STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. Y-11/18-792
	)	
Appeal of	)	
	)	

INTRODUCTION

Petitioner appeals her substantiation by the Department of Disabilities, Aging and Independent Living ("Department" or "DAIL") for abuse and neglect of a vulnerable adult (an individual to whom she provided services as an employee of a local mental health agency). The following is based on an evidentiary hearing held August 30, 2019 and post-hearing submissions of the parties, with the record closing November 5, 2019.

FINDINGS OF FACT

1. Petitioner was a Community Integration Specialist ("CIS") for a designated mental health agency in June 2018, when the allegations were made leading to her substantiation by DAIL. Petitioner was a CIS for the alleged victim (hereinafter "R") at that time. Following an investigation by APS, petitioner was recommended to be substantiated for abuse and neglect of R.

2. R is a developmentally disabled adult. He is non-verbal and (at the time of the events in question) typically required a walker for ambulation due to what was described as an unsteady or "off" gait. Due to his limited mobility, communication barriers, as well as other medical issues, R requires constant "24/7" supervision of varying levels (although his specific needs and functional independence in June 2018 is discussed in more detail below). R lives with a developmental home provider who sees to his daily needs and overall supervision and safety; he has lived with this home provider for more than 25 years (including during June 2018).

3. R has a specific need (as he did in June 2018) for supervision of his consumption of food, due to a risk of overeating – what was described as his tendency to engage in "shoveling" food - and (separately) the risk that larger pieces of food will become stuck in his esophagus. Thus, proper supervision of R during mealtimes involves limiting the amount of food placed in front of him at any one time and cutting larger pieces of food into smaller pieces.

4. R's issues with the consumption of food cause him to be at risk of choking and aspiration (fluid in the lungs), both of which pose a significant risk of harm and possibly death.

5. R also requires supervision around toileting, although the parties dispute what the evidence established regarding R's function and needs in June 2018, in part because R's mobility needs have worsened since that time. As to this question, the following conclusions are drawn about R's toileting needs at the time (June 21, 2018) of the allegations at issue:

a. R was able to ambulate with a walker and transfer from his walker to the toilet and back.

b. R was able to "toilet" himself meaning he used toilet paper appropriately for the most part (he sometimes would overuse toilet paper and empty the roller).

c. At home, R would be assisted going into the bathroom – because there was a step before the entrance - but otherwise his home provider would "wait outside the door." R's home provider specifically testified that he was independent toileting at the time.

d. R had a propensity to exit the bathroom without pulling his pants completely up.

6. R also experiences significant tactile sensitivity, with a low tolerance for pressure or other contact with his

skin. For example, R would need to be restrained while having his blood pressure taken or if he were to require insertion of an IV into his arm.

7. In June 2018, petitioner had been R's CIS for approximately 1 ½ years. In this role, petitioner would take R out into the community for various activities, including shopping and meals. While under her supervision, it was reasonably expected that petitioner would attend to R's routine health and safety needs – for example, assisting him with safely ambulating from one place to another. Petitioner was familiar with R's issues around eating and swallowing food.

8. On June 21, 2018 petitioner picked R up from his home just before noon. From there, they drove to a local restaurant for lunch. Petitioner had previously brought R to this restaurant around 4-6 times, always for lunch.

9. DAIL presented testimony from two witnesses – employees of the restaurant – who were present on June 21, 2018. Both of these employees were waitstaff (as well as part-time hosts) at the restaurant, although neither waited on petitioner and R that day. Both witnesses recalled seeing petitioner and R at the restaurant on previous occasions. What follows is a summary of each witness's material

testimony (what may be credibly concluded from such testimony will be addressed separately).

a. Witness 1 testified that he saw petitioner enter the restaurant (around lunchtime) with R and that he did not have a walker; petitioner was physically assisting him to walk into the restaurant and sit down.

b. Shortly after they sat down at the table, ordered and began eating, Witness 1 saw R begin to cough and "choke a little." The coughing and choking would subside after he took a drink of water; then started back up when R began eating again and would subside again when R took a drink.

c. Witness 1 described petitioner as not responsive or seemingly concerned about R's coughing and choking, and instead was described as being "on her phone." When Witness 1 went to their table to inquire as to whether R needed any assistance, petitioner declined and stated that everything was "ok."

