

Investigation of the Adult Protective Services Response to Reports of Neglect Regarding the John Doe

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Disability Rights Vermont received a complaint that during 2011 Adult Protective Services failed to properly respond to allegations of abuse and neglect reported to them regarding John Doe, an 80 year-old man who was at a high risk for falls, had dementia, depression, and diabetes requiring 24/7 care and supervision. The report indicated that this failure allowed John Doe to be subjected to significant neglect, pain and suffering and may have ultimately contributed to his death on October 8, 2011. With the permission of John Doe's legal guardian, DRVT subsequently obtained records and interviewed various parties with knowledge about this case. The results of our investigation are presented below.

Timeline of Events

March 3, 2011

On this date APS received a complaint that John Doe was "very weakened and has dementia, a UTI, spinal stenosis and diabetes. That the doctor wants him in a nursing home, but [John Doe] wants to stay home. [John Doe] lives with his son...and depends on him for care. Son says he is with [John Doe] all the time, but that is questionable, as he often does not follow through on getting his father his medications. [Son] has also failed to use telemonitoring system and BP monitor. He appears minimally concerned about his father's increasing needs. His medical condition requires a more astute attention that [sic] he is currently getting under the care of [his son]. [Son] is neglecting his father's caregiving needs."

Page 14 of the APS Intake Form for this complaint documents the following:
Response Priority Assessment – checked as a "priority 3" – "the vulnerable adult is

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receiving services from another agency that will prevent maltreatment from occurring.” In this case, it appears APS is referring to a home health agency.

Page 16 of the APS Intake Form for this complaint documents the following: Final Decision – priority 3 equals face to face visit with the victim within 10 business days. States this was assigned to an APS Investigator on 7-11-11 via email.

DRVT found that this form indicated it had been “reviewed and approved by” the APS Interim Program Chief on 2-02-11 (a month before the intake date of 3-03-11). The records reviewed did not provide any indication as to why the date reviewed and approved precedes the actual intake date, nor why the form indicates that the case was not assigned until approximately four months after the intake.

April 14, 2011

On this date APS completed another intake form in response to another report of neglect regarding John Doe which outlined the following:

“[Son] appears to have difficulty understanding how to care for his dad. VNA has instructed him several times but he does not follow through. He leaves [John Doe] alone for periods of time. [Son] is not providing supervision and caregiving to [John Doe] that [he] needs. Services providers (AAA) refuse to return since [Son] talked about getting out his gun if anyone talked about guardianship. The question is really whether [Son] is neglecting his dad or that he lacks the capacity to understand what his dad needs. It is also not clear who [John Doe] or [Son] refuses to pay for services even though they have significant financial resources. There is a sense that [Son] is blocking services for [John Doe] because he gains from access to [John Doe’s] money. [John Doe] drove to his last appointment and said he was fine to drive as long as I don’t look to the side when he stated he sees double. [John Doe] also has prescribed pain medication and [John Doe] complained about the pain. [Son] said I give it to him in the morning. However, [John Doe] is supposed to get pain medication twice a day. Hard to know if [John Doe’s] dementia prevents him from remembering or that [Son] is diverting the meds.”

Page 15 of the APS Intake Form for this complaint documents the following: Response Priority Assessment has this as a “priority 2” which is defined in part as:

“the alleged perpetrator has denied medical care or treatment which is likely to result is [sic] an imminent impairment of the vulnerable adult’s health.”

Page 17 of the APS Intake Form for this complaint documents the following:
Final Decision: Assigned to field investigator – priority 2 – face to face visit with the victim within 2 business days. Date Assigned: 3-14-11 with a note, “Case was sent to [APS Investigator] as an attachment on 7-11-11. Case was previously assigned to [APS Investigator] under case #22639, which was removed from the system to avoid having two investigators duplicating efforts by working on the same case at the same time.”

DRVT again notes the discrepancy in dates, as the 4-14-11 complaint is noted as having been assigned to an investigator on 3-14-11. Also, there is no explanation provided in the records regarding the note about removing duplicate cases related to John Doe or why if there were two intakes in March and April of 2011, the case was not assigned to an investigator until July.

