

Vermont Protection & Advocacy, Inc.

141 Main Street, Suite 7
Montpelier, VT 05602

(800) 834-7890 (Toll-Free)
(802) 229-1355 (Voice)
(802) 229-2603 (TTY)
(802) 229-1359 (Fax)
Email: info@vtpa.org

EXECUTIVE DIRECTOR

Torin D. Fogut

SUPERVISING ATTORNEY

Beth A. Danon

ADVOCATE

Paul Poirier

ADVOCATE

Linda Cramer

ADVOCATE

Merry Postemski

ADVOCATE

Karen Vastine

PABSS ADVOCATE

Liz Manfredi

INTAKE SPECIALIST

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OFFICE

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Preliminary Investigative Report

RE: Death of *CJ*
November 20, 2001

I. Summary of Investigation

Vermont Protection and Advocacy, Inc. (VP&A) learned of the death of *CJ* by way of an article that was published in the Caledonian-Record on July 24, 2001. Per our agency's federal mandate, VP&A began an investigation into *CJ's* death, as an adult with a mental illness and residing in a community home in Vermont. A call was placed to Adult Protective Services (APS) in Vermont. Initial conversation with Virginia Werneke, an investigator with APS, who referred VP&A to *CJ's* brother of the deceased. Upon receiving signed releases from *CJ's* brother, VP&A was able to obtain records from Vermont Adult Protective Services, the Vermont State Police, the Chief Medical Examiner's Office in Vermont, White Mountain Mental Health in New Hampshire, and On The Green Assisted Living in New Hampshire. Interviews have been conducted with *CJ's* brother and Sgt. Bachand of the Vermont State Police. Evelyn Nunn declined VP&A's request for an interview. Attorney Dona Feeney who represents the non-profit agency who oversees White Mountain Mental Health was contacted regarding possible interviews with employees of the agency. She asked that these interviews be postponed until after a mediation session with *CJ's* brother, *CJ's* brother, and his attorney, to assist in reaching a settlement in a potential wrongful death claim against her clients.

To date VP&A has not received the following documents:

- a) Copy of the internal investigation report done by the Northern New Hampshire Mental Health & Developmental Services state office.
- b) Copy of the signed contract between Evelyn Nunn and White Mountain Mental Health & Developmental Services.
- c) White Mountain Mental Health & Developmental Services policies and procedures.

II. Chronology of Events

- a) *CJ* was a 49 year-old male who suffered from Cerebral Palsy, schizophrenia, mild retardation, and depression. He has resided at On The Green Assisted Living in Haverhill, New Hampshire since 1998.

... C.J. had a history of being a difficult client. From the various progress reports included in the information, it was noted that he routinely let himself fall to the ground, causing injury to himself and potentially others. He had the ability to walk and maneuver himself around, but was quite dependent on others to help him. It was stated that he had a hard time adapting to change and that he was upset about having to leave On The Green Assisted Living. In the past when C.J.'s behavior and/or health deteriorated he was involuntarily emergently admitted to the New Hampshire Hospital.

In January 2000, C.J. was given a 30-day notice from On The Green Assisted Living that he would have to leave due to his disruptive behavior. In June of 2000, the decision was made that C.J. would be placed in a home in West Danville, Vermont, with another client whom he knows. The home provider would be Evelyn Nunn. On September 2, 2000, C.J. was transferred from his placement at On The Green Assisted Living in New Hampshire to the home of Evelyn Nunn in West Danville, Vermont. C.J. died on September 12, 2000.

b) Evelyn Nunn was an employee (Service Coordinator) of White Mountain Mental Health for 18 years prior to resigning her position to become a licensed home provider for C.J. She also investigated human right's issues for the agency. She received temporary certification from the State of New Hampshire Office of Licensing and Regulation on August 25, 2000 to have two certified beds in her home.

c) C.J. was placed with On The Green Assisted Living on August 24, 1998. On January 24, 2000, Mike Carbonneau, C.J.'s case manager, was notified via letter from Albion Estes of On The Green Assisted Living that C.J. was given a 30-day notice to leave On The Green. The letter cited concern for C.J.'s safety as well as the safety of others as a reason, plus it cited C.J.'s "continued lack of respect both for himself and the other residents with regard to his behavior, hygiene and attitude is totally unacceptable." C.J. remained at On The Green Assisted Living until September 2, 2000, when he was placed in the care of Evelyn Nunn.

d) At the time of his death, C.J. was receiving services as a client of Common Ground / White Mountain Mental Health and Developmental Services, which is run by Northern New Hampshire Mental Health, a private, non-profit agency.

e) September 2, 2000 - C.J. was transferred from On The Green in New Hampshire to Evelyn Nunn's residence in West Danville, Vermont.

