Report to
The Vermont Legislature

Report of the Vulnerable Adult Fatality Review Team
2019 Report to the Legislature

In Accordance with Pursuant to 33 V.S.A. § 6961 legislation establishing the Vulnerable Adult Fatality Review Team

Submitted to: **The Vermont General Assembly**
Governor Phil Scott

Submitted by: **Vermont Attorney General's Office**

Prepared by: **Lauri McGivern, Chair**
Virginia Merriam, Vice-Chair
Vulnerable Adult Fatality Review Team

Report Date: **January 9, 2020**

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TABLE OF CONTENTS

Introduction..... 4
Focus area..... 5
Case details..... 6
Summary..... 9
Prevention and Recommendations..... 10
Conclusion and Future Activities..... 11

ADDENDUM A – Team Members

Introduction:

The Vermont General Assembly enacted legislation establishing the Vulnerable Adult Fatality Review 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
- 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 reviews cases. The Teams purpose is not to place blame on one agency or department but to work together to identify deficiencies and make future recommendations.

Case Review Process:

The Team selects cases within their focus area and receives cases for review from Team members, professionals or members of the public. A subgroup reviews the case submission and determines if it falls within the Teams authority for review. Cases which are still in litigation are held until adjudicated which is why many cases may be several years old. The case review process includes creating a timeline for the case, identifying risk factors and vulnerability, reviewing medical records, police and medical examiner reports and any other documents pertinent to the case. Family members, healthcare providers, law enforcement and other witnesses may be invited to provide testimony. Subject matter witnesses may also be invited to review the case and provide an expert opinion.
The multi-disciplinary Team meets in person and develops a timeline for the review. Complicated cases may require several meetings of the Team. After the review, Team members make conclusions and recommendations focusing on lessons learned and prevention strategies.

Team Outreach:

The Vulnerable Adult Fatality Review Team created two public service messages, one with the Vermont Department of Health and the other through the Vermont Attorney General's office. The messages brought attention to cold weather and the danger it poses to the elder and vulnerable population. Resources and heating assistance programs were included in the messaging. The Chair of the team interviewed with a local news crew to educate and heighten Vermonters awareness of the dangers of cold

weather especially in the vulnerable population. These activities followed the focus of the Team the previous year in reviews of hypothermia deaths in vulnerable adults.

2019 Review – Focus Area: Decubitus Ulcers

Case Reviews: During the period September 2018 through September 2019 the Team met for a total of 7 full-team meetings, reviewing 4 cases (see Table 1). Executive Team members met weekly to prep cases and do follow up as necessary. During two of the full team meetings, subject matter experts were brought in to educate the team on prevention, treatment and causes of decubitus ulcers. The experts represented hospital, hospice and residential care settings. A wound care nurse was invited to sit on the Team to provide expertise and guide the team in the case reviews. The team also invited a representative from the Department of Disability, Aging and Independent Living (DAIL), Adult Protective Services to discuss neglect and self-neglect. Many of the cases involved ethical considerations so the team added an Ethics expert to assist in those discussions.

Table 1. Number of cases reviewed September 2018 through September 2019 (13 months)	
1	Decubitus Ulcers - undetermined
1	Failure to thrive-decubitus ulcers- Natural
1	Failure to thrive-decubitus ulcers- homicide
1	Sepsis due to decubitus ulcers- undetermined
4	**Total Cases Reviewed**

Case Details:

Below is a brief summary of the cases reviewed by the Team with identifying information removed for protection of the individual. We feel it is important to give an overview of the issues surrounding Vermont's vulnerable population.

Case A: Elderly female with a past medical history of diabetes, Parkinson's disease, heart disease and limited activities of daily living (ADL's), was cared for at home by a family member. Outside professional nursing services along with a home care agency provided medical and home services and became concerned when they observed signs of neglect and possible abuse. Both agencies recommended more care as the patient had developed decubitus ulcers requiring frequent pressure off-loading and dressing changes. The female was losing weight and had several hospitalizations for the decubitus ulcers and malnutrition. The additional care was declined by the family care provider. There were concerns that the family member may be financially exploiting the female and not providing her with the care she required. Investigations into the claims were unfounded as the patient denied any abuse, neglect or exploitation from the family care provider. The female was found to be of sound mind and able to make decisions. After several months, the patient was admitted to the hospital for decubitus ulcers and malnutrition and died on that final admission.

Cause of death: Failure to thrive and decubitus ulcers
Manner of death: Homicide*
*of note, manners of death are the circumstances surrounding the death. Manners are not used the same way as in the legal justice system and in this case, homicide is defined as "death at the hands of another".

