

# MAINE ELDER DEATH ANALYSIS REVIEW TEAM



## 2006 Annual Report

MAINE ELDER DEATH ANALYSIS REVIEW TEAM  
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**TABLE OF CONTENTS**

<b>Quote from Hubert Humphrey .....</b>	<b>3</b>
<b>Mission Statement .....</b>	<b>4</b>
<b>Chair Report .....</b>	<b>5</b>
<b>Members List.....</b>	<b>6</b>
<b>2006 Case Summaries and Recommendations .....</b>	<b>9</b>

***“It was once said that the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy and the handicapped.”***

***Hubert H. Humphrey***

## **MISSION STATEMENT**

The Maine Elder Death Analysis Review Team (MEDART) will examine deaths, and cases of serious bodily injury, associated with suspected abuse or neglect of the elderly and vulnerable adults. The purpose of MEDART is to review deaths related to abuse and neglect, and to identify whether systems that have the purpose or responsibility to assist or protect victims were sufficient for the particular circumstances or whether such systems require adjustment or improvement. MEDART will foster system change that will improve the response to victims and prevent similar outcomes in the future.

MEDART recognizes that the responsibility for responding to and preventing fatalities related to abuse or neglect of the elderly and vulnerable adults lies within the community and not with any single agency or entity. It is further recognized that a careful examination of the fatalities provides the opportunity to develop education, prevention, and strategies that will lead to improved coordination of services for families and our elder population.

## CHAIR REPORT

The Maine Elder Death Analysis Review Team (MEDART) has begun its fourth year of examining deaths and cases of serious bodily injury associated with suspected abuse or neglect of elderly and vulnerable adults. During 2006 the Team reviewed four cases which included victims of homicide, murder/suicide, neglect and an avoidable death.

Current statistics from the Northeastern University Center for Labor Studies highlights the aging nature of Maine. Maine has the nation's highest median age at 41.2 years and the lowest percentage of residents under age 18. As Maine's population over age 60 doubles in the next several years, unfortunately so will the number of elder abuse, neglect and exploitation victims which is currently projected at approximately 13,000 each year.

The challenge for Maine's communities will be to develop and expand resources to meet the needs of these victims. MEDART helps to identify gaps in our client and victim services areas and makes recommendations for systemic change. The 2006 Annual MEDART Report highlights the need to increase awareness, services and screening for elder suicide, increase Maine's capacity for quality elder care and to build on the data needed to properly determine the extent of elder abuse.

MEDART members wish to recognize the efforts of Attorney General Steven Rowe in fighting the crime of elder abuse. General Rowe's continued support and advocacy for older victims has made a significant difference in the prosecution of cases in Maine, recent legislation on reporting elder abuse from financial institutions and the high priority given to older victims by staff of the Office of the Attorney General.

*Ricker Hamilton*  
Chair

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## **2006 Case Summaries & Recommendations**

### **Case Summary #2006-01**

This review focused on the events surrounding the death of a 53 year-old man who was reported missing by a family member and after a police investigation was found to be the victim of a homicide. The decedent died due to a gunshot wound to the head and his body was found dismembered and buried in the woods behind the residence of an acquaintance in a rural Maine town.

The information contained in this report derives from persons involved in the investigation, and representations and scientific examinations originating from a number of sources including the Maine State Police, Office of the Chief Medical Examiner, and the Waldo County Sheriff's Department.

### **Recommendations for Case #2006-01**

1. This review resulted in no recommendations but served as a valuable learning exercise for the team.
2. The team concluded that the decedent was able to care for himself, but unfortunately as a result of previous head trauma lacked "some reasoning" affecting who he associated with. Apparently, the suspect wanted possession of the decedent's disability payments and food stamp card benefits.
3. It is the opinion of the Team that all of the agencies involved in this investigation did a skilled, impressive and professional job. The Team would like to recognize the superb investigation conducted by the Maine State Police and Waldo County Sheriff's Office, as well as the skilled individuals of the Maine Warden Service in their assist with the search for the body. The Team would also like to acknowledge the expert examination of the Office of the Chief Medical Examiner and Forensic Anthropologist.

### **Case Summary #2006-02**

This review focused on an elderly couple from northern Maine who died as the result of an apparent murder/suicide. The elderly couple was preparing to move into an assisted living senior citizen apartment complex. The couple was found by a woman who lived next door and

who had gone to the decedents' residence the morning they were scheduled to move. She discovered the couple deceased in their bedroom and called the police. The Medical Examiner's Office and the police ruled it was a murder/suicide with the 80 year old husband shooting his 78 year old wife and then turning the gun on himself.

