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DRC has released a white paper examining two tragic deaths, one in 2009 and the other in 2010, of individuals with developmental disabilities served by New Hampshire’s developmental services system. The paper also reviewed four previous deaths occurring under similar circumstances. Titled “**Examining Preventable Deaths in the Developmental Services System--A Call to Action—Keeping Vulnerable Citizens Safe from Harm,**” the paper is highly critical of the developmental services system from failing to learn from previous tragedies and thus preventing the successive deaths. The developmental service system is overseen and supervised by the NH Department of Health and Human Services and operated by regional area agencies.

The paper and the investigation reports, which have been forwarded to state and area agency officials, are available at www.drcnh.org/deaths.html.

DRC conducted investigations of 2009 and 2010 deaths and one of the previous deaths and relied primarily on other agency investigations of the other deaths in preparing this paper. DRC found that neglect and careless mistakes and deficiencies at all levels of the system contributed to each death. The DRC is the federal protection and advocacy system for the state of NH and has authority to conduct investigations of suspected cases of abuse and neglect of individuals with disabilities.

As the paper’s author, Richard Cohen,¹ stated, “Each of the earlier deaths, occurring in 2000, 2004, and 2006 were tragic enough. Violations of basic industry standards at all levels of the system caused or contributed to these deaths. What makes each successive death, and particularly the 2009 and 2010 deaths especially tragic and inexcusable is that DHHS and area agencies failed to learn from and apply the lessons from the previous deaths.”

The white paper also lists findings and recommendations from five reports commissioned by the Legislature and/or the Governor from 2001-2010 which were designed to address what turned out to be many of the underlying causes of these deaths. While some of the recommendations were

¹ Cohen has been DRC’s E.D. for over 10 years, and previously served as head of the Massachusetts developmental services abuse and neglect investigations division and for over 15 years served in judicial/oversight monitoring capacities over state systems of care or services in NH, MA and MN.

instituted, according to the paper, the Legislature or responsible executive branch officials failed to implement most of them.

The 2010 death was of a 33 year old man. Like most of the other victims he lived in a Medicaid certified and funded enhanced family care residence, with a single caretaker and without night time awake staff. And like the most of the others, he had multiple disabilities, including developmental, mental health or behavioral issues, and/or medical issues. He died from choking on food (brownies) that he got into while his provider was asleep in the early morning hours, despite the fact that he had a known history of seeking out food, choking, and sleeplessness at night. Adequate preventative steps were not taken to address these risks, nor was the provider equipped to deal with previous incidents or this one. During this last and fatal incident, she failed to intervene when he awoke her while he was choking believing instead that he was just seeking attention.

The 2009 death was of a 26 year old woman. In addition to intellectual disabilities, she was non-verbal. She died in an early morning fire in a second floor apartment in Pittsfield. While this was her family's apartment, the apartment and provider (her mother) was subject to some of the same requirements as out-of-home community residences. The mother was a certified Medicaid provider and receiving Medicaid funds to provide for her daughter. As with a 2006 fire in Tilton, those requirements were not enforced. They included adequate evacuation plans and drills and interconnected smoke detectors, measures which may have prevented this women's death.

The other deaths were of two women who died in an early morning fire in Tilton in an enhanced family care home referenced above; a 70 year old women who died from dehydration after being left on the floor by her 20 year old untrained enhanced family care provider, and a 49 year old year old man who died of pneumonia 10 days after moving in with an enhanced family provider who, among other things, left him outside at night in the cold or on the floor in his own urine.

The state level actions that were taken as a result of the deaths or previous government reports were primarily directed or promoted by the Bureau of Developmental Service of DHHS or the State Fire Marshall's Office. However according to Cohen, "as was the case before these deaths, more needs to be accomplished to prevent these and other tragedies in the future in staff training, clarification or enforcement of policies and standards, funding, and in incident reviews and investigations. As the White Paper states: "The overarching purpose in focusing attention on all of these deaths and the antecedent and contributing conditions is to create an urgency and impetus for additional needed changes so as to prevent future deaths and other tragedies."