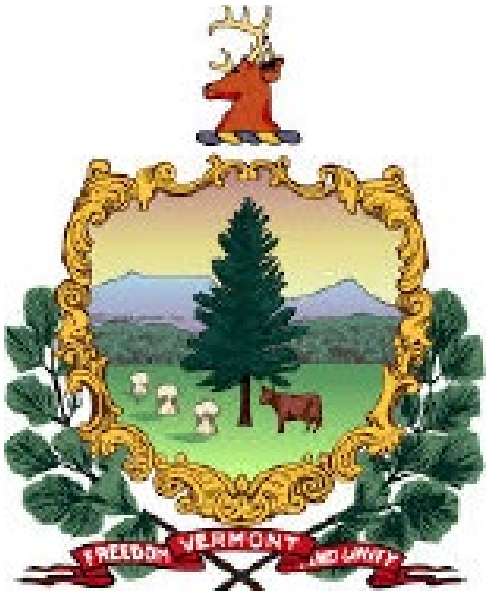


# Vulnerable Adult Fatality Review Team

# 2022 Report

# Vulnerable Adult Fatality Review Team
# 2022 Annual Report

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# Vulnerable Adult Fatality Review Team
# 2022 Annual Report

## Dedication

This year we would like to dedicate this report to Bard Hill. Bard joined the State of Vermont in August of 1987 and has served in a number of roles in disability/aging/mental health. Bard retired on December 31, 2022, after 35 years of service, most recently as Principal Assistant to the Commissioner of the Department of Disabilities, Aging and Independent Living (DAIL). Bard's dedication to DAIL's mission to make Vermont the best state in which to grow old or to live with a disability – with dignity, respect, and independence – and his significant contributions to improving the lives of countless Vermonters over the past three and a half decades, are greatly appreciated by all who had the good fortune to work with him.

Bard has also been a valued member of the Vulnerable Adult Fatality Review Team since its inception. His insights and observations always brought forth meaningful discussions and shaped many of the recommendations made by the Team over the past six years. He will be missed.

We wish him the best of luck in his next adventure.

## Introduction

The Vermont General Assembly enacted legislation establishing the Vulnerable Adult Fatality Review Team (VAFRT), hereinafter referred to as "The Team", 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 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 L. 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 (Co-Vice chair)
- Shawna Mead, Adult Protective Services (Co- Vice chair)
- Rhonda Williams, Vermont Department of Health
- Alicia Moyer, Long-Term Care Ombudsman
- Nietra Panagoulis, Victim Advocate, Chittenden Co. States Attorney
- Jeanne Hutchins, University of Vermont Medical Center
- Tina Hagen, Disability Rights Vermont
- Devon Green, Vermont Association of Hospitals and Health Systems
- Jill Mazza Olson, VNAs of Vermont
- Cindy Bruzzese, Vermont Ethics Network
- Lisa Edson Neveu, Adult Services Division
- Lindsey Owen, Disability Rights Vermont
- Ursula Margazano, Gifford Health
- Erin Roelke, Age Well, Director of Care and Service Coordination at Age Well

## 2022 Activities

This is the sixth report for the VAFRT. During the year, the Team did an in-depth review of five cases involving deaths of vulnerable adults that occurred as a result of wandering/eloping. The cases spanned a broad spectrum of living environments including licensed caregiving facilities, unlicensed board and care homes, and private residences. The topic 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 associated with wandering/eloping, which often occurs when a person has a diagnosis of dementia or Alzheimer's.

## Missing Vulnerable Vermonters Statistics

According to the Department of Public Safety (DPS) in 2021 there were 87 individuals who were considered vulnerable that were reported missing. In this capacity, a vulnerable individual is defined as anyone for whom there is a concern for their cognitive well-being or an individual who is experiencing a mental health crisis at the time of being reported missing. Of the 87 individuals reported missing, there were 26 juveniles (ages 0-20), 42 adults (ages 21-59), and 19 individuals over the age of 60. In 2022, there were 95 vulnerable individuals who were reported missing, including 24 juveniles, 46 adults, and 25 individuals over the age of 60. These totals only represent those individuals that who were entered into National Crime Information Center (NCIC) as a missing person (not all missing persons are entered into NCIC).

## Team Activity

In 2022, the Team met on February 8, April 12, June 14, October 11, and December 13. The executive committee, made up of Lauri McGivern, Shawna Mead, Virginia Merriam, Elizabeth Anderson, and supported by Karen Lapan, continued to meet on a weekly basis (with some exceptions) throughout the year.