d. Witness 1 testified further that – after their meal ended – petitioner brought R to the bathroom and went to the front counter (about 20 feet away)

to pay their bill. Afterwards, she sat down on a bench near the cash register; in the meantime, R had come out of the bathroom but had not pulled his pants up. According to Witness 1, petitioner did not appear to notice R's situation until alerted by another employee, at which point she went over to assist him. Following this, petitioner and R left the restaurant.

e. Witness 2 testified that she was also present and working in the restaurant on the day in question, when petitioner and R had lunch.

f. Unlike Witness 1, Witness 2 saw R come into the restaurant using his walker. She recalled that petitioner took R to the bathroom – not (as recollected by Witness 1) when she was paying their bill at the end, but instead when they first came into the restaurant or sometime after they were seated. Witness 2's recollection was that petitioner brought R to the bathroom and told a waitress that she needed to go out for a minute to retrieve R's bag. Witness 2 did not see R come out of the bathroom.

g. In addition, Witness 2 testified that R was standing with petitioner while she was paying the bill at the register. She testified that R vomited on the floor at that point and that petitioner showed no apparent concern or interest in cleaning up his vomit (which she said was cleaned up by another employee). Witness 2 did not see R eating that day, nor did she see R come out of the bathroom.

h. Both Witness 1 and Witness 2 testified that they had seen petitioner and R in the restaurant together before (and only with each other, never separately), between 4-6 times. Witness 1 testified that he had seen R experience apparent coughing and choking problems on other occasions. Witness 2 did not recall seeing R experience problems with eating or choking before.

i. Neither witness saw R "shoveling" his food nor was there any testimony from either witness regarding the type of food served to R that day or any failure by petitioner to cut R's food into smaller pieces.

j. Witness 1 did not see R vomit at or near the cash register nor at any other time he was in the restaurant that day.

10. Taken together, the testimony of both Witness 1 and Witness 2 is contradictory on certain details, such as whether R was using a walker, when and under what circumstances petitioner brought R to the bathroom, and what happened following R's exit from the bathroom. Given these contradictions, the fact that neither witness was assigned to wait on petitioner and R that day, and that petitioner and R had been in the restaurant together several times before – this affects the reliability of their testimony and results in a pronounced lack of clarity about what actually occurred on the day in question (even assuming that the events as testified to meet the statutory standard for abuse or neglect).[1]

11. Following their lunch, petitioner drove R back to the home of his home provider, typically about a 20-25 minute drive home (the nearest hospital is about a 5-10 minute drive from the restaurant). There appears to be general agreement that petitioner brought R back home by around 2 p.m.

[1] The testimony of Witness 1 and Witness 2 was disparate enough to create the impression – in the estimation of the hearing officer – that the testimony concerned different events and dates.

12. At that time, petitioner reported to R's home provider that he had started coughing while at the restaurant and she (petitioner) thought he "might be coming down with something." Petitioner remained at the home for around 10-20 minutes before leaving.

13. R's home provider described him as continuing to cough and "throw up" saliva to the point that the front of his shirt was "soaked." Throughout this event, R was able to breathe without any issues but not able to swallow liquids. Around 2:30 p.m., R's home provider contacted his case manager to inform her about the situation, although no specific action was taken at that time. Instead, the home provider contacted R's primary care physician, and after some discussion of the situation (the doctor's office initially suspected food poisoning), the home provider was advised to take R to the hospital. The home provider contacted R's case manager just before 3 p.m. to inform her that she was taking R to the hospital.

14. The hospital is about a 20-minute drive from R's home. Hospital records establish that R was checked into the emergency room at 5:01 p.m.; there is no other evidence that contradicts this timing. While it may have reasonably taken some time to get R into the car and then, once at the

hospital, out of the car and to the ER, it is not clear why the entire process from home to the hospital took two (2) hours. The home provider changed R's shirt (and petitioner recalled that the home provider started a wash of R's clothes, which the home provider does not recall), but this does not explain what occurred during this time period, nor is it clear why it was necessary to change R's shirt under the circumstances (at least as alleged by the Department).

15. Once at the hospital, R was evaluated and determined to have an esophageal obstruction. He was eventually given a medication – at 5:47 pm according to hospital records - that eased the obstruction down his esophagus. Although there was no direct evidence of the object in R's esophagus, it is reasonably concluded from the evidence that it was food. R was discharged from the emergency room at 6:23 pm. Throughout this process, R was able to breathe without any issues but continued to have difficulty swallowing anything.

