



DISABILITIES RIGHTS CENTER, Inc.

**Investigation of the Death of S.T., a Client of the NH Health
and Human Services and Area Agency System**

Prepared by the Disabilities Rights Center

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The DRC is the designated federal protection and advocacy system for New Hampshire and is a member of the National Disabilities Rights Network.

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I. Introduction

The Disabilities Rights Center, Inc. (“DRC”) is the independent agency designated by the Governor of the State of New Hampshire pursuant to federal statutes to protect the legal rights of people with disabilities. The DRC’s mandate, in accordance with federal statutes, includes the authority to investigate violations of these rights. The federal statutory scheme confers upon the DRC broad powers to seek records, conduct interviews, and gather all necessary information in the course of an investigation and/or review of the death of an individual.

S.T. was a thirty-three (33) year-old man who had been diagnosed with severe mental retardation, psychomotor retardation, post-traumatic stress disorder (PTSD) and a behavior disorder. He died in February 2010 after falling in his provider’s bedroom at approximately five o’clock in the morning. The provider awoke as a result of the noise created by S.T. falling to the floor. The provider told S.T. to get up himself and that she would be back to check on him. She then went into the kitchen to have a cigarette and possibly used the bathroom. Upon her return, she noticed that S.T. was non-responsive. An effort to revive S.T. by a neighbor was unsuccessful.

New Hampshire’s Chief Medical Examiner, Thomas A. Andrew, MD, concluded that S.T. died “as a result of upper airway obstruction by food bolus (brownies) stemming from abnormal eating patterns due to an organic brain disorder of unspecified etiology.” A partially eaten brownie was found next to S.T. and a gallon sized Ziploc bag of brownies was found at the foot of the provider’s bed. There were also brownie crumbs found in the living room and bedroom. S.T. had a tendency to put more food in his mouth than he could safely eat. This had caused at least one prior choking incident.

At the time of his death, S.T. received services through New Hampshire’s area agency system, which was developed to safely integrate individuals with developmental disabilities into New Hampshire communities. The system consists of ten regions in the state. S.T. was provided services by Moore Center Services, Inc. (Region 7). Moore Center contracted with Independent Services Network (ISN) to provide residential and day services to S.T. ISN in turn contracted with and supervised the provider to provide the residential services. She was an enhanced family/foster care provider. As such, the provider, as the primary direct support person in S.T.’s life, had a number of prescribed, caretaking, treatment and other service responsibilities toward S.T.

The DRC determined, upon its initial review, that there was probable cause to investigate the matter in relation to the level of care that was provided to S.T., including, given the circumstances of the death, whether concerns existed as to whether the provider was adequately trained and whether the oversight provided by the area agency and vendor were sufficient to support the provider.

To review the issues involved in S.T.'s death, the DRC obtained information from Moore Center Services, Inc., ISN, the Concord Police Department, and the Office of the Chief Medical Examiner. The DRC interviewed the provider who was S.T.'s provider, Kerry Ryan who was the S.T.'s ISN day program manager, Cindy Bringham who was S.T.'s ISN residential manager, Gus Gustavo Moral who is President of ISN, and James Fischer who was assigned to S.T. as part of ISN's day program.

II. S.T.'s Life and Circumstances Surrounding his Death

A. S.T.'s Life

S.T. had a severe cognitive impairment, psychomotor impairment, posttraumatic stress disorder (PTSD) and Behavior Disorder. S.T. was cognitively equivalent to a child according to those who worked with him on a daily basis. It was also very unusual for people to get more than three words out of S.T. at any one time when communicating with him. He could walk independently but had a very unsteady gait. S.T. would also tend to get loud as he enjoyed the vibrations from being loud. He would also get loud and bite when upset.

He attended and graduated from the Easter Seals' Jolicoeur School in June 1997. S.T. received one-on-one services while he attended Jolicoeur because of behavioral issues. At Jolicoeur, he also began living in a 24-7 staffed group home that was operated by Moore Center Services, Inc. ("Moore Center Services"). S.T. moved into the group home because his mother and stepfather were unable to handle his needs. ISN was not S.T.'s provider during this period.

In June 2000, S.T. transitioned into adult foster care. S.T. was placed with an adult foster parent named Bob Snow. After the transition, Moore Center Services noted that he seemed happier, more communicative, more independent, and easier to refocus and redirect. S.T. attended a day program operated by Moore Center Services. S.T. moved several times with Mr. Snow. In June 2005, Mr. Snow purchased a home in Claremont, NH. S.T. and another area agency client moved with Mr. Snow to Claremont.

