress in preparing a case for full review at each regularly scheduled Team meeting until the case is

[1] Medical records containing patient healthcare information are protected from disclosure under the federal HIPAA statute. Absent an effective waiver authorizing disclosure, records containing PHI may not be distributed to the Team. However, there are Team members who are authorized in their official capacity to obtain and view medical records contain PHI. Those members may review the records and provide oral summaries of critical information to the Team. When such a summary is deemed necessary, the Case Group should coordinate and make arrangements with the chair or vice chair.

presented. The Case Group will determine when their assigned case is ready for review by the full membership and will coordinate scheduling with the chair and vice chair.

3. Case Review Responsibilities of the Team Membership

a. The Team membership is responsible for conducting the full case review as presented by the Case Group.

b. To ensure a productive meeting, each Team member agrees to review and consider all materials distributed in advance by the Case Group and to actively participate in the Team's deliberations.

c. During the review meeting, Team members may ask factual, clarifying and follow-up questions, and may request the Case Group to obtain additional information when necessary.

d. The primary responsibility of the Team membership is to engage in group discussion and analysis of the presented case for the purpose of generating, conclusions, lessons and recommendation related to the Team's statutory purposed.

e. Following the case review, Team members will offer and submit recommendations to the Case Group. The Case Group will compile the submitted recommendations and submit them to the Team for possible inclusion in the annual report.