Maine Elder Death Analysis Review Team

("MEDART")

2004 And 2005

Annual Reports

MAINE ELDER DEATH ANALYSIS REVIEW TEAM

MAINE OFFICE OF THE ATTORNEY GENERAL

6 STATE HOUSE STATION

AUGUSTA, MAINE 04330

In Remembrance:

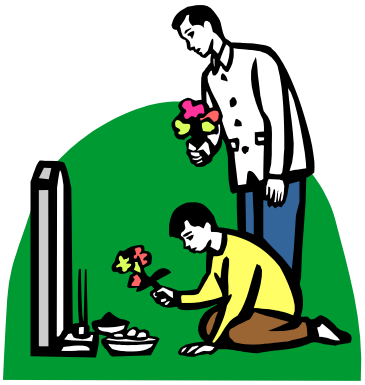
"Let us not forget those who have gone before us.

Let us not forget the significance of their lives.

Let us not forget the greatness of life.

And

Let us reflect on their deaths and learn lessons for all."



"We are losing our elders to an epidemic rarely talked about or even acknowledged. An epidemic that leaves some ashamed, some afraid and too many dead."

American Academy of Family Physicians

TABLE OF CONTENTS

MAINE ELDER DEATH ANALYSIS REVIEW TEAM

2005 LEADERSHIP

Ricker Hamilton, Chair

Protective Program Administrator

Office of Elder Services

161 Marginal Way

Portland, Maine 04101

Telephone: (207) 822-2150

E-mail: ricker.hamilton@maine.gov

Marci Alexander, Vice Chair

Director, Healthcare Crimes Unit

Office of the Attorney General

6 State House Station

Augusta, Maine 04333

Telephone: (207) 626-8520

E-mail: marci.alexander@maine.gov

Panel Staffer:

Amy Bailey

Legal Secretary

Office of the Attorney General

6 State House Station

Augusta, Maine 04333

Telephone: (207) 626-8520

E-mail: amy.m.bailey@maine.gov

MAINE ELDER DEATH ANALYSIS REVIEW TEAM

2005 MEMBERSHIP

Seth Blodgett, Detective, Maine Office of the Attorney General

Laurel Coleman, MD

Gregory Cross, Volunteer Coordinator, Long Term Care Ombudsman Program

Tracy L. Devoll, Assistant District Attorney, Kennebec County

Lou Dorogi, Assistant Director, DHHS, Licensing and Regulatory Services

Mary Farrar, Victim Witness Advocate, Maine Office of the Attorney General

James Ferland, Administrator, Office of the Chief Medical Examiner

Brenda Gallant, Director, Long Term Care Ombudsman Program

Denise Giles, Victim Services Coordinator, Department of Corrections

Brad C. Grant, Assistant District Attorney, Kennebec County

Margaret Greenwald, Chief Medical Examiner

Lloyd Herrick, Sheriff, Oxford County, Maine Sheriffs Association

Brian MacMaster, Director of Investigations, Maine Office of the Attorney General

James P. Madore, Sheriff, Aroostook County, Maine Sheriffs Association

Peter Mauro Jr., Assistant Director, Community Services

Brian McDonough, Lieutenant, Maine State Police Criminal Investigation Division

Michael Miller, Assistant Attorney General, Maine Office of the Attorney General

Rick Mooers, Protective Program Administrator, Office of Elder Services

Donald O'Halloran, Chief of Police, Old Town, Maine Chiefs of Police Association

Joseph Rogers, Chief of Police, Hampden, Maine Chiefs of Police Association

James Urquhart, Sergeant, Maine State Police Criminal Investigation Division

TEAM MISSION STATEMENT

The Maine Elder Death Analysis Review Team (MEDART) will examine deaths, and cases of serious bodily injury, associated with suspected abuse or neglect of the elderly and vulnerable adults. The purpose of MEDART is to review deaths related to abuse and neglect, and to identify whether systems that have the purpose or responsibility to assist or protect victims were sufficient for the particular circumstances or whether such systems require adjustment or improvement. MEDART will foster systems change that will improve the response to victims and prevent similar outcomes in the future.

MEDART recognizes that the responsibility for responding to and preventing fatalities related to abuse or neglect of the elderly and vulnerable adults lies within the community and not with any single agency or entity. It is further recognized that a careful examination of the fatalities provides the opportunity to develop education, prevention, and strategies that will lead to improved coordination of services for families and our elder population.

CHAIR REPORT

In March 2003, the American Bar Association, Commission on Law and Aging, selected Maine as one of four project demonstration sites for "Promising Practices in the Development of Elder Abuse Fatality Review Teams." The ABA stated goal for the project was to expand the fatality review team concept to deaths resulting from elder abuse in order to foster examination of and improvement in the response of adult protective services, law enforcement officers, prosecutors, victim services, health care providers and others to the growing number of victims of abuse.

The Maine Elder Death Analysis Review Team, (MEDART) under the auspices of the Office of the Attorney General, is charged with examining deaths and cases of serious bodily injury associated with suspected abuse or neglect of elderly and vulnerable adults. The team meets six times a year to review selected cases, the purpose of which is to identify whether systems that have the purpose or responsibility to assist or protect victims were sufficient for the particular circumstances or whether such systems require adjustment or improvement. MEDART seeks to foster system change that will improve the response to victims and prevent similar outcomes in the future. MEDART was recognized by the Maine Legislature in 2003 with enabling legislation that provides for among other things, access to information and records, and confidentiality.

The success of MEDART is due to the Team's diverse makeup and because of the members' passion, dedication, commitment and expertise. Maine is now the third oldest State in the nation. Our population of citizens 60 and older will double over the next several years. MEDART strives to make our communities safer for older citizens and it is through the case review process that MEDART will foster changes that will result in an improved systemic response to the needs of older victims. During 2004 and 2005, MEDART reviewed eleven cases. On September 6, 2005, the Homicide Review Team and MEDART met to conduct a joint case review.

2004 Case Summaries

Case Summary # 2004-01

This review focused on the circumstances surrounding the alleged neglect and financial exploitation of a 93-year-old woman, who later died as a result of cardiovascular disease; the death was not directly attributed to neglect or exploitation.