On February 8, 2022, the Team received an educational overview of the topic of wandering and dementia from experts within the field. This included a presentation from Meg Polyte, of the Vermont Alzheimer's Association. A discussion on the proposed Silver Alert Bill led by Ron LaFond, Deputy Director of the Vermont Intelligence Center (VIC) at the Department of Public Safety. A presentation by Erin Roelke, Director of Care & Service Coordination, at Age Well on the Area Agency on Aging's (AAAs) response to wandering/elopement, best practices, and recommendations for community-based services. Finally, Pam Cota, Licensing Chief with Survey & Certification at the Department of Disabilities Aging & Independent Living (DAIL) outlined the licensing rules and regulations for Residential Care Homes (RCH), Assisted Living facilities, and Nursing Homes in the context of caring for residents who have a propensity to wander or exhibit elopement behaviors.

As part of the Team's commitment to protecting vulnerable Vermonters, Erin Roelke, Director of Care & Service Coordination for Age Well, and Meg Polyte, with the Vermont Alzheimer's Association were invited to join the team due to their familiarity and expertise on this year's topic.

## Wandering Incidents from a Licensed Caregiving Facility

On April 12, 2022, the Team reviewed the death of two vulnerable adults A.B and C.A, who were residents of St. Joseph's Care Home (SJCH), a level III Residential Care Home (RCH) located in Burlington, Vermont.

**Case #1**

A.B had been a resident of SJCH since August of 2012 and had a diagnosis of dementia and depression. The facility documented A.B's behaviors to include a risk of wandering and they were identified as an elopement risk.

On February 26, 2015, at approximately 1:45am, A.B was found outside of the dining room door of the facility by a LNA on duty. A.B was confused and wearing only a tee shirt and underwear. The outside temperature was reported to be well below zero. A.B was transported to the University of Vermont Medical Center (UVMMC) where they were found to be suffering from frostbite and hypothermia. A.B was admitted to UVMMC and later discharged to a nursing home where A.B passed away on March 29, 2015.

OCME determined hypothermia and frostbite were contributing factors to A.B's death and the manner was ruled accidental.

As part of a plan of correction, with the Division of Licensing and Protection, SJCH installed alarms on all exit doors which were to be activated from 9:00 pm until 5:00 am.

**Case #2**

On June 8, 2015, less than four months after A.B's elopement, a second resident, C.A wandered away from SJCH in the early morning hours and was later found on the lawn of a Burlington fraternity house at 3:30 am.

C.A had been admitted to SJCH on June 1, 2015 and assessed to be an elopement risk. On June 4, 2015, C.A eloped from the facility (even though the exit doors had alarms on them) and was found by a staff person in the parking lot, at 4:40 am, after C.A rang the doorbell attempting to re-enter the facility.

Four days later, on June 8, 2015, C.A was observed to be in their room at approximately 1:15 am and noted missing at 3:15 am. Again, all door alarms were allegedly working. C.A was subsequently located off the home's property by the local police department and transported to UVMMC where they were admitted and treated for a number of serious injuries including, a fractured clavicle, cervical spine, and nine fractured ribs. C.A was discharged to a nursing facility where they suffered a stroke on June 16, 2015. C.A's family chose comfort care for C.A, and they were discharged to Vermont Respite House where they passed away on June 26, 2015.

OCME ruled C.A's death as accidental.

**Wandering Incidents from Private Homes**

On June 14, 2022, the Team reviewed the deaths of R.N and H.E, who were both community members who did not receive support services from local caregiving agencies. In both cases, the individuals lived at home with their natural families.

**Case # 3**

On May 31, 2021, R.N, who suffered from dementia, wandered away from their home. Vermont Search and Rescue protocols were activated and over the course of four days, multiple state and local agencies searched for R.N, including: the Vermont State Police Search and Rescue Team, Ludlow Police Department, Ludlow Fire Department, Proctorville Fire Department, New England K9 Search and Rescue, Upper Valley Wilderness Response Team, Killington Search and Rescue, Vermont Air National Guard, Rescue Inc, and the Vermont Fish and Wildlife Warden Service.

R.N was found deceased on June 4, 2021, in a puddle of water in the middle of a logging trail, approximately a mile-and-a-half away from their home. R.N was not wearing pants or underwear when found. The pants, underwear, slippers, and glasses were found neatly piled nearby with no personal items missing. The scene was suggestive of paradoxical disrobing. Family reported R.N's dementia had been worsening in the days leading up to their death and that R.N had attempted to elope on three occasions on May 31, 2021 prior to the last successful attempt.