July 1, 2011

On this date APS completes a third intake form regarding a report of neglect for John Doe which reported the following:

“Reporter states that [John Doe] was recently discharged from [nursing home] to return home in the care of his son...[nursing home] discharge team reportedly made sure that [Son] knew that [John Doe] needs 24/7 supervision and should not be left alone. [Son] told [nursing home] that he had 24/7 care givers lined up for home. Reporter made social work visit on 7/1/2011 with a nurse and found this not to be the case. In fact, [John Doe] had already been left alone for over 5 hours this am. as [Son] was away at work. Reporter contacted [Son] by cell phone and he admitted that he did not have care set up for [John Doe]...A family friend, asked to be present for this visit on 7-1-2011 and during this visit agreed with [Son] to stay during the day with [John Doe] for 20/day but stated she would only be able to stay with [John Doe] off and on over the week-end. [Son] also said he would only be present off and on over the week-end as he would be out riding his motorcycle. Reporter tried to get [Son] to see why [John Doe] doctor’s and others thought [John Doe] would be unsafe alone but [Son] appeared to lack insight into this. [Son] stated “I don’t see why my father needs to be babysat all the time.” [Son] was agreeable with contracting with [home health agency] for bathing 3xs/week. [Son] did not accept further recommendations for support when he or [family friend] might not be there.”

Page 16 of the APS Intake Form for this complaint documents the following:

Response Priority Assessment: “priority 2.”

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Page 18 of this APS Intake Form documents the following:
Final Decision: "Assign to field investigator. Priority 2 – face to face visit with victim within 2 business days." Date Assigned: 7-5-11.

July 5, 2011

APS records document a phone call to the reporter, and having left a message requesting a phone number for John Doe and his son.

July 6, 2011

APS did an unannounced visit to John Doe's home and found him alone. The investigator noted that John Doe appeared to be suffering some confusion, but he was able to say that he wanted to remain at home and feels he needs and wants more help. The investigator noted that they went to the home health agency to speak with two employees involved with John Doe but they were not available.

July 7, 2011

APS received calls from home health stating they could no longer provide services because of concerns of violence by his son. Office of Public Guardianship notified that John Doe may need emergency guardianship. APS investigator called his son and said possible removal from home of John Doe if his needs are not met. Son agreed to home health and adult day program 5 times per week, to start 7-11-11.

APS called John Doe at home and documents state: "Spoke [with John Doe]. [John Doe] said he was trying to do something. Didn't say what. Asked [John Doe] if he fell; [he] said 'no.' Said he was sitting. Couldn't say where he was sitting. Asked [John Doe] if he had eaten. [John Doe] said 'yes,' but couldn't recall what or when. Asked [John Doe] if he felt dizzy or confused. [He] said 'I guess so.' [John Doe] said he was outdoors but was back in the house. Didn't say what he was doing outside, said he was sitting down...he did not want me to call the police or an ambulance to check on him. [John Doe] denied being in any pain or being hurt."

APS investigator spoke with the APS Interim Program Chief about the situation and the potential for emergency guardianship.

July 8, 2011

The APS investigator called the Office of Public Guardian to discuss case more in detail, and emergency petition was approved if needed. Plan was to (1) call AAA for more information and (2) try contacting [son] again.

The APS investigator called John Doe and was told that his son not there, he had gone to work. The investigator asked John Doe if he was feeling okay, and he replied "I guess so." Asked if he had eaten this morning, he said "no." Asked about coming to visit him, he said "I don't care."

There was a notarized letter to the APS Investigator from John Doe's physician on this date. It reads:

"This letter is written on behalf of [John Doe] with deep concern for his welfare. [John Doe] established care with me in July, 2010. At that time he presented with poor insight and poor judgment, likely influenced by active depressive symptoms and some component of dementia. I referred him to physical therapy for assessment of balance and need for assistive devices with walking because I was concerned about his frequent falls.

[John Doe's] health has significantly deteriorated since then. It is unclear if these changes are a progression of his dementia or more likely a result of insufficient care and neglect at home. Based on our clinical assessment, [John Doe] does not have the capacity to care for himself adequately. He needs assistance with preparation of regular diabetic meals, monitoring of his medications and blood sugar, support with bathing and other activities of daily living, socialization, counseling for depression and transportation to medical appointments. He is a high fall risk.

Note that he has been seen emergently at [hospital] three times in 4 months this year for preventable health concerns: dehydration, extremely elevated blood sugars, increased confusion and anemia, which in his fragile state is dangerous. He has been found at home by...Home Health Care nurses with severely low blood sugars as well.

If [John Doe] does not have twenty four hour care and monitoring, any one of these events repeated could lead to irreparable physical and mental damage and even death."

July 11, 2011

The APS investigator made a note which read "discovered that [APS investigator] also had a case open with [John Doe and his son], as well as another report waiting in Queue. Corrected data error and sent all intakes to [APS investigator]. Spoke with home health to confirm services started and went smoothly."