S.T. had a major medical/behavioral event in May 2006 which highlights the complexity of caring for S.T. with respect to medical and safety issues. The difficulty centers some degree on his limited communication skills. In May 2006, S.T. became agitated at a bowling alley while participating in his day program. He threw his day program staff member to the floor and bit the staff member. S.T. was taken to the Valley Regional Hospital in Claremont and was given Haldol, Ativan, and Valium over a six-hour period. He was then discharged to Mr. Snow. S.T. became agitated again within a couple of days, yelling out for his mother ("mommy") and becoming difficult to redirect. He was again taken to the Valley Regional Hospital, sedated and returned home.

S.T. became agitated the next day and was brought to Catholic Medical Center in Manchester for evaluation. He spent two days at Catholic Medical Center. The Center made

some adjustments to his medications. S.T. was observed pacing and grunting at the Center and the behavior continued after discharge.

S.T. was next taken to the Elliot Hospital ("the Elliot") to be evaluated. The Elliot ran tests and S.T. was placed on some new medications while the ones he was already on were increased in dosage. S.T. continued to be agitated and Elliot's Psychiatry Department recommended that S.T. be placed in the developmentally delayed unit at Hampstead Hospital. S.T. was not placed at Hampstead Hospital. Rather, the Elliot discharged S.T. and suggested that he be taken to Dartmouth-Hitchcock Medical Center ("DHMC").

Within an hour, S.T. was at DHMC. DHMC contacted the Elliot to have S.T. readmitted to the Elliot. The Elliot refused. Hampstead Hospital was also called by DHMC but the calls were not returned. S.T., consequently, began a stay at DHMC for safety and stabilization.

DHMC put S.T. on several medications in an attempt to lessen his pain and agitation, including Zyprexa. He was placed on opiate pain medication. It temporarily lessened the agitation from the pain he was experiencing. The source of the pain was not known at that time. S.T.'s difficulty communicating was likely a major obstacle to understanding the source of the pain. The effect of the medicine only lasted hours and then S.T. was back to being agitated.

DHMC next placed S.T. on longer lasting opiate pain medication. The initial results of the medication were positive. However, the positive initial effects dissipated and negative side effects began occurring. Opiates were, as such, abandoned. Thorazine was next tried without success and was discontinued after one day. S.T. was then placed on Zyprexa and Ativan to assist with sleeping and there was some minor improvement with respect to his agitation at times. But the agitation generally remained.

On May 23, 2006, Jennifer McLaren, MD wrote the following letter in and around the time of the discharge: "[S.T.] is currently suffering from severe behavior agitation. The patient's current diagnosis is agitated depression vs. mixed manic state. [S.T.] has currently been tried on multiple different medications with little benefit. The current recommended treatment, which these patients would greatly benefit from, is a series of electroconvulsive therapy treatments. This is the standard care for agitated depression and mixed manic state that is unresponsive to medication trials. The side effects from this treatment are minimal and the potential benefits greatly outweigh these side effects."

However, akathisia (a syndrome that is characterized by feelings of inner restlessness) was also considered as a possible diagnosis. The medications that S.T. was taking that had akathisia as side effect were discontinued and S.T. was given Seroquel, which does not have akathisia as a side effect. The Seroquel was increased as the agitation began to subside. Depakote was added for mood stabilization. S.T. was pleasant at this point and was enjoying watching television in the DHMC's common area. S.T. was ready for discharge. On or about June 5, 2006, he was discharged to his brother even though he was living with Mr. Snow in a foster care setting during this general period.

Moore Center Services records indicate that it was in contact with the hospitals during this period and made site visits to assist. Denise Gookin of Moore Center Services generally kept in contact with the various hospitals and made several site visits.

As a result of these difficult and complicated medical/behavioral issues, Mr. Snow determined that he was unable to care for S.T. any longer due to the danger that S.T.'s agitated state might pose. Ms. Gookin spoke to S.T.'s brother regarding this fact. S.T.'s brother was also his guardian. The conversation resulted in a decision that S.T.'s brother would take S.T. into his home until a "suitable and safe home could be found for" S.T.

Thus, in June 2006, S.T. was temporarily placed with his brother and guardian in Manchester. He was also placed with ISN's Manchester day program.

A July 2006 note from Moore Center Services' Shared Homes department that addresses the issue of placement indicates that it conducted seventeen interviews. Of those interviews, only six were willing to move forward due to S.T.'s instability. One of these individuals was ruled out by Shared Homes because there would be small children in the home. S.T.'s brother did not think that any of the remaining five were suitable. At this point, the process slowed.

The record is very detailed on the many activities that S.T. was able to participate in during this general period while he was living with his brother and participating in the ISN day program. His activities ranged from Frisbee to basketball to walking the Bedford Mall while enjoying holiday decorations. S.T. also became a regular at the Audubon Center in Auburn, NH. He was fascinated by birds and lit up anytime birds were mentioned. He also made a bird themed collage in art class and took pictures of birds. He accomplished this with the assistance of ISN staff guiding his hands with their hands. Two of his favorite activities were swimming and swinging. He also began volunteering at an animal shelter.