Risk Factors Identified: Age, multiple chronic medical conditions, limited activities of daily living requiring assistance, mobility issues placing female at increased risk for decubitus ulcers and isolation, family member care provider with substance abuse issues. Concerns that the family member may be suffering from Post-Traumatic Stress Disorder (PTSD) from prior military service and whether services in the home for him could have mitigated risks.

Case B: Elderly female with history of traumatic brain injury (from fall years prior), stroke and paralysis on one side of her body. The female had been bed-bound for over 6 months and had developed some decubitus ulcers. A professional nursing organization treated the ulcers and discharged the female from care. Months later, the spouse of the female reported an open wound on her elbow and took her to the physician's office without an appointment. She was declined care at that time because she did not have an appointment. The spouse appeared to be overwhelmed. A few weeks later, the primary care physician performed a home visit and found the female to have a small area of redness over her hip and ordered wound care by a professional organization. By the time referrals were in place, the area presented as an unstageable decubitus ulcer with professional nursing care being provided 3 days/week and wound care provided by spouse 4 days a week. Of note, the spouse had significant medical conditions of their own. After several months, decision was made to transition female to hospice care in which she died.

Cause of Death: Decubitus ulcers due to immobility, stroke and heart disease
Manner of Death: Undetermined

Risk Factors Identified: Age, multiple chronic medical conditions, limited activities of daily living requiring assistance, mobility issues placing female at increased risk for decubitus ulcers and difficulty making in person healthcare appointments, elderly care provider with health issues, limited coverage for professional nursing care prior to being placed in hospice.

Case C: Elderly female with history of Alzheimer's dementia who lost her ability to speak, walk, stand and eat. She required full care and lived with a family member who worked full-time. While the family member worked, the elderly female would sit in a chair for up to 8 hours a day. There were no outside resources to support her care. The female presented to a local hospital with a decubitus ulcer. A report was made to Adult Protective Services (APS). During the hospitalization, several resources were offered to the family member and a decision was made to send the female home with hospice services. Hospice nurses visited 3-4 times a week and the female continued to worsen and develop multiple pressure wounds on her body. She died several months later.

Cause of Death: Failure to thrive due to Stage 3 decubitus ulcers and Alzheimer's Disease
Manner of Death: Natural

Risk Factors Identified: Age, Cognitive decline (dementia), limited activities of daily living requiring assistance, mobility issues placing female at increased risk for decubitus ulcers, family member who worked full time resulting in prolonged immobility, limited access to resources, isolation (living in rural area).

Case D: Male with multiple medical conditions including chronic obstructive pulmonary disease, hypertension and history of stroke leaving him with left sided paralysis and seizures. He lived independently with assistance from outside sources (private duty) to perform housework/chores. After the stroke, he required more care, so a family member moved in to assist him with his activities of daily living just shortly before he died. He was unable to walk and needed to be propped up when sitting in a chair. Per the family member, the male gave up and refused all care including basic toileting and bathing. He refused to get out of his recliner for 2 weeks and eventually was found dead when the family member returned from an errand.

He was found to be covered in urine and feces, maggots and fruit flies. He had multiple unstageable decubitus ulcers on his body.

Cause of Death: Decubitus ulcers due to immobility, stroke and heart disease, self-neglect
Manner of Death: Undetermined

Risk Factors Identified: Limited activities of daily living requiring assistance, mobility issues placing male at increased risk for decubitus ulcers, multiple underlying medical conditions, refusal of care. Recent divorce with order to vacate residence. Limited finances with inability to pay for basic utilities.

Summary:

The Team reviewed four vulnerable adult deaths (Ages 64- 89 years old) who died between 2014-2018. All four vulnerable adults had decubitus ulcers listed as the cause or contributory cause of death. The Team was able to examine the factors that may have influenced their death, including a lack of access to services. In these cases, all were dependent on others to provide care. Although abuse may not have been substantiated, neglect and self-neglect played a role. National research from the National Center on Elder Abuse, (NCEA) indicate there are factors which increase an individual's risk of becoming a victim of elder abuse including:

- Low social support increases the risk of all forms of mistreatment
- Having the diagnosis of dementia increases the risk of abuse by 50%
- Functional impairment and poor physical health are associated with greater risk of abuse among older persons
- Women are more likely to be abused than men

In reviewing the data (2014-2018), the Vulnerable Adult Fatality Review Team has noted several key factors among deaths involving decubitus ulcers. All information is subject to the availability and comprehensiveness of the reports available for case review. A review of these cases indicates:

- Most had limited access to outside formal or informal support services such as home health, transportation, professional nursing and medical services.
- All had a family member or spouse who provided care or support to them.
- All had experienced a significant prior health condition (stroke, Parkinson's, Alzheimer's)
- Many had limited access to transportation and healthcare providers due to their rural location, limited mobility and family capacity.
- All relied on others to provide activities of daily living (ADL's).