July 12, 2011

The APS investigator made a note which read in part "...Followed up with...OPG as situation seems to stabilized [sic] so that no longer emergent. May still end up seeking a financial guardian (at least) under a standard petition..." There is no documentation in the records justifying the determination that John Doe's situation was stabilized and not emergent.

July 18, 2011

(APS intake reporting form reads 6/18/11 for this entry which we believe to be an error).

APS noted a telephone call with a registered nurse who stated that on 7-16-11 the reporter received a call from John Doe's caregiver who reported that John Doe was in pain and appeared to have a swollen shoulder and she wanted to know if he had been injured at the [adult day program]. The nurse looked at John Doe's records and stated there was no indication of John Doe falling while at [adult day program]. She advised the caretaker to take John Doe to the hospital for an evaluation of a new injury. The caregiver stated that John Doe did not want to go. The caretaker suggested that medication be picked up at [adult day program] and before the nurse could tell her there was none at [adult day program], the caregiver had hung up the phone. A man arrived for the medication and the nurse explained that there were only 2 Fentanyl patches and they had been administered. He responded that they would have to get more. The nurse repeated that if John Doe has a new injury, he should be taken to the hospital and the man responded that that would just create a big bill and left. The caregiver called the nurse back and stated that John Doe had 50 patches when he left the nursing home and "I know you have them or you are giving them to someone else." The nurse said she didn't know what to make of this situation. The nurse has not heard anything further about this situation.

July 18, 2011

APS investigators visited John Doe at home, release forms obtained for financial institution. There was some confusion noted between the caregiver, adult day program staff and home health regarding bathing and pain patches for John Doe.

July 29, 2011

There was a team meeting (physician, home health agency, adult day program staff and APS) by phone and guardianship was discussed. The doctor's office, home health and adult day staff felt the situation would be emergent if they weren't involved, and wanted APS to put forward an emergency petition. The APS investigator explained that a standard petition would be filed for guardianship because John Doe was not at serious risk of harm or death, and that providers could contact the court themselves to plead their cases for an expedited guardianship if so inclined.

August 2, 2011

The APS investigator received another follow up call with concerns that John Doe was agitated this morning, making suicidal statements and may have a UTI. John Doe was sent to [adult day program] to be monitored. Call from their victim's advocate stating that [adult day program] was worried, and hoped that John Doe's current condition will warrant emergency guardianship.

August 3, 2011

The APS investigator received call from home health saying that John Doe was taken to the hospital that morning and was barely responsive. They suspect John Doe may have a UTI.

The APS investigator received an angry call from adult day program stating hospitalization is APS's fault because APS refused to file emergency petition for guardianship. APS investigator called the DAIL attorney who apparently concurred that emergency petition not warranted.

August 4, 2011

A standard petition for guardianship was filed by the APS investigator. The records indicate that the investigator then met with the APS Interim Program Chief and the Licensing & Protection Division Director, to update them on situation, as angry calls from adult day program had reached the Commissioner's office.

The guardianship petition stated the following: "80 year old male suffering from brittle diabetes, depression and dementia. [John Doe] is unable to provide for, direct, or understand his own care needs. [John Doe] lives in his own home with his adult son and POA for healthcare. [Son] has shown limited understanding and interest in provided [sic] the care [John Doe] requires, which has placed [John Doe's] health and safety in jeopardy. While [Son] has allowed service providers into the home to assist [John Doe] he has only done so following initiation of an APS investigation. Furthermore, despite the services [John Doe] receives during the day, [John Doe] continues to rely on [Son] as his primary caregiver, and [Son] continues to fail to provide [John Doe] with adequate care in the evenings and overnight when the day service providers are not available. There is ongoing concern that [Son] will cease the current services in place for [John Doe] following the conclusion of the APS investigation, as reportedly [Son] has refused services in the past, despite [John Doe] physician recommending that he receive 24 hour care and supervision."

August 5, 2011

Note by the APS investigator – home health agency calls with discharge questions. APS investigator advised that discharge planning should be done with his son, as he has legal authority to make decisions. Social worker says John Doe to be discharged home with services from home health agency and adult day care.

August 8, 2011

APS received calls from John Doe's temporary caregiver, a staff person at the home health agency and from a nursing home – reporting that John Doe had a rough weekend and the home health agency does not have staff to send in for next week; caregiver gone for 3 wks, John Doe is refusing to go back to the adult day program.

The caregiver stated that John Doe's blood sugar this morning was 48. He was very confused, agitated, throwing cane, and fell twice over the weekend. His son was home over the weekend but apparently did not do anything to help out with John

Doe's care. Caregiver stated that home health told her to call the ambulance and have John Doe taken back to the hospital.

