

STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. 12,795

)

Appeal of)

)

INTRODUCTION

The petitioner appeals the decision by the Department of Aging and Disabilities "substantiating" a report of neglect against the petitioner involving a disabled adult under her care at a community-based residential facility. The petitioner seeks to have the report destroyed and not entered on the Department's "registry".

FINDINGS OF FACT

Until November 11, 1993, the petitioner was employed as a support person by a community mental health service to provide personal care to a severely retarded adult woman, C.A., who resides in a private home in the community as part of Vermont's community access program for retarded adults.

C.A. is non-verbal and has severe behavioral problems that require intense supervision. She has a guardian (not the petitioner) who is an employee of the Department of Mental Health.

The worst of C.A.'s behaviors is her propensity for self injurious behavior (SIB), which usually consists of hitting herself repeatedly on the side of her head with her

fists. The parties agree that the frequency and severity of C.A.'s SIB has been cyclical over the years.

C.A. spent many years of her life in the Brandon Training School. The petitioner first had contact with C.A. in 1990, when she was hired as an aide at the training school. Sometime between 1990 and 1992 C.A. was placed in the "women's cottage" at the training school where the petitioner worked frequently with her. The petitioner got along well with C.A. at the cottage and was praised by her supervisors for her work with C.A.

In February, 1992, C.A. left the training school and was placed in a private apartment in the community under the auspices of the mental health agency in that community. The mental health agency

aggressively recruited the petitioner to leave her job at the training school to work exclusively with C.A. providing direct care for her in the apartment she had been moved to in the community. The petitioner accepted, and began this job on March 6, 1992.

The job consisted of the petitioner basically living in an apartment with C.A. providing full-time personal care and supervision. In the summer of 1992, a retarded adult man, with his own full-time support person, was also placed in the same apartment. In December, 1992, both residents and their support persons moved to the home where the incident that is the subject of this proceeding took place.

Since the time of her placement in the community C.A. has had a written Individual Program Plan (IPP) developed by the community mental health agency. The "goals" of the IPP are to increase C.A.'s socialization, communication, and personal management skills, and to secure meaningful day activity for C.A. The petitioner, as C.A.'s support person, was primarily responsible for implementing C.A.'s IPP. Reducing and controlling C.A.'s SIB has always been a primary objective in the implementation of her IPP. One of the petitioner's primary responsibilities was to attempt to physically "block" SIB whenever C.A. initiated it.

In the fall of 1993, C.A.'s SIB became markedly worse, to the point of being reflected in her physical appearance

--e.g., hair loss around her temples and scabs and bruises on her face. At the instigation of C.A.'s guardian, C.A.'s IPP was amended to provide for two-to-one staffing for C.A. at most times to ensure that each and every attempt by C.A. to engage in SIB was successfully blocked. In addition to the petitioner, the case manager for the mental health agency's community access program, who was the petitioner's immediate supervisor, was to personally provide this double staffing.

The results of this double staffing were dramatic and timely. Within a few weeks C.A.'s SIB decreased markedly to the point where the petitioner's supervisor stopped coming to the home to provide additional direct service. It was understood, however, that the petitioner would continue to provide C.A. with attentive one-on-one care and supervision.

On November 11, 1993, about a week after the double coverage of C.A. had been discontinued, the support person for the resident who shared C.A.'s home was having a problem with her ankle and wanted to see a doctor. She called her and the petitioner's supervisor, who agreed that she could have a friend drive her to the doctor. The supervisor didn't speak with the petitioner that day, but she understood that the petitioner would be in the home alone with C.A. and the other resident while the other resident's support person was at the doctor.

What happened after the other support person left the home that morning is the subject of considerable dispute. The petitioner maintains that she bathed and dressed the other resident. The support worker recalls that she had bathed him before she left to go to the doctor. At any rate, the petitioner testified that C.A. was doing well that day--as she had been for at least the preceding week--and was giving no indication that she was likely to engage in SIB.