That said, he had behavioral issues while living with his brother and participating in the ISN day program. He would have inappropriate outbursts involving yelling, laughing, becoming loud, and being aggressive. His aggression would include throwing things off a table, tossing over tables and trying to bite his hand.

In early 2007, ISN located a potential new residential provider, Karyl Cohen, for S.T. Ms. Cohen was one of ISN's contract providers. In March 2007, S.T. began spending time with Ms. Cohen. The plan was to move him in with the new provider in June 2007. S.T. moved in with Ms. Cohen on June 11, 2007. The move corresponded with an increase in yelling incidents by S.T.. Some of these incidents would last in excess of eight hours. It was determined that Ms. Cohen might not be a good fit for S.T. She was not able to handle S.T.'s behaviors and routinely needed assistance from ISN staff.

S.T. was moved on June 29, 2007 to a new provider, the provider, who lived in Concord

and had many years of experience in Massachusetts and New Hampshire working with individuals with behavior issues. She was also a contract provider for ISN's residential program. Upon moving in with the provider, S.T.'s behavior improved immediately. In the summer of 2007, S.T. also transitioned from ISN's Manchester day program to its Concord day program. S.T. continued with many of the types of activities that he had enjoyed while living with his brother.

However, by late 2007, his negative activities were steadily increasing. The records indicate that an increase in negative activities at the end of the year was not unusual and may have been linked to a fascination with Santa Claus. The behaviors included yelling, severe highs and lows, and sleeplessness. S.T.'s day program staff member, Jim Fischer and ISN's Concord Program Manager, Andy LeCompte met with an ISN psychological consultant to address the behavior issues. They came up with a new method for tracking behavior.

In 2008, S.T. continued to live with the provider. He primarily worked on the goals of dusting and vacuuming. The provider also worked with S.T. on trying to understand that heat from cooking and moving vehicles were dangerous. His comprehension of danger was limited. Consequently, she taught him the trigger word "danger" to help him guard against both. As noted above, S.T. had limited communication skills. As time passed with the provider, S.T. began socializing with the provider's neighbors and her friends. He also enjoyed taking care of two birds, "Ham" and "Cheese," that were bought for him.

In May 2008, S.T. developed an MRSA infection. MRSA is the abbreviation for methicillin-resistant *Staphylococcus aureus*. Staphylococcus is a group of bacteria, familiarly known as staph (pronounced "staff"), that can cause a multitude of diseases as a result of infection of various tissues of the body. S.T.'s staph infection cleared up in July 2008. There was a reoccurrence in September 2008. S.T. was taken to the hospital and antibiotics were prescribed. The infection again cleared up. It came back once again in December 2008 and S.T. was again given antibiotics for it.

There is no doubt that the provider and Jim Fischer cared about S.T. and there was a strong bond among the three. S.T. made gains in socialization, nutrition and other areas while living with the provider. However, there were serious safety concerns that were not sufficiently addressed during S.T.'s time with the provider.

B. Unaddressed Safety Concerns

In addition to the safety concerns related to S.T.'s lack of understanding of the potential dangers of everyday living, the provider also quickly learned that S.T. had issues due to his lack of coordination and difficulty governing the amount of food he put in his mouth. These issues were well known to all that worked with S.T.

S.T.'s inability to regulate the amount of food he put in his mouth resulted in the danger of him choking on food. Though not detailed in the records of ISN or Moore Center Services, it

was generally accepted that S.T. was not able to eat safely by himself due to the danger of choking.

Mr. Fischer explained during his interview that he first observed S.T. choke at ISN offices in July 2007. S.T. was, at the time, training with another ISN employee and had yet to be assigned an ISN client to work with as a provider. But it was understood that he would be working with S.T. S.T. was having lunch and began to choke. The ISN employee acted quickly to stop the choking by removing some of the food from S.T.'s mouth by hand. While relating this story, Mr. Fischer also explained the eating process he used with S.T. It was a hand-over-hand process where S.T. would take a bite and then have to demonstrate that his mouth was empty before Mr. Fischer would permit him to take another bite. Mr. Fischer learned through experience that certain foods were more dangerous for S.T. S.T. would, for example, tend to try to stuff submarine sandwiches into his mouth beyond his ability to safely eat the sandwich. The overarching problem as explained by Mr. Fischer was that S.T. did not have an "off button like the average person" when it came to eating.

The provider provided a detailed example of this eating-based danger. On December 12, 2008, the provider had a hairdresser's appointment in Penacook, NH. As it was a Saturday and S.T. was not attending his day program, the provider took S.T. with her to the hairdresser's appointment. She bought him lunch at Subway to eat while she had her hair done. Because the provider was getting her hair done, she was not able to sit with S.T. while he ate his lunch. Shortly after starting to eat his lunch, S.T. began to choke. The provider was physically unable to perform the Heimlich maneuver on S.T. because of S.T.'s size. A person ran over to a nearby veterinarian's office for assistance and a call was made to 911. The veterinarian came to assist with the situation and was able to position S.T. over a chair so that he could perform the Heimlich maneuver on S.T.

