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MAINE ELDER DEATH ANALYSIS REVIEW TEAM



2008 Annual Report

Maine Elder Death Analysis Review Team
Maine Office of the Attorney General
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(*) To be mailed case records to be reviewed by the Team

REPORT OF THE CHAIR

In 2003, the Maine Elder Death Analysis Review Team (MEDART) was established by the Maine Legislature under the auspices of the Maine Office of the Attorney General. 5 M.R.S.A. § 200-H. MEDART is charged with examining deaths and cases of serious bodily injury associated with suspected abuse or neglect of elderly or vulnerable adults. MEDART meets monthly to review selected cases. MEDART's membership includes representation from state, local, and county law enforcement, prosecutors, victim services, licensing and regulatory services, medical examiner services, adult protective services, long-term care ombudsman, mental health, emergency medical services, physicians, and healthcare crimes enforcement. The purpose of the review 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 chosen early on as one of four "elder fatality review teams" in the United States to serve as a pilot program for a Department of Justice funded initiative managed by the Commission on Law and Aging of the American Bar Association. The goal of the pilot program was to expand the fatality review team concept, and to develop and disseminate a replication and best practices guide.

In August 2008, the Maine Elder Death Analysis Review Team was recognized at the National Adult Protective Services Association annual conference. The Team's annual reports, procedures, recommendations, findings, enabling legislation, membership, and case reviews were discussed during a session that highlighted national promising practices and programs. Several communities across the country have contacted the Maine Team as they begin to develop new Elder Death Analysis Review Teams.

In July 2008, the percentage of Maine's population over age 60 rose to 21.2% (279,707). Maine was third in the United States, with Florida (22.9%) being first and West Virginia (21.7%) being second. Studies indicate that approximately 5% of us over age 60 are victims of elder abuse, approximately 14,000 in 2007. The need for MEDART to continue its systemic review has never been greater and our challenge to better serve older victims never so important.

Margaret Mead said, "Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has." Over the past five years, MEDART members have strived to make a difference in the lives of older victims by making findings of fact and recommendations regarding the cases reviewed.

MEDART is made possible through the support of the Office of the Attorney General and because of our outstanding Team members who are dedicated to helping older victims. Thank you.

Ricker Hamilton, Chair

MESSAGE FROM ATTORNEY GENERAL JANET MILLS

Since its inception in 2003, the Maine Elder Death Analysis Review Team, initiated and led by then-Attorney General G. Steven Rowe, has undertaken a thorough review of a number of tragic incidents involving elderly citizens. The insightful analyses and recommendations of the Team have resulted in legislative and operational changes designed to reduce preventable deaths among this vulnerable population.

Maine is a “graying” state. The recent growth in our retirement population, in conjunction with the current recession, highlights the added responsibilities of families and communities, the greater statistical probability of preventable deaths and the importance of prevention and safety in residential and medical settings. It is my hope that the availability of MEDART will encourage professionals who deal with seniors to raise questions when appropriate, to speak up on behalf of elderly citizens, and to make use of this important vehicle to provide a sensitive and expert analysis of deaths occurring under questionable circumstances.

The effectiveness of the Team is driven by the dedication and work of so many professionals who contribute both their insights and a great deal of their time. They have my sincerest thanks.

The goal of MEDART is to make our state safe for elderly citizens to live their final years here in comfort and peace. The work continues.

Janet Mills
Attorney General

2008-01 CASE SUMMARY:

This case focuses on the events surrounding the March 30, 2007, homicide of a 76-year-old woman who was shot to death by her 42-year-old son in the driveway of their home. The decedent's son (*hereinafter referred to as "the son"*) lived at home with his mother and was diagnosed with schizophrenia. He was disabled and unable to sustain an independent living environment.

The decedent was predeceased by her husband who died in 2005 at the family residence due to choking. She was also predeceased by her eldest son who died in 2006 of a suspected accidental drug overdose. The decedent and her husband had intended that the bulk of their estate would go to their grandson, the eldest son's child. The decedent had been very generous with her sons, continuing to provide for them into adulthood.

