

Chart Depicting Similarities or Related Characteristics Across all Deaths

Characteristics/Issues/Facts	Non-Fire Related Deaths			Fire Related Deaths	
	CJ - 9/00	VH - 12/04	ST - 2/10	Tilton Fire-2/06	JH - 06/09
<b>Multiple disabilities &amp; challenging issues/behaviors</b>	Mild Intellectual disab., M.H., behav. Issues, balance and ambulation issues, limited communication, incontinent	Mild Intellectual disab., M.H., behav. Issues, balance and ambulation issues, plus signif. medical issues; choking risk, incontinent	Mild Intellectual disab., M.H., behav. Issues, balance and ambulation issues, Limited communication; choking risk	All had developmental disabilities. Level and other impairments not determined	Significant Intellectual disability, limited communication, incontinent
<b>On behavioral medications</b>	multiple	multiple	multiple	Multiple	Not determined
<b>Residential Model</b>	EFC ( & one other client)	EFC (no other client)	EFC (no other client)	EFH (3 clients in total)	Individual's family (no other client)
<b>Overnight Awake staff</b>	<b>No</b>	<b>No</b>	<b>No</b>	<b>No</b>	<b>No</b>
<b>Prior placement no longer able to handle individual</b>	<b>Yes</b> (previously group assisted living)	<b>Yes</b> (previously EFH)	<b>Yes</b> (previously, mostly EFH)	Not determined	Not applicable
<b>Length of time with placement before death</b>	<b>Short</b> -10 days	<b>Short – 6 weeks</b>	<b>Moderate</b> -- 30 months	Not determined	Not applicable
<b>Provision of Training or Procedures for home provider(s) relative to factors that contributed to death</b>	<b>Inadequate/None</b>	<b>Inadequate/None</b>	<b>Inadequate</b>	<b>None/Inadequate</b> (e.g. nothing on fire safety/evaluation)	<b>None</b> (e.g. nothing on fire safety/evaluation)
<b>Poorly trained or equipped home provider/exercise of poor judgment</b>	<b>Yes</b>	<b>Yes</b>	<b>Yes</b>	<b>No specific finding made.</b> (DRC did not conduct an investigation.)	<b>No specific finding made.</b> Investigation looked at gov. or gov. funding entities' responsibility.
<b>Adequate Risk Assessment for Personal Safety Issues</b>	<b>No</b>	<b>No</b>	<b>No</b>	<b>No</b>	<b>Not investigated</b>

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<i>Risk Assessment for fire safety, evacuation or other environment hazards</i>	No	Not determined	No	No	No
<i>Warning signals, recommendations or prior similar incidents pertaining to the individual <u>not</u> heeded or addressed</i>	Yes	Yes	Yes	Not applicable	Not applicable
<i>Precautions or programmatic interventions taken of a preventative nature</i>	None or Inadequate	None; did contrary to what was recommended	None, inadequate, or short-lived e.g. no functional behavioral assessment or professionally recommended actions to deal with eating issues; no awake staff, instead unsuccessfully drugged him so he would sleep at night	None; Home last certified in 1989; in 2006, when fire occurred out of compliance due to critical life safety violations.	None; client on second floor-no self evacuation ability. No precautions put in place to ensure her rapid evacuation.
<i>Consideration of additional supports, other housing models, which would include overnight awake , and/or more highly trained staff</i>	No evidence of such	No, despite explicit medical recommendations that client needed nursing home level of care or other services	No	Not investigated	No

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<b><i>Adequacy of Incident Review Process for prior similar or related incidents which could have triggered prompt remediation and prevention steps</i></b>	<b>None</b> , done despite multiple incidents warranting incident reports, e.g. falling, hitting head, staying on ground or floor, refusing to eat, drink	<b>None done</b> , despite falls, broken bones, hospitalizations, choking incidents	<b>None done</b> , despite at least 2 previous choking incidents, and 3-4 falls per month, one of which resulted in ST wedged between a dresser and bed	Not determined	35 reports related to HJ's personal care and/or care of the home from 6/05-4/09. Little changed until 5/09, a month before JH died
<b><i>AA/Vendor intervention when clear evidence of deterioration or conditions that caused death</i></b>	<b>No</b> , e.g. despite numerous calls over days reporting that CJ was getting sicker, AA did not respond, seek or require medical intervention	<b>No, not adequately or at all</b> , During prior months of deterioration and immediate 24 hrs of rapid decline, and despite calls from home provider of VH's deterioration, medical intervention was not provided and poor instructions were given. AA would not grant request by vendor for increased funding as budget had become insufficient due to VH's deteriorating condition.	<b>No, see above</b>	<b>Not applicable</b> as fire itself unexpected	<b>Not applicable</b> as fire itself unexpected

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<b><i>Cause of Death</i></b>	<b>Dehydration with contributory ...Pneumonia.”</b>	Cardiac arrhythmia due to electrolyte imbalance from <b>dehydration due to refusal of food and water</b>	<b>Choking due to abnormal eating patterns</b>	<b>Smoke inhalation, one of two found in fetal position in bedroom</b>	<b>Smoke inhalation, found in fetal position in bedroom</b>
<b><i>Investigation of Death itself at AA level</i></b>	<b>AA investigation completely inadequate</b>	<b>AA investigation thorough in reporting of facts, but conclusions not completely adequate; and no resolution provided per regulation. Investigation and review of incident led to some corrective actions.</b>	<b>No investigation report done, though AA stated they conducted interviews.</b>	<b>Investigation not done.</b>	<b>Not determined</b>
<b><i>Incident (Sentinel) Reviews or Investigation at DHHS level</i></b>	<b>Reportedly one done, but DHHS refused to provide DRC a copy asserting quality assurance privilege.</b>	<b>Reportedly done, but DHHS refused to provide DRC a copy asserting quality assurance privilege.</b>	<b>Reportedly done, but DHHS refused to provide DRC a copy asserting quality assurance privilege.</b>	<b>Not known, one done by State Fire Marshall.</b>	<b>Not known, one done by State Fire Marshall.</b>