The provider notified both Moore Center Services and ISN of the incident. Emergency personnel did arrive at the scene but were not needed due to the Veterinarian's actions. Moore Center Services' case notes provide some limited factual details on the incident. ISN did not make a record of the incident.

Moore Center Services nor ISN conducted an incident review or inquiry to specifically address the December 2008 choking incident to address safety issues that might have been raised by the incident, to review the issue of how the incident was handled by the provider, and to determine how reoccurrence could be prevented. S.T.'s treatment team did meet seven weeks later to work on his annual service agreement ("ASA"). And the treatment team did put in the medical section of the single spaced seven page 2009 ASA that "[i]t is also very important to know that [S.T.] will eat very quickly and needs to have his food cut into bite size pieces so he won't choke." The statement was the omitted from his 2010 ASA, which was developed before S.T.'s death. The 2008-2010 ASA do provide a more limited statement indicating that food should be cut for safety purposes. There is no mention of how a choking incident should be handled.

There is no other indication of the December 2008 choking incident in the records of Moore Center Services nor ISN, nor a record of a dissemination or warning to the provider concerning same. The applicable regulations require Moore Center Services “[d]etermine and implement necessary action and document resolution . . . when health and safety issues have arisen.” See He-M 503.09 (b)(7).

To address the danger of choking, the provider only left out soft foods such as bananas that S.T. would not choke on. She also used childproof latches on her kitchen cabinets. The latches were used on the cabinets to restrict S.T.’s unsupervised access to food. The latches had been installed with the prior tenant. She asked ISN if it was okay to use the latches and ISN agreed. The provider would have liked to install locks on the cabinets but was under the impression that doing so would have violated S.T.’s civil rights. The problem with the latches is that they did not actually lock the cabinets. There was a gap between the door and the frame of the cabinet that was similar to the gap that is left when a person uses a security chain on a door.

ISN did not have any specific requirements or protocols in place as to these food based behavioral issues. That said, both the provider and ISN’s day program would not permit S.T. to eat without assistance or monitoring due to the serious danger of choking. Mr. Fischer, once stated, that S.T. would not choke on his watch.

When discussing the issue of safety during her interview for this report, the provider indicated that she was also concerned with S.T.’s lack of coordination. Due to coordination issues, S.T. would fall three or four times a month. The provider did orally report some of the falls to ISN’s Cindy Bringham who is the ISN’s residential manager who worked with the provider and S.T. Ms. Bringham did not detail these incidents in S.T.’s ISN records and did not formally report them to anyone at ISN. The provider did not report the falls to Moore Center Services. The provider did not report many of the falls at all because she viewed it as just part of who S.T. was. S.T. would do things such as fall over coffee tables.

There were three falling incidents that particularly concerned the provider. The first was when he fell in the bathroom and his head landed between the tub and the toilet. If he had fallen a little to the right or left, his head would have struck the toilet or tub. There was a time when S.T. pulled the shower curtain down as he fell to the bathroom floor. S.T. also fell between the provider’s bed and the wall in a position where he could not get up and she could not get him up.

Due to S.T.’s general difficulty sleeping, he was often awake unsupervised in the middle of the night. The provider would get up in the night to check on him but had to sleep during the night because she worked during the day at Community Bridges, where she is still employed. Community Bridges is an area agency for the Concord area. S.T.’s nighttime wakefulness posed a problem due to his inability to care for himself or to recognize danger. For example, S.T. once caused a glass candleholder to fall. The candleholder shattered and S.T. did not recognize it as a danger. Luckily, the provider caught the situation before S.T. was injured.

The provider stated during her interview that she believes that more training/guidance should be given to providers who work with individuals with complex behavioral/safety needs such as S.T.. As to S.T., she expressed concern over the lack of her ability to fully supervise S.T. because she had to sleep and she didn't have a more secure way of locking cabinets.

C. S.T.'s Death

The provider gave S.T. a sleeping pill (Temazepam) at about 8:30 pm on February 3, 2010. It was the second night that S.T. had been on Temazepam to help him sleep. The first night it left S.T. "dazed and confused." The provider stated in her interview that she subsequently contacted Moore Center Services to see if she should take him off Temazepam. She indicates that she was told to try it for another night. Moore Center Services reports that its nursing staff would have handled such a contact and that there is no record of it in Moore Center Services records or recollection of it by Moore Center Services' staff. Moore Center Services believes that the provider might have called S.T.'s medical provider at Greater Manchester Mental Health Center or ISN. S.T. did remain on Temazepam and fell asleep on the couch at about 9pm. The provider went to bed at 10pm.

