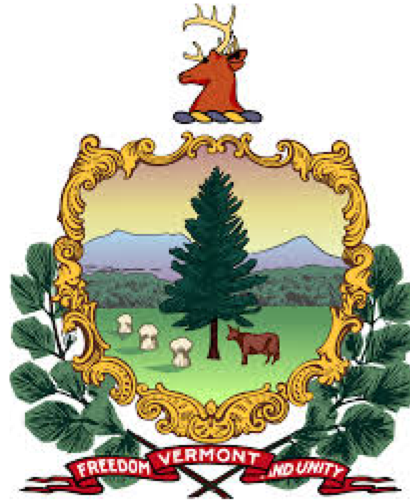
State of Vermont



Vulnerable Adult Fatality Review Team

2021 Report

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2021 Annual Report

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Vulnerable Adult Fatality Review Team
2021 Annual Report

Dedication

This year we would like to dedicate this report in the memory of Joan Senecal, who passed away on October 28, 2020, after battling pancreatic cancer. She worked for the Department of Disabilities, Aging and Independent Living (DAIL) from 1995-2010 serving as the Commissioner from 2007-2010. Her dedication to serving her community and protecting vulnerable Vermonters is an example to us all. Her obituary listed *"her work life's golden thread was finding the most fair and efficient way to better the lives of Vermonters"* due to *"Joan's unshakable belief that everyone should be able to live their lives with choices and dignity."*

Introduction

The Vermont General Assembly enacted legislation establishing the Vulnerable Adult Fatality Review Team (VAFRT) in May 2016. Pursuant to 33 V.S.A. § 6961, the Team functions under the auspices of the Office of the Attorney General. The purpose of the Team is to examine select cases of abuse and neglect related fatalities and preventable deaths of vulnerable adults in Vermont to:

- Identify system gaps and risk factors associated with the deaths that are brought to the attention of the Team.
- Educate the public, service providers, and policy makers about abuse and neglect related fatalities and preventable deaths of vulnerable adults and strategies for interventions; and
- Recommend legislation, rules, policies, procedures, practices, training and coordination of services to promote interagency collaboration and prevent future abuse and neglect related fatalities

The VAFRT Team achieves this purpose by bringing together members from multiple disciplines, who work with vulnerable adults, to share their experience and expertise. Together the Team comprehensively reviews cases. The Team's purpose is not to place blame on one agency or department but to work together to identify deficiencies and make future recommendations.

Team Members

The multidisciplinary team consists of members representing State and private entities and associations. The team is comprised by the following members:

- Elizabeth Anderson, Office of the Attorney General (Co-chair)
- Virginia Merriam, Office of the Attorney General (Co-chair)
- Bard Hill, Department of Disabilities, Aging and Independent Living
- Joy Barrett, Department of Disabilities, Aging and Independent Living
- Scott Dunlap, Department of Public Safety
- Lauri McGivern, Office of the Chief Medical Examiner
- Shawna Mead, Department of Disabilities, Aging and Independent Living - Adult Protective Services (Co-Vice-chair)
- Rhonda Williams, Vermont Department of Health
- Sean Londergan, Long-Term Care Ombudsman
- Nietra Panagoulis, Victim Advocate, Chittenden Co. States Attorney
- Rose Hill, MD, University of Vermont Medical Center
- Tina Hagan, Disability Rights Vermont
- Devon Green, Vermont Association of Hospitals and Health Systems
- Jill Olson, Visiting Nurses Association
- Cindy Bruzzese, Vermont Ethics Network
- Donna Benway, University of Vermont Medical Center
- Erin Roelke, Age Well, Director of Care and Service Coordination at Age Well

2021 Activities

This is the fifth report for the Vulnerable Adult Fatality Review Team (VAFRT). During the year the Team did in-depth reviews of two cases involving potential self-neglect vs. self-determination. The topic of self-neglect vs. self-determination was chosen due to an increase in cases observed by protective services personnel, law enforcement, the Office of Chief Medical Examiner (OCME) and the complexity of the issues in determining if a person is making a personal choice through self-determination or if a system failure occurred contributing in any manner to the person's death.

The Team met on March 23rd , May 11th , July 13th, September 14th & November 14th. The executive committee continued to meet on a weekly basis (with some exceptions) throughout the year.

On March 23rd the VAFRT received an educational overview of the topic of self-neglect from experts within the field. This included a presentation from an expert, from Skidmore College, who holds a Doctorate degree in Sociology & Social Work. The experts' work focused on 1) the health and well-being of vulnerable and oppressed older adults, particularly in terms of homelessness, housing, and social environment, and 2) the education and training of social workers, especially in terms of interprofessional practice in health and aging. The VAFRT also received an overview of the Vermont self-neglect study completed in March 2014 and current recommended interventions and best practices from the expert who coordinated the study.

Additionally, the VAFRT heard from staff from the Disabilities, Aging & Independent Living (DAIL) Adult Services Division (ASD), who oversee the Choices for Care (CFC), Brain Injury Program (BIP), Attendant Services Program (ASP) and HighTech Nursing (HTN). The Unit on Aging Director provided an overview of what services are currently available for vulnerable Vermonters who have been identified as self-neglecting (over the age of 60) and the current approach by the local Area Agencies on Aging for care and interventions. The Director of the Division of Licensing & Protection who provided an overview on the Self Neglect Working Group established in 2020.

