

CONSULTANTS REPORT ON FINDINGS FROM REVIEW OF VERMONT'S ADULT PROTECTIVE SERVICES SCREENED –OUT CLOSED CONTACTS AND INVESTIGATIONS OF ALLEGED REPORTS OF ABUSE, NEGLECT, OR FINANCIAL EXPLOITATION

Prepared by L. René Bergeron, PhD, MSW and Richard Cohen, Esq.

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Introduction

This project from Vermont Legal Aid and Disability Rights Vermont (hereinafter sometimes referred to as “plaintiffs’ counsel”) was conducted by two independent expert consultants in the field of disability, vulnerable abuse and neglect, investigations and protective services at the request of plaintiffs’ counsel. The experts, who will be referred to in the first person, are responsible for the data entries and the analysis in this report. Resumes may be found in Appendix A. Confidentiality documents were signed by both experts. Copies may be found in Appendix B

The purpose of this project was for us to review completed investigation/case files and screened-out closed files of the Vermont Adult Protective Services (APS-V) unit within the time-frame of August 1, 2012 to October 31, 2012. APS-V is a unit within Division of Licensing and Protection, which in turn is a division within Department of Disabilities, Aging & Independent Living within the Vermont Agency of Human Services

These files came from Vermont’s Adult Protective Services’ (APS-V) new computer database, Harmony. Plaintiffs’ counsel’s reason for requesting a review of these files was to assess if APS-V was complying with the Vermont APS Statutes in specific areas. APS-V’s own policies were also reviewed to aid in this effort—“Vermont Adult Protective Services December 2011 Policies and Procedures Manual.” Plaintiffs’ counsel designed the data charts that we used to record our findings in several areas. We were requested to render our opinions to the following questions:

1. Did the cases that were not accepted for investigation meet the definitions in the statute for abuse, neglect, or exploitation of a vulnerable adult?
2. Did the files reviewed have a written coordinated treatment plan when required by statute?
3. Were closed cases screened out/resolved within 48 hours?
4. Did investigations commence within 48 hours?
5. Were investigations completed within the policy of 60 days?

6. Were investigations substantiated when a reasonable person would believe that abuse occurred?
7. Is APS-V operating a system that substantially fulfills the legislative intent?

Additionally, as we looked at the Closed Contact files we were asked to render an opinion as to whether reports of abuse, neglect, or financial exploitation were being wrongly closed.

Method of Research

This is a retrospective, descriptive study using closed files provided by the APS-V to the plaintiffs' counsel for the months of August 2012 through October 31, 2012. We received approximately 210 completed investigations/case files and 273 of screened-out closed files.

Given the amount of files available for review, we decided to use a probability sampling procedure for several reasons: 1) It is the primary method for selecting samples used in social research; 2) the population sample consisted of all reported cases of vulnerable adults to APS-V and all within the same three months. Thus, using the probability method of selecting cases for this project, the sample would be a typical representation of the larger population and would be an accurate representation of all the APS-V cases submitted to plaintiffs' counsel; and 3) statistically reviewing all the files would not tend toward more accurate results.

Procedure Employed

We first divided the received files between the two of us. Once divided, each set of files was arranged by dates of referral to APS-V, the earlier referral placed as the first file and so forth, to ensure a representative sample from each month. We systematically pulled every third file for review. Consultant #1 (Richard Cohen) reviewed 37 of the completed case files and Consultant 2 (Renee Bergeron) reviewed 34. The same process was used for the screened-out closed files, Consultant #1 reviewed 46 and Consultant #2 reviewed 43 files.

Before beginning our independent reviews we needed to ensure our separate analyses would not differ in our individual interpretation of the case data. To ensure a mutual understanding of and consistent application of the methodology, we separately reviewed the first five cases of the completed investigation case files and the first three of the screened-closed files and independently read and recorded the information on the charts, computing our results separately. Once completed, we came together to discuss and compare our results for clarification of our understanding of the column headings and make any needed changes. Periodically we would discuss a file to ensure we were following the directions of the plaintiffs' counsel.

Analysis Procedure

We recorded our data manually on the charts provided by plaintiffs' counsel for both the completed investigations/case files and screened-out closed files. Chart entries were double-checked with their corresponding file. We met to review the accuracy of our charts and combined them for data analysis. We also developed code sheets for data entry.

The completed charts were given to Expert #2's research graduate assistant to 1) convert the charts to excel sheets, 2) insert the corresponding code sheets, 3) enter the data, and 4) run statistics. She worked strictly from the information on the charts; no files were available to her. The graduate assistant's confidentiality statement may be found in Appendix C.

Findings

I. Is APS screening out cases that should have been accepted for investigation?¹

A. Background

Neither the statute nor the policy (Section IV(C) of the APS-V Policy Manual) provides explicit guidance in this area on the substantive standard to be applied in making the decision to open or close a case. In fact 33 V.S.A. 6906 states that the Commissioner "shall cause an investigation to commence within 48 hours after receipt of a report made pursuant to section 6904." While that would seem to require an investigation in every case, when read with the definitions of abuse, neglect and exploitation and vulnerable adult and widely accepted investigation practices, it would be reasonable to conclude only those cases should be screened in for investigation in which there is some evidence or reason to believe that the alleged victim in the report was a vulnerable adult and that s/he may have been a victim of abuse, neglect, or financial exploitation (sometimes hereinafter referred to as "ANE").

Given the nature and purpose of the APS statute and system, and the quoted statutory language, it would be expected that APS-V staff should err on the side of investigative action in close cases. The policy in fact requires that if the information in the intake report of ANE is insufficient to make the determination, the intake reporter "will forward the Intake Report to a Field Investigator." The investigator in turn is to perform considerable follow up activities to obtain the needed information including but not limited to interviewing the victim and witnesses, reviewing records, conducting assessments, etc. Section IV (D) of the APS-V Policy Manual. Another widely required APS practice, which is incorporated in the policy is the requirement of the Program Specialist (the intake person making the decision) "to obtain the necessary

¹ This is a different way of stating the first question that we were asked to address—"Did the cases that were not accepted for investigation meet the definitions in the statute of abuse, neglect or exploitation of a vulnerable adult?"

information from the reporter to ensure an accurate assessment” as to whether or not the case should be accepted for investigation. Id. at p. 1.

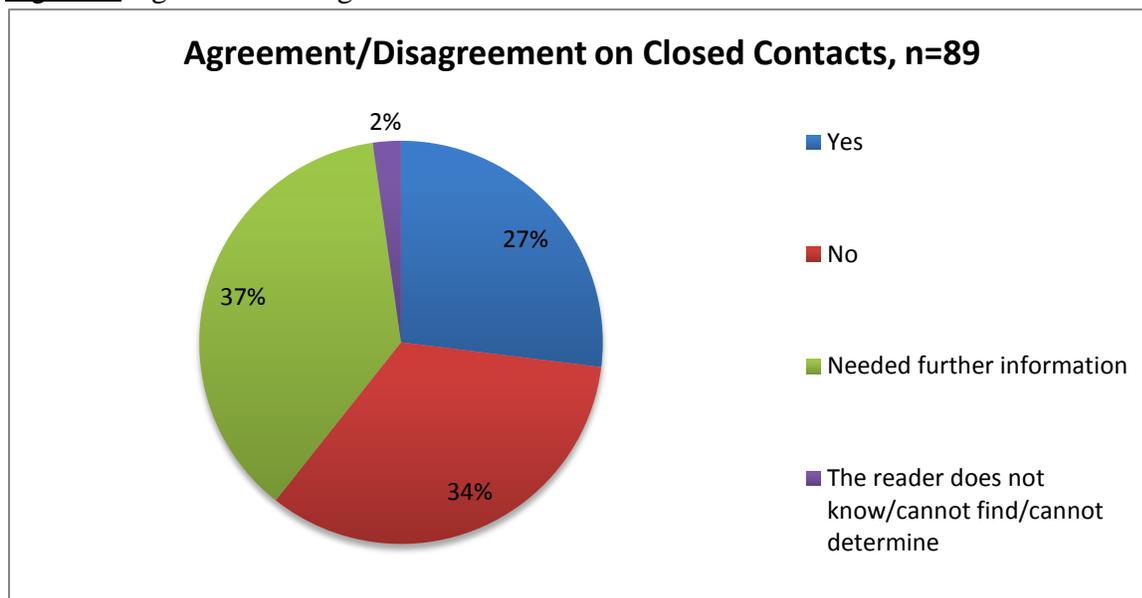
These policies incorporate and reinforce the care that should be taken in making these decisions and the need to acquire as much information as possible before making a decision and certainly before screening out a case. As discussed below, based on our review, these policies and practices are generally not followed.