The son's medical history revealed that he was involuntarily committed to a psychiatric hospital from July 1992 – September 1992 with a diagnosis of chronic paranoid schizophrenia. The son's mental illness was treated successfully with medication, however, he did not always take his medication as prescribed and reportedly also used alcohol. Purportedly, when the decedent's husband was alive, he was vigilant in making sure that his son took his medications. When not taking his medication, the son was paranoid and verbally hostile with family members. The son had no friends.

The son and the decedent shared the same primary care physician. He was last seen by the physician in January 2007, and the physician said the son seemed appropriate. The physician was not aware of the son having suicidal/homicidal ideations or thoughts. On March 7, 2007, the son visited his psychiatrist, who reported that he appeared stable, did not present signs or symptoms that he was psychotic, and did not indicate any suicidal/homicidal thoughts or ideations.

According to an uncle and a family friend, the son acted agitated and aggressive when not taking his medication. The decedent could not control her son except by placating him. They reported that stress was a trigger for the son to act out aggressively when he was off his medication, and they both expressed concern for the decedent's wellbeing prior to her death.

During the year prior to his 2005 death, the son's father gave a number of firearms to the family friend for safekeeping. This family friend was the decedent's caretaker and also the executor of the father's estate. The decedent had an attorney represent her concerning probate

and estate matters. After his father's death, the son began to demand that the family friend return the firearms. The family friend refused, believing that the son was too unstable to possess firearms. The son routinely discussed with his mother the issue of getting the guns back from the family friend. Finally, the decedent relented and sometime in the year prior to March 30, 2007, she asked the family friend to return the guns to the son. The family friend tried to persuade the decedent otherwise, but returned the firearms out of fear that if he did not, he would lose contact with the decedent.

In early March 2007, there was a confrontation between the family friend and the son. It was clear to the friend that the son was off his medication and was acting out in a very hostile fashion. The son told the family friend to leave and not return. The decedent later told the family friend that after this confrontation, the son armed himself with an AK style assault rifle, and spent a significant time lying in wait for the family friend to return, saying that he would cause him harm.

The decedent was under a doctor's care for osteoporosis that had resulted in a number of broken bones, including her hip, which required hospitalization and rehabilitation. The family friend once questioned the decedent if the broken bones were the result of abuse by the son, but the decedent denied any such physical abuse. The decedent expressed to the friend that the son was verbally abusive, but had never physically abused her.

The decedent could not manage many of her personal or financial needs and received weekly services from a visiting nurses program from an area home health care business. A visiting nurse came to the home to assist the decedent every day. The decedent could not drive and relied upon the son as her means of transportation to doctor's appointments. At times, the son was unreliable in this regard.

The decedent had routine contact with her brother, sister, her grandson's mother, and the family friend. The decedent had no social network or religious group affiliations and had limited contact with her neighbors. A cleaning woman came in once a week to clean the decedent's home.

The decedent's brother, sister and the family friend would on occasion talk to the decedent about considering a group home placement for the son because he would not be self sustaining after her death. The son wanted the decedent to purchase a condo for him, but she did not have the financial resources to do so.

Since 1995, the son had been required by the Maine Bureau of Motor Vehicles to submit a physician-endorsed Driver Medical Evaluation document in order to maintain a valid Maine driver's license. He fulfilled this obligation and presented the required documentation in 1995, 1999 and 2003.

In the weeks prior to March 30, 2007, the Maine Bureau of Motor Vehicles sent the son a notice that his right to operate was due for renewal and that his driver's license could not be renewed on March 30, 2007 (the expiration date) without the required Driver Medical Evaluation. On March 29, 2007, the decedent learned about the notice from the Bureau of Motor Vehicles for the first time. The decedent telephoned motor vehicle officials that day in an attempt to persuade them to allow the son to renew his license. At some point on March 29, 2007, the decedent talked with her brother about the matter and told him that the son was highly agitated, and had been screaming while she attempted to converse with the Bureau of Motor Vehicles.