The couple had lived at their farmhouse residence for many years. Due to their deteriorating health and aging, the wife wanted to move to an assisted living center. Police interviews with the couple's children, other family members, a family friend and neighbor revealed that the husband did not want to move. The general depiction of the husband's demeanor was that he was stubborn, controlling and verbally abusive. There was, however, no allegation of physical abuse.

The couple had five children. Two of the children lived out of State, and three lived locally. One son recalled a discussion about his parents moving to the assisted living facility, but could not recall whose idea it was. The couple's children were not aware that admission forms for the assisted living apartment had been signed by both parents. One son went to his parent's residence the day prior to the scheduled move, and was surprised to find that they had already moved some of their belongings to the apartment. None of the couple's children knew the name of or had visited the apartment. One son stated that he went to his parent's residence four times a week to do grocery shopping, and to get prescriptions or anything that they needed. The couple's other children would visit and help out as much as they could.

The father had talked about suicide for years, saying things like he ought to just shoot himself. He had made these types of comments for about 15 years. The son describing these statements indicated that he did not take them seriously, but rather thought that it was his father's way of getting pity. His father's statements related only to himself, and there were no threats of harming his wife. They stated that their father had a "mean streak," but they never thought "in a million years" that this (murder/suicide) would happen. One son told police that his mother really wanted to move because his father's legs were in bad shape. He said his father recognized that he needed to leave, but he didn't want to.

According to a longtime friend, the wife could not get around very well. She used a cane or walker and was prone to falls. The husband had difficulty with swelling in his legs and he had trouble putting on shoes. The couple tended to each others needs, but doing so had become much more difficult. The wife was excited about the move. The husband was determined not to

go. The farmhouse was his home and he did not want to move. The friend said it did cross his mind that the husband might kill himself, but he never thought that he would harm his wife.

The neighbor that found the decedents felt that it was unsafe for them to stay in their house due to their deteriorating physical conditions. No one checked on them on a daily basis. The husband had discussed suicide with the neighbor in the past when he was in a lot of pain and having serious problems with his feet. He told her that he didn't want to leave the farm and thought about shooting himself.

The day before the shooting, the wife and neighbor had moved some of the couple's belongings and discussed that the husband didn't want to go. The wife told the neighbor that her husband was making statements like he would be "better off dead" and that he mentioned murder/suicide. The wife told the neighbor that her husband had made comments like this in the past. The neighbor indicated that the wife did not say this as though she felt threatened. In no way did the wife express to the neighbor that she was in any kind of danger at all. She appeared happy and optimistic about the move. She had responded to her husband that she "wasn't ready to go yet" and laughed. The wife assured her neighbor that she could handle the situation.

The wife's sister told police that she told her that her husband would kill himself before he would move. Her sister's husband was not easy to live with and had a temper. A nephew who plowed the couple's driveway said his uncle was the old-school type who would not want to leave his wife to fend for herself or to be a burden on someone else. This nephew said he first heard of his uncle's suicidal threats from another relative on the day of the murder/suicide and said that if he had known his uncle was threatening suicide all summer, he would have definitely been concerned for his aunt's safety. The nephew said his aunt would never commit suicide or agree to it, because of her religious beliefs.

There were two gun racks on a wall in the dining room. A relative said someone was supposed to get the guns out of the house, because of what the husband was saying, but attempts to remove the firearms from the residence were unsuccessful.

### **Recommendations for Case 2006-02**

1. Develop and implement education and awareness programs about elder suicide in the community. Evaluate elder suicide prevention awareness resources and determine what options exist for people who are dealing with elders in their families and community who

talk about suicide. Physicians should play a key role in elder suicide prevention by being able to steer people toward agencies that can help them with their feelings of hopelessness. Managers at assisted living centers should be aware of a person who appears despondent or very hesitant about going into the assisted living facility. The facility should be able to direct the individual to agencies that may be able to assist them in staying in their home longer; such as home health services and meals on wheels.

### **Case Summary #2006-03**

This review focused on the events surrounding the death of a 68 year-old man admitted to a nursing facility on July 6, 2004. The decedent had cancer of the bladder and was at the nursing facility for physical and occupational therapy in the skilled units. On July 22, 2004, the decedent was discharged from the nursing facility and transferred to a boarding home as his attending physician felt that he was stable. The decedent arrived at the boarding home at 9:35 A.M. and then died at approximately 7:00 P.M. that same day.

Prior to being discharged from the nursing facility, a lab sample had been taken from the decedent. The lab results were completed at 12:26 P.M. and the decedent had critically high amounts of potassium in his blood. The lab communicated the results only to the RN at the skilled unit.

The RN that received the decedent's lab results said he realized that the lab results were serious and stated that he called the boarding home at approximately 9:15 A.M. (note the RN's times are not correct because the lab had not completed the tests until 12:26 P.M.). He told a person at the boarding home that the decedent's lab results were critically high and that the decedent's doctor needed to be notified immediately.