The decedent lived with her 55-year-old son. They resided together at the decedent's home, which was once occupied by the decedent's late husband. The decedent was legally blind and suffered from cardiovascular disease. The decedent was dependent on her son to make financial decisions, pay the bills and also to purchase and administer her medications. The decedent's son did not have power of attorney, nor was he the legal guardian or conservator.

The decedent's Social Security check was deposited directly into her checking account at a local bank on the third of each month. The decedent's son's name was not on the bank account. To access the bank account funds the decedent's son would have his mother sign checks and have his mother call the bank teller and authorize the withdrawal. When interviewed, the bank teller indicated that she was always suspicious of the decedent's son because he usually smelled of alcohol and would withdraw all the funds in the account the day the social security check arrived each month. However, the bank teller did not report her concerns about the son to anyone.

From January 2000 through March 2003, Adult Protective Services (APS) received four reports regarding the decedent. The first referral was filed in January 2000, after the decedent's residential taxes had gone unpaid for three years. APS initiated a case and secured a psychological evaluation of the decedent. The decedent

was found competent and refused intervention. The second referral was filed in September 2000 after the decedent went six months without utilities, including electricity. APS re-opened the case, and in order to restore electric power to the decedent's home, APS made an initial payment to Central Maine Power, and then arranged a payment plan for the balance. The decedent's son neglected to make any additional payments resulting in services being disconnected yet again in May 2001. The third referral was filed in March 2001 when concerns surfaced that the decedent's son was not purchasing his mother's medications. APS arranged for a second evaluation of the decedent. Once again, she was found to have capacity. The fourth and final referral was made in March 2002 when the decedent was admitted to the hospital for malnourishment. It was then that the decedent was diagnosed as suffering from arrhythmia as a result of not taking her cardiac medication. The decedent was without cardiac medication because her son was not purchasing it. The decedent was evaluated for capacity yet again, this time resulting in a determination that she was unable to manage her own finances, and was in need of a conservator.

Based on the above facts, APS made a referral to the Investigations Division of the Maine Office of the Attorney General. A criminal investigation was initiated and forwarded to the Healthcare Crimes Unit for prosecutorial review. The case was later presented to the Cumberland County Grand Jury resulting in the Indictment of the decedent's son for Theft by Deception and Endangering the Welfare of a Dependent Person. The decedent and her son both died of natural causes before the case was adjudicated.

Recommendations for Case # 2004-01

1. The decedent was evaluated by medical staff at least three times before she was determined to lack the capacity to manage her own finances, despite the fact that she was legally blind and dependent on her son. Notwithstanding evidence that the son was misappropriating his mother's funds, Bureau of Elder and Adult Services (BEAS) was limited in its ability to assist the decedent because she was found to have capacity. The decedent was without basic services, such as electricity, and, as a result, was unable to function safely. It appears that these circumstances were not initially considered in her evaluations. It is recommended that training be made available for physicians that would focus on the consideration of all circumstances leading to the request for a determination of capacity.

2. Financial institutions should be encouraged to seek additional training surrounding the signs and symptoms of elder abuse. They should be encouraged to contact Adult Protective Services to report appropriate concerns.

Case Summary # 2004-02

This review focused on the events surrounding the death of a patient who succumbed to exposure after wandering away from a boarding home in February 2003. While the patient was reported missing to the local police department within three hours of his disappearance, the patient's body was not recovered for two weeks.

In February 2003, at approximately 1:00 P.M., after being released from the local hospital, the decedent was admitted to a boarding home. He had recently undergone surgery for a brain tumor. The decedent was disorientated, on medication, and was known to the discharging hospital to be a risk for wandering. The boarding home was not a "locked" facility. At approximately 5:15 P.M. on the same day, after being served dinner, staff at the boarding home allowed the decedent to leave the facility unaccompanied "for a walk." The decedent never returned.

Pursuant to facility policy, the staff waited two hours before contacting police. Police were not notified until 7:30 P.M., approximately two hours and fifteen minutes after the decedent was allowed to leave the facility. Staff advised the police that the decedent had not returned from his walk, and provided an officer with a physical description. Staff did not offer any information to the police regarding the patient's medical condition.

The police searched local roads, bars and restaurants, and also the hospital, but were unable to locate the decedent. At approximately 9:05 P.M., the police issued a teletype message requesting that other law enforcement agencies attempt to locate the decedent. A more detailed, missing person teletype was never issued. The officer who responded to the complaint continued to patrol local roads in search of the decedent. The decedent remained missing for thirteen days. The responding law enforcement agency did not contact the Maine Warden Service. The Warden Service only became involved after a local game warden read about the missing patient in the news, and took it upon himself to offer assistance. It was only then, 13 days after being reported missing, that the decedent was found. The body was a short distance from the facility.

Recommendations for Case # 2004-02

1. While it is important for facilities to develop comprehensive policies regarding how and when staff report critical incidents to law enforcement such as a missing patient, certain flexibility needs to be considered in their development. Policies should be dynamic in that they are able to meet individual client needs, risks, and challenges. Policies that are static in regards to how long staff are required to wait before contacting police should be revisited to allow for a more rapid response by law enforcement, in cases where a patient is at risk. Such policies should allow release of specific medical history, concerns, or risks, when necessary for the wellbeing of the resident.

2. Recognizing that hospitals appear to be under tremendous pressure to discharge patients, and that the number of "locked" facilities in Maine are minimal, a system to ensure proper placement of those patients who are at risk for wandering is critical. Individual patient needs should be identified prior to discharge from the hospital and admission to the facility. Methods that will help to protect the patient and avoid accidents or fatalities attributed to incidents of wandering include, proper screening, hospital discharge notes, past supervision patterns and the individual needs of the patient.

3. Additional training for law enforcement, or the development of a best practices guide regarding how to search for elders missing from facilities should be developed. This training should reflect the importance of proper use of law enforcement teletype alerts, and the need for a timely release of information to other agencies, including the Maine Warden Service when applicable.