16. In order to receive treatment, R needed an IV line and that required him to be restrained to insert. Until the resolution of his blocked esophagus, R was continually "spitting up" saliva and "very restless" (as described by medical staff). Although R suffered no serious medical

consequences from this event, it was clearly a source of distress to him and the blockage in his esophagus – if it had remained untreated – posed a significant risk of harm to him.

17. Prior to this event, R had experienced at least two (2) other similar events related to his difficulty eating. One event occurred several years prior to June 21, 2018, while R was with his home provider and had food lodged in his throat that he could not swallow. The home provider called 911; R did not need medical attention as the home provider was advised to allow the blockage to work its way down his throat naturally (which it eventually did).

18. The second similar event occurred while R was at the office of the local community health agency, approximately a year before the events at issue here. Both petitioner and (intermittently) R's case manager were present after he had food (apparently, hash browns from a fast food restaurant) lodged in his throat. There was no need for emergency intervention at that time and the food eventually made its way through R's throat.

19. Following the above events, a report was made to APS, and an investigation was commenced. The investigation concluded with a determination that petitioner had abused and neglected R, based on two alleged bases: one, that R was left

in the bathroom unsupervised; and two, that R did not receive timely medical attention from the point he began having problems swallowing food in the restaurant.

20. There was no evidence regarding any actual distress or harm that R suffered from allegedly being left alone in the bathroom; the Department's substantiation is based solely on the potential risk to R. However, the evidence fails to support a principal assertion of the Department – that R needed to be supervised (at that time) *inside* the bathroom. To the contrary, based on the Department's evidence, R toileted independently at the time and the primary risk was that he would exit the bathroom without pulling up his pants. As noted above, even R's home provider would leave him in the bathroom on his own, while waiting for him outside. In addition, the testimonial evidence is in part contradictory and in whole lacks clarity and persuasiveness as to when and to what extent petitioner left R without proper supervision in the bathroom, leaving insufficient evidence to show that R was *likely* to suffer or, even if less-than-likely, was at a material risk of suffering any adverse consequences for the alleged lack of supervision for a brief period of time.

21. As noted above, there is no evidence that petitioner failed to undertake the specific precautions

needed when R was eating – that is, cutting up his food into smaller pieces and ensuring that he was not "shoveling" his food. What remains is a claim that petitioner delayed emergency medical treatment for R when it became apparent that he was experiencing problems swallowing at the restaurant (that R was having these problems was largely undisputed in petitioner's testimony).

22. However, it cannot be concluded that petitioner acted recklessly or even unreasonably under the circumstances, given the resulting (and greater) length of time R spent with his home provider before being taken to the hospital (and the deliberation and consideration that went into that decision), the previous times that R's problems with swallowing had eased on their own, and R's "tactile" issues that might be aggravated by a trip to the hospital. Petitioner, in fact, brought R directly from the restaurant to his home provider and reported to his home provider that he had started coughing at the restaurant. The home provider did not take R to the hospital immediately, but contacted R's case manager and primary care physician – eventually leading to the recommendation to take R to the hospital - a process by itself that took a significant amount of time outside of any involvement or responsibility of petitioner.

ORDER

DAIL's substantiation of petitioner is reversed.

REASONS

The Department of Disabilities, Aging and Independent Living investigates allegations of abuse, neglect and exploitation concerning vulnerable adults. *See* 33 V.S.A. §§ 6901, *et. seq.* Names of individuals substantiated for abuse, neglect or exploitation are placed on a registry maintained by DAIL which may be disclosed to potential employers or volunteer organizations serving vulnerable adults, *see* 33 V.S.A. § 6911(b), potentially affecting an individual's employment, livelihood, and associations. On the other hand, the overarching purpose of the statute is to protect vulnerable adults from abuse. *See* 33 V.S.A. § 6901.

Appeals from a substantiation finding are reviewed by the Board de novo and DAIL has the burden of establishing the substantiation by a preponderance of the evidence.

The record establishes that R was a "vulnerable adult" under the statute; among other things, he had a medical condition "that results in some impairment of the individual's ability to provide for his or her own care without assistance, including the provision of food, shelter,

clothing, health care, supervision, or management of finances." *See* 33 V.S.A. § 6902(14)(D). The evidence further establishes that petitioner was in a caregiver relationship to R.