The person that the RN spoke with at the boarding home was the resident care director which is a similar position to a medical aide or med-tech. She told the RN that she wasn't a nurse and couldn't take an order over the phone. She asked the RN to fax the blood work results for the decedent and stated that when she received them, she would fax those results to the decedent's doctor's office. The RN faxed the critical lab results, but the fax was received by someone else. The person who received the lab results called the RN to advise that the fax was received in error. The RN said he re-sent the fax to the boarding home.

The RN assumed that the doctor had been called by the boarding home personnel. According to the boarding home worker, the fax never came in. The boarding home worker said

that she did not realize how important the message was and that the RN never said the decedent could die or anything, just that the potassium and digoxin levels were high (the decedent's potassium level was 9.3 and normal is between 3.6 - 5.2) and (the decedent's digoxin level was 3.4 and normal is between 0.8 and 2.2.). The boarding home has no licensed staff. An RN comes in once a week and was not there on the day the decedent arrived.

The RN said he didn't call the decedent's doctor himself with critical lab results because the decedent had already gone to the boarding home. He thought that he was only obligated to pass the results on to the boarding home and believed that the boarding home would then notify the doctor. The decedent's doctor was not informed that day of the lab results and said that she would have had the decedent taken to the emergency room immediately if she had been.

The information contained in this report was derived from persons involved in the investigation, as well as representations and scientific examinations originating from a number of sources including the Maine Attorney General's Office and the Office of the Chief Medical Examiner.

### **Recommendation for Case #2006-03**

1. Nursing facilities appear to be under pressure to discharge patients. Prior to discharge from the hospital or nursing facility, individual patient needs and requirements should be identified and communicated to the boarding home prior to the patient's arrival. Because the transfer of patient information and medical history is extremely important, there should be training for hospital, nursing, and boarding home staff regarding the proper procedures to safely and accurately accomplish this.
2. The reporting policy of the laboratory should be changed to include that the patient's doctor and/or the ordering physician or practitioner be notified immediately with any critical lab result.
3. Hospital and Laboratory staff should undergo continued training and emphasis on the importance of documentation and follow-up concerning critical lab values.
4. Trainings on the policies and protocols regarding the reporting of critical lab results to physicians and proper documentation of reporting should be held periodically so that staff is aware of the importance of notifying the patient's physician regardless of the location of patient.

5. A recommendation was made that MEDART send out copies of the Medical Examiners Model Policy to Nursing Homes and other Long Term Care Facilities in Maine regarding the reporting of deaths. Individual facilities should continue to provide individual training programs for staff regarding the protocol for reporting deaths.

### **Case Summary #2006-04**

This case focused on the events surrounding the death of a 76 year-old woman on September 28, 2005, as a result of sepsis (infection in the blood), with multi-system inflammation due to cellulitis (a skin infection) and decubitus ulcers (pressure sores).

On September 22, 2005, the decedent was transported by the local fire department to the hospital. The fire department personnel were unable initially to move the patient because her mattress bedsprings had become embedded into her skin. The fire department personnel were unable to separate the bedsprings and mattress from the woman and she had to be transported to the hospital in a box truck. The mattress was saturated in urine and feces and had rotted around the decedent.

Prior to her death, the decedent lived next door to her son and daughter-in-law. They had been her caregivers for the prior eleven years. According to information from her family and her medical records, she had suffered a stroke in 1996 and refused to go to the hospital. She did allow a doctor to come and treat her in her house. The stroke caused the decedent to lose some mobility in her right arm and leg. According to her son, the decedent refused physical therapy causing her to be almost completely bedridden. In addition, the son reported that caregivers were hired to help take care of the decedent but were all fired by her. The son stated that his mother was a very stubborn woman and she was sharper mentally than he and his wife “put together.” The decedent had medical insurance. With the exception of the doctor’s visit following her stroke, she had not visited a doctor in 25 years. The decedent did not take any medication except for Tylenol PM.

The daughter-in-law described the decedent as an “ornery woman” who was proud of the fact that she lived without running water. The daughter-in-law carried water to the decedent weekly. She said the decedent was an intelligent but controlling person. The decedent would not let her clean the house, throw anything away, or even change the bed sheets. She had basically built a barricade around her bed with various items and wouldn’t let anyone get within an arms reach of her.

The son told investigators that his mother claimed to be not mobile and she was always in the bed when they were there, but he and his wife had several reasons to believe that she was getting up and moving around. For example, sometimes items in the decedent's home that were out of her arms reach were moved. The daughter-in-law had not seen her up and walking around since 1996. The son said that the house would not allow for a wheelchair because of limited space.