Decisions are largely made just on the information provided by the reporter, some of whom are mandated reporters and some not, very likely with wide variability in training (if any) or knowledge of how and what to report.

B. Response to the Question

As to the specific question asked, we reviewed 89 closed contacts (selected randomly from 266 in total) for reports of ANE that were screened out and not accepted for investigation. As shown in Figure 1, we agreed with the screen out decision in 24 or 27% of the cases; found that 30 cases or 42% should not have been screened out but accepted for investigation; and in 33 cases or 37% further information should have been sought before making a decision. In 2 cases we could not determine based on the intake form; giving a total of 65 very questionable closures. As with all of our decisions this was based on the information in each case file which was all the information on which that the APS-V program specialist based his/her decision.

Figure 1: Agreement/Disagreement on Closed Contacts



C. Illustrations of reports that should have been accepted based on the available information.

AGO 17980. The AP² (aunt) who lives at a private home with the AV (niece) and her mother and both of whom are dependent on AP, stabbed AV with a fork while AV was displaying frustration and approaching AP. The stab was to AV's face requiring 6-7 stitches. The matter was screened out because it happened several months prior and despite that fact that there is ongoing tension in the home and AV continues to have behavioral issues.

AGO 11807. Report from mandatory reporter that AV who has severe intellectual, physical and communication disabilities was being cared for by a home provider who allegedly was smoking marijuana prior to driving AV in her vehicle. The matter was screened out as not meeting the definition of "A/N/E" based on the word of an employee of the agency that employs the AP stating that they had not witnessed any issues.

AGO 18007. Report stating that the AV who is a wheelchair due to spina bifida and under guardianship had no food in the house, and that the money the AV's mother gives to AV to purchase food may be being taken by the AP who has sexual assault charges pending against him. This reported case of neglect and financial exploitation was screened out as not meeting the definition of "A/N/E" without any follow up.

D. Illustrations of closed contacts in which the information was insufficient and more information should have been obtained.

AGO 17960. AV received 24 hour supervision due to suicidal ideation and other mental disorders. She also received care-giving services through an agency due to a wound she suffered in the military. The allegation is that the AP, her caregiver, kept AV's medication outside a locked box where AV had access to them, contrary to protocol. On one occasion AV had access and took 15 pills and told the AP that she was doing so and overdosed. The AP did nothing so AV called a friend who called 911 after which she was taken to the emergency room. It was also alleged that AP kept a handgun in AV's house when he was not suppose to. AV had fired AP which may have influenced the decision to screen it out. It was officially stated that the allegations did not meet the definition of A/N/E, however on its face it did appear to meet the definition. At the very least follow up should have occurred, for example, to confirm the emergency room visit and the reasons for it.

AGO 11925. AV is cared for by his spouse who is in a wheelchair. She allegedly stands in the way of getting care. AV will run across a 50 mph road seeking help. His children fear for his safety. He was using a ladder unsupervised and fell on his wife, splitting his

² The abbreviation AP and AV are used for alleged perpetrator and alleged victim, respectively.

head open and breaking her hip. Once in the “rehab unit” he wanted to remain there but his wife (AP) would not allow it. It is further alleged that she is physically unable to care for him and that she allows AV to do things that he is no longer able to do and sometimes he gets hurt doing them. This ongoing dangerous situation was screened out without explanation or further inquiry.

AGO 17788 Two residents of a residential care facility began verbally abusing each other in the dining hall, ending with them wrestling up against the wall and one getting scratched in the face. Staff pulled them apart and spoke to them. No further action was taken. No call to the reporter who was a staff member of the facility. This case reflects the need for APS-V to investigate for systemic issues by ascertaining a history of violent interactions and protection policies to prevent and intervene in such events. This case was closed based only on the faxed report by the facility. No follow-up by APS.

E. Possible Trends and Patterns --While each case is different, the consultants did note certain patterns and trends which cut across or underlied many of the APS-V workers’ decisions.

1. One was the practice of not accepting for investigation an otherwise valid/required case for investigation in which the alleged victim (AV) was in a nursing home or other care or treatment facility merely because the facility or vendor was reportedly doing its own internal investigation. Not only is such a “deferral” contrary to the letter of the statute, but also contrary to the very purpose of the APS system--to have an independent external review of suspected cases of abuse, neglect or exploitation. Examples include:

AGO 11912. LNA who visits home found a skin tear on AV’s right elbow and her right ankle swollen. There was no record of any falls. AV had trouble ambulating as a result and was experiencing signs of pain. AV is 84 with significant dementia and functional abilities. It is not clear whether she lives alone or with her son. A personal care attendant and LNA both visit AV and provide care at the home. This suspicious injury of unknown origin could have a number of causes and cried out for an APS investigation. Instead it was screened out as not meeting A/N/E, indicating “an internal investigation [presumably by the staff’s agency] of internal staff is in progress.”

AGO 11995. Staff member witnessed another staff member (AP) slap a resident on the top part of her thigh when she saw AV looking through her (AP’s) pocketbook. AV was 56 years old and had a mental disability. AP had left the pocketbook next to AV. APS-V screened it out determining that there was no A/N/E and cited the fact that the Human Resources Department of the facility was going to meet with the AP. Clearly should have been screened in.

2. A second practice that was discerned was the non-acceptance of cases for investigation in which the alleged perpetrator (AP) was no longer employed at the site of the alleged ANE or otherwise no longer present. This is highly problematic.

The statute does not provide an exemption for this situation. This defeats one of the purposes of an APS system, to help prevent perpetrators from engaging in ANE on children or vulnerable adults in the future. 33 V.S.A. 6911(b)-(c) provides that all founded perpetrators shall be listed on a registry (subject to perpetrator's exercise of due process rights) which prospective employees may or must check before hiring a person to provide services to children or vulnerable adults. By screening out these reports, potentially substantiated perpetrators escape the protective purpose of the registry and again can obtain employment caring for other vulnerable individuals.

This practice was in evidence in **AGO 17960** described above, among other cases we saw.

3. A third type of report that was screened out without justification involved incidents of one resident harming or assaulting another resident in a care or treatment setting. In addition to **AGO 17788** described above, further examples include:

AGO 17994 where one resident of a nursing home punched the AV, a 87 year old male leaving a mark on his lip. This was closed as not meeting definition of A/N/E.

AGO 18034 where one resident (91 years old) hit another in the face.

See also **AGO 18044** and **AGO 11871**.

While in these cases both individuals (the AV and AP) might meet the definition of vulnerable adult, and the assaulting behavior may be a manifestation of the person's disability, that does not make the harm or victimization any less. Most of these incidents are occurring in nursing homes or other group care settings of younger adults with developmental disabilities. The nature of the settings coupled with the vulnerabilities of the AVs means that to a large degree they may not be able to escape the assaultive behavior and fear recurrence.