4. Missing person searches for elderly and dependant adults require a unique assessment of their mobility and mental capacity to determine a probable search area. In this case and others like it reviewed by the Team, the probable search area is usually within a quarter mile of the facility based on the limited mobility of elderly and

dependant adults. Factors to consider in determining a probable search area should include the missing persons:

(1) physical condition;

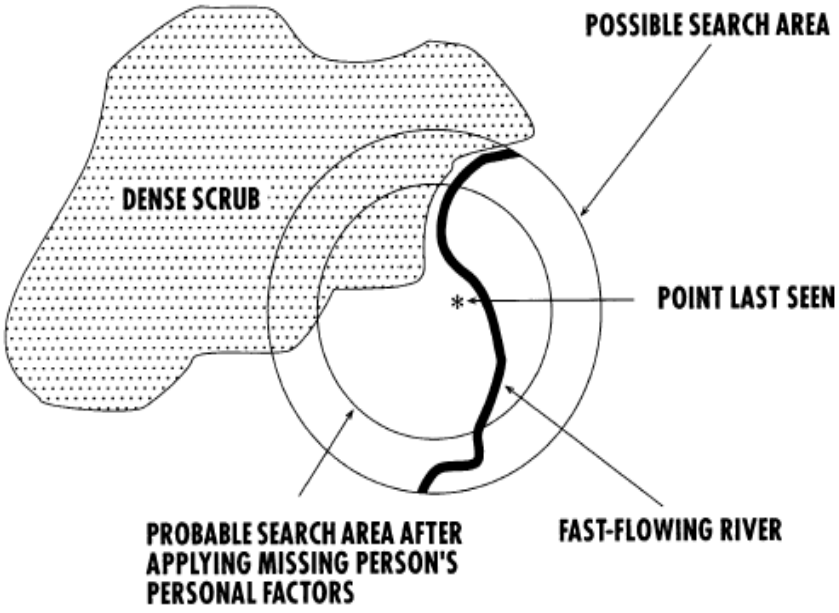
(2) age and sex;

(3) experience in the area or facility and general outdoor ability; and

(4) weather.

5. To ensure that patients receive proper treatment, hospitals and facilities need to ensure that a proper transfer of both the patient and the patient's medical records occurs. This is particularly important in cases where the patient is at high risk for wandering, or has other special needs. Documentation, similar to evidentiary chain of custody, should be implemented to guarantee accountability.

EXAMPLE:



Case Summary # 2004-03

This report focused on the circumstances surrounding the death of a 78-year-old woman suffering from dementia who, after leaving a residential care facility and being unable to return as the doors locked behind her, died as a result of hypothermia.

The facility's admission policy stated that it would not accept patients with dementia. Despite this, and with the knowledge of the decedent's condition, she was accepted as a private pay resident. The decedent had a history of wandering. Family members informed the facility of this history. The decedent was "missing" on numerous occasions from the facility and was found outside by facility staff and neighbors. The facility only employed one staff member during the hours of 10 P.M. to 6 A.M. On January 26, 2000, the decedent exited the facility unknown to staff. Police reports indicate that the decedent tried to regain entry to the facility, but was unable to do so as the doors had locked behind her. Police reports also state that the decedent attempted unsuccessfully to gain entry to a nearby vehicle. Staff had last seen the decedent in her room at approximately 4:00 A.M. The decedent was found later that morning, at approximately 6:15 A.M., when an additional employee arrived at work. The decedent had succumbed to exposure and died of hypothermia. The facility administrator destroyed all 24-hour incident logs the following day.

The facts of the patient's death were reviewed by prosecutors for potential criminal prosecution, but no charges were filed. At the time, 17-A M.R.S.A. § 555, Endangering the Welfare of a Dependent Person, read in part: "a *person is guilty of endangering the welfare of a dependent person, if that person knowingly endangers the health, safety or mental welfare of a person who is unable to perform self-care because of advanced age, physical or mental disease, disorder or defect.* (Emphasis added). Since then, the law has been amended to include not only a knowing state of mind, but an *intentional* or *reckless* state of mind. Additionally, the Department of Human Services, Adult Protective Services and Division of Licensing and Certification

reviewed the case. These reviews found that the facility failed to take necessary steps to protect the resident, and substantiated neglect resulting in the patient's death.

Recommendations for Case # 2004-03

1. Facilities need to ensure that their admissions policy include a system to ensure proper placement of those patients who are at risk for wandering. Individual patient needs should be identified prior to discharge from the hospital and admission to the facility. Proper screening, to include hospital discharge notes, past supervision patterns, and the individual needs of the patient are all methods that will help to protect the patient and avoid injuries or fatalities attributed to incidents of "wandering."

2. *Minimum* staffing standards do not always equate to *adequate* staffing standards. Staffing patterns should reflect not just the number of patients, but the individual needs of the patients. Facilities that accept patients with a history of wandering, or other special needs that require frequent night time response, should staff a minimum of two personnel. Additionally, facilities should consider the tasks placed upon employees, and whether these employees will be able to properly care for and maintain contact with patients.

3. In addition to proper staffing, improvements to the physical plant, such as door alarms, can assist the facility in recognizing whether a patient has wandered. Facilities with patients who suffer from dementia, Alzheimer's, or have a history of wandering, should be required to install door alarms.

4. Facilities should be required to implement a method to allow non-administrative staff access to medical records in the event of an emergency. Facilities should be required to retain all 24-hour shift notes for a period of one year, or until the next survey by Licensing and Certification.

Case Summary # 2004-04

The decedent was an 83-year-old male who suffered an accidental death on January 23, 2003, in a licensed long term care facility as a result of asphyxia caused by compression of the neck when he slipped off an overlay air mattress and became entrapped in the bed rail.

At the time of his death, the decedent was a resident in a licensed long term care facility and suffered from dementia, decreased mobility, poor judgment and high risk for falls. The decedent needed extensive assistance with his activities of daily living and had difficulty repositioning himself in bed. The decedent's bed had quarter length bedrails on both sides and the facility placed an overlay air mattress on his regular bed mattress to decrease the likelihood of pressure sores. The smooth surface of the air mattress was somewhat slippery. A motion detector was attached to the decedent's clothing because of his dementia and his frequent attempts to get out of bed

On January 23, 2003, the decedent was found by staff trapped between a raised bed rail and a pressure relieving air mattress. The decedent was seated on the floor with his head and chin stuck between the raised quarter rail and the air mattress. Facility staff waited approximately one hour before notifying the authorities of the death, during which time they moved the decedent back onto his bed and pursuant to the facility's policy, bathed him, dressed him, shaved him, and placed a flag in his hands.