The day in question was unusually warm and sunny. The petitioner testified that in an attempt to engage C.A. and the other resident in some outdoor activity she began to wash her car, which was parked

directly in front of the house a few feet from open windows and doors. The petitioner stated that from where she was standing just outside the house she could see and hear the activities of C.A. and could respond promptly if there was any problem. It does not appear, however, that from outside the petitioner could directly see all areas of the house in which the residents could have wandered.

The petitioner was outside washing her car when the other support person and the woman who had driven her returned from the doctor. They had been gone from between one and two hours. They found C.A. lying on the couch in the living room and the other resident upstairs in his room, neither one of them in any distress.

The woman who had driven the other support person to the doctor was an employee of the Department of Mental Health who had worked with C.A. and the petitioner at the training school, and was familiar with C.A.'s needs and case plan. It appeared to her that the petitioner's washing her car was neglectful of C.A.'s needs, and she reported what she had seen to the petitioner's supervisor and to C.A.'s guardian.

The petitioner was subsequently discharged from her employment and the incident was reported to the Department, which "substantiated" it as one in which C.A. had been subject to "neglect" by the petitioner.

Based on the evidence presented, however, the worst that can be found is that the petitioner used questionable judgement on the day in question in washing her car while C.A. remained in the house. Regardless of her motives in doing so (i.e., whether or not she was attempting to engage C.A. in outdoor activity), it cannot be found that the petitioner failed to provide C.A. with "care necessary for her well-being" (see infra) that day.

The Department does not allege that C.A. engaged in SIB on the day in question, and there is no evidence that there was any particular reason to believe she was likely to do so. The Department does not dispute that the petitioner was the person most familiar with C.A.'s needs and behaviors. There is no evidence that while the petitioner was outside that day she at any time failed to note where C.A. was in the house and what C.A. was doing, or that the petitioner could not have promptly responded if C.A. had required her care.

It is also uncontroverted that for at least a week prior to that time C.A. had not engaged in SIB, and that it appeared to all concerned that she had "cycled out" of a severe period of such behavior. A week prior to the day in question the petitioner's supervisor (apparently unilaterally) had discontinued altogether the double coverage of C.A. she had helped the petitioner to provide. Moreover, on the day in question, the petitioner's supervisor was not concerned about diluting C.A.'s coverage even further by leaving the petitioner alone in the home to care for C.A. and the other resident. Indeed, under the circumstances, for the petitioner's supervisor to have fired the petitioner for violating "protocol" on the day in question, and for the Department to then single out the petitioner as having "neglected" C.A. that day, strikes the hearing officer as disingenuous.

ORDER

The Department's decision "substantiating" the report of neglect by the petitioner is reversed, and the report shall be destroyed and not entered on the Department's registry.

REASONS

The Commissioner of the Department of Aging and Disabilities is required by statute to investigate reports regarding the abuse of elderly and disabled persons and to keep those reports that are "substantiated" in a "registry" under the name of the person who committed the abuse. 33 V.S.A. §§ 6906 and 6911. Within 30 days of notification that a report of abuse has been substantiated against them individuals can apply to the human services board for a fair hearing on the grounds the report is unsubstantiated. Id § 6906(d). Reports that are found to be unsubstantiated must be destroyed pursuant to 33 V.S.A. § 6906(e) and not entered in the Department's registry.

"Neglect" is defined by 33 V.S.A. § 6902(9) as: "...the lack of subsistence, medical or other care necessary for well being." The issue in this case is not whether the petitioner discharged her duties to the satisfaction of her employer, but whether her actions rose to the level of "neglect" as defined by the above statute. The facts and circumstances of this case, as found above, do not support such a conclusion.

The Department presented no compelling evidence that the "care necessary (for C.A.'s) well being" on the day in question required the petitioner to be in C.A.'s immediate vicinity at all times. Moreover, it is found that decisions made by the petitioner's supervisor that same day directly belie this assertion. The petitioner may have used questionable judgement that day, but it cannot be concluded that by going outside and washing her car the petitioner "neglected" C.A. within the meaning of the above statute. The Department's decision is reversed.

###