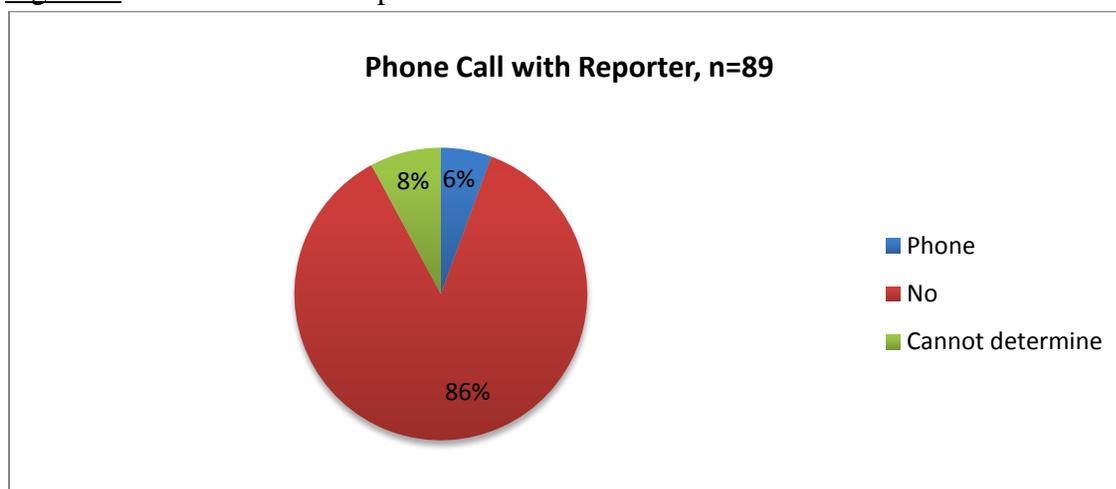
In these settings a duty exists to provide a safe and caring environment. Persons in nursing homes and in other residential settings whether in their later years or middle years should feel safe and secure and not live in fear. An investigation in these cases should be conducted to determine whether one or more of the caretakers (or agency) failed in their legal and professional duty. For example, if the conduct was foreseeable e.g. where the assaulting resident had repeatedly displayed this behavior, then it would be expected that either the resident's care or treatment plan would have a strategy to eliminate the offending behavior. In addition or alternatively, protective measures should be in place to protect the AV or other residents who may be the target of the assaultive behavior. An investigation would look at whether or not these steps were taken and thus the agency staff was adequately discharging their duty of care. As

noted, this is not occurring; these cases are just not being accepted for investigation, nor is there even a preliminary field inquiry as contemplated by the APS policy.

F. Frequency with which the intake worker calls the reporter before making closing the case or sends out a field investigator to obtain further information

Out of the 89 screened out reports, calls were made to reporters in only 5 or 6% of the cases. No calls were made in 76 or 86% of the cases. In 7 or 8%, of the cases it could not be determined. As noted above, APS also does not send out a field investigator to clarify or gather more information before closing a case. See Figure 2

Figure 2: Phone Call with Reporter



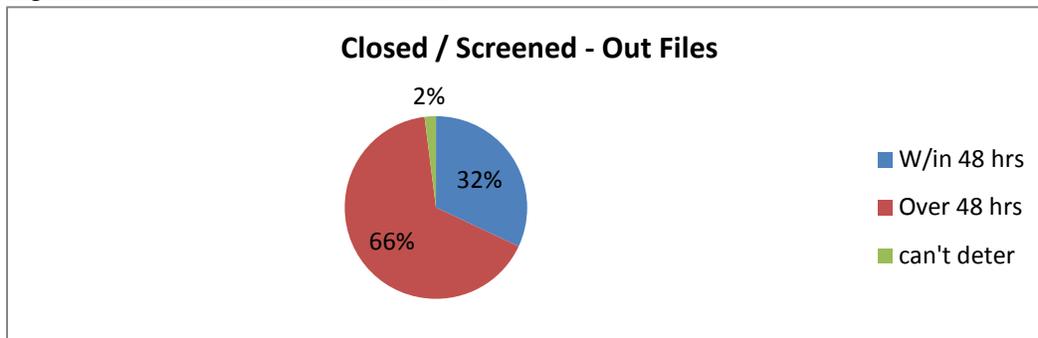
G. Conclusion

Given the protective nature of the APS system, not just in substantiating and unsubstantiating cases, but in ensuring vulnerable individuals are protected through such mechanisms as Written Coordinated Treatment Plans (discussed further below), it would be expected that a high percentage of reports would be screened in for investigation. This is not the case. Our findings in reviewing a representative sample confirm that APS-V is not screening in a significant number of cases that warrant investigation. APS-V is also not requiring that workers in actual practice seek more information when more information is needed before making that critical decision not to investigate.

II. Are Reports being reviewed and resolved/assigned within 48 hours?

As shown in Figure 3, of 89 closed contacts reviewed, 28 or 32% were processed and closed within 48 hours; 59 or 66% were not; and in 2 cases or 2% there was not enough information to make a determination.

Figure 3: Closed / Screen-Out Files

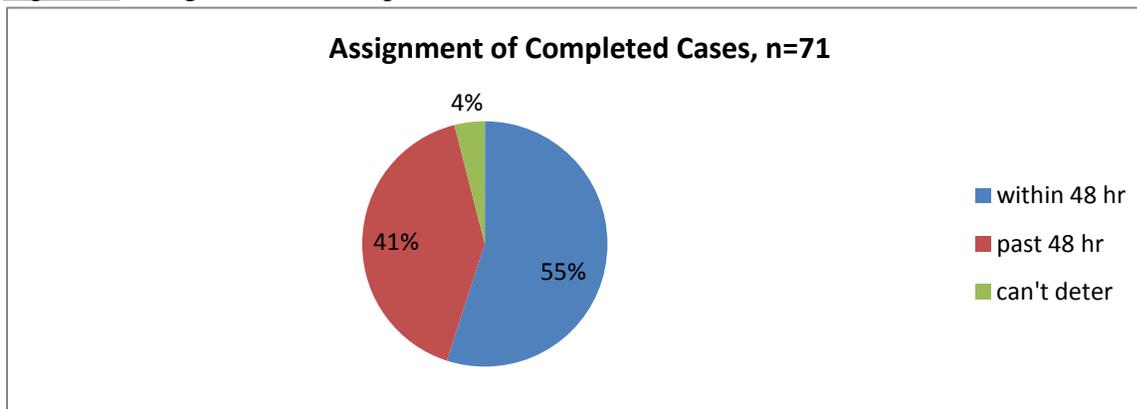


III. Are investigations being commenced and completely in accordance with the prescribed timelines?

A. Are investigations being assigned for investigation within 48 hours after receipt of report of ANE as required by 33 V.S.A 6906?

Based on the 71 completed case files we reviewed for investigation, APS has a significant problem in assigning or initiating investigations in a timely manner. Timely assignment of cases occurred in 39 or 55%. However, 29 or 41% were assigned over the 48 hour statutory requirement; and 3 or 4% could not be determined because of missing data. See Figure 4. Some of the figures used within the 48 hour range were cases whose hours were over the 48 hour benchmark, but before the third day. Therefore, we counted those cases whose assignment occurred before twelve p.m. because we felt that the intent of the statute was being met.