The death was investigated by local law enforcement, the Maine Office of the Attorney General Healthcare Crimes Unit, and the Office of the Chief Medical Examiner. It was determined that the death was accidental and resulted from asphyxia caused by compression of the neck.

According to a U.S. Department of Health and Human Services review of the matter, the facility did not conduct assessments as to the use of quarter length bedrails for this particular resident since the facility did not consider them a restraint. The

facility was cited for failure to comply substantially with federal requirements governing participation of long term care facilities in Medicare and State Medicaid programs or, more specifically, for failure to properly assess the use of an air mattress in connection with bedrails. Although not a factor in the review of this matter, a similar death occurred in June, 2004. In that particular case, the decedent, a 93 year-old female, died form asphyxiation after being becoming wedged between the wall and her bed. In this case, the decedent's bed was also equipped with an overlay air mattress for pressure sores.

Recommendations for Case # 2004-04

1. Recognizing that patients can slip between an overlay air mattress and the bed rail and that such incidents have led to injury and death, facility staff should have a heightened level of concern when using an overlay air mattress in conjunction with any bedrail, including quarter rails.

2. Facility staff should observe and monitor bed rails, mattress height / fit and bed choice to ensure patient safety. Staff should be watchful of any product failure or malfunction and report any concerns or problems to the supervisor and to the manufacturer immediately.

3. Training should be provided to facility staff regarding proper individual patient safety assessments and ongoing patient monitoring to determine the benefits and/or risks of using bed rails and other safety restraints.

4. Family members should receive educational material about the proper use and also the risks associated with the combined use of overlay air mattresses and any bed rails, including quarter length rails.

5. The Maine Office of the Attorney General should issue a consumer bulletin regarding the risks associated with the combined use of overlay air mattresses and bed rails, including quarter length rails. The bulletin should be distributed to all Maine licensed facilities and medical supply companies. *See APPENDIX ONE*

6. Air mattresses and bed rails sold for home use should bear a warning label, which identifies the risks of the combined use of overlay air mattresses and any bed rails, including quarter length rails.

7. When a facility determines that the use of an emergency notification device such as a motion sensor is appropriate, staff should ensure that the devices have been appropriately applied and are working properly. Attention should be given to the length of the cord.

8. Training should be offered and a model policy developed for medical staff regarding unexpected, unnatural, unexplained or suspicious deaths. Specifically, the training should incorporate the requirements of Title 22 M.R.S.A. §§ 3021 to 3025 (2006) ("The Medical Examiner Act"). *See APPENDIX TWO*

Case Summary # 2004-05

This report focuses on the events surrounding the death of an 86-year-old man who resided in a secured Alzheimer's unit within a multi-level long term care facility. The decedent died as a result of pneumonia on January 13, 2002. However, on January 8, 2002, a few days prior to his death, the resident was found lying on the floor in the dining room following a physical altercation with another resident.

While residing in the Alzheimer's Unit, the decedent received daily assistance from a privately-paid personal care attendant ("PCA"). On January 8, 2002, at 3:00 P.M. the decedent's PCA left him for the day and documented in her notes that the decedent was clean, dry, and in good health. On January 8, 2002, at approximately 5:30 PM, the decedent was involved in a physical altercation with another resident. A facility caregiver heard a verbal confrontation between the two residents and then observed the decedent lying on the floor. The existing documentation is unclear and contradictory as to which patient was the aggressor, but, as part of the altercation, the facility caregiver saw a hand fly in the air. The immediate result of the physical altercation was that the decedent fell to the floor and was unable to get up. The decedent told the facility caregiver, "*I'm not ok*."

There was only one caregiver working in the unit when the decedent was injured because the unit manager had unexpectedly left the unit earlier that afternoon and no other staff was called in to take the unit manager's place. As a result, one caregiver was responsible for the care and supervision of fourteen Alzheimer patients, including dispensing medications and delivering food. The caregiver that found the decedent injured on the floor was not a licensed nurse and had to call to the other part of the facility for a licensed nurse to come to evaluate the decedent. In fact, the caregiver had to make three or four calls to the other part of the facility before a nurse finally arrived.

The facility did not meet its minimum staffing requirements for this Unit and made no documented effort to correct the problem. The responding nurse called the decedent's doctor and left a message. X-Ray service was not available that night. The decedent's doctor prescribed a pain medication.

The next morning when the privately-paid PCA arrived, she was very concerned for the decedent. Specifically, she noted that the decedent was soaked in urine, had a new bandage on his right middle finger and his left shoulder was swollen, bruised and painful. The PCA asked about an X-Ray and was told one would be taken that day. When the X-ray was taken, the decedent was found to have a broken arm in two places. Prior to the January 8th incident, the decedent was able to walk and feed himself. After the incident, the decedent's condition declined rapidly and he became reliant on the facility for total care. On January 11, 2002, the patient was transferred to the nursing home side of the facility for pain management and rehabilitation. On January 12, 2002, he was diagnosed with aspiration pneumonia and transferred to the hospital. On January 13, 2002, the patient died.

The medical record reflected that after the altercation, the decedent suffered an acute decomposition in mental status because of the pain medications administered for his broken arm. A complaint report completed by the Maine Division of Licensing and Certification stated that "there was no link between the incident and the patient's cause of death." However, it was noted as part of the review that this finding was outside the scope of the authority and expertise of the licensing surveyor to make as seen by the contrasting report completed by the Maine Office of the Chief Medical Examiner that specifically found that the injury caused by the altercation contributed to his death. A review of the facility records indicated that at no point was this incident reported to Adult Protective Services as is required by the mandatory reporting requirements of Maine law.

Recommendations for Case # 2004-05

1. Training for facility staff on the proper procedures for dealing with resident falls and injuries, including, but not limited to, training in basic emergency care, how to assess for injury, patient not to be moved, and when to call an ambulance to have the person taken to the hospital for evaluation and x-rays.

2. Training for staff on the importance of and process for keeping patients safe from other patients.

3. Training for staff on mandatory reporting obligations to Adult Protective Services and responsibility for proper documentation of resident-to-resident altercations, including progress notes, incident reports, physician notes, etc.