The vulnerable adult abuse statute provides the following relevant definitions:

> (1) "Abuse" means:
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> > (A) Any treatment of a vulnerable adult which places life, health, or welfare in jeopardy or which is likely to result in impairment of health.
> >
> > (B) Any conduct committed with an intent or reckless disregard that such conduct is likely to cause unnecessary harm, unnecessary pain, or unnecessary suffering to a vulnerable adult.
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> ****
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> (2) "Caregiver" means a person, agency, facility, or other organization with responsibility for providing subsistence or medical or other care to an adult who is an elder or has a disability, who has assumed the responsibility voluntarily, by contract, or by an order of the Court; or a person providing care, including medical care, custodial care, personal care, mental health services, rehabilitative services, or any other kind of care provided which is required because of another's age or disability.
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> ****
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> (7)(A) "Neglect" means purposeful or reckless failure or omission by a caregiver to:
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> > (i) provide care or arrange for goods or services necessary to maintain the health or safety of a vulnerable adult, including food, clothing,

> medicine, shelter, supervision, and medical services, unless the caregiver is acting pursuant to the wishes of the vulnerable adult or his or her representative, or an advance directive, as defined in 18 V.S.A. § 9701;
>
> (ii) make a reasonable effort, in accordance with the authority granted the caregiver, to protect a vulnerable adult from abuse, neglect, or exploitation by others;
>
> (iii) carry out a plan of care for a vulnerable adult when such failure results in or could reasonably be expected to result in physical or psychological harm or a substantial risk of death to the vulnerable adult, unless the caregiver is acting pursuant to the wishes of the vulnerable adult or his or her representative, or advance directive, as defined in 18 V.S.A. § 9701; or
>
> (iv) report significant changes in the health status of a vulnerable adult to a physician, nurse, or immediate supervisor, when the caregiver is employed by an organization that offers, provides or arranges for personal care.
>
> (B) Neglect may be repeated conduct or a single incident which has resulted in or could be expected to result in physical or psychological harm, as a result of subdivisions (A)(i), (ii), or (iii) of this subdivision (7).

33 V.S.A. § 6902.

In general, the allegations against petitioner are in the nature of "omissions" rather than affirmative "actions," which invites the preliminary question of whether the definition of "abuse" is applicable in this case ("abuse" being defined as "treatment" or "conduct"). This question is

amplified when reading the definition of "abuse" in comparison to "neglect," the latter clearly contemplating "omissions" and/or "failures" by a caregiver – meaning the distinction with "treatment" and/or "conduct" in the definition of abuse is arguably meaningless if "abuse" were also to include "omissions." However, it is not necessary to reach this question given that the factual record does not establish that petitioner behaved intentionally, with reckless disregard, or in a way that jeopardized or was likely to result in impairment of R's life, welfare or health (or likely to cause unnecessary pain or suffering).

There is no evidence or apparent allegation that petitioner failed to properly prepare R's food or failed to prevent him from "shoveling" his food. To the extent that petitioner was aware or should have been aware that R was having issues with his food, and passively delayed addressing those issues, she returned him home - and directly from the restaurant - within a period of time that is a fraction of the time it took for R's home provider to consider the same situation and – *after* consulting with both his case manager and physician - bring him to the hospital. That process – of trying to determine how to address R's situation at the time - was more deliberate than it was urgent, and not

unreasonable given R's history, medical issues (including his tactile sensitivity) and the overall circumstances. Petitioner's role in that process does not rise to the standard of "abuse" or "neglect" under the law.

What remains is confounded and unpersuasive evidence of what occurred when petitioner took R to the bathroom and following his exit from the bathroom. In addition, the evidence does not support one of the Department's main assertions – that R needed supervision *inside* the bathroom. As such, the factual record does not establish any conduct or omission – reckless, purposeful, or otherwise - by petitioner which caused or exposed R to likely harm, jeopardy or impairment of his health or safety, under the statutory standard for abuse or neglect.

For the foregoing reasons, DAIL's substantiation of petitioner is inconsistent with the applicable law and the Board must reverse. *See* 33 V.S.A. § 3091(d); Fair Hearing Rule No. 1000.4D.

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