The APS investigator spoke with an attorney from Disabilities, Aging & Independent Living and was informed that the attorney would assist with an emergency petition as needed.

APS records on this date also document that the son refused to pay for John Doe to go to a particular nursing home. The night before John Doe went to the hospital and was not given evening medications.

The APS Investigator spoke with staff at another nursing home. His son did talk with them and wants to go through with admission of John Doe.

August 9, 2011

John Doe settled in at local nursing home.

August 11, 2011

Guardian appointed by the court – John Doe remains in health care facility.

October 8, 2011

John Doe passed away at a nursing home.

October 31, 2011

APS sends letters to John Doe and his son, the alleged perpetrator, stating the neglect complaint was not substantiated.

APS report states: "A case was opened and assigned for investigation on July 1, 2011" although page 18 of initial intake states the date assigned as July 5, 2011 via email.

The APS report stated that John Doe met the definition of a vulnerable adult, but the complaint was not substantiated because his son did not seem to understand John Doe's medical conditions. The APS investigator submitted a guardianship petition to the courts which was ultimately granted, naming a guardian and placing John Doe in

full service nursing care facility. The APS report states that it does not appear that his son purposely neglected John Doe.

Conclusion

Areas of concern from this review include the following:

1. Report made on 3-3-11 that was not adequately pursued by APS.
2. Report made on 4-13-11 that was not adequately pursued by APS.
3. Confusing and inconsistent documentation re: dates in the first 2 APS intakes.
4. A letter from John Doe's primary care physician dated 7-8-11 to APS outlining concerns of neglect and stating strongly that if "If [John Doe] does not have twenty four hour care and monitoring, any one of these events repeated could lead to irreparable physical and mental damage and even death" did not result in immediate follow up and intervention.
5. On 8-3-11 John Doe was taken to the hospital barely conscious. During the time period between the 7-8 letter and the 8-3 hospitalization, John Doe appears to have suffered numerous neglect situations and his health deteriorated. John Doe continued to deteriorate after his return home.
6. On 7-7-11 the APS investigator was discussing the possible need for emergency guardianship, but then on 7-29-11 APS notes state that standard petition would be filed. It is not clear from the records why emergency guardianship that had initially been considered was not pursued in between these dates. On 8-8-11 there was another APS reference to filing an emergency petition if needed, but no such petition was ever filed.
7. APS records reflect that APS failed to provide protective services, in this case necessary medical care, after receiving evidence of medical neglect as required by 33 V.S.A. §6907.
8. APS records reflect that John Doe entered a nursing home in St. Johnsbury on 8-9-11. This is another source of documentation confusion in his records, as John Doe died at a different nursing home in Lyndonville on 10-8-11.

9. APS records demonstrate conflicting conclusions. In the 8-4-11 petition for guardianship by APS, the investigator wrote: “[Son] has shown limited understanding and interest in provided [sic] the care [John Doe] requires, which has placed [John Doe’s] health and safety in jeopardy. While [his Son] has allowed service providers into the home to assist [John Doe] he has only done so following initiation of an APS investigation. Furthermore, despite the services [John Doe] receives during the day, [John Doe] continues to rely on [Son] as his primary caregiver, and [Son] continues to fail to provide [John Doe] with adequate care in the evenings and overnight when the day service providers are not available. There is ongoing concern that [his Son] will cease the current services in place for [John Doe] following the conclusion of the APS investigation, as reportedly [Son] has refused services in the past, despite [John Doe’s] physician recommending that he receive 24 hour care and supervision.” DRVT notes that while this petition reflects that his son was failing to care for his father seemingly knowingly and with intent to stop if the APS investigation ends, the final APS report states that the son didn’t “seem to understand [John Doe’s] medical conditions.”

It appears the APS investigation ceased once John Doe was moved into the nursing home and a guardian was appointed. As there was no autopsy done on John Doe, DRVT does not have information regarding his cause of death.

Our review of the APS response to reports of neglect regarding John Doe identified that APS failed to commence an investigation within 48 hours of the reports of neglect, failed to provide adequate protective services based on evidence of neglect identified during the pendency of investigations, failed to maintain records that adequately demonstrated the reasons for these failures or that these failures were identified and would be remedied, and failed to substantiate clear neglect by a caregiver, contrary to APS’ statutory duty.

DRVT concludes that the failure of APS to abide by their statutory duties outlined in Title 33, Chapter 69 did prolong the time John Doe suffered without proper care and resulted in his sustaining avoidable injuries and hospitalizations prior to mid-August when a guardian was finally appointed.