4. Training for staff on responsibilities for reporting to the Office of the Chief Medical Examiner.

Case Summary # 2004-06

This report focuses on the events surrounding the death of an elderly man due to ischemia of the bowel. The decedent also had bowel perforations which occur when the bowel wall gets weakened and causes an infection. The decedent was in very poor health when he was brought to the hospital, he had acute respiratory failure. The cause of death was not clinically determined because an autopsy was not performed. Because of his poor lung capacity, it is clear the decedent had no circulation to his bowels due to a blockage. The decedent was in a hospital setting not a nursing home or geriatric facility where patient's bowels are monitored closely. The hospital focused primarily on the decedent's lung problems. The hospital was cited for failure to monitor the patient's bowels. The decedent was also restrained, which contributed to the bowel problems. The decedent did not have an advocate, family or other support system.

Recommendations for Case # 2004-06

1. While geriatric facilities pay special attention to patients' bowels with the use of a check list because bowel problems are so common among elderly patients, hospitals don't always take the patients' bowels into consideration, especially when the patient has been admitted for another chronic illness. The recommendation is to develop a system to keep track of a patient's bowel processes with a bowel check list or a bowel protocol, in order to pay attention to things like drugs the patient may be taking that may slow down bowel production and to check frequently for dehydration, etc., especially in elderly patients and patients who cannot communicate.

2. Acute care facility policies should be changed to help facilitate the availability of familiar faces for cognitive/behavior challenged people, so that they would have someone who is able to communicate one on one with them. Even someone from the previous nursing home the patient was in could go to the hospital and sit with the patient and communicate; someone the patient liked and is familiar with. Facilities

should recognize the challenges of dealing with these types of patients with mental illness and the need for the patient to see a familiar face or someone they are comfortable with.

2005 Case Summaries

Case Summary # 2005-01

This report focuses on the death of a 92 year old woman who was alleged by her estranged daughter to be the victim of neglect and financial exploitation at the hands of her non-related caregiver. Based on the information available at the time the case was reviewed, the Maine Elder Death Analysis Review Team made several findings, but no recommendations.

The decedent, a woman, was admitted to a hospital four days prior to her death after complaining of chest pains. The decedent's family members lived out of state and she was accompanied to the hospital by an unrelated caregiver. On day two of her hospital admission, the decedent requested to return home with the unrelated caregiver. The decedent was released to the caregiver, possibly against medical advice and died two days later. The decedent was 92 years old and had suffered two strokes in the past. An out-of-state estranged family member requested an autopsy, which revealed nothing to indicate the death was the result of physical abuse or neglect.

Prior to her death, the decedent nominated her non-related caregiver as power of attorney. The decedent also changed her Will making her non-related caregiver, as opposed to the estranged daughter, the sole beneficiary. The decedent owned at least three dwellings on the same piece of waterfront property, one of which was a two unit apartment house. The decedent occupied the first floor apartment and rented the other. The decedent's unrelated caretaker lived in the second home, which was located adjacent to the two unit rental apartment house. The caretaker's family lived in the third home, which was also on the property. Prior to the decedent's death, allegations

were made that the caregiver was isolating and neglecting the decedent and financially exploiting her. The Bureau of Elder and Adult Services investigated the matter twice. In both cases, the decedent was found to have the ability to make informed decisions. In both cases, neither neglect nor financial exploitation was substantiated.

Based on the information available to them at the time, the findings made by the Bureau of Elder and Adult Services and the Maine Office of the Chief Medical Examiner were appropriate. Most of the records provided in this review were obtained indirectly from an estranged family member of the decedent. The records appear to be incomplete and left to question among other things, the final outcome of a civil suit filed by the family member against the alleged perpetrator.

Recommendations for Case # 2005-01

The Maine Elder Death Analysis Review Team made findings, but no recommendations for this case review.

Case Summary # 2005-02

This report focuses on the events surrounding the death of a 57-year old man who was a Ward of the State with a long-standing history of schizoaffective disorder, mental retardation and gastroesphageal reflux disease. The decedent's caseworker alleged possible inappropriate use of restraints and inadequate nursing care at a medical facility related to the decedent's bowel status.

Prior to his death, the decedent was unable to make informed decisions or handle finances. According to the DHHS, BEAS assessment, "the decedent has significant problems with his mental status and functioning. This impairs his ability to make informed decisions. He has very little ability to limit himself from compulsive behaviors or understand the consequences on his health of such activities. He does not have a lot of insight into his need for care and supervision."

On February 5, 2004, the decedent was admitted to the hospital with fatigue and chronic obstructive pulmonary disease exacerbation. The medical record reflects that the decedent complained of his stomach hurting and respiratory issues. During the decedent's stay at the hospital, he did not have an advocate to act in his best interest.

The medical records contained physician orders for the use of restraints to keep the patient from removing the oxygen supply he needed as part of his treatment. The medical record reflected that he repeatedly tried to remove the oxygen, get out of bed and was flailing about in bed. DHHS Licensing and Certification found the use of restraints medically necessary.

The medical record reflected that from February 5, 2004 through February 19, 2004, (fourteen days) there was no documentation of a bowel movement. The record reflected that a patient should not go more than five (5) days without a bowel movement before placing the patient on a bowel protocol. At some point during the decedent's hospitalization somewhere around February 19 or 20, the patient was noted

to be in respiratory failure requiring mechanical ventilation due to sepsis. A CT scan revealed ischemic bowel for which he was taken to the operating room on February 20 for exploratory laparoscopy. DHHS Licensing and Certification found "inadequate assessment and reporting to physicians of bowel status by nursing staff resulting in the patient undergoing surgical intervention." Nurse interviews revealed patients behavior from mental illness a contributing factor in inadequate nursing assessments. On February 23, 2004, the decedent was transferred to a medical facility for hypotension, massive edema and failure to respond to medical therapy. The decedent expired on March 5, 2004, as all life support was removed.

Recommendations for Case # 2005-02

1. Hospital staff needs to be trained on unique challenges of ensuring adequate medical care for patients suffering from mental illness.

2. Patients suffering from mental illness need access to an advocate to monitor their treatment to ensure adequate medical care.

