AN INVESTIGATION INTO THE DEATH OF JORDAN MACHIA

DISABILITY RIGHTS VERMONT
141 Main Street, Suite 7
Montpelier, Vermont 05602

June 20, 2019
Public Report

DRVT is the Protection & Advocacy System for Vermont and our State's Mental Health Ombudsman.

Table of Contents

I. Acknowledgement

Disability Rights Vermont (DRVT) appreciates the cooperation of Jordan's family as well as the Vermont Department of Disabilities, Aging and Independent Living (DDAIL) and Lamoille County Mental Health (LCMH) during the course of our investigation and their willingness to work collaboratively with DRVT in reviewing and responding to our investigation. Collaboration among those intent on reviewing tragic situations such as occurred with Jordan Machia only serves to improve the system of care for individuals with disabilities and to ensure that best practices are in place for monitoring the placement of individuals with disabilities living with contracted home providers.

II. Introduction

This report presents the results of an investigation conducted by DRVT into the circumstances surrounding the death of Jordan Machia on December 5, 2017. Jordan was an individual receiving Developmental Disabilities Home and Community-Based Services through Lamoille County Mental Health (LCMH) and services from Amici Associates. He lived with support workers in Duxbury, Vermont. Jordan was 22 years old at the time of his death. His medical history included Autism Spectrum Disorder, Anxiety and Atopic Dermatitis and obesity. He had self-injurious behaviors, aggression toward others and a limited ability to communicate. Jordan had an extensive history of property damage and assaultive behaviors throughout his home placements. Jordan was under the supervision of a public guardian from the Office of Public Guardian at the time of his death.

In 2011 Jordan was placed in a shared living home when his mother felt she could no longer maintain his health and safety in her home. On October 1, 2016 Jordan was placed with a new shared living provider as his Barre City home provider was no longer able to manage his behaviors by himself. Unfortunately, this new provider was also unable to manage Jordan's behaviors and as a result Jordan then transitioned to crisis bed operated by the Vermont Crisis Intervention Network (VCIN) on November 4, 2016, for 26 days before being moved in with a new shared living provider in Duxbury, Vermont on November 30, 2016, where he resided until the time of his death.

III. Agencies and Entities

a. Disability Rights Vermont (DRVT) is a federally-funded, not-for-profit organization mandated to investigate abuse, neglect and rights violations effecting people with disabilities.
b. Division of Disability and Aging Services (DDAS) is the state agency responsible for all community-based long-term care services for older Vermonters, individuals with developmental disabilities, traumatic brain injuries and physical disabilities.
c. Lamoille County Mental Health (LCMH) is a nonprofit organization that provides comprehensive community mental health, children, family, and person-centered developmental disability services in the Lamoille County area.
d. Amici Associates, LLC (AMICI) is a small agency located in the Upper Valley of Vermont that provides wraparound support services for individuals with emotional, behavioral and/or developmental disabilities.

IV. Information Reviewed

DRVT's investigation of this case included the following:

a. Review of records from Disability, Aging and Independent Living.
b. Review of records from Lamoille County Mental Health Services.
c. Autopsy and AME report from the Medical Examiner's Office.
d. Review of the Vermont State Police report.
e. Lamoille County Mental Health Consumer Rights Handbook
f. Behavior Support Guidelines, Division of Disability & Aging Services October 2004
g. Vermont Critical Incident Reporting Policy February 2016 – Adult Services Division, Developmental Services Division
h. Health and Wellness Guidelines November 2017, Developmental Disabilities Services Division
i. Vermont Developmental Disabilities Services Home Visit Requirements May 2010
j. Vermont Housing Safety and Accessibility Review Process Protocol January 2017, Developmental Disabilities Services Division

V. Relevant Events

What follows below is a brief outline of events leading up to Jordan's death on December 5, 2017. The facts related below are not a complete recitation of every event or activity that occurred during this time period, but are facts that are relevant to an understanding of the context and circumstances of Jordan's life and subsequent death.