However, S.T. did not sleep through the night. A neighbor, while walking her dogs at four in the morning, heard S.T. talking to himself inside the provider's apartment. At about five in the morning, the provider awoke when she heard a "thud" in her room. The thud was the sound of S.T. falling to the floor next to the provider's bed. The provider told S.T. to get up himself. She said that she would be back to help him up if he was not able to get up himself. The provider explained that she thought that S.T. liked to be babied and that she did not think it was good to encourage that behavior. The provider then went into her kitchen to smoke a cigarette and may have used the bathroom. The exact time lapse is not known. The provider has stated that it was possibly between four to six minutes. When the provider returned to her room to check on S.T., she found him with his eyes rolled back in his head and "stuff" coming out of his mouth. The provider was unable to locate her phone. She ran to her neighbors, the Eastmans, for help.

Steven Eastman called 911 and followed the 911 operator's instructions. He was unable to revive S.T. It was later determined that S.T. had choked on brownies. The brownies had been given to the provider the day before. She thought that she had put them in one of the cabinets that had a childproof latch. She opined that S.T. might have gotten to the brownies through the gap between the door of the cabinet that the childproof latch leaves even when engaged.

As to the brownies, there was a partially eaten brownie by S.T.'s side and a gallon size Ziploc bag with brownies on top of the hope chest that was at the foot of the provider's bed. There were also brownie crumbs in the bedroom and leading into the bedroom from the living room. The provider stated that that she did not notice the brownies because she wasn't fully awake when S.T. fell next to her bed. She was unconcerned that he had fallen in her bedroom

because he fell 3 to 4 times a month and would play on the floor around her bed. The provider became very emotional when discussing the incident.

An ISN incident report was completed as to the event that took S.T.'s life. The written incident report is one paragraph long and recounts the basic details of the death from the provider hearing the fall to the inability of Mr. Eastman to revive S.T. There were later interviews conducted by ISN. The interviews were of Kerry Ryan, Cindy Bringham, Jim Fischer and the provider. They are factual in nature. There is no analysis of the situation in the record nor any analysis of the contributory factors or ways to improve ISN practices.

D. Failure to Require Safety Training and Address Safety and Behavioral Issues

The ISN service agreement with the provider required her to maintain skills and participate in a minimum of ten hours per year of related training in certain listed areas and/or others as required by ISN. The areas listed: (1) First Aid/CPR; (2) Social Role Valorization; (3) Medication Training certified in accordance with He-M 1201; (4) Seizure Training (if applicable); (5) Specific competency-based training.

ISN provided the DRC with a copy of the provider's training record. The record has 17 entries covering December 27, 2006 to May 29, 2009. The training covered such topics as defensive driving, social role valorization (2 entries), medication administration and client rights (2 entries). Absent from the training record was any notation of First Aid training and/or CPR training. The provider stated that she had some First Aid/CPR training prior to beginning with ISN. She believed that the training was only required every two years. The period covered by the training record was two and a half years. ISN did not indicate in interviews that it had ever required her to attend First Aid/CPR training and no specific training with regard to S.T..

ISN did also provide the "Independent Services Network, Inc. Residential On-Call protocol" which details who at ISN should be notified in case of a medical emergency.

E. ISN's and Moore Center Services' Oversight as to Residential Issues While S.T. was in the provider's Care

The records provided by Moore Center Services that cover the period in which S.T. was in adult foster care with the provider are very detailed as to ISN's day program. There are monthly progress reports from ISN for both residential services and day program services and some Moore Center incident reports relating to incidents at the ISN Offices. There is also a brief notation and description in the Moore Center Services of the choking incident that occurred at the provider's hairdresser in December 2008, fourteen months prior to the choking incident that ended S.T.'s life.

The notes in the Moore Center Services records are passive in nature in terms of detailing the facts. For example, the notation for the December 2008 choking incident simple states:

Writer received a call from provider the provider on December 12th that [S.T.] had choked during lunch while in a restaurant due to eating too fast. Provider tried the Heimlich maneuver and when it did not work called 911. A veterinarian next to the restaurant came over and was successful in doing the Heimlich maneuver. S.T. was fine after this incident. His brother . . . , who is his guardian, was called.

See Moore Center 2008 Case Notes. The note is inaccurate in that S.T. choked at a hair salon after getting a submarine sandwich with the provider from Subway. There was no follow up on why the Heimlich attempted by the provider was unsuccessful or any other aspect of the incident.

The ISN records lack any mention of the December 2008 choking incident even though they were apprised of the incident. The ISN records are also devoid of any risk assessment as to S.T.'s tendency to fall and his propensity for choking. They similarly lack an assessment of ways to reduce the chance of S.T. choking and/or the provider's ability to handle a choking incident. The Moore Center Services Annual Service Agreements for 2008-2010 do somewhat address the issue of reducing the chance of choking in that they state that S.T.'s food should be cut into pieces for safety reasons. And the 2009 Annual Service Agreement more specifically states that S.T. eats quickly and needs to have food cut into bite size pieces so that he didn't choke. However, neither the Moore Center Services records or the ISN records give any meaningful assessment of the myriad risks that S.T. faced on a daily basis or strategies to address them.