Prevention Recommendations:

The Team recognizes that there are systemic issues involved in these cases that go beyond state recommendations such as barriers within Medicare policy which dictate requirements for healthcare and on-going treatment.

1. In at least one case, the person had missed several important medical appointments. It is recommended that Primary Care Providers create a system to identify and follow up on complex patients who are vulnerable and may not have the resources or support to meet basic health milestones and routine follow up.

2. To support recommendation above, Electronic Health Records (EHR's) should have the ability to flag patients who have not followed up on critical care such as coumadin checks, wound follow up, etc.

3. In discussion with home health providers, there was frustration that when a decubitus ulcer is healed, in most cases, their services are cancelled. In at least one of the cases, the patient was being treated by nurses who worked diligently to improve and heal a decubitus ulcer, when the ulcer was healed the patient was discharged from their service even though she was high risk (bed-bound). That patient developed another decubitus ulcer which rapidly deteriorated and by the time service was re-instated, the ulcer was unstageable, and the patient was placed in hospice care. The Team recommends regular follow up on patients who are at high risk for developing decubitus ulcers.

4. Adult Protective Services (APS) was awarded a $1 million three-year federal grant to create a restorative justice program for vulnerable adults. The federal funding will go towards hiring two case managers with the goals of reducing recidivism and revictimization by working with perpetrators who are close family members or caregivers to restore a proper care environment. The Vulnerable Adult Fatality Review Team supports a restorative justice approach and believes additional support and services for vulnerable individuals may increase their quality and duration of life.

5. This Team recommends additional support for APS Investigators to include the model, similar to the Department of Children and Families, of differentiated response, which may assist with reducing risk.

6. In Vermont there is limited support for individuals with self-neglect. The State should clarify who is responsible (which agency) to respond to these cases and what support systems are needed to reduce risk, injury and death.

7. In one case, the patient did not qualify for home health services because they had not seen their physician in over a year due to mobility issues. Medicare requires patients to be seen by their primary care provider within a specific time frame in order to qualify for home health services. In cases where transportation is difficult or not available, alternative options such as telemedicine and primary care provider home visits should be considered. Vermont has many vulnerable people who live in rural areas where transportation is not readily available.

Conclusions and Future Activities:

- The Team will continue to fulfill our legislative mandate by meeting quarterly for case review and trainings that will serve as a foundation for future recommendations that prevent deaths of Vulnerable Adults in Vermont.
- The Team will focus the next year on deaths in residential settings with paid care providers.
- The Team will elect a new Chair and Vice-Chair in 2020, per bylaws.

Definitions:

Manner of Death

The manner of death refers to the circumstances surrounding the death. Generally, there are five manners of death: Natural, Accident, Suicide, Homicide, and Could not be Determined (or Undetermined).

Cause of Death

The cause of death is the disease or injury responsible for starting the sequence of events which ultimately lead to death. Cause of death is coded by the International Classification of Disease, 10th revision (ICD-10).

ADDENDUM A – VULNERABLE ADULT FATALITY REVIEW TEAM MEMBERS

Representative	Title
McGivern, Lauri - Chair	Office of the Chief Medical Examiner
Merriam, Virginia – Co-Chair	Office of the Attorney General
Purdy, Linda	Office of the Attorney General (left team in Oct 2019)
Anderson, Elizabeth	Office of the Attorney General (replaced Linda Purdy)
Barrett, Joy RN	Department of Disabilities, Aging and Independent Living
Dunlap, Scott	Vermont State Police
Courcelle, Andre	Department of Disabilities, Aging and Independent Living (left team in June 2019)
Mead, Shawna	Adult Protective Services
Bell, Chris	Office of Emergency Medical Services and Injury Prevention
Londergan, Sean	Long-Term Care Ombudsmen
Panagoulis, Nietra	Victim Advocate, Chittenden County States Attorney
Hill, Rosy MD	University of Vermont Medical Center
Paquin, Ed	Disability Rights of Vermont
Ruben, AJ	Disability Rights of Vermont
Green, Devon	Association of Hospitals and Health Systems
Olson, Jill	Visiting Nurse Association
Hill, Bard	Department of Disabilities, Aging and Independent Living
Bruzzese, Cindy	Vermont Ethics Network
Benway, Donna	Invited subject matter expert – University of Vermont Medical Center
Lapan, Karen	Administrative Assistant to Team, Vermont Department of Health