September 3, 2000 - Evelyn Nunn noted in her progress notes that C.J. allowed himself to fall several times. She stated her bathroom was small, so when C.J. fell in there he would hit the toilet, tub and sink cabinet. Also according to her progress notes, C.J. fell on the floor right after lunchtime after using the bathroom, and he remained on the floor until 0430am the next morning.

September 4, 2000 - C.J. refused to eat in the morning. Evelyn brought him to the "Littleton" office for a shower. He fell in the bathroom there, hitting his head. When Evelyn returned home with C.J. he fell down to the ground as he got out of the car. Evelyn stated in her progress notes that C.J. refused to get up. (Unclear as to what time this happened). Evelyn watched him from inside the house. C.J. made it to the front door (crawling) around midnight. Evelyn opened the door and he crawled inside. C.J. spent the remainder of the night on the floor.

September 5, 2000 – According to Evelyn’s progress notes, CJ refused to go to the kitchen for breakfast. CJ vomited some liquid in the bathroom earlier in the morning. He ate lunch, then vomited again. He vomited a few more times after that. Then he went to bed. Phone records indicate that beginning at 1255 and ending at 2312, nine phone calls were placed by Evelyn Nunn to 603-444-0760. This is apparently the number to reach the Housing Coordinator for Common Ground, Deb Fullerton. All but one of the phone calls lasted 1 minute, with one lasting 2 minutes. This was also one of the two days that Burt Guilburt, day program worker for WMMH & DS, went to Evelyn’s home to provide help in caring for CJ and the other resident for a few hours.

September 6, 2000 – According to Evelyn’s progress notes, CJ spent two nights on the kitchen floor (one span of time). He lay in urine for the entire time. CJ sat up on September 8 with assistance. Phone records indicate one call was placed to 603-444-0760, Housing Coordinator, at 0845 lasting for 2 minutes. Evelyn also noted in her notes that CJ was physically weaker at this point. Phone records also show that Evelyn placed three calls to the WMMH Mental Health phone number at 603-444-5358; one call was at 0848 for 4 minutes; one call at 0959 for 2 minutes; and one call at 1054 for 17 minutes. There were also two calls placed to WMMH Developmental Services phone number at 603-444-6894; one call at 0854 for 6 minutes; and one call at 1416 for 2 minutes.

September 7, 2000 – Phone records indicate two phone calls were placed by Evelyn Nunn to the Housing Coordinator at 603-444-0760. One at 1358 for 1 minute, and one at 1842 for 1 minute. Two phone calls were also placed to WMMH Developmental Services phone number at 603-444-6894; one call at 1359 for 1 minute; and one call at 1400 for 1 minute.

September 8, 2000 – Phone records indicate five phone calls were placed by Evelyn Nunn to the Housing Coordinator at 603-444-0760. Four of these calls lasted for 1 minute, one call lasted for 10 minutes. A call was also placed to WMMH Developmental Services at 603-444-6894 at 0846 lasting for one minute. This was also a day that Burt Guilburt was present for a few hours.

September 11, 2000 – Evelyn’s notes state that CJ did not get out of bed and that he was being assisted with feeding. He only nodded his head for communication purposes. The notes stated that Evelyn found CJ to be sweaty but he had no temperature. At 0939 phone records indicate a 24 minute phone call was placed by Evelyn Nunn to the Housing Coordinator number at 603-444-0760. Also, a phone call was placed to WMMH Developmental Services phone number at 603-444-6894 at 1104 lasting for one minute. Mike Carbonneau, covering Case Manager during Scott Ryder’s vacation, indicated that he received a telephone call from Evelyn Nunn on this date reporting CJ’s behavior. Mike stated he offered to go to Evelyn’s home, but she declined because she had a meeting scheduled with Mike Carbonneau on September 14th and felt it could wait until they met.

September 12, 2000 – Evelyn’s notes indicate that she found CJ had passed away in his bed sometime after 1600. She stated she called Danville Rescue and Scott Ryder, (CJ’s Service Coordinator). The Vermont State Police were notified upon Danville Rescue’s arrival, and Sgt. Leo Bachand responded. CJ’s body was sent to the Chief Medical Examiner’s office in Burlington, Vermont for an autopsy. Phone records indicate that two calls were placed by Evelyn Nunn to WMMH Developmental Services phone number of 603-444-6894, one call at 1225 lasting 1 minute; and one call at 1632 lasting for 1 minute. Six calls were placed to the Housing Coordinator’s phone number at 603-444-0760. One call at 1632 for 2 minutes; one call at 1644 for 1 minute; one call at 1645 for 1 minute; one call at 1646 for 1 minute; one call at 1647 for 1 minute; and one call at 1648 for 1 minute. Records also show that a call was placed to On The Green at 603-989-5545 at 1228 for 1 minute. A call was placed to WMMH Mental Health phone number at 603-444-5458 at 1646 for 1 minute.