There also did not appear to be any consideration as to the need for awake overnight staff for S.T. when residential changes were being made, at the annual service agreement meetings, or at any other time. Given all the safety considerations and risky behaviors that S.T. engaged in, at the very least overnight staffing should have been considered, if not required.

F. Sentinel Review of the Death

The ISN records include a "sentinel review" of the matter. It does not have a stated author. The review contains basic factual information regarding S.T.'s death. This section is only a single paragraph. The review then provides a similarly short section on various topics such as "Clinical Description Describing [S.T.]," "Functional Status," "Physical Health Status," "Psychological Status," "Cognitive Status, etc. None of the sections provides an in-depth analysis. For example, Psychological Status section simply provides "PTSD (post traumatic stress disorder)." It is a very pro forma review of the matter. The review lacks any findings, conclusions and/or recommendations.

G. Other Post Death Reviews, Investigations or Recommendations

Moore Center Services conducted an internal review of S.T.'s death. The review team spoke with the provider, Jim Fischer, and ISN executive director. The team also met with S.T.'s case manager and reviewed case notes. Its review, according to Moore Center Services, "identified a number of concerns regarding [S.T.'s] care." "Of particular concern to the [Moore Center Services] was what it would characterize as a serious breakdown in communication from the vendor (ISN) and with ISN's residential services provider." Moore Center Services did not complete a formal written report.

Moore Center Services has indicated that it worked in 2010 on enhancing its ability to assist and protect clients with significant medical or behavioral needs. These efforts include: (1) training case managers on identifying eating and related choking issues; (2) training case managers on responding to sentinel events; (3) training three case managers to better their ability to address complex behavioral issues; and (4) beginning a formal process of reviewing the case plans for its most needy, complex or fragile consumers.

ISN also conducted an internal review of the matter. It also did not issue a written report.

The Concord Police Department did an incident report about the immediate circumstances surrounding S.T.'s death. An autopsy report was completed by the State of New Hampshire Office of the Chief Medical Examiner on February 5, 2011.

III. NH Services for the Individuals with Developmental Disabilities and Applicable Standards

New Hampshire statute regarding services for the developmentally disabled states that its purpose is to enable the department of health and human services ("the department") to maintain and coordinate a comprehensive service delivery system for developmentally disabled persons. RSA 171-A:1. New Hampshire's policy is that persons with developmental disabilities receive services that emphasize community living. *Id.* New Hampshire's programs are to be based on, among other things, services based on individual choice, satisfaction, **safety**, and positive outcomes. *Id.* (emphasis added). To effectuate this goal, New Hampshire's statute states that services are to be provided by competent, appropriately trained and compensated staff. *Id.* New Hampshire's statute goes on to provide that "[e]very developmentally disabled client has a right to adequate and humane habilitation and treatment including such psychological, medical, vocational, social, educational or rehabilitative services as his condition requires to bring about an improvement in **condition within the limits of modern knowledge.**" RSA-A:13 (emphasis added).

Under New Hampshire regulations, individuals with development disabilities who are living in community residences have the right to a safe living environment. See He-M 310.09.

The services provided to individuals with developmental disabilities are to be designed to promote the individual's health and safety. See He-M 503.08(b)(3). "If the area agency determines that a provider chosen by the individual or guardian is posing an immediate and serious threat to the health or safety of the individual, the area agency shall, with input from the individual or guardian, secure another provider and issue a notice to immediately terminate the service contract of the current provider, specifying the reasons for the action." See He-M 502.08(g). The certification standards for community residences require them to offer services in a manner that promotes physical well being. See He-M 1001.5(b)(6). The number of providers in the residence must be sufficient to meet the client's needs. See He-M 1001.5(C)(1). The entity overseeing the operation of the community residence is required to arrange an annual health assessment for the client for the purpose of making recommendations regarding strategies for promoting and/or maintaining optimal health. See He-M 1001.06.

IV. Findings, Conclusions and Recommendations

A. Findings and Conclusions

1. There was a lack of risk assessment and appropriate interventions and safeguards in place on many levels as detailed below for known obvious risks for a client whose history showed that his medical and safety needs were a complex matter to address. The failure to properly manage his environment and otherwise engage in appropriate human resource and oversight responsibilities were contrary to S.T.'s right to live safely in the community as guaranteed by New Hampshire law. It further violated his right to be cared for by adequately trained individuals. Both of these rights are guaranteed by RSA 171-A. Overall, there was a failure by Moore Center and/or ISN to select and properly train the home provider in the necessary competencies to properly care for S.T., to design and implement services or positive intervention to address behaviors which contributed to his death, provide adequate preventative or protective measures, and properly investigate or heed warning signs or otherwise engage in adequate oversight.
2. The Department, Moore Center Services, and ISN failed to adequately identify S.T. as a person at high risk for adverse events. This failure to so identify is inconsistent with New Hampshire's right for persons with a developmental disability to receive service in the community in a safe manner.
3. The Department, Moore Center Services and ISN failed to identify the fact that S.T. was often unsupervised in the middle of the night without food being properly secured. Childproof latches were an insufficient means to secure food. This failure to so identify is inconsistent with New Hampshire's right for persons with a developmental disability to receive service in the community in a safe manner. It further violated S.T.'s right to be cared for by properly trained

individuals as such individuals would have noticed the deficiency and corrected it.