Figure 4: Assignment of Completed Cases



Failing to commence investigations in a timely manner is concerning generally, but particularly in this area, in which the alleged victims are vulnerable adults, many with memory and recall

issues. Cases may go unsubstantiated because victims or other witnesses have trouble recounting key details of an incident when substantial time elapses. Even after the investigation is started, interviews of witnesses, including the AV or AP, do not commence until weeks after the report was filed compounding the problem further. See examples

AGO 09589 in which it was alleged that a father was inappropriately touching his 18 year old daughter who had a significant intellectual disability. The first interview was six weeks after the allegation was reported and the next another three plus weeks later. Given the intellectual disability, and potential memory/cognition issues, it would be expected the interview of the AV, in particular, should have occurred immediately after receiving the report or within a day. The nature of the allegations also demanded a rapid response.

AGO 13008. The report and assignment date was 4/17/12. However in spite of the fact that the AV resided with the AP, the housing provider, and the report indicated that AV had memory problems, the interview was not scheduled until 4/24. On 4/23, the social worker who was reporter of the physical abuse called the investigator and said AV was hospitalized. The investigation does not indicate why, nor does it indicate why the AV could not have been interviewed at the hospital. On 5/11, over two weeks later, the investigator called the reporter as a “follow up” and was told AV had died. Thereupon without inquiring as to cause of death (or at least not putting it in the report), the investigator closed the case as unsubstantiated.

AGO 12568. An initial report of physical abuse and financial exploitation came in of a 76 year old women receiving home health services but also being “cared for” by her granddaughter who was the alleged abuser (AP). It was not until 19 days later that the AV was interviewed at which time she appeared confused to the investigator. No action was taken. Subsequent reports came in of abuse by the AP, stealing or refusing to provide medication and neglect (e.g. allowing AV to remain in bed in her own urine, skin breakdown in groin area). While one interview of AV was reasonably prompt, a subsequent interview responding to still more reports of abuse and neglect occurred after another four to five weeks lapse. Delays in interviews and other time lapses in this case resulted in an over four and half month delay in resolving this ongoing case of abuse and neglect.

AGO 17111. Reported on 12/4/13 for financial exploitation by son of over \$300,000, mother thought to have dementia. Case was assigned on 3/13/12 and then again on 4/18. That investigator requested an extension which was approved on 7/27/12. The alleged victim did not get interviewed until 9/7/13. The alleged victim died on 9/17/13. Although this person had attorney representation she did not receive a fair investigation. I could not find explanations for the delay of services.

B. Are investigations being completed within 60 days?

The 60 day timeline³ is required by policy, Section VII(A) of the Vermont APS Policies. No specified timeline is contained in the statute.

Based on our review, it is determined that most cases are not being completed in 60 days. Moreover as required by Section VII(C) of said policy, there are very few instances in which requests for extension are being made to the APS Program chief or designee.

As shown in Figure 1, out of the 71 reviewed files 41 or 58% were over the 60 day policy with an average of 144 days per case. Thirty or 42% investigations were within 60 days with an average of investigations or 29 days and per case. Of the total cases 71 sampled, the average time to completion was 95 days.

Table 1 60 day limit to investigate cases: Section VII(A) of the Vermont APS Policies					
N=71					
Cases Completed Within 60 Days			Cases Completed Over 60 Days		
# of cases completed w/in 60 days	% of cases completed w/in 60 days	Average # of days per case completed cases <60 days	# of cases completed over 60 days	% of cases completed w/in 60 days	Average # of days per case completed cases >60 days
30	42%	29 days	41	58%	95 days

Prolonged or unduly tardy investigations do a disservice to all concerned, including the AP as shown in the cases above and other cases we reviewed. For those cases that are eventually unsubstantiated a cloud remains over the AP for months. For those cases that are eventually substantiated, the AP may have already found new direct care employment, and escaped the purpose and impact of the abuse registry of preventing hiring of perpetrators. While this is a risk in any case, the possibility of re-hire in direct support positions is increased as time passes.

C. Conclusion

APS-V is not meeting their obligation to initiate and complete investigations on time with all its attendant consequences of jeopardizing the quality of the investigation, keeping individuals at risk, and unnecessarily maintaining a cloud over APs on cases that are ultimately and should be unsubstantiated. It would be expected that in an efficiently working system, the compliance rate in this area would approaching 100%, allowing for some exceptions. In contrast our findings showed only 55% were initiated on time and 42% completed on time. We also found contrary to

³ The average deadline is 29 days for completion of investigations amongst the states. National Center on Elder Abuse's report on Vulnerable Adults (2000). P. 20 at <http://www.ncea.aoa.gov/Resources/Publication/docs/apsreport030703.pdf>.

policy that APS-V workers generally do not make a practice of requesting extensions of the 60 timeline for investigations.

IV. Are cases being unsubstantiated which should have been substantiated?

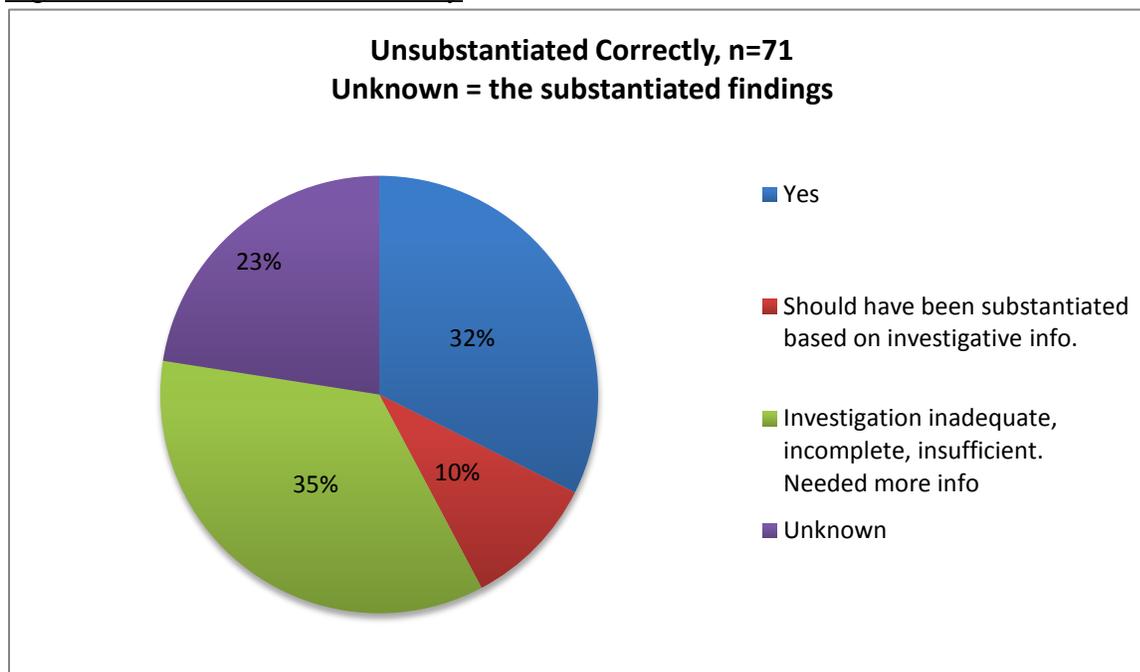
A. Results

In evaluating each sampled investigation for this question, we only generally considered the evidence or other information that the investigator put in the investigation. A quality, objective investigation should include and summarize all relevant evidence and not include or favor only evidence that supports the investigator's ultimate conclusion. Where the investigator made a considered credibility determination, we gave deference to the investigator's judgment.

We found unsubstantiated cases which should have been substantiated based on the information presented. We also found a significant number of cases in which the investigations were inadequate or incomplete, and therefore an unsubstantiated finding was unjustified. That is based on standard investigation practice, more information should have been obtained (e.g. additional witnesses interviewed or re-interviewed) before a determination should have been made.