February 2017 DS Monthly Summary:
"February 7…Jordan would not get out of bed in time for his labs today so I rescheduled with Stowe Family for tomorrow at 11…"

March 2017 – Individual Support Agreement for Jordan:
#4: "[Shared living provider] *will write monthly notes and keep track of goal outcomes on a chart that he will hand in with monthly notes. Service Coordinator…will meet at the home with* [shared living provider] *and Jordan monthly or as needed to review notes and outcomes.* [Service Coordinator], [shared living provider] *and the Guardian will be in contact on a regular basis as needed so everyone is up to date with Jordan's support needs."*

March 2017 Summary by LCMHS: "…*paperwork: the hardest part of this job believe it or not. I have made up tracking sheets for ISA goals and they are not being filled out but they are filling out…behavior sheets.* [shared living provider] *is a horrible written reporter and the guys do text. I'm wondering if I should just print out all my texts until I can find a simple way for them to document…"*

April 2017 DS Monthly Summary:
"April 5: I asked [shared living provider] *to reschedule the [doctor] visit but when I returned here to the office* [staff] *had received med refills from* [shared living provider] *and noticed he hadn't rescheduled the next visit yet and so I took care of it and let* [shared living provider] *know the date…"* P.4: *"April 21: Jordan had a rough morning due to [support person] slept through an episode where Jordan got up for the day and since* [overnight support staff] *was not available to direct Jordan to the bathroom he went in his clothing… So [shared living provider] does not want* [overnight support staff] *working nights anymore because he can't stay awake…"*

May 2, 2017 – Annual Physical Exam at Community Health Services of Lamoille Valley. Did receive a flu shot with recommendation that he receive one in the fall.

May 2017 LCMHS Note: *"…paperwork: May still shows lack of follow through on proper protocol and this is still frustrating to me…All of us have had ongoing issues with the guys not filling out med sheets daily or losing our monthly ABC and tracking and summary sheets for ISA goals. Incident reports are written on the ABC sheets as opposed to the incident reports."*

May 2017 DS Monthly Summary:
P.4: *"May 30…he fell asleep again and Jordan deficated* [sic] *in his room after he woke at 1:30 a.m. and* [overnight support staff] *didn't wake up when Jordan wants mac and cheese…*[shared living provider] *is pretty frustrated."*

September 2017 Note by Amici Psychiatrist: *"Jordan comes to Amici from LCMHS. He is essentially nonverbal, and prone to sudden, intense physical attacks and/or destruction of property. A heavy, muscular man, he can (and has) hurt people. At the end of 2016 he suddenly lost his HCP, a day staff and school, which resulted in an extended period of aggression with daily physical attacks, some of them quite serious. He is maintained in a developmental home with 2 male staff 24/7 eyes on supervision…Jordan has limited communication skills. He echoes, and requires a lot of support communicating his wants and needs. He needs consistent verbal cueing, prompting, patience and encouragement when try to communicate his needs. He can become quite frustrated if he is not understood. He likes geese, ducks, chickens, working outdoors, and hard rock music..."* At this time Jordan's medication list consisted of: Abilify, Seroquel, Haldol, Celexa, Remeron, Depakote, Clonidine, Lorazepam, Synthroid, Folic acid, Omega 3 fish oil, daily vitamin, probiotic, Vitamin D3 and Omeprazole.

September 13, 2017 Developmental Services Monthly Report. *"…I told* [shared living provider] *they need to make a PCP appointment today and I need to know date and time today. I also went to check on the water in the hot tub and there were 3 bedding quilts on the top laying spread out in the sun but they were wet with urine. When I commented*

on this they said they 'dry out pretty well' and I said they stink and the guys said 'well its laundry day.' I sent [shared living provider] *a message once back at the office stating that the blankets needed to be laundered…I called Stowe family practice at 4:14 and they had not received a call for an appointment for Jordan so I set one up for tomorrow at 10:40 so they can look at Jordan's swollen ear…"*

September 29, 2017 – LCMHS note: *"*[shared living provider] *met me at the agency today to review medications and do the controlled substances count. It was noted that the last count done on 9/27/17 there were 9 tabs of Lorazapam 1mg tabs, and todays count was 6.* [Shared living provider] *did not know how the count was off and did not think it was a counting error on his part. He did state that he was suspicious of certain staff on the night shift that have access to the med box.* [Shared living provider] *plans to have the med box accessible only to the day staff and the day staff will administer all Jordan's morning meds. He will count meds at change of shift with staff when medication needs to be administered by them."*

October 10, 2017 note by Amici Psychiatrist: *"Prior to his transfer to Amici, Jordan was frequently violent. There were about 20 severe physical attacks a day for 10 months. He pulled a toilet out of the floor about 40 times, as well as damaging refrigerators, tables and chairs…It turned out Jordan was being given too much Haldol. When this was decreased and changed to Depakote he began to do better…LCMHS requires 2:1 staffing 24/7. Relationships are key for Jordan. He responds well to calm, consistent presence…He responds adversely to behavioral techniques, like limiting his access to favored activities in response to some transgression. He does better if he takes a vigorous walk with a staff person…he is highly sensitive to sound that he finds unpleasant…"*