4. The Department, Moore Center Services, and ISN failed to ensure the provider was capable to address likely behavioral and safety concerns, including S.T.'s propensity for falling and his propensity for eating food in a dangerous manner. This failure fell below the statutory responsibility to ensure that services be provided by competent and appropriately trained staff. It further violated S.T.'s statutory right to live safely in the community.
5. ISN failed to ensure that the provider received first aid/CPR training even though she was caring for a man with complicated and potentially life threatening medical issues. First Aid / CPR training is specifically called for in the provider's service agreement with ISN. This failure fell below the statutory responsibility to ensure that services be provided by competent and appropriately trained staff. It further violated S.T.'s statutory right to live safely in the community.
6. Moore Center Services and ISN failed to investigate the December 2008 choking incident. Even a cursory investigation into that incident would have revealed that the provider was not physically capable of handling an instance where S.T. was choking. It would have also revealed that her first aid trainings were not up to date. Failure to investigate the December 2006 incident and take appropriate corrective action violates the obligation under New Hampshire law to ensure that services are provided safely in the community and by competent and appropriately trained staff.
7. A. S.T. was prescribed a plethora of medications at various points in the reviewed time period. At one point as detailed in Section II-A of the report, S.T. was shuttled among acute care providers and being prescribed medication to try and address a behavioral issue. It was determined that it was actually one of the medications S.T. was receiving that was causing the behavior issue. Moreover, the use of the sleep medication that the provider was hesitant about using after the initial dosage may have played a contributing factor in S.T.'s death. There should have been a behavioral assessment to address S.T.'s behavioral/sleeping issues.

B. While at various points during the period reviewed, there were a number of hospitalizations and medical reviews, they did not seem well coordinated and certainly did not lead to answers.

C. Given S.T.'s behaviors and disorders and the amount of medication he was on, a more systematic and high quality approach should have been pursued by Moore Center Services in their role as service coordinator to address the behaviors, including but not limited to a comprehensive functional behavior

assessment, efficacy analysis of the medication and other interventions that were being used, and use of outside consultants or technical assistance to address these matters. The failure to implement these or other necessary actions was contrary to Moore Center's responsibility to provide services "within the limits of modern knowledge" in accordance with RSA 171-A:13.

9. As noted above, until or unless these actions were successful, the Moore Center and ISN had a duty to ensure S.T.'s safety through preventative or protective measures, such as overnight staff, locked food cabinets, removal of other environmental hazards, and/or staff fully trained in and qualified to administer the Heimlich maneuver or CPR.
10. The actions and omissions of the provider immediately preceding S.T.'s death constituted neglect and likely contributed to S.T.'s death. Even without any training, her actions and omissions constituted poor judgment and were neglectful on her part when S.T. entered her room with a bag of brownies and fell to the ground. The thud he made when falling to the floor was sufficient to wake the provider. Based upon S.T.'s past history of dangerous falls regardless of times when he would play next to her bed on the floor, she should have recognized that it was essential to ascertain his condition prior to leaving him for a cigarette break. This is a very basic precaution that any reasonable lay person giving care would have recognized as necessary.

Additionally, given her caretaking responsibilities and his risky and challenging behaviors, her inability to rapidly access a phone for an emergency call was neglectful on her part. Considering the December 2008 choking incident and ST's behaviors generally, there should have been an effective plan to prevent dangerous incidents and/or to properly handle them when they did occur so that the risk of harm is eliminated or reduced (as referenced in findings 8c and 9, respectively). The provider should not have been left to work on her own emergency preparedness plan.

11. DHHS/BDS in response to a previous death of a person with challenging medical and behavioral issues living with an enhanced family care provider reportedly issued a memorandum instructing or advising area agencies to survey all enhanced family care provider homes where such persons were or may be residing. The purpose was to assure that the living arrangement was suitable and, if not, for area agencies to take steps to assure the person's health and welfare. The previous death occurred in December 2004.¹ It would appear that the memorandum was designed to prevent

¹ DRC investigated that December 2004 death as well. DRC found there that the client, V.H., a 70 year old women with challenging medical and behavioral issues as well, was inappropriately placed with an ill-equipped, undertrained, inexperienced and poorly supervised enhanced family care provider, a situation which contributed to her death. (V.H. investigation available at <http://drcnh.org/Issue%20Areas/Mental%20Health.htm>). DHHS/BDS

precisely the conditions that led to S.T.'s death, a placement not suitable to the challenging medical/behavioral needs of a person served by the system. S.T.'s death and the conditions leading to it indicate that the memorandum on its face or as implemented was not adequate to achieve its purpose or that the follow-up on adherence was lacking.