OCME determined the manner of death was accidental with the cause of death as hypothermia, secondary to dementia and cardiac arrhythmia.

**Case #4**

H.E suffered from dementia and sundowners and lived with their family in Groton with no outside support services in place. On the evening of February 14, 2021, H.E made several attempts to leave the house but eventually was convinced to go to bed at approximately 10:00 pm. At approximately, 2:00 am on February 15, 2021, a family member discovered H.E was no longer in the residence and was subsequently located approximately 50 feet from the residence on the snow-covered ground. It is believed H.E exited the residence, fell, and due to mobility issues was unable to get up. At the time of the elopement the outside temperature was -21 degrees (without the windchill factored in) and there was an estimated 12 inches of snow on the ground. The family called 911, brought H.E into the home where H.E was later pronounced deceased by EMS.

OCME ruled the manner of death accidental with the cause as hypothermia.

**Wandering Incident from a Non-Licensed Board and Care Home**

On October 11, 2022, the team reviewed the death of P.K, a vulnerable adult, who suffered from Alzheimer's disease.

**Case #5**

P.K was receiving privately paid care from a non-licensed care home located in Lyndon, Vermont. The owner of the non-licensed home had prior training as a LNA and had been working as a private caregiver for 30+ years. The owner routinely cared for two unrelated adults in the home at the same time and therefore was not subjected to oversight and monitoring from

the Division of Licensing and Protection (Vermont law only requires a home to be licensed if they provide care to 3 or more, unrelated individuals). As the home was unlicensed there are no regulations requiring a formal care plan and there were not any risk assessments completed.

According to the owner, on the evening of July 16, 2019, P.K reportedly did not sleep well and had been wandering in and out of the rooms of others residing in the home. The last time, according to owner, was around 4:00 am when they directed P.K to return to their room. The owner stated they did not check on P.K again until around 6:00 or 7:00 am that morning, at which time they reported P.K was in their room. Around 9:00 or 10:00 am, the owner checked again and found the room was empty, the window was open (PK's room was on the second floor) and the window screen was pushed out.

The owner subsequently found P.K outside lying on the ground after falling an estimated 12 to 15 feet from the roof above. P.K was conscious and soaking wet (it was pouring rain). It was estimated P.K had been outside for one to two hours before being discovered. P.K was transported to the local hospital where it was determined they had a left hip comminuted fracture and comminuted superior ramus fracture. Approximately 45 minutes after arriving at the hospital, P.K began to vomit blood and was placed on comfort care. P.K passed away on June 18, 2019.

OCME ruled the manner of death accidental with the cause of death being related to the injuries sustained from the fall.

## Review of Bill H.530

In April 2022, the House Committee on Human Services took testimony on H.530, an Act relating to the creation of a Silver Alert Program. The bill was proposed, in part due to the death of Clinton Casavant, an 89-year-old Essex man who went missing in December of 2020. He was later found deceased after a week-long search.

H. 530 proposed a statute regarding broadcasting information about and locating missing individuals who are 60 years of age or older or who have a psychiatric disability, developmental disability, or cognitive impairment. The Department of Public Safety (DPS) requested that the matter be studied further in part because DPS did not recommend using the Amber Alert Statute (20 V.S.A § 1828) as a template for a Silver Alert program in Vermont. As a result, the Committee requested DPS submit a written report to the House Committee on Human Services, the Senate Committee on Health and Welfare, and the House and Senate Committees on Government Operations with its recommendations.

DPS's final recommendation was a draft policy, Missing Vulnerable Person Alert, which expands the adult missing person search tools to include Wireless Emergency Alerts (WEA) in certain circumstances. WEA is a mass cell phone notification system, for a particular geographic area, that provides alerts regardless of whether the cell phone user opted into the alerts. The policy states:

*The use of WEA is limited to certain criteria and to those deemed a "missing vulnerable person" under the policy. The policy expressly does not use an individual's disability status as part of the definition of a missing vulnerable person, but rather the circumstances created by an individual's disability or impairment. The policy does not have an age limitation.*

*A Missing Vulnerable Person is defined as "A person whose whereabouts are unknown, who is unable to protect themselves from significant harm and is believed to be in danger of death or serious bodily injury due to an inability to be located safely or an inability to return to safety without assistance."*