As shown in Figure 5 only 32% were unsubstantiated correctly, 10% should have been substantiated based on the evidence in the report. 35% percent had inadequate or incomplete information to make a determination and needed further investigation. And 23% reflect those files which were substantiated. Therefore 45% of cases were improperly unsubstantiated.

Figure 5: Unsubstantiated Correctly



B. Illustrations of unsubstantiated investigations that should have been substantiated include:

AGO 15484 failed to substantiate a physical assault by AP against AV, a 52 year old man who has mental illness, is substance dependent, and on full veterans' disability. The evidence was uncontroverted, but was closed because the investigator could not locate the AP to interview and it did not appear likely at that time that he would move back in with the AV. The efforts to locate the AP were inadequate under the APS-V policy. Moreover failure to locate is not a reason to unsubstantiate a report. Evidence indicates abuse occurred and AV is a vulnerable adult. Other information about the AP indicated that he is exploitative. He appeared to be an appropriate candidate for the registry.

In **AGO 10979** the investigator concluded abuse (domestic violence) likely occurred but erroneously concluded the AV is not a vulnerable adult based on assessment of others outside of APS-V whose opinion should not be determinative. While some diligent efforts were made to reach the AV to interview her, when she finally settled in a specific residence, efforts to reach her for an interview ceased

C. Illustrations in which more information should have been obtained include:

AGO 13477. The unsubstantiated findings in this financial exploitation case could have possibly been substantiated as a neglect case under 6902(7)(A)(i). However the investigation was not thorough enough to make that determination. Supporting substantiation was the fact that two rent checks to the landlord by the AP who was responsible were short by \$500 to \$600, putting the AV, who was quadriplegic, in jeopardy of being evicted and being deprived of a necessary service.

The AP was also a paid care give through the Choices for Care Program raising questions of the supervision and hiring practices of that program or its contractors that were not explored. It is a problem or at least an issue that arose in other cases we reviewed.

AGO 16633. While this case was substantiated as neglect due to failure of the caretaker to seek medical attention for injuries and report the incident to his supervisor, there was no determination made regarding whether the caretaker caused the injuries by physically assaulting the AV or engaging in neglectful behavior, the core parts of the allegation. The AV has significant cognitive issues, behavioral issues and autistic-like symptoms. His head was described as misshapen as a result of the injury. He had a shiner, bruises on his arms chest and face as well as 3 finer shaped bruises on his inner right arm, and yellowing type bruises to his chest. The investigation report noted that the AV had a blood clot on the outside of his brain from a prior injury and any head or facial injury would be potentially very serious. The AP, who was interviewed by phone and not in person, indicated that the

injuries were caused by AV slipping on a rug during a behavioral episode (he has poor balance) and due to other non-abuse reasons. A treating physician had reported that the injuries were not consistent with that version of events. The physician was never interviewed, nor were medical records or photos looked at or discussed. The treatment plan was not reviewed to see if any strategies were outlined and followed (or not followed) by the AP when AV began acting out. There was also no probe as to whether the agency properly trained the AP caretaker who was caring for AV for a two week period rather than the usual three day period. No site visit was undertaken. These and other probes, and more thorough interviews should have been done and analyzed so that conclusions could have been properly drawn about the cause of the injuries.

See other examples described in trends and patterns sections which immediately follow.

D. Possible Trends and Patterns –Many of the shortcomings in the investigations were case-specific, but there were some discernible trends and patterns.

1. Failure to interview all relevant witnesses, even AVs or collateral contacts

Illustrations include:

AGO 11462. The allegation indicated that AP, a caretaker who provides in-home weekend-long respite to an individual with severe intellectual disabilities and with behavioral issues (requiring restraint) smoked marijuana while caring for the individual and may have been under the influence of alcohol. It was unsubstantiated based primarily on the interview of the AP who said he made these statements in jest. The person to whom he made these statements was never interviewed, nor were any background checks made on the AP or a review of his agency's personnel record. The AV was also not interviewed. If he was not interviewable, then it should have been noted.

AGO 09158. AV suffered an injury due to an attendant failing to perform a proper lift. This unsubstantiated case should have been substantiated at least as neglect. The allegation had come in as abuse. Not only did the investigator fail to review the plan of care requiring a two-person lift and other specified instructions, but the investigator failed to interview nurses who oversaw the care of AP that evening about what they knew and did and what role they were performing.

AGO 14221. This is a case of the alleged victim living with her son, the alleged perpetrator. The report of alleged abuse came from the hospital where the alleged perpetrator refused to care for the catheter or pick up a needed prescription; it was also noted there was bruising on the AV's arms and legs. The investigator interviewed the AP at length and visited the home, but because the AV was sleeping she did not interview her and

made no follow-up attempts , instead unsubstantiating the case based on the AP's statements. Personnel at the hospital were not interviewed.

AGO 15353. This is a case of a 58 year old female extremely impaired from a stroke. She had been living at home with her dying mother and caregiver sister and it was from that living situation that physical and emotional abuse was reported. There is some contradictory evidence from community services about the accusation. Notes are not good in this case but it appears that one attempt was made to speak to the AV, the AV did not wish to talk that day – no other attempts were made. The case was decided without AV involvement.

AGO 10220. This was an alleged case of sexual abuse of one brother against another brother who is a 57 year old individual who is blind and has developmental disabilities. While there was some reason to believe that the incident(s) that the AV was referring to occurred when the two brothers were young children, there was inadequate interviewing of the AV. Interviews of the mother and sister on the possibility that this could have occurred as recent as nine months earlier were not performed.

AGO 15390. This is a case in which there was a report of financial exploitation by a community service agency – overcharging of services. From the file reviewed there was no evidence of the investigator interviewing the AV. Investigator's notes are handwritten and difficult to follow. This case was unsubstantiated although a note in the file indicates that the AV was having TIAs, hospitalization and “getting worse.”

AGO 12315. In this case it was alleged among other things that the home provider kept food locked up so that the AV could not access it. There was a fairly extensive typed up in-person interview of the home provider, the AP. That interview was substantially relied on in the report. There was only a phone interview of the AV which did not appear legibly recounted in the file, nor was it discussed, discounted or cited in the investigation report.

2. Failure to interview AP without making adequate efforts to locate the AP in accordance with Section VII(D) “Requirements for Diligent Search” of the APS-V Policy Manual.

See e.g. **AGO 15484** described above.

3. Failure to conduct multiple interviews across the span of the day of persons with documented dementia or confusion. Such individuals will communicate differently at different times of the day. The height of confusion is early evening, or when it begins to get dark. This is called “sundowning” and it frequently occurs among people who are confused. Standard interviews with clients who are confused/ demented is for the interviewer to select three different times of day for three different interviews – one in the

a.m., one early afternoon, one in late afternoon. In all the cases reviewed only one was found where the investigator completed this process. Also if the interview involves an incident, interviewing as close to the incidents occurrence as possible is recommended. In cases we reviewed the AV if confused would have a brief visit or none at all; the investigator relying solely on the assessment of caregivers.