Case Summary # 2005-03

This report focuses on the death of a 73-year-old male who was removed from his home and placed in emergency temporary guardianship, following allegations that the decedent's caregiver financially exploited him. The caregiver, who was also the decedent's partner, contested the courts finding and eventually filed several complaints with the Division of Licensing and Certification regarding the decedent's subsequent care, which she believed contributed to his death. This review focused not on the alleged financial exploitation by the caregiver, but on the allegations of abuse and lack of care which according to the caregiver, may have contributed to his death.

Based on the information available at the time the case was reviewed, the Maine Elder Death Analysis Review Team made six findings, but no recommendations.

The decedent, a 73-year-old male, resided with his caregiver who was also his partner of seven years. According to records, the decedent may have suffered from Alzheimer's disease and was incompetent. He wandered frequently and could be violent.

In August 2002, the decedent's daughter filed a complaint with Adult Protective Services alleging that her father's partner was financially exploiting him and unable to provide appropriate care. Later that month, the daughter was appointed temporary guardian. The decedent's partner disputed the grounds upon which the order was issued and requested a hearing. The decedent died before a hearing could occur. The temporary guardian did not allow the caregiver to participate in any of the healthcare decision making for the decedent. The decedent's partner asked her Legislator to submit bill to alter how a plaintiff obtains emergency temporary guardianship. A public hearing has occurred; however, at the time of review no workshop had been scheduled.

Following the issuance of the temporary guardianship order, the decedent was admitted to a hospital. The decedent's partner filed a complaint with the Division of

Licensing and Certification alleging several violations of the decedent's rights, including overmedicating with Haldol, verbal abuse by staff and a lack of assessment and treatment pertaining to his medical condition. An investigation was performed by the Department; none of the allegations were substantiated.

Approximately two weeks following his admission to the hospital, the decedent was transferred to a nursing facility where the use of Haldol was continued. According to records, the decedent's condition deteriorated with speech and mobility skills declining. The decedent's partner filed a second complaint with the Division of Licensing and Certification alleging that the facility was overmedicating the decedent with Haldol and had allowed him to fall to the floor repeatedly. Additionally, the decedent's partner alleged that the wheelchair assigned to the decedent by the facility didn't fit him properly, resulting in him being poorly positioned. An investigation was performed by the Department; none of the allegations were substantiated.

Based on the records available, it seems clear that despite having yet to be diagnosed as having Alzheimer's disease, the decedent's physical condition was declining prior to his admission to the hospital. He was unable to care for himself and in fact was at risk for injury resulting from his existing, undiagnosed medical condition. The decedent was unable to verbally communicate at the time he was admitted to either facility. Based on the records available and the testimony of those who had knowledge of the persons involved in this matter, it cannot be determined whether or not the decedent was financially exploited by his caregiver.

Recommendations for Case # 2005-03

Based on the information available at the time the case was reviewed, the Maine Elder Death Analysis Review Team made six findings, but no recommendations.

Case Summary # 2005-04

This report focuses on the events surrounding the death of a 53 year-old woman who committed suicide shortly after the body of her friend/companion was pulled from a nearby lake. It was determined that the decedent committed suicide by a drug overdose. The decedent lived alone and suffered from chronic pain and mental illness including anxiety disorder and was taking numerous medications. Adult Protective Services received a referral on the decedent from the Coastal Community Action Program ("CCAP"). CCAP was concerned about her ability to care for herself, her home and finances. Immediately prior to her death, the decedent's health was declining, she was confused, in a lot of pain, her house was dirty, she was very depressed and in financial crisis. Her ability to make informed consent decisions was called into question. The decedent would place herself in danger by taking too many medications or reportedly having her medication stolen by men she met through personal ads. The decedent didn't have any family or independent support system to help her with day-to-day decisions and activities. Referrals made to a homemaker agency for additional in-home support were not successful because the agency could not find staff to place in the home. The agency noted staff shortages in the area.

In order to assess her mental capacity, the decedent's caseworker wanted her to undergo a thorough neuropsychological evaluation. The decedent refused a voluntary evaluation, so in order to secure a Court ordered evaluation a petition for appointment of public guardian and conservator was filed with the Probate Court. The Court did order a neuropsychological evaluation. The recommendation of the psychologist who performed the neuropsychological evaluation was for a conservator to be appointed to assist the decedent with her finances. The goal was to stabilize the decedent's financial situation, reduce her stress level and that her other issues of anxiety and questionable decision-making could be dealt with through case management and psychotherapy interventions.

When the decedent refused to undergo a voluntary psychological evaluation to determine capacity, she withdrew her authorization for the Department to secure her medical records. The decedent felt extreme anxiety with regard to a Court ordered psychological evaluation. She felt her caseworker from APS was "terrorizing" her. She felt overwhelmed and was feeling severe anxiety and stated words to the effect that she will kill herself, if she becomes a ward of the state.

Case Recommendations for # 2005-04

1. Increase training opportunities for community support workers and other community professionals to enable them to recognize signs of abuse, neglect, financial exploitation, and health issues.

2. Explore options to the Probate Court process for court ordered psychological evaluation process that requires the completion of a lengthy and involved petition package. Service of the petition package to the alleged incapacitated person might cause stress and anxiety.

3. Make available to Adult Protective Services, consultant psychiatrists and/or psychologists so as to provide clinical insight into mental health issues involved in adult protective cases.

4. Explore options to expanding the availability of community health services in underserved areas of the State. Review the current impediments to providing community health staff in undeserved areas, such as wages, retention and caseload.

Case Summary # 2005-05

This report focuses on the events surrounding the death of an elderly husband and wife. The 86-year-old husband and the 98-year-old wife were found deceased at their residence after the police department received a call from the husband stating his wife had passed away and would like an officer to respond. Upon arrival, emergency personnel concluded the caller (the husband) was also deceased. The husband and wife had both died due to gunshot wounds to the head. Emergency personnel concluded the scene as a homicide/suicide.