*The alert requirements include the following:*

1. *Missing person meets the definition of Missing Vulnerable Person.*
2. *Report has been made to Vermont law enforcement agency with geographic jurisdiction over the missing person case.*
3. *Person(s) have been entered into the National Crime Information Center (NCIC) as a "Missing Person-Endangered."*
4. *A request has been made to the Vermont State Police (VSP).*
    a. *Business hours: appropriate Barracks Commander.*
    b. *After hours: Appropriate VSP Watch Commander.*
5. *The request for a Missing Vulnerable Persons Alert has been submitted to Vermont Emergency Management Watch Officer via the request form AND follow up with a phone call via 800-347-0488.*
6. *Requests for a Missing Vulnerable Persons Alert to be issued via WEA and reverse landline dialing will only be issued during the hours of 6:00 am to 10:00 pm.*

***Criteria for a Missing Vulnerable Person Alert via VT-Alert to Reverse landline dialing and Wireless Emergency Alert System:***

1. *Missing vulnerable person has been missing for 24 hours or less.*
2. *Missing vulnerable person is believed or known to be on foot.*
3. *There is sufficient information available to disseminate that could assist in locating the missing vulnerable person (i.e., physical description, clothing description, last known location, etc.) and*
4. *The search for the missing vulnerable person has been initiated and is still being conducted.*

***Criteria for a Missing Vulnerable Person Alert via VT-Alert opt-in subscribers**:*

1. *Missing vulnerable person has been missing for 72-hours or less, and*
2. *There is sufficient information available to disseminate that could assist in locating the missing vulnerable person (i.e., physical description, clothing description, last known location, etc.)*

***Suggested additional actions of the lead law enforcement agency***

1. *Issue a press release to local media to include a recent photo of the missing person.*

2. *Social media postings on official department/agency pages.*
3. *Consult with the Vermont Intelligence Center via 802-872-6110 for additional assistance and broadcasts.*
4. *Lead law enforcement agency should notify the Vermont Emergency Management Watch Officer when the missing vulnerable person is located.*
    a. *A cancellation alert should be considered if the missing vulnerable person is located within 24-48 hours. Cancelation alerts will be issued only to VT-Alert opt-in subscribers.*

**Recommendations:**

(1) The Team supports and agrees with the recommendations of the Department of Public Safety to implement the proposed Missing Vulnerable Person policy. This approach offers a uniformed response to missing vulnerable Vermonters across all living and geographical settings.

(2) The Team recommends a Tips for Preventing Wandering training be developed with input from experts in the field (The Vermont Department of Health, Area Agency on Aging, Primary Care Physicians, Alzheimer's Association and the Department of Disabilities, Aging and Independent Living) to be made available to individuals, families, medical professionals, and caregiving facilities. The training would include a description of what wandering/elopement is, ways to prevent wandering/elopement, and tools available to help mitigate risks.

(3) The Department of Health (DOH) is in the process of upgrading their website, which is anticipated to be completed by February of 2023. The Team recommends the DOH add new pages to the website that contains available resources for families, caregivers and medical professionals related to the risks of wandering and available resources. Once complete, the Team recommends the DOH issue a Public Service Announcement on the risks of wandering and available resources.

(4) Similarly, the Team recommends a segment on the risks of wandering be developed and shown on Across the Fence, or other media outlets, to help inform the public of the dangers of wandering, early warning signs, available resources and possible tools that can be used to mitigate the risks.

5) The Larner College of Medicine at the University of Vermont Continuing Education Series is holding its annual Gerontology Conference, on May 15, 2023, in Burlington, VT. The Team recommends an overview of available services be provided, including those of the adult family service division; area agency on aging supports; available resources from the Alzheimer's Association; the role of Adult Protective Services and the Attorney General's Medicaid Fraud and Residential Abuse Unit in cases where there are concerns of abuse, neglect or exploitation.

(5) The Team recommends DAIL explore using the allocation of Federal Medical Assistance Percentage (FMAP) funding in the Home & Community Based settings for the purchase of equipment to mitigate the risks of wandering (e.g. the installation of cameras, fences as a perimeter boundary, door alarms and/or home alert systems).

(6) Finally, the Team recommends that the State of Vermont housing inspection form should be updated to include a question related to possible environmental hazards that may exist such as the presence of water on the property which would pose increased risks for an individual who wanders. Any agency that is placing an individual in a Shared Living Provider (SLP) home is responsible for making sure the environmental assessment is consistent with the individual's needs.

## Conclusions and Future Activities

As Vermont's population continues to age, having resources and tools in place and available for families, caregivers, and community at large for vulnerable Vermonters prone to wandering and suffering from dementia will be increasingly important. The Team believes the recommendations above will help to better protect these individuals.

In looking to next year, the Team is currently taking recommendations from members regarding a topic or theme for review.

Respectfully submitted,

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