There was no working refrigerator in the house. The decedent kept a little cooler in her residence and they brought ice packs every day. The son and daughter-in-law did her grocery shopping, banking, and picked up her mail. The decedent was a vegetarian and ate vegetable soups, organic fruits, nuts, vegetables and nutrition drinks. The decedent was morbidly obese but was diagnosed as having protein calorie malnutrition.

There was limited electrical supply throughout the house due to a fire at the residence in the early 1990's. The decedent would not let her son take care of the electrical repairs that were needed. The decedent did have a working telephone beside her bed. The son said that his mother wanted the thermostat set at 75 to 80 degrees even in the summer. The decedent would make diapers out of paper towels and then put them in bags to be taken out. The daughter-in-law said the decedent kept her face clean and her hair combed.

According to the son and daughter-in-law, no other family members or neighbors came to visit the decedent and she shut everyone out of her life. A neighbor would drop care packages off on the doorstep because the decedent did not want the neighbor to come into the house. The decedent did correspond with her half brother in another state. The daughter-in-law said the relationship between mother and son was "up and down." There was an allegation that she had sexually abused him as a young boy, but that they currently got along okay depending on her mood at the time.

A couple weeks before the decedent was transported to the hospital, the son and daughter-in-law noticed signs that her health was slipping. For example, they reported that she was not eating right and not drinking her nutritional drinks. The decedent complained of pain in her leg and they tried talking her into seeing a doctor but she refused and would not go to the hospital. The son started making calls to different agencies to try to find out if they could get decedent help against her will. The son stated that back in May 2005 his mother told him a spring had popped through her mattress and had caught her left buttock. She was treating it by

putting tissues in there, and she told him that it was healing. He said that he and his wife spent a whole day looking for mattresses for his mother.

The decedent's son worked for the local fire department and on September 21, 2005, went to the fire chief and told him he had finally talked his mother into going to the hospital and requested assistance to remove her from the residence. He said he was very concerned with her condition and that she had some open wounds on her leg. The son told the fire chief that he didn't want the chief to dispatch the guys to the call and wanted him to get together a select crew to move her because his mother weighed 300 pounds, that she was stuck to the bed and that the bedsprings might be up inside of her. The fire chief indicated that they could transport her right then, but he said that his mother wasn't ready to go, and that he and his wife needed to go in and do some cleaning first. They arranged for her transport the next day (09/22/05) at 10:00 A.M.

The next morning, the fire department personnel were met outside the residence by the son and daughter-in-law. One of the firefighters said they were standing approximately 30 feet from the house and they could hear moans coming from inside the house. The daughter-in-law told fire department personnel they would probably need nose plugs. According to fire department personnel, the decedent's house was heavily cluttered. She was found lying on a mattress with the springs exposed. Her skin was growing around the springs and the mattress had deteriorated around her. When they tried to move her, she would scream in pain. The decision was made to transport her to the hospital still attached to the mattress. The fire department crew cut a hole in the wall of the decedent's house to get her and the mattress out.

A firefighter said the pillow under the decedent's head was all sweat stained and the window in her room was duct taped shut. The thermostat was on 85 degrees. Another firefighter said he saw maggots and fruit flies when they moved the decedent and that outside of her room there was a dead rat. There were rat feces on the floor and in the bed with the decedent. The decedent commented that she should have never let it get this far and kept apologizing.

Another firefighter said he has been in the area for 20 years and had been to the decedent's residence two to three times in the past and her residence was no different than on this day (09/22/05). The decedent knew him and knew his name. He said as long as she didn't move she was comfortable. One firefighter reports that the decedent made reference to her poor physical condition but that she had lived her life the way she had wanted.

## **Recommendations for Case #2006-04**

1. Create public education materials that include broadcast radio and television public service announcements advising the public of local services available to the elderly and their families. This education and outreach effort to the public regarding elder care should include information regarding issues such as competency, home health assistance, the importance of diet and proper hydration, safety, mental health resources, and personal hygiene.
2. Targeted education of healthcare workers and volunteers regarding elder independence issues including unsanitary living conditions, hygiene, medical assistance, and access to public utilities like power, heat, and water. Even in situations when an elderly person is deemed to have mental capacity and state that they want to live in those conditions, there should be a duty to report the unsanitary living conditions that place their health and wellbeing in jeopardy so that the elder is offered options and alternatives. The elderly person should be encouraged to seek help. Increase education and outreach efforts for seniors to make them aware of services and programs that are available to them.
3. Firefighters should be added to the list of mandated reporters to the Adult Protective Services Act.
4. Conduct a review of the Endangering the Welfare of a Dependent person statute to determine if it needs clarification as to what constitutes a “dependent person” and what constitutes a “caregiver.”