According to the Dr. Paul Morrow, Chief Medical Examiner for the State of Vermont, the cause of death in C's case was dehydration with contributory incipient right lower lobe pneumonia.

According to the investigative report done by Adult Protective Services, Mark Vincent – WMMH Program Director – stated he had received a telephone call from Evelyn Nunn, but he was not sure of the date. She had told him things were not going well. Mark indicated their conversation lasted a while and he then referred her to C's case manager, as he felt it would be better handled by him. (Note: there was a 17-minute phone call placed to WMMH on September 6th. This perhaps could have been this conversation between Evelyn Nunn and Mark Vincent).

The Adult Protective Services report indicates that Evelyn said she was reporting everything that was happening in her home to the staff at WMMH. She felt they should have intervened.

New Hampshire Mental Health and Developmental Services performed an internal investigation upon notification by the agency of C's death. We have been told this report on the outcome of the investigation has not yet been completed.

III. Findings by Vermont Protection and Advocacy:

- a) After reviewing all the documents provided to Vermont Protection and Advocacy by White Mountain Mental Health & Developmental Services, there is no evidence that the Housing Coordinator, Deb Fullerton of Common Ground, performed a routine home inspection of Evelyn's residence before C was placed in her care. Therefore, no one from the agency visited the home prior to C's placement, yet Deb Fullerton signed a Client Information Form that was submitted to the New Hampshire Office of Licensing and Regulation attesting to the following statement: "...I believe that this residence / day hab program is in full compliance with the statutes and regulations governing these services." As you further read in this report, it appears many statutes and regulations were not met.
- b) After reviewing all the documents provided to Vermont Protection and Advocacy by the Vermont State Police, Adult Protective Services, On The Green Assisted Living, White Mountain Mental Health and Developmental Services, State of Vermont Chief Medical Examiner's Office and the State of New Hampshire, Department of Health & Human Services, Office of Licensing and Regulation, there is no evidence that anyone from Common Ground / White Mountain Mental Health and Development Services visited the home of Evelyn Nunn to assure continuity of care for C, even after repeated telephone calls to the agency by Evelyn Nunn, and at least one telephone conversation with Mark Vincent, Program Director, and Mike Carbonneau, Case Manager, in which Evelyn stated she was having difficulty with C. Mike Carbonneau, as C's acting case manager, should have insisted on visiting Evelyn's home because he was aware of C's behavior in the past, and that C's history indicated that he had been involuntarily admitted on an emergent basis into the hospital when his behavior resembled the behavior he exhibited while in Evelyn's care. The agency had the ultimate responsibility to oversee Evelyn Nunn and to provide her with support and information to make informed decisions as they related to the care of C. He-M 1001.13 Quality Assurance(a)
The area agency or community mental health program shall have ongoing responsibility for monitoring community residences within its geographic area.
- c) After reviewing all the documents provided to Vermont Protection and Advocacy from the entities listed in (b) above, it cannot be found where C's death was reported by White Mountain Mental Health & Developmental Services to the State of New Hampshire, Department of Health & Human

Services, Office of Licensing and Regulation, as Evelyn Nunn had only at that point a temporary certificate for community residence. Upon telephone conversations with the New Hampshire Office of Licensing and Regulation, it was found that there are no requirements that this information be reported by the agency directly to Licensing and Regulation; only that the agency notify the New Hampshire Department of Mental Health, as was the fact in this case. This appears to be a substantial loophole in the New Hampshire rules for licensing.

Certification Standards for New Hampshire Residences, He-M 1001.10 Denial and Revocation of Certification (a)(4)(b) reads: *Application for certification shall be denied or revoked, following written notice pursuant to He-M 1001.10 (b)(2) and opportunity for a hearing pursuant to He-M 1001.12, due to: Any reported abuse, neglect, or exploitation of individuals by residential providers or persons living in the residence, if: Such abuse, neglect, or exploitation is founded based on a protective investigation performed by the division of elderly and adult services in accordance with He-E 700 and an administrative hearing held pursuant to He-E 200, if such a hearing is requested.* Further, He-M 1001.11 Suspension of Certification (a) reads *In the event that a violation poses an immediate and serious threat to the health and safety of the individuals, the director shall suspend a community residence's certification immediately upon issuance of written notice specifying the reasons for the action.* Based upon this regulation, it is difficult to determine how this would be enforced if there is no reporting requirement directly from the agency to the Office of Licensing and Regulation.