October 17, 2017 note by Amici Psychiatrist: *Jordan has been calm and rather self-contained this month. There were no reports of aggression or loss of control…"*

October 31, 2017 LCMHS Note: *"*[Shared living provider] *met me at the agency today to review medications and do the controlled substances count.* [He] *forgot to bring along his September or October MARS to review. We did counts on all controlled substances and counts were all correct.* [Shared living provider] *has kept the med box accessible to*

himself and the day staff and has been administering evening medications himself. Reviewed all medications with [Shared living provider] *and noted that there have not been any recent med changes."*

October 31, 2017 Contract for Services signed between [Shared living provider] (contractor) and LCMHS. Attachment A: (1) Be responsible for the care of the Consumer, twenty-four hours per day during the term of the Contract. Contractor will provide the level of supervision described in the Consumer's ISA and in accordance with any Consumer specific support plans, protocols or court orders. (2) Complete State of Vermont mandated pre-service training prior to assuming the residential care of the Consumer, and complete the State of Vermont mandated in-service training within 90 days of the Consumer's moving into the Contractor's home…(6) Provide a residence for the Consumer that continually meets the safety and accessibility standards of the Vermont Division of Disability and Aging Services and that promotes respect for the Consumer's rights as defined in the Vermont Developmental Disabilities Act…(19) Ensure that the Consumer receives regular medical examinations and any appropriate medical treatment, including follow-up care and emergency services if the need arises…

November 21, 2017 note by Amici Psychiatrist: *"Jordan got upset with himself and hit himself repeatedly about his face and head. Staff was unable to identify a precipitant. Other than that, he has been calm and rather self-contained this month…"*

November 2017 – Developmental Services Monthly Summary – *November 1:* [Shared living provider] *comes to pick up his slp check and room and board. More negative comments about his life and how he doesn't get a break and child support and lawyers, etc. November 7: Meet with* [team]*…discuss finances and respite budget woes so…can help hone in the rate that* [shared living provider] *is spending…*

December 1, 2017 LCMHS Note: *"*[Shared living provider] *was at the agency today to meet with service coordinator… I was unable to complete the controlled med counts with him while he was at the agency since he had not brought JM's medications with him. He did not turn in his MARS… today either. Plan to schedule…*[Shared living provider] *another meeting time for medication counts and to review medications."*

December 5, 2017 Critical Incident Report Form completed by home provider which reads *"Jordan went to bed around 8pm after taking his meds. Throughout the night I could hear him snoaring* [sic]*. Then at 3:30 when I could not hear him snoaring* [sic] *I checked on him and found irresponsive* [sic]*. Then I got* [shared living provider]*. I got hold of* [shared living provider]*, he called 911…"*

December 5, 2017 LCMHS Note: *"At 4:00 am I received a call from* [Service Coordinator] *then called* [shared living provider] *as a three way call to get me more details…I asked if they had done CPR.* [Shared living provider] *reported that Jorden (sic) was not warm and there was no pulse, so they did not perform CPR…Jorden (sic) had a little cough with cold that* [Shared living provider] *was planning on taking him to walk in care in the morning to get checked out.* [Shared living provider] *got off the phone with us…"*

December 5, 2017 LCMHS Note: *"*[Shared living provider] *reported that Jorden [sic] had been sick with a cold for the last couple of days…"*

December 11, 2017 LCMHS Note: *"*[Shared living provider] *was asked to attend a mandatory training for home providers on guidelines for administering medications that I presented at the agency on October 11, 2017. He did not show up for this training. I repeated the training on November 3, 2017 for those who could not attend the first training.* [Shared living provider] *was aware of the second training as we talked about the upcoming training when I met with him on October 31st to do a medication count.* [Shared living provider] *did not show up for the second medication training presentation either."*

February 18, 2018: Chief Medical Examiner's Final Autopsy Report. Cause of Death: Bronchopneumonia Complicating Tracheobronchitis of Probable Viral Etiology. Contributory: Autism, Obesity. Manner: Natural.