B. Recommended Corrective Actions

1. DHHS/BDS should review their regulations, policies, procedures, practices, and contract specifications to identify whether there are systemic weaknesses or areas in need of improvement in the areas identified in the findings, including but not limited to:
 - a. The process and standards for recruiting and selecting both the type of the living arrangement (e.g. enhanced family care vs. full time staff arrangement or combination) and the actual person(s) serving and supporting the individual and the actual person(s) selected;
 - b. The quality, effectiveness and comprehensiveness of the required pre-service, in-service, continuing education training (including periodic refresher course(s) e.g. in CPR, Heimlich) that is (i) of general applicability to the enhanced family provider position and the other responsible positions relevant to the issues identified in this review and (ii) specific to the needs and services of the individual, including potential emergency issues identified in risk assessments.
 - c. The individual service planning process, including evaluations of challenging, complex or serious behaviors and medical issues and risk assessment (including as in this case or as applicable) functional behavior assessments, risk assessments,² and medication efficacy assessments) and development and implementation of the needed interventions, services, safeguards, and protective measures based on assessments.
2. The Moore Center and ISN should review their respective policies, procedures, practices, and contract specifications to ensure compliance and where needed exceed compliance in areas enumerated in 1(a)-(c) above and the weaknesses identified in the findings.

had indicated in response to that investigation that it had issued the above referenced memorandum to prevent such deaths from occurring in the future.

² Risk assessment here includes but is not limited to an assessment of actual or potentially harmful behaviors and residential or other environmental hazards. S.T.'s eating and falling issues represented the former in this matter and the small bathroom and lack of adequate locks on food storage areas, absent a successful behavior plan, represented the latter.

3. DHHS/BDS should review all enhanced family provider placements in the state, especially those under the auspices of Moore Center or ISN, and, as needed, make or facilitate changes in services, staffing, safeguards or placements in accordance with the needs and wishes of individuals or guardians.
4. DHHS/BDS should strengthen their ongoing structure of oversight and supervision, and in particular, the service delivery system's Quality Assurance, Licensing, Certification, Contract Monitoring, Investigation and Incident Review processes in order to ensure that these processes are designed and operated on an ongoing and permanent basis to identify, proactively when possible, weaknesses and deficiencies in placements/living arrangements of individuals with challenging, complex and/or serious behavioral and/or medical issues so that corrective steps can be and are taken in a timely manner.
5. DHHS/BDS/Area Agencies should consider a structure which provides for the assignment of highly, appropriately, and specially qualified and/or trained service coordinators to individuals with challenging, complex and/or serious behavioral or medical needs or issues. The multiple and pivotal roles of the service coordinator in the system would appear to require this policy and practice.
6. DHHS/BDS/Area Agencies should review, and consider changes where needed in regard to medical, psychiatric, and hospital visits and resultant evaluations, discharges, and recommendations, particularly of individuals with challenging, complex, or serious behavior and/or medical issues to ensure (a) that admissions are made in the first instance to the appropriate facility so far as possible, (b) that pursuant to its advocacy and protective role that hospitals provide proper treatment and do not inappropriately refuse admission or prematurely discharge individuals, and (c) that recommendations from these stays, evaluations, and plans are properly considered, coordinated, and carried out in accordance with the needs and wishes of the individual or his/her guardian.³ The change recommended in service coordination in No. 5 may provide some of the solution. More reliance on the medical home model should also be considered.
7. The system of supervision and mentoring of enhanced family care providers and other direct support staff should be enhanced and otherwise improved to ensure (a) that on-the-job training takes place, (b) that periodic and as-needed supervision between supervisory staff and the provider or caretaker occurs in order to ensure implementation of staff training, relevant components of the service agreement, job descriptions, vendor and provider contract provisions, (c) that existing, emerging and/or

³ There are questions raised by the services provided and recommendations made by some of the hospital facilities where S.T. was admitted or was not able to gain admissions in 2006. Among other things, there seemed to be a "pass the buck" mentality at work. Precise recommendations on these subjects are beyond the scope of this report; however DHHS' Division of Public Health Services may consider reviewing these 2006 admissions, stays and discharges.

changing needs of the individual are being addressed properly, and (d) that questions and concerns of the provider/caretaker are being addressed.

8. It is recommended that Moore Center and ISN take appropriate personnel action, or if applicable, contract actions against individuals or entities who did not adequately fulfill their responsibilities in regard to S.T. and in this matter generally, as more fully outlined in Findings.