- d) After reviewing the investigative report filed by Adult Protective Services in Vermont, it wasn't until December 2000 that White Mountain Mental Health and Developmental Services reviewed the contents of Evelyn Nunn's progress notes sent to the agency after C J's death and then contacted Vermont Adult Protective Services after learning that New Hampshire Adult Protective Services did not have jurisdiction. These notes were only reviewed by Jane MacKay after C J's brother of the deceased, obtained a copy of them and called Jane questioning the notes and Evelyn's care of C J.
- e) The other client who was placed in Evelyn Nunn's care at the same time as C J, was allowed to remain in the home even after C J's death. According to an interview with Sgt. Leo Bachand of the Vermont State Police, this other client should have been pulled, at least as a precaution, from Evelyn's care by the agency until the cause of C J's death was known.
- f) There was concern about the accessibility of Evelyn Nunn's home in relation to C J's physical limitations. There were steep, wooden stairs leading up to the one story modular home. Aside from C J's physical limitations due to Cerebral Palsy (he used a walker), he also had a phobia of stairs. There was no ramp to the house for easy access of C J with his walker. According to the New Hampshire Office of Licensing and Regulation, ADA accessibility requirements in community residences are dependent upon the individual's physical needs. In C J's case it may have been desirable, given his disability and phobia, for there to be ramp access to the home. He-M 1001.04 Administrative Requirements (1) *A community residence shall be so constructed, and living space shall be so arranged and maintained as to provide for the health and safety of all household members.* According to notes there was one grab bar in the bathroom, however, the bathroom was too small and caused injury to C J each time he fell. The house did have a fire safety inspection prior to New Hampshire issuing temporary certification.
- g) After reviewing all the documents provided to Vermont Protection and Advocacy by the entities listed in (b) above and after interviews with Sgt. Leo Bachand and C J, it cannot be determined if Evelyn Nunn's residence carried the necessary Professional Liability Insurance as required. In accordance with He-M 1001.04 (h) Administrative Requirements *community residences shall have*

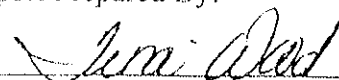
personal injury liability for the residence and for vehicles used to transport individuals. A certificate of insurance shall be on file at the premises. As the contracting agency, White Mountain Mental Health had the responsibility to make sure adequate insurance protection was in place prior to CJ moving into Evelyn's home.

- h) There is question as to whether any Vermont laws or regulations govern any kind of notification requirements regarding a New Hampshire certified home in Vermont. According to the Vermont Department of Aging and Disabilities, Licensing and Protection, as long as a home is certified for 2 or fewer beds, New Hampshire is not violating any Vermont law regarding licensing. If New Hampshire certified a home in Vermont for 3 or more beds, that home would also need to be licensed by Vermont.
- i) After reviewing all the documents provided to Vermont Protection and Advocacy by the entities listed in (b) above, there is no indication that Evelyn Nunn was provided any type of manual to help her in decision making during emergency conditions, or conditions where a course of action pertaining to a difficult client is unclear. It was stated in the Adult Protective Services report that Mark Vincent, Jane MacKay and Mike Carbonneau all reported that because of Evelyn Nunn's professional background, she would have been aware of resources available to her. They do not say that she had actually been given a list of resources for help. Vermont Protection and Advocacy is unable to determine what type of information was actually provided to Evelyn Nunn as a home provider. He-M 1001.07 Health and Safety reads: (a) *The residence administrator shall, in coordination with the case manager, have arrangements for access to medical services at all times, including emergency services. The residence shall have a written policy that specifies the procedures to be followed in medical emergencies...* (f) *A risk assessment, based on an actual evacuation drill conducted in the individual's current residence, and individual training plan shall be completed for each individual... (1) a risk assessment shall be completed within 5 days of the individual's placement in a community residence; (2) a risk assessment shall review the individual's ability to evacuate his or her residence within 3 minutes, with or without assistance; (3) for each individual unable to evacuate his or her residence within 3 minutes, a training plan shall identify the cause(s) for such inability; and (4) a training approach aimed at reducing the evacuation time to under 3 minutes shall be specified in the ISP.* Upon reviewing all records received, there is no indication that the agency coordinated either an access to medical services plan or a risk assessment with Evelyn Nunn for CJ.
- j) Vermont Protection and Advocacy has yet to receive a copy of the contract for services between Evelyn Nunn and the agency. We have been told by Dona Feeny that the contract was not actually signed until approximately 3 weeks after CJ's death. This is in violation of He-M 1001.04 Administrative Requirements (f) *"A community residence shall have a written service agreement with the appropriate area agency or community mental health program..."*

IV. Conclusion

Until Vermont Protection and Advocacy has had an opportunity to interview the employees named herein of the agencies responsible for CJ's care, we will refrain from reaching any conclusions regarding probable cause to believe that these agencies have committed negligence in this matter. This report will be amended after the interviews take place in early December 2001.

Report Prepared By:


Tina M. Wood, Paralegal