At approximately 10:30 a.m. on March 30, 2007, events in the residence had apparently reached a threat level and the decedent tried to flee, wearing only her nightgown and slippers. She was shot by the son at close range in the driveway only feet from the dwelling. The son then engaged the police in a lengthy standoff inside the home and fired upon the officers. The son was ultimately shot and killed by a member of the State Police Tactical Team.

FINDINGS OF FACT:

1. The son and the decedent shared the same primary care physician. He was last seen by the physician in January 2007 and the physician said the son seemed appropriate. The physician was not aware of the son having suicidal/homicidal ideations or thoughts. On March 7, 2007, the son visited his psychiatrist who reported that he appeared stable, did not present signs or symptoms that he was psychotic, and did not indicate any suicidal/homicidal thoughts or ideations. However, there was no ongoing medical monitoring of the son by any known provider. There was no record of the son's health care providers having alerted DHHS Adult Protective Services that he lived in the same residence as his elderly mother and that when the son was not taking his medication, he could be aggressive and out of control.

2. The physicians, medical providers and visiting nurses treating the decedent did not appear to have addressed any concerns that might arise because she lived alone with her son who

had been a person judged disabled because of a mental illness and who was known to show signs of violence if untreated. The visiting nurses were in the decedent's home on a daily basis. There was no record of any risk assessment done on the decedent and her living environment by the visiting nurses. According to the decedent's brother, the visiting nurses may not have been aware of any potential threat because when people came to the house, the son would often withdraw to his bedroom. The decedent may not have exhibited any fear or offered any information or concerns about living with her son. The decedent was very protective of her son.

3. No family member or the family friend made a report to law enforcement or DHHS Adult Protective Services on behalf of the decedent regarding the potential jeopardy of the decedent after witnessing the son's behavior and disclosures made by the decedent. The decedent always expressed to the family friend and family members how much she relied on him for transportation and her protectiveness of him. There was a concern that if they made a report to authorities they would lose contact with the decedent.

4. There had been no legal venue in which the son's right to possess a firearm had been revoked or conditioned. He should not have had access to firearms due to his schizophrenia diagnosis. The 1992 involuntary committal should have impacted his ability to purchase or possess a firearm. However, the firearms that he possessed belonged to or were purchased by his father. Even though his father had given them to the family friend for safekeeping, the family friend returned them to the son at the request of the decedent.

5. Both the decedent and the son were recipients of government managed programs. There appears to have been no component within those programs that included a risk or threat assessment.

RECOMMENDATIONS:

1. A risk assessment for individuals with serious mental health issues who have the potential to cause harm to themselves or others when not taking their medication properly may have revealed the need for safeguards or other action. The MEDART team recommends that physicians and other health care providers who treat such individuals have a standard risk assessment protocol with questions including: What are the living conditions? Who resides in the home? Are there any guns or other weapons in the home? Is there a medication administration monitoring system in place for the individual?

2. In this case, the visiting nurses may not have been aware of the jeopardy in which the decedent was potentially placed, given the fact that the son would withdraw to his room when people came to the residence. Visiting nurses and home health aides are in a unique position to routinely assess risks of the individual for whom they are caring or providing personal services. Recognizing this unique position, the MEDART team recommends that home health care givers also have a risk assessment protocol to address environmental risks to those to whom they provide care.

3. Under state and federal law, it is unlawful for a person who has been committed involuntarily for psychiatric care or treatment to possess a firearm [although there is a process under certain circumstances for an application for relief from this prohibition]. Notwithstanding this prohibition, the son who had been involuntarily committed in the past obtained firearms from the family friend at the request of the decedent. The MEDART team recommends that safety assessments for patients with mental illness or for those living with or caring for them include inquiry at appropriate opportunities regarding access to weapons and that those performing such assessments be aware of applicable prohibitions so that appropriate action may be taken if necessary.¹

2008-02 CASE SUMMARY:

This case focuses on the events surrounding a 90-year-old man with dementia who was a resident at a residential care facility and a victim of sexual assault by an employee at the facility. On August 22, 2006, the local police department received a telephone report from the facility administrator of an alleged sexual assault that had occurred five days prior. The incident occurred during the night and early morning hours of Friday, August 18, 2006. The administrator said that she did not realize that she needed to call the police, and thought that