4. **Over reliance on phone interviews when in-person interviews would be the preferred or necessary course, including of APs.** See e.g. **AGO 09158** in which AP was interviewed by phone about six months after report came in and investigation was started. See also **AGO 16633** and **AGO 15315** discussed above.
5. **Use of group interviews, including where AP was present during interview of AV.** See e.g. **AGO 12670** visit and interview of AV who was in his late 90's with dementia, incontinence and inability to get out of bed and move around on his own. This was an allegation of abuse by the AP, the AV's son's girlfriend. The interview of AV took place in the presence of the AP. See also **AGO No. 13930** in which it was alleged that the AP, wife of AV, came home five hours late knowing AV could not be left alone. AV is 51 with MS, uses a wheelchair and is dependent on others for most of his activities of daily living. Interview of AV initially was with AP and staff person present. Then AV was interviewed immediately thereafter still with AP in the home.
6. **Failure to review or consider AV's treatment or care plan which formed the basis of the duty of care against which to evaluate the AP's conduct,** e.g. in **AGO 09158** in which the AP failed to carry out a proper lift/transfer with an individual with a physical disability in accordance with the AV's care plan. See also **AGO 16633** above in which the plan of care was not consulted on how to address the behaviors of the AV in that case; and in **AGO 13930** to determine what the plan of care stated in regard to the AV being alone for up to 5 hours.
7. **Failure to perform or document background checks of APs.** This seemed to be the case with every investigation.
8. **Failure to address all allegations in reports.**

AGO 15429 in which it was alleged that the AP financially explicated and abused AV who had psychiatric issues. The abuse was not addressed.

9. **Misinterpretation or misapplication of the standard or definition of ANE.** See e.g. **AGO 10979** in which a female allegedly subject to domestic violence was not considered a vulnerable adult based on sources outside of APS-V even though she

had a representative payee, and had mild mental retardation, among other factors. See also **AGO 15484** in which as noted above, the investigator concluded while the AV was a “vulnerable adult,” he could not substantiate physical abuse because he could not contact the AP.

10. Failure of the investigator and supervisor to properly consider or analyze the evidence. In addition to examples above, see AGO 13526 in which it was alleged that the AP, a staff person at a group care setting stole cash and other items from all 11 residents. However, the investigator only found financial exploitation with regard to three of the residents. With regard to the other eight residents, the investigator merely stated that the evidence was insufficient without indicating what evidence there was and why it was insufficient.

E. Conclusion

Quality and thorough investigations are a core part of this protective and preventative process. Based on our review, in which we found 45% of the unsubstantiated investigations wrong or questionable, APS-V is performing far below acceptable legal and professional standards in this critical area.

V. Do investigation files include “written coordinated treatment plans” (WCTP) where warranted?

A. Analysis

33 V.S.A 6907 states that “[i]f the investigation produces **evidence** that the vulnerable adult has been abused, neglected, or exploited, the commissioner shall arrange for the provision of protective services in accordance with a written coordinated treatment plan.” (Emphasis added.) The statutory provision recognizes that protective or treatment services may be needed in substantiated cases as well as in cases in which the precise criteria of abuse, neglect, and exploitation may not be met. This policy is consistent with the policy and purpose behind the APS system.

Unfortunately in actual practice, we found very few cases where whatever action was taken amounted to a “written coordinated treatment plan,” (WCTP) and a number cases in which none of the needed actions were taken. None of the cases in which some actions were taken were characterized as “a written coordinated treatment plan.” This was the case in both substantiated and unsubstantiated cases.. Part of the reason is likely due to the failure of the APS policy to call for a WCTP or otherwise require actions which would constitute a WCTP.

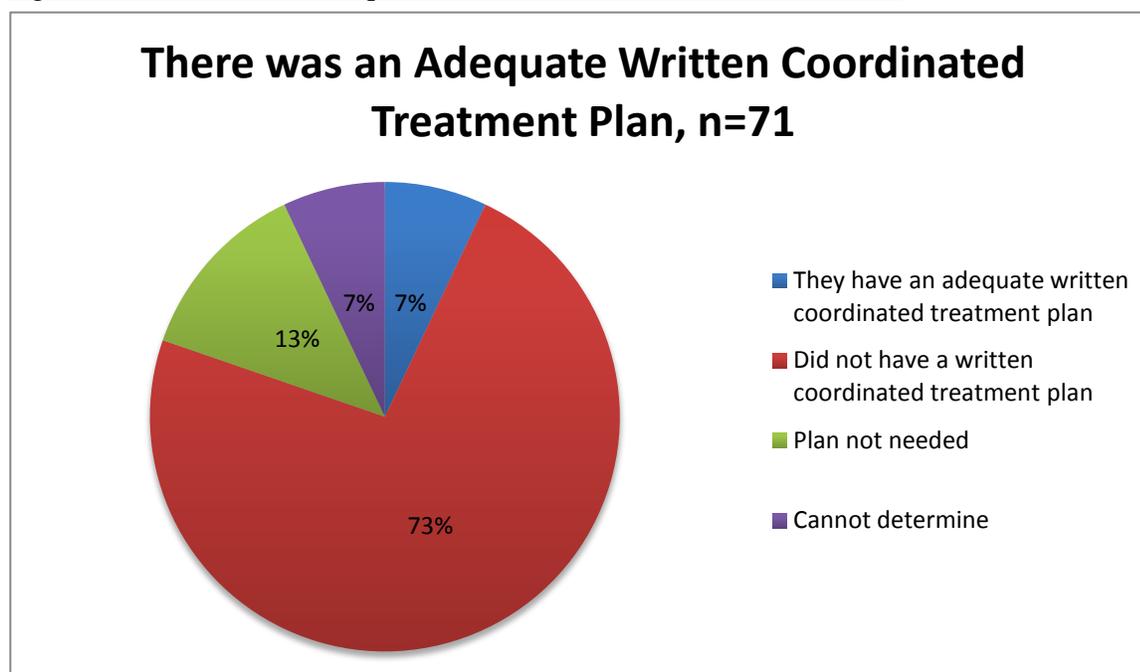
Section IV of the APS-V Policy entitled Assessment at Case Conclusion has some good components. However it does not direct the investigator or any other staff to develop and

implement a written and coordinated treatment plan to ensure protection of the victim in the short and long term and address factors that may have caused the ANE. It merely states that the “APS Investigator will review any protective services or actions taken during the course of the investigation and determine whether the victim has need for any additional assistance and/or referrals.” The Policy does not require specification of actions or activities, timelines, persons or agencies responsible, provision of follow-up to ensure full implementation (etc) , which would typically be the components of a WCTP.

B. Results

We reviewed the 71 investigations to determine whether and in how many cases WTCPs were needed. As seen in Figure 6, of the 71 investigations reviewed, we could not make a determination in 5 cases (7%) leaving 66. Of the 66 we found that in 9 cases (13%) a WTCP was not needed, leaving 57 where it was needed. Of the 57, we found that APS-V had what amounted to a WTCP in 5 or 9% of the remaining cases, and did not have a WCTP to ensure the safety and welfare of the vulnerable adult in 52 or 91% of the cases.

Figure 6: There was an Adequate Written Coordinated Treatment Plan



C. Illustrations of cases in which a WTCP was needed, but not developed.

AGO 16259. A WTCP was needed in this case as AV who is on Social Security Disability was significantly depleted of resources due to the financial exploitation substantiated in this investigation. His furnace was down and he had other financial issues that could adversely affect him.

AGO 19771. A WTCP was needed here to ensure that the severe behaviors of AV which led to the alleged abuse and put AV and those around him at risk was addressed.

AGO 12568. While AP was out of the house due to an Relief from Abuse Order, the AP was the prime caretaker. Because AV will not move to a residential setting and wants to remain in his home, alternative caretaking plans needs to be instituted in the home.

AGO 11198. This case has excellent worker notes with a substantial amount of data collected. The AV lives with her daughter the AP, and attends respite care on weekends. Multiple bruising, abrasions, skin tears and scratches on various extremities were reported by the Respite Care Facility. Noted is that the AV has a balance problem and the AP can account for many of the reasons for the bruising. The AP blames the respite care facility for most of the injuries. It is noted in the AV's medical record that she has both long and short term memory problems. This case was unsubstantiated because there was no credible evidence that the AP committed abusive actions. Further follow-up is needed to ascertain if ongoing injury continues to occur, and a plan is needed for the facility and the AP together to document the condition of the AV upon entering and exiting the facility. Referrals for the AP may be needed. In spite of a good investigation the worker stopped short.