As part of the Team's commitment to protecting vulnerable Vermonters we added Erin Roelke, Director of Care & Service Coordination for Age Well and a local expert on self-neglect to the VAFRT Team.

Case #1

During our May 11, 2021, meeting the VAFRT reviewed its first case involving the untimely death of an 81-year-old individual. The individual was found in the winter of 2021, after the local police were asked to conduct a welfare check. Upon arriving, they found mail and food stacked on the front steps/porch. Neighbors reported not having seen the individual for approximately two weeks. Upon making entry into the home, rescue personnel found the house to be in a condition they described as "unlivable."

Photos of the scene depicted a home with waist high levels of garbage/trash and visible mold and decay. Water was found to be falling from the ceiling from what was determined to be a burst pipe. The victim was found upstairs, in a bedroom, essentially unresponsive and had been incontinent of urine and feces. It was noted

that parts of the victims' feet were black in color and there was evidence of an infected laceration to their stomach area. It was determined the victim had a core temperature of 91 degrees. The victim was transported to the local hospital where they passed away.

The VAFRT heard testimony from the local police department, rescue squad, town heath officer (THO), and local agency on aging personnel. During our review of the case the VAFRT identified the following recommendations.

Recommendations

1) It was determined that some Town Health Officers (THO) and Emergency Medical Services (EMS) providers were unclear about the process and procedures for addressing self-neglect cases. The THO handbook lacked specific guidance about how to report cases of self-neglect. Based on this finding, the VAFRT was asked to contribute to an upcoming revision of the THO Handbook. Our proposed edition to the Handbook was submitted to the Department of Health, Environmental Health Division, Town Health Officer Oversight Manager.

2) The VAFRT identified a need for additional training for EMS personnel, local law enforcement agencies, and Town Health Officers on Self Neglect and Hoarding vs. Squalor. The team recommends that the Self-Neglect Working Group develop a training that can be provided statewide on the topic and include presenters from the Area Agency on Aging, Adult Protective Services, and an expert in hoarding.

3) It was also determined during our November 9, 2021, meeting that the above training would also be beneficial to staff (case managers and social workers) of local hospitals.

Case # 2

On July 13th and September 14th, the VAFRT reviewed a second case involving the untimely death of a 39-year-old year old individual who died from Influenza A upper respiratory infection, Myasthenia Gravis, Autism, Congenital adrenal insufficiency, unsanitary living conditions and Hydromorphone and Promethazine intoxication. The latter finding, the medication intoxication, is what led this case to be referred to the VAFRT as questions arose regarding the person's capacity to administer such a complicated medication regime. The VAFRT heard testimony from caregivers who worked at the local Designated Agency (DA), the primary care physician (PCP), and a local expert on hoarding.

The individual in this case had a history of refusing to accept services, hoarding like behaviors, and at the time of their death was in the process of transitioning from agency directed care to a self-managed model. At the time of this individual's death there was a State of Emergency in place which limited how many services could be provided in the home by the DA and local home health agency.

Recommendations

1) During the review the VAFRT determined that collaboration between agencies would have been key to identifying any risks or mitigating circumstances involving this person leaving agency directed care to a self-managed model. Although the DAIL Developmental Services (DS) program was notified of the victims' death, there are no rules or regulations which would require the DA to notify the DS program if an individual chooses to leave services. The VAFRT also determined that, until this review, the DS Quality Team had not been aware that there were APS and MFRAU investigations into this untimely death. This case has outlined the importance of having a process to share information among key agencies. Our recommendation is that MFRAU, APS, OPG and DS meet on a quarterly basis to review specific cases in which all parties have an interest. These meetings would require confidentiality agreements to be in place.

2)The VAFRT recommends that DAIL develop a process that allows for notification of instances in which an individual, without a court appointed guardian, terminates services from either DS services or ASD services within the Choices for Care (CFC), Brain Injury Program (BIP), Attendant Services Program (ASP) and HighTech Nursing (HTN) when that termination poses a potential risk to their well-being. It is also recommended that an "informed consent" form be developed which highlights any risks the primary agency has identified and that all parties, if possible (the recipient, natural support system and service providers) sign the form or document in the form that the agency addressed the risks, or attempted to, with the recipient of the services. This could be similar to forms used in hospitals to document when a person leaves Against Medical Advice (AMA). While the VAFRT recognizes that current State and Federal legal framework does not allow for treatment to be provided over a person's objection (except in certain circumstances when authorized by a court), notification to DAIL may allow the service providers, or DAIL to determine if a referral to APS, local social service agencies, or a local law enforcement agency is warranted.

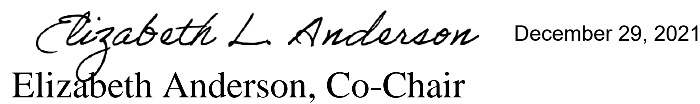
3) The VAFRT recommends that DAIL review what is considered a reportable event under the current critical incident reporting (CIR) requirements to determine if withdrawal from services should be a reportable event for both the DS program and the ASD program and consider relevant revisions to the critical incident reporting requirements.

4) The VAFRT also recommends that for people who self-neglect that the Self-Neglect Working Group include a review of the CIR process as part of its comprehensive work and recommendations regarding self-neglect.

Conclusions and Future Activities

The Team is currently taking recommendations from members regarding the topic for the next year's review.

Respectfully submitted,


December 29, 2021

Elizabeth Anderson, Co-Chair

December 29, 2021

Virginia Merriam, Co-Chair