¹ After the review of this case and the submission of this recommendation, the Maine Legislature enacted a statute that mandates that “discharge planning must include inquiries and documentation of those inquiries into access by the patient to firearms and notification to the patient, the patient’s family, and any other caregivers that possession, ownership, or control of a firearm by the person to be discharged is prohibited. . .” P.L. Chapter 451 (2009). See 34-B MRSA §3871, sub-§7.

calling the “licensing people” was enough. She had since been told by a detective from the Attorney General’s Office that she needed to call the police.

During the overnight shift, a Certified Nursing Assistant (CNA) had walked into the male resident’s room and found the resident unclothed in his bathroom with a male CNA. The male CNA had the resident’s penis in one hand and a towel in the other hand and appeared to be masturbating the resident. The Office of the Attorney General Healthcare Crimes Unit (HCU) received a copy of a facility incident report dated August 18, 2006, to DHHS Licensing & Regulatory Services. The referral stated that there was some “inappropriate behavior” between a staff member and a resident. A HCU detective was assigned to the case on August 22, 2006. The detective called the facility administrator to confirm the case facts in the referral, to note any additional information, and to confirm that the facility had called the police. Neither the administrator nor the charge nurse had called police and was advised by the detective to do so immediately.

A local police detective arrived at the facility, was briefed on the situation by the administrator, and met with the family (daughter and granddaughter) of the resident who had been allegedly assaulted. The family expressed frustration in that this had all come to light Friday, August 18, 2006, but not a lot had been done since. The detective gave them information about sexual assault support services in the area and the family members were happy to hear about those services.

The police detective interviewed the male CNA who admitted touching the resident while cleaning him, but denied sexually assaulting him. The detective also interviewed the female CNA who witnessed the incident. She was absolutely firm about what she saw, was not afraid to relate it, and was very upset about what she had seen. The investigation revealed that the resident had related to family members starting almost immediately after his admission that a “burly man” was rough when he was cleaning him, touched his private areas, and was forcing unwanted sexual touching onto him. The family attributed the resident’s statements to his dementia. The family had been informed by the facility that the resident was sometimes “very sexual” as part of his dementia, including at least one report of public masturbation. The family consulted a psychiatrist and the resident was put on an antidepressant also known to decrease libido. After taking the medication, there were no further reports of public sexuality.

As a result of the resident's comments to his family regarding the "burly man," the resident's daughter requested that he not have any male caregivers. She sent this request to the charge nurse on the unit in July 2006. The family thought that its request had been honored. The facility only had one male employee providing direct care, the male CNA, and he was not restricted from providing care to the resident.

The investigation further revealed that the male CNA had commented to a co-worker that he was amazed that a man 90 years old could still get an erection. Co-workers also described the CNA as having a particular interest in the resident and that it was odd that the CNA would shower the resident when he was not scheduled for one. Normally, the workers have trouble completing the shower schedules. The CNA also awakened the resident at least one time in July to shave him in the middle of the night.

The CNA claimed that on the night in question he was in the resident's room to give him a shave because the resident really likes his shaves. He claimed this even though he was not assigned to take care of the resident that night and was assigned to an entirely different area of the facility. The CNA also told police that the reason he would volunteer to take care of the resident on days he was not scheduled or when he was scheduled to be in a different part of the facility was because the resident's "sexuality would come out with the dementia," and a lot of the female employees were uncomfortable working with him. The investigation revealed that no female employees had said this.

The CNA's employment records showed that he had a 1963 misdemeanor conviction for assault, and a 1994 conviction for criminal trespass. This information came from the CNA Registry. The employment application only requested felony convictions. During the interview with the CNA, the detective asked him about the 1963 conviction for assault. Initially he said that he could not remember the circumstances, but then said that he had picked up a young male hitchhiker who had accused him of touching him. He said he pled guilty to spare the young man a trial because the young man was "so effeminate." The 1994 criminal trespass conviction occurred at a rest area that was known for homosexual activity.