Two additional points. First, as noted the lack of WCTPs or a facsimile occurred in both substantiated and unsubstantiated cases in which there was evidence that a WCTP was needed.

Second, in some of the cases in which there should have been a WCTP, some actions were reportedly proposed or taken, to include by agencies outside of APS. but they were either insufficient or not mandatory or guaranteed. Nor in such cases did APS assume any monitoring or follow-up role to ensure that stated actions were actually implemented. These include:

AGO 15673. WTCP needed because AV requires assisted living as she was significantly deteriorating and still in a vulnerable position. Despite court involvement, daughter who has a number of issues continues to reside with her.

AGO 09589. While the alleged sexual abuse case of father toward his 18 year old daughter discussed above was not substantiated the investigator suggested parenting classes to deal with "boundary issues." However it was merely a suggestion and a WTCP was needed in order to ensure that the classes were taken and that they were geared toward this issue.

AGO 14188. This was an unsubstantiated case despite the fact that the caretaking son admitted grabbing his father around the neck. The father is quite ill and frail. The antecedents to the incident still exist, and suggestions were made by the investigator on how the family could get help. Given the situation, clearly a plan should have been developed to ensure the right help was sought out and obtained.

Third, as discussed further below, there were cases in which part of the responsibility of neglect lied with others who supervised or managed the direct support staff that were the immediate subject of the report. Findings potentially could have been made against others responsible for hiring, supervising or training of these direct staff, but this was never explored. Additionally or alternatively, a WTCP could have been devised to ensure these underlying failures were remedied going forward. This is not occurring. Examples include:

AGO 16633. This case, discussed above, there may have been significant training or treatment plan issues that may have been a factor in the way AP treated or mistreated the AV. These should be corrected and monitored under the auspices of a WTCP.

In **AGO 11338.** while a loving husband of 46 years was the AP in the investigation for a case where AV had to be hospitalized for skin condition caused by neglect, home health was also coming to the home twice a week, but no consideration was given to their possible culpability. At the very least a WTCP should have been put in place to address the antecedents for the skin issue, including what the role of home health was as well as other issues of concern such as the condition of the home.

In **AGO 14561** the report stated that the “the A/V [who was “mentally disabled/physically disabled/elderly/frail”] has a pressure ulcer on his coccyx and open areas on both feet” called “pressure ulcers,” resided in a licensed residential care facility, and was totally dependent on hired caretakers for care. The report further indicated that the AP, a hired caregiver, did not following medical care plan orders that stated the AV had to be repositioned every so many hours to assist in the healing of current sores and in preventing future sores. Various interviews (in person or by phone) were conducted, including of the AV, various staff, and the Survey and Certification Nurse. The investigator also reviewed various reports and documents. The AP who was negligent in following care-directives was never interviewed because while the staff “guessed” who that might be, they had no proof; furthermore the AP was no longer employed by the facility. No one could say with absolute certainty that the AP did not do his job and that the sores (ulcers) developed under the AP’s care. Therefore despite excellent documentation of “someone” not doing his/her job the case was unsubstantiated by the worker because the AP did not have “substantial, credible evidence presented in this investigative report [therefore] does not support a recommendation for a substantiated finding of neglect of a vulnerable adult pursuant to 33 V.S.A. § 6902(7)(A).” And yet the AV met the standard of § 6902(1) (A). The recommendation of the worker, based on no proof of a cause and effect of harm by the reported AP, unsubstantiated the report, although acknowledging the AV was impaired both physically and cognitively. The worker’s approach needed to go further, investigating all staffing having knowledge of AV care plan and if their lack of involvement might be culpable, and if this might indicate

systemic behavior by caregivers in this residential facility. This case was treated as if the AP was the unit of service and not the AV.

Alternatively, given that there was evidence of neglect a WCTP may have been in order addressing possible systemic factors. This was not considered. The victim is reported to have “passed away,” however a WCTP could help prevent other similarly situated residents from being neglected.

C. Conclusion

As the figures and illustrations reveal, there is a wholesale failure to carry out this core purpose of the Vermont statute, assuring a WCTP where the evidence warrants protective and remedial action to stop ongoing ANE and future ANE. Clear and effective action is needed to address this major failure.

VI. Other findings

A. APS does not appear to have a systematic or consistent method for maintaining files by each worker with the exception that most cases began with an Investigation Summary Report. For example, **AGO 17111** begins with a type of tracking sheet; **AGO 11658** begins with an Investigation Summary form; **AGO 09992** begins with Adult Protective Services_Investigative Report. Intake form, worker notes, required letters of finding, and fax and on-line documentation had no consistent or logical placement in the files. The Division of Adult Abuse Protection Intake and Screening Form, appears to be an informational gathering form and decisional tree form, is used in some of the files, but not in the majority of files.

Moreover, oftentimes the investigator’s hand wrote their notes and many could not be read because of poor handwriting and a disorganized presentation on paper. Discounting poor quality of photocopying, some were literally scrawled notes lacking chronological dates and a line-by-line presentation of material. A good case which shows both organization and disorganization is **AGO 09775**. It would probably benefit the workers, the agency, and the state, if notes were all typed with a prescribed order, e.g. note in a chronological format. The APS-V needs to decide what forms are mandatory for workers to use and the order they should be placed within the case file.

Additionally, the worth of a form is only as good as its acceptance and use by workers. For example, the Division of Adult Protection Intake & Screening Form, which specifies the necessary information and creates a decisional tree of sorts for workers to follow, is not found in every chart. Without having a blank copy of the form, I can only ascertain by my

examination of what is contained in the files of what the full form looks like is and it appears that in some files where the form is used it abruptly ends, e.g., **AGO 16527**; and many files do not contain the form at all, e.g., **AGO 09696**, **AGO 12756**, **AGO 15198**. Yet some workers appear to fully utilize the Intake & Screening Form, e.g., **AGO 16444** and **AGO 12277**. APS-V has several forms that I found in various charts, those being: 1) Adult Protective Services Intake Report, 2) Investigative Summary Report, 3) Documentation of Face-to-Face Visit, 4) Adult Protective Services-Contact Sheet, 5) Adult Protective Services Reporting Form, and 6) Summary Sheet. All these forms varied in usage from case-to-case. So while some of these forms were well thought-out, a systematic usage is not demonstrated.

This lack of consistency and the other file deficiencies are problematic for proper supervision, for background if future reports are filed, and if an alleged victim or alleged perpetrator sought legal action for allegedly poor services. It also makes it difficult to maintain a systemic quality assurance system and performance with inconsistent approaches and uses of forms and illegible notes. It would be difficult for a supervisor or other quality assurance evaluator to analyze the worker's effectiveness and efficiency if systematic recording is not maintained by each worker.

With few exceptions,⁴ we also did not see any evidence of investigation plans prior to, at the onset of the investigation, or at any point. Once such a plan is developed it gives structure to the case, helping the worker to comply with his/ her own plan, allowing for explanations confirming his/her actions or lack of actions, and upon closing a file provides a summary of work and referrals.

Finally, not having consistent formatting in the files by workers at all levels leads to practice diversity among workers in the interpretation of the Statutes and APS policies regarding investigations. This seemed to have happened in many cases.

B. Investigator supervision during the course of most if not all the investigations seemed grossly inadequate or wholly lacking. This was apparent from the poor and inconsistent recording of information and management of case files discussed above as well as the lack of an investigation plan approved by the supervisor. There was also no evidence in the case files of feedback or dialogue during the investigation on a periodic, ongoing or as-needed basis between supervisor and investigator. The best of investigators

⁴ Only one caseworker outlined a plan for investigation before investigating. In other words, there appeared to be a thoughtful vs. reactionary approach to the case. Several cases had a plan of action that was fluid with the case that the reviewer could follow.

need and benefit from collaboration, feedback and brainstorming. The investigator appears to be left on his/her own. Finally, in almost all cases the investigation reports were approved the same day or the day after they were completed by the investigator, and there was no evidence of any investigation reports being turned back for additional work, clarification, etc. It appears perfunctory approval is just given.