The decedents were a very independent couple. The decedents were financially secure. The decedents kept to themselves in the community and were self-sufficient. The decedents were quite reclusive according to neighbors and had no real close friends. The decedents did not have any children and the only living relative was a nephew who lived some distance away. There was no reported history of domestic violence between the decedents. At the scene, the investigator found a suicide note written by the husband. The husband stated in the note that he had cancer and could not leave his 98 year old wife of 65 years all alone. Subsequent medical tests confirmed that the husband did not have cancer. Also included with the suicide note in a plastic bag were bankbooks, a checkbook, safe-deposit box keys, house keys and car keys. There was also a note upstairs in the house notifying the beneficiary of the house that the roof leaks. Medical records were not requested for either the husband or the wife. Medical records are routinely not requested by law enforcement under current protocols for similar cases.

Case Recommendations for #2005-05

1. Increase education and outreach to the public to improve awareness of elder issues and how to provide assistance if necessary and to alert people how to watch out for their elderly friends and neighbors and recognize signs of depression, anxiety or other health issues. Department of Motor Vehicles (DMV) may be helpful in accomplishing such outreach.

2. Hair dressers, barbers, hygienists, store clerks, waitresses, financial institution personnel and other professionals who see elderly people on a regular basis should be educated on the services that are available for elderly people who need help and what they can do to help especially when there is no "next generation" to help elderly parents and observe any out of the ordinary behavior. The Area Agencies on Aging may be in the best position to perform this outreach effort.

3. Increase education and outreach efforts for seniors so that they can become more aware of services and programs available to them (i.e. fraternal organizations, service centers, veteran programs, civic groups).

4. Physicians should add to their patient questionnaires and screening tools questions like: "do you have any firearms in your home", since most murder/suicides are committed with the use of guns. Medical professionals may want to inquire about firearms in situations where they are concerned about the patient's failing health or mental health or when the patient is experiencing increased demands for caring for another person. A potential screening may also ask seniors if there is any "next generation" involvement.

5. Review Maine's "Death Investigation Protocol" to ensure that the protocol includes the suspicious deaths of elders or dependent adults.

6. Consider developing an elder/dependent adult "checklist" similar to the checklist utilized by law enforcement in child deaths. This may also help in data collection and analysis for elders and dependent adults in Maine.

7. Review whether Adult Protective Services should receive notification of suspicious elder and dependent adult deaths similar to Child Protective notification in child deaths.

8. This case highlighted for the Team the issue of suicide among the elderly in Maine. In fact, from 1999-2003, 13% of Maine suicide victims were under 25 years of age; 68% were ages 25 to 64; and 19% were age 65 and older. Further, nationally, the highest suicide rate of any age group occurs among persons aged 65 years and older. At this time, no program exists in Maine to provide outreach and education to prevent suicide among Maine's elderly. A program does exist for children, titled the Maine Youth Suicide Prevention Program, which incorporates many of the goals of the Federal National Strategy for Suicide Prevention report. At this time, the Team recommends that our Chair Ricker Hamilton contact the Maine Youth Suicide Prevention Program to find out what resources or entities might be best suited to provide an Elder Suicide Prevention resource in Maine.

9. After reviewing medical records from this case, a potential recommendation discussed how to educate healthcare professionals on the potential for seniors to commit suicide or homicide-suicide.

Case Summary #2005-06

This case focuses on the death of a 30-year-old American Indian woman who was found dead in her apartment by her 15-year-old stepbrother on January 28, 2004. The decedent was mentally retarded, was born with fetal alcohol syndrome, had experienced a brain injury at a young age, and suffered from cerebral palsy and seizures. The decedent's stepbrother reportedly told police that he found the decedent on the dining room floor with her pants down around her ankles lying in a pool of blood. After finding the decedent, the stepbrother went and got the decedent's adoptive father. The adoptive father then placed the decedent in the shower in an attempt to revive her as he had done in the past when the decedent had a seizure, but was unsuccessful in reviving her and the police were called. Prior to police arrival, the decedent's father washed her, dressed her in clean clothes and placed her on the hallway floor. There was no evidence of a struggle or trauma other than the decedent having multiple abrasions and contusions. The stepbrother and father explained these injuries as a result of seizures and self destructive tendencies.

The exact cause of death is unknown. Autopsy findings revealed that the decedent suffered from dehydration, starvation, severe pica – as she had paper, foil and other objects in her colon and also had acute pancreatitis. Also during the autopsy, one sperm was located in the decedent's mouth. Blood test kits were obtained from the father, stepbrother and the family friend who all had access to the apartment. However, one sperm was not enough of a sample to make an accurate comparison. The decedent's father indicated that the semen could have come from a tissue the decedent ingested, as both the stepbrother and adoptive father admitted to masturbating in the apartment and cleaning up with a tissue. He thought the decedent could have taken the tissue out of the trash and eaten it, as she had a history of ingesting non-food items.

The decedent had been adopted in North Dakota at age 7. The decedent's adoptive father and his first wife got divorced when the decedent was 10 years old, with the adoptive mother moving back to North Dakota and the decedent staying with the

adoptive father, who was her overall caretaker. The adoptive father's current wife had very little contact with the decedent, as they did not get along well with each other.

Prior to living in the apartment, the decedent lived with her adoptive father, stepmother and three other stepsiblings. The decedent's father obtained the apartment originally, due to a domestic situation with his current wife about a year ago and had the decedent move in with him. When the domestic situation improved with his current wife, the adoptive father moved back home and kept the apartment for the decedent. The decedent's family resided a few hundred feet from the decedent's apartment complex. She lived there alone, according to the adoptive father. Reportedly, her 15-year-old stepbrother, a family friend or himself checked on her daily. The stepbrother was reportedly looking in on her everyday after school. The stepbrother and father did all of the cooking as the decedent was not capable. According to the decedent's father they always left finger foods around for her to eat, like popcorn or cereal. On occasion, the stepbrother or adoptive father would stay over night in the apartment.

The decedent received SSI and reportedly her adoptive father paid for her apartment with this money. The apartment only had one bedroom upstairs that the decedent reportedly did not use. According to the stepbrother and father the decedent preferred to sleep in the bathtub or on the floor. They also stated she was not very good at climbing stairs and rarely went up to the bedroom.

The decedent's father said she never left the apartment and did not have friends or visitors – other than him, his son, other family members or a family friend. In checking with neighbors of the decedent, none of them were even aware that she lived in the apartment. The decedent's apartment was locked at all times and she was unable to unlock the door if she did need to get out.