The CNA frequently spent the winter months in Florida and he had a number of convictions in that state for misdemeanor lewd and lascivious behavior. When asked about these convictions, he said that he could not remember all of them, but they involved situations in the

restroom where he forgot to put “him” away. There was no evidence that this CNA worked in health care facilities in Florida.

The detective reported that the administrator of the facility was concerned about what this incident would do to the facility’s image.

FINDINGS OF FACT:

1. The facility personnel failed to follow reporting protocols for suspected sexual abuse. They did not call Adult Protective Services and/or the police immediately after learning of the alleged sexual assault. The facility did notify DHHS Office of Licensing and Regulatory Services, albeit 13 hours after the incident. The police did not learn of the crime until five days after the incident. Licensing and Regulatory Services staff did not contact Adult Protective Services. The delay in reporting negatively impacted the ability to collect physical evidence.

2. The daughter of the resident had requested the facility to restrict the resident’s caregivers to female employees because the resident was reporting sexual encounters with a male caretaker that were disturbing to him. This request was not honored.

3. The investigation revealed that the CNA's prior convictions for assault and criminal trespass were sexual in nature. The facility where the CNA worked only had criminal record information from Maine even though he spent his winters in Florida. The employment application only asked for felony convictions.

4. No one from the facility was reported for failing to follow the mandatory reporting requirements for elder abuse, including the CNA, the charge nurse, and the administrator.

NOTE: Facilities in Maine have received in-service training on mandated reporting and elder abuse. A training manual and video explaining the protocols of what to do and who to report to regarding alleged abuse, neglect and exploitation was developed and widely distributed to facilities.

RECOMMENDATIONS:

1. There is confusion among mandated reporters, including employees and facilities, regarding the requirements of reporting suspected abuse or neglect. It is recommended that there be a uniform protocol developed by DHHS for reporting suspected abuse, neglect, or

exploitation for all nursing and health care facilities in Maine that clearly states the proper procedure, including who to call to report abuse, neglect, and exploitation issues.²

2. Family members are often in the best position to assess the needs of a loved one who is a resident in a facility. It is recommended that health care facilities and other providers consider requests of family members and clearly communicate what action, if any, will be taken in response to such requests.

3. MEDART recommends that the hiring process for individuals employed at health care facilities include obtaining information regarding all convictions, not just felony convictions and not just in-state convictions. Mandated reporters who are found not to have met the standards of 22 M.R.S.A § 3477 should be referred to the appropriate Board, Registry, and/or prosecutorial agency.

NOTE: In this case, the male CNA was convicted of Unlawful Sexual Contact and Endangering the Welfare of a Dependent Person. The family of the resident did not want jail time for the CNA based on his age (77 at time of the offense). He was sentenced to 30 months imprisonment with all but three months suspended, and two years probation with several conditions, including no work in the health care field.

2008-03 CASE SUMMARY:

This case focuses on the events surrounding the death of a 93-year-old woman who was recuperating at a nursing home/rehabilitation center after having abdominal surgery. Prior to the surgery, the decedent lived alone, was generally independent, and still occasionally drove her automobile. The decedent's daughter lived nearby and checked on her frequently.

On March 24, 2007, the decedent went to the hospital complaining of abdominal pain and discomfort. The decedent was admitted to the hospital and underwent exploratory abdominal surgery the next day. The operation revealed that the decedent had adhesions and what appeared to be a mildly ischemic bowel section. The surgeon resolved the adhesions. The decedent

² After the review of this case and the submission of this recommendation, DHHS established a protocol for reporting abuse, neglect, and/or exploitation in a licensed facility. The protocol states that Adult Protective Services will be immediately contacted if there is suspicion that an adult has been or is at substantial risk of abuse, neglect, or exploitation.

tolerated the procedure well and was sent to the recovery room in satisfactory condition. During the decedent's hospital stay (March 25 through April 3, 2007), she continued to feel better and improved to the point where she could go to a nursing home for rehabilitation.