VI. Findings

Jordan was reportedly sick for a few days prior to his death, yet his shared living provider did not report the illness to LCMHS nor did he take Jordan to be evaluated by a physician. There is a history of the shared living provider not being dutiful in making and/or keeping

doctor's appointments for Jordan when needed. One example noted earlier in this report is that in September 2017 LCMHS had made a request for the home provider to make a doctor's appointment for Jordan for a swollen ear, and when LCMHS called the doctor's office at the end of the day, the appointment had not been made, so LCMHS made it. The contract for services clearly states that the contractor shall: *"Ensure that the Consumer receives regular medical examinations and any appropriate medical treatment, including follow-up care and emergency services if the need arises."*

Jordan's shared living provider routinely did not comply with providing required monthly documentation on medication administration.

Standard 9: Medication Prescription & Administration, Training and Monitoring #3: Ongoing monitoring of all people who administer medications is required to ensure safe medication administration practices. Documentation of this monitoring is required. Monitoring includes tracking of medication errors, review of medical professional's orders, and regular (monthly is recommended) check of medication administration sheets.

The overnight support staff person discovered Jordan unresponsive at 3:45 a.m. on December 5, 2017. Instead of immediately calling 911 and initiating CPR, he went to get the shared living provider in another part of the house. It is unknown if this decision not to attempt CPR initially contributed in any way to Jordan's death. Had a 911 call and CPR begun immediately, the outcome may have been different.

When the shared living provider arrived to assess the situation with the overnight support staff person, he called 911 after determining that Jordan was not breathing and had no pulse, however, he neglected to start CPR, stating that *"…(he) was not warm and there was no pulse, so they did not perform CPR…"* EMS pronounced him dead at 0407, only 2 minutes after being on scene. There was at least 20 minutes with no CPR attempted by the shared living provider or the overnight support staff person. That does not include the amount of time that it took the overnight support staff person to get the shared living provider to respond to Jordan's room.

DRVT is not able to find any documentation in the records provided to show that the shared living provider or the overnight support staff person received basic first aid training and/or CPR certification.

If Jordan was in fact not "warm" when discovered, as the shared living provider reported, then the question arises of how long Jordan had not been snoring before he was actually checked on. Overnight staff were expected to remain awake while on duty and provide observation of, and assistance to, Jordan throughout the night.

Regulations Implementing the Developmental Disabilities Act of 1996 Effective October 1, 2017, Part 9. Training. 9.5 In-service Training (4) Basic First Aid. In the LCMHS records provided there are training checklists for the home provider and the overnight support staff person and both reflect that they were provided with "in-service training." However, there is nothing detailing what that training consisted of, e.g., CPR certification or basic first aid, and who provided the training.

Jordan moved into the Duxbury home on November 30, 2016, and by spring of 2017, LCMHS already had concerns about this home as suitable placement for Jordan. It is not clear from the documentation provided what steps LCMHS had been taking to find a new placement for Jordan. From review of the records it is evident that LCMHS did make attempts to get the shared living provider to adhere to completing and submitting required paperwork on time. However, the records were equally clear that these efforts were ineffective, that the shared living provider continued to fail to adhere to documentation requirements with no apparent consequences.

VII. Conclusion

DRVT understands the difficulty of being able to predict tragedies such as what happened with Jordan Machia, that home providers and agency staff are greatly affected by the loss of any resident and that overall, services are provided with care and compassion. DRVT also recognizes the difficulties that service agencies have in finding suitable and safe housing for individuals with disabilities who may be challenging and possible threatening to their caregivers. With that said, continued utilization of a shared living provider (SLP) who does not adhere to

required policies and procedures only increases the risk of irreparable harm for the individual who is placed there.

DRVT recommends that LCMHS consider making CPR certification a necessary requirement for all SLP's and their support staff. Not to make this mandatory is contrary to providing a safe and protected home environment for future clients in any home placement.

DRVT also recommends that LCMHS create clear policies or directives to guide SLPs on when it is necessary to consult with a medical provider about any change in the client's health in general, no matter how insignificant the SLP may consider it to be.

LCMHS, through their attorneys, were offered the opportunity to review and provide comments on this report prior to it being made public. DRVT appreciates the time that they devoted to providing us with those detailed comments and suggestions, and to that end, DRVT did make changes to our report based on their response.

DRVT again thanks Jordan's family and all those involved in producing information that formed the basis of this investigative report. Going forward the recommendations contained herein, and continued vigilance on the part of everyone in our community, will hopefully create a safer and more fulfilling system of care for people with needs like the late Jordan Machia.