- C. There was evidence that APS investigators are not adequately trained to interview victims of alleged sexual abuse with significant cognitive limitations.** APS-V should evaluate this and obtain the necessary training with follow up evaluation and supervision to assure proper interviewing techniques are used. See e.g. **AGO No. 09589** and **AGO 10220** described above.
- D. Failures by mandatory reporters to report alleged ANE is not being addressed in investigations.** There were instances where the reporter or others knew about the reportable incident prior to, and sometimes well prior to, the actual report that was made, but did not file a report in a timely manner. These individuals were mandatory reporters. In such cases the investigator should have determined that mandatory reporters did not report a reportable incident or condition in a timely manner and either filed a new report of neglect (to wit: failure of mandatory reporter to file report) or make a finding in the final investigation report relative to the mandatory reporter(s) failure.
- E. The investigator is closing investigations when the AV dies during the course of investigations with no finding.** See **AGO 13008** and **12670** for illustrations. This is problematic for several reasons. First, no determination is being made as to whether the alleged abuse or neglect was a factor in the death, the most sentinel of all events. Second, even if the death was unrelated, the investigation should be completed to determine whether the alleged ANE occurred either to remove a cloud over the AP, if unsubstantiated, or to ensure that the AP is put on the ANE registry, if substantiated.
- F. We found a failure to determine or address immediate and particularly underlying causes of the incident beyond the direct actions or inactions of the AP.** There were a number of cases in which some or even a major part of the responsibility for neglect lied with other staff, particularly higher credentialed staff, supervisors, agency management, or possibly other state or private programs. In these cases the investigator as a mandatory reporter should have filed a new report or made appropriate findings in the then-current investigation against superiors, or management, e.g. , **AGO 16633, AGO 13223, AGO 09158, or AGO 13477** in which home care providers under the Choice for Care program did not suitably protect the welfare of the AV raising the issue of the agency's hiring, training, supervision and oversight capability that should have been investigated.

AGO 11658. This case is about two vulnerable adult males living in a respite home. The AP began inappropriately touching the AV, who clearly stated he didn't like it. The AV was easily manipulated by the AP into a few other situations. The AV sought staff help. Per order of the Team Director the AP was removed from the home. Notes are not very thorough on this case but it appears APS interviewed the reporter only. No probe was done to determine whether the actions could have been prevented. Nor was there follow-up was done to see about future management of these situations even though it is stated that the facility had no policy or guidance on dealing with these situation. There was also no evidence that they were addressing the propensities of the AP in his new going forward.

See also **AGO 14561** in which the alleged victim with multiple maladies needed complete care in this residential facility. He had multiple skin ulcers which in a frail 84 year old man, bedbound, can become very large exposing bone and leaving the patient open to infections. This patient needed to be turned by a staff member every hour. Apparently the alleged victim's assigned staff person did not do this. He was cited for alleged neglect but left the facility before he could be interviewed by APS. Although the notes via staff interviews show clear neglect of duty, the worker states the AP "does not meet the statutory definition of neglect as set forth in 33 V.S.A. § 6902(7)" despite the clear documentation of the home's supervisor. APS never did a follow-up to the home about whether other staff members were properly trained or were competent to work with patients requiring such intensive care, and whether there is enough staff.

As discussed above, an alternative approach would be to address the underlying factor in the WCTP, e.g. ensuring the AP or other employees received enhanced training or supervision when that lack of those elements may have been a factor in the incident. Unfortunately we saw no evidence of this practice.

VII. Overall Conclusion

Based on our review and findings, in our opinion the APS-V is not operating a system that substantially fulfills the purpose and requirements of the APS statute, 33 V.S.A. 6901 et seq in the areas that we examined. Our focus was on the specific questions asked by plaintiff's counsel and issues that arose from that inquiry. Based on the sampling we conducted⁵ and review of policies and practices, we found that:

- An extraordinarily high percentage of cases that were improperly screened in the order of 57%..
- Substantial delays in initiating investigations, critical interviews and completing investigations, shortcomings which can be very prejudicial in obtaining fresh and

⁵ Our review of the initial five investigations and three closed contacts on which we jointly conferred also support the findings from the larger sample.

accurate accounts of incidents and cause undue delays in the initiation of appropriate remedies, including placing perpetrators on the registry.

- Of the cases that were investigated, there was an extremely high percentage of cases that were unsubstantiated that should have been substantiated or were unsubstantiated on the basis of incomplete or inadequate investigations. Not surprisingly, based on all of our findings, the Vermont substantiation rate of even the relatively low number of cases they investigate is one of the lowest in the country at 7.5%.⁶ The national average substantiation rate is 48.5%.⁷
- In the 57 investigations in which we could determine Written Coordinated Treatment Plans (WCTPs) were needed to ensure a safe environment for the vulnerable adult, they were non-existent even on paper in 52 or 91% of the cases.
- Either as part of the findings in investigation reports or as part of the WCTPs, efforts are generally not being made to determine or address even obvious causes of the alleged or substantiated ANE, including poor or subpar hiring, training or supervision of employees who were the subject of the report, despite the fact that there were a number of cases where such a probe was clearly warranted. Addressing underlying causes is key to prevention of future abuse or neglect.

While no system is perfect, it would be expected that non-compliant cases or subpar performance would be the exceptional case. A system functioning in accordance with acceptable professional practices and Vermont law should have a compliance and performance rate at or approaching 95%. The frequency of the noncompliance/nonperformance in Vermont and the severity and nature means that many of the individuals who have been alleged victims remain at risk. This includes cases which were unsubstantiated as well as substantiated. They also include cases in both categories in which a WCTP was needed and not provided. Unless comprehensive changes are made, we can only conclude that many more of Vermont's vulnerable citizens will remain at risk or unsafe going forward.

Additionally, a system that also has a poor track record of delays, in screening in or substantiating cases also loses credibility in the community and amongst potential mandatory and nonmandatory reporters. This can have the effect of discouraging individuals from reporting, further compounding the very problem the system is designed to address, the safety of vulnerable adults from abuse, neglect, and financial exploitation. In viewing the closed-screened out files reporters were not called back to 1) affirm the report was received and 2) to ascertain more information. This is poor practice as workers begin to assume they "already know the answer" or

⁶ National Center on Elder Abuse's report on Vulnerable Adults (2000). P. 25 at <http://www.ncea.aoa.gov/Resources/Publication/docs/apsreport030703.pdf>

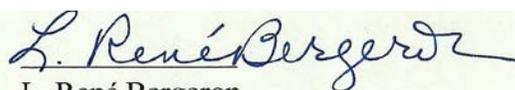
⁷ Id.

the report simply “is not worth their time.” This begins to set a practice tone within agency offices that doing “little is good enough.”

The possible or likely factors contributing to the findings in this evaluation are insufficient numbers of staff, particularly field investigators and possibly supervisors, inadequate training of investigators and supervisors, and inadequate supervisor or real time or ex post facto quality control as well as lack of clear regulations, policies or protocols in areas outlined above as well as in other areas. While determining the root cause of the deficiencies cited in this report was beyond the scope of this project, the core of a remedial plan should include an evaluation of the extent that these or other factors are responsible for the significant and widespread deficiencies we found and the development and implementation of a corresponding corrective plan.



Richard Cohen



L. René Bergeron