The decedent was discharged from the hospital on April 3, 2007, to a 24-hour skilled nursing facility for rehabilitation. Discharge notes from the hospital stated that the decedent was doing well, eating well, and was in no distress. She denied any chest pain, shortness of breath, or belly pain. The decedent stated that she felt better and had no pain in her abdomen.

The decedent was at the nursing home from April 3 - April 9, 2007. The nursing home noted that the decedent had great family support, with one of her children visiting each day. The decedent complained of abdominal discomfort on April 6 and 7, 2007, but refused to take any pain medication. On April 8, 2007, the decedent complained of feeling claustrophobic and anxious, and requested anxiety medicine. On April 9, 2007, the nursing home facility staff noticed blood in the decedent's stool and that she was very pale. The decedent stated that she was having difficulty breathing. She was sent to the hospital emergency room. The decedent had a DNR Order (Do Not Resuscitate).

The decedent arrived at the hospital emergency room with abdominal pain and lower GI bleeding. She was awake, alert, and would open her eyes when spoken to. The decedent's daughter arrived and discussed the decedent's prognosis with the doctor. The doctor explained to the decedent and her daughter that the decedent's prognosis was quite poor, that the chance of her recovering from this illness was very small, even with aggressive medical treatment. The decedent's daughter stated that her mother certainly would not want any surgery nor would she want any heroic measures. The decedent stated that she did not want any blood, she wanted to be made comfortable, and she did not want to prolong the process of her dying. The daughter accepted her mother's wishes and thought that was an appropriate decision. The decedent was given morphine for comfort and expired approximately two hours after admission.

FINDINGS OF FACT:

The care that the decedent received at the hospital and nursing facility seemed appropriate and timely. The decedent's death appears to have been unavoidable and the physician followed the decedent's wishes. The staff and the doctors documented clear and concise communication

with the decedent and the decedent's family. Established procedures and protocols appear to have been followed.

RECOMMENDATIONS:

The Team concluded that no recommendations were necessary for this case.

2008-04 CASE SUMMARY:

This case focuses on the events surrounding the death of a 91-year-old man who was a resident at a nursing and rehabilitation facility and who died shortly after being given a medication for comfort. On February 1, 2008, the decedent was admitted to a local hospital with cellulitis. On February 3, 2008, he aspirated and was placed on a respirator. A few days later, the decedent pulled the tube out. Family members indicated that they did not want the tube to be reinserted. The tube was not reinserted. The decedent also suffered an acute myocardial infarction and was stabilized. After 12 days of hospitalization, he was discharged to the nursing facility on February 13, 2008.

The decedent was admitted to the nursing facility with the following diagnoses: Acute MI, Atrial Fibrillation, Diabetes Mellitus, Hypertension, Coronary Vascular Disease, Arthritis, Pneumonia, Cancer, Renal Failure, and Allergies. On February 13, 2008, the decedent's physician wrote Do Not Resuscitate and Do Not Intubate orders in the medical record. His children stated that the physician did not discuss these orders with them and that their father would want to be full code. According to the physician, the resident had clearly expressed his wish to be a Do Not Resuscitate and Do Not Intubate. On February 16, 2008, the resident received 25 mg Demerol for comfort care. He began having difficulty breathing. He died shortly thereafter. The Office of the Chief Medical Examiner reviewed the case and determined that the decedent had multiple medical conditions that ultimately led to his death.

FINDINGS OF FACT:

1. The decedent was given 25 mg Demerol for comfort care on February 16, 2008. The decedent began having difficulty breathing. He expired shortly thereafter. Some family

members disputed the DNI and DNR orders written by the physician. The physician stated that the decedent clearly expressed that he did not want to be resuscitated.

2. The Office of the Chief Medical Examiner's review of the case revealed that the decedent's death was not attributable to the administration of the medication, but rather resulted from multiple medical conditions.

RECOMMENDATIONS:

The Team made no recommendations regarding this case. After review, the Team found that the decedent's wishes were documented and followed, and that administration of the medication was not the cause of his death.