The decedent did not have a regular doctor or dentist and was not taking any medication. According to the decedent's father, she would refuse and fight going to the doctor, so he stopped bringing her. He also said the decedent hadn't been to a dentist

in about twenty years, because he was unable to find a dentist that took MaineCare. The decedent's last contact with a doctor was in 1995 (ten years ago), when she was 21 years old. The decedent had wandered away from her house and was found by police and taken to the emergency room to be evaluated, due to concerns of a potential abusive home situation, because she had told police that her "other mother" had slapped her. The hospital contacted the Mental Retardation Advocate (MR Advocate) regarding their concerns of abuse. The MR Advocate spoke with hospital staff by telephone and told them they could release the decedent to her father. The decedent was not seen or interviewed by the MR Advocate. The decedent went to school until age 16, when she was taken out because the school said she was a disruption. This was her last indication of services with DHS. The decedent's father said there was no help available from the State due to budget problems. He said if he wanted help from the State, he would have to make the decedent a Ward of the State. He said there were day programs in a nearby community, but there was no transportation available. The decedent's adoptive father stated that he reached out for services several times from the State and didn't receive any. There were no records to prove or disprove this statement.

Recommendations for Case #2005-06

1. The decedent was eligible for all of MaineCare benefits and services. A system should be set in place to alert personnel at MaineCare when a client hasn't received a service for 36 months. If a client hasn't received a service or had any contact with MaineCare in 36 months, a well-being check of the client should be done. MaineCare should employ Forensic Nurse Examiners to check on such clients. The Forensic Nurse Examiners are able to examine and evaluate the client and to testify in Court if necessary.

2. A review of current protocols and procedures should be conducted for Bureau of Mental Retardation.

3. The Director of MR Adult Protective Services will be invited to the next MEDART review to outline current policies, procedures and protocols for responding to MR APS referrals.

APPENDIX ONE

THE USE OF AIR MATTRESSES AND BEDRAILS CAN CAUSE DEATHS OR SERIOUS INJURY TO ELDERLY AND VULNERABLE MAINE CITIZENS

The Maine Elder Death Analysis Review Team ("MEDART") and the Maine Office of the Attorney General issue this Consumer Safety Alert to warn Maine citizens about the potential danger to elderly or vulnerable individuals from combining the use of air mattresses and bedrails. Individuals susceptible to decubitis ulcers or pressure sores are frequently placed on an air mattress on top of a regular mattress. Unfortunately during the last two annual reporting periods, MEDART has reviewed cases involving deaths attributed to asphyxia caused by compression of the neck after an individual slipped off an air mattress and became entrapped in a bed rail.

According to the U.S. Food and Drug Administration, there are about 2.5 million hospital and nursing home beds in use in the United States in facilities and homes. Between 1985 and 2005, 691 incidents of patients caught, trapped, entangled, or strangled in beds with rails were reported. Of these reports, 413 people died, 120 had a nonfatal injury, and 158 were not injured because staff intervened. Most patients were frail, elderly or confused.

What you need to know:

1. You should have a heightened level of concern when using an air mattress in conjunction with any bedrail, including quarter length rails.

2. You should continually check and monitor the bed rails, mattress height / fit and bed choice to ensure patient safety. You should be watchful of any product failure or malfunction (such as loss of air or compressibility due to weight) and report any concerns or problems to the facility where your family member resides or to the manufacturer if you are using the product at home.

3. Your family member should receive a proper individual patient safety assessment and ongoing patient monitoring to determine the benefits and/or risks of using bed rails and other safety restraints from either facility or home care professionals.

For additional information check out the following website and reports.

A. On August 21, 1995, the Food and Drug Administration (FDA) sent an "Alert" to hospitals and long-term care facilities which warned them of the dangers that bed rails pose.

See http://www.fda.gov/cdrh/beds/index.html

B. On July 13, 2001, the Veterans Administration issued a Safety Alert concerning patient entrapment because of bedrails and air mattresses.

See http://www.va.gov/NCPS/alerts/BedEntrap.doc

C. On March 9, 2006, the Food and Drug Administration (FDA) issued FDA Issued Guidance on Hospital Bed Design to Reduce Patient Entrapment.

See http://www.fda.gov/bbs/topics/NEWS/2006/NEW01331.html

D. A Bed Safety Entrapment Kit is available for purchase at:

NST Sales & Customer Service Office:
5154 Enterprise Blvd.
Toledo, Ohio 43612
(800) 678-7072

APPENDIX TWO

Deaths in Nursing Homes and other Long Term Care Facilities

Model Policy for Medical Examiner Cases

I. While most cases in a chronic care facility are natural expected deaths; occasionally, due to unexpected, suspicious or traumatic circumstances, cases will require certification by the Office of Chief Medical Examiner.

II. If a caregiver or facility has determined that a patient is deceased and that no further resuscitation will be performed, the facility must evaluate whether the death is reportable to the Office of Chief Medical Examiner.

III. The following types of cases must be reported to the Office of Chief Medical Examiner as required by 22 M.R.S.A. § 3025.

- Any suspected HOMICIDE
- Any suspected SUICIDE
- Any death involving **any** ACCIDENT or INJURY that will appear on the death certificate (including hip fractures, unless they are specifically designated as pathologic or non-traumatic; or remote injuries, such has cervical fractures that have contributed to disability and death)
- Any death of a CHILD
- Any death in CUSTODY
- Deaths of SUSPECTED GROSS NEGLIGENCE during a Medical Procedure
- SUDDEN DEATH from an UNKNOWN cause
- UNIDENTIFIED persons
- OCCUPATIONAL Deaths (Work related)
- Unnatural Deaths in a Mental, Residential Care or DHS Facility
- Any death that might ENDANGER or THREATEN the Public Health

IV. When a case has been reported to the OCME, the facility is responsible to maintain the patient and the immediate environment as it was found until the OCME either releases jurisdiction or gives permission for the patient to be moved as per 22 M.R.S.A. § 3027. If the circumstances require further investigation (i.e. possible suicide, homicide or unusual accident), the facility will be required to await the arrival of the investigating police agency and/or the assigned medical examiner. However, in most cases, the OCME will be able to allow the facility to remove the body to the funeral home without delay.

V. The supervisor should be prepared to provide all records related to the illness and/or death as requested by the OCME as per 22 M.R.S.A. § 3022.