INCAPACITATED AND VULNERABLE ADULT FATALITY REVIEW COMMITTEE

2021-2022 Biennial Report
November 2022

CONTENTS

ACKNOWLEDGMENTS

Sincere appreciation goes to the members of the Incapacitated and Vulnerable Adult Fatality Review Committee (IVAFRC), who have continued to work diligently and respectfully to study New Hampshire's incapacitated and vulnerable adult fatalities, in an effort to prevent future deaths.

These deaths are difficult and painful to review. The IVAFRC has worked to honor the lives that have been lost and to examine ways to help prevent future fatalities. The IVAFRC would like to recognize and thank all of the individuals who have made presentations at IVAFRC meetings and who have participated as guests in reviewing the cases. We are indebted to these individuals for assisting us in better understanding the complexities of the issues surrounding these fatalities.

The IVAFRC has welcomed new members Joi Smith, Matthew Boucher, Dr. Stuart Lewis, Dr. Heather-Ayn Indelicato, and Josanne Mirolo, whose participation and engagement have helped continue the work of the Committee. The IVAFRC is also pleased to welcome three new members from law enforcement to the Committee, Officer Jacqueline Pelletier, a Support Services Officer from Goffstown Police Department, Deputy Charles Pendlebury from Merrimack County Sheriff's Office and Sergeant Justin Rowe, the State of NH Coordinator for Amber/Blue/Silver Alert Programs from New Hampshire State Police. They join us following a Committee recommendation to increase representation of senior law enforcement officers and establish wider connections within the law enforcement community to facilitate the sharing of resources statewide to aid in the prevention of incapacitated and vulnerable adult fatalities.

We also express our sincere thanks to Dr. Thatcher Newkirk, Mark Feigl, Amanda Sexton Grady, Marie Linebaugh, Bryan Townsend and Stacey MacStravic, who have departed the Committee, but whose time, experience and insight have contributed to the work of the IVAFRC and to the content of this report.

The IVAFRC would also like to acknowledge the many people who worked in long-term care settings during the Covid-19 pandemic. These staff faced unfathomable challenges in the midst of an unknown virus. Covid-19 had significant impact upon the residents of the various long-term care settings, such as assisted living, nursing homes, and group homes, and yet staff continued to show up for work to care for some of our most vulnerable citizens.

We thank you for your dedication and appreciate, beyond words, your actions during such difficult times.

MISSION STATEMENT

To reduce incapacitated and vulnerable adult fatalities through systemic multidisciplinary review of incapacitated and vulnerable adult fatalities, evaluation of practices, policies, relevant data and trends and through recommendations for changes in law, policy and practice.

We recognize the responsibility for responding to, and preventing, incapacitated and vulnerable adult abuse and neglect fatalities lies within the community, and not with any single agency or entity. We further recognize that a careful examination of the fatalities provides the opportunity to develop education, prevention, service delivery, management, quality assurance strategies and, if necessary, prosecution strategies that will lead to improved coordination of services for incapacitated and vulnerable adults and their families.

OBJECTIVES

1. Determine and report on trends and patterns of incapacitated and vulnerable adult deaths in New Hampshire.

2. Recommend policies, practices, and services that will promote collaboration among service providers for and reduce preventable fatalities among incapacitated and vulnerable adults.

3. Evaluate policies, practices, intervention and responses to fatalities among incapacitated and vulnerable adults and offer recommendations for any improvements in those interventions and responses.

4. Evaluate and report on high risk factors, current practices, gaps in systematic responses, and barriers to safety and well-being for incapacitated and vulnerable adults in New Hampshire.

5. Recommend improvements in the sources of data relative to preventing fatalities among incapacitated and vulnerable adults.

6. Educate the public, policy makers, and budget authorities about fatalities that involved incapacitated and vulnerable adults.

7. Identify and evaluate the prevalence of risk factors for preventable deaths in the population of incapacitated and vulnerable adults.

8. Development and dissemination of a biennial report to state officials describing any trends and patterns of deaths or serious injuries or risk factors. Recommendations for changes in law, policy, and practice that will prevent deaths and related serious occurrences and special reports when doing so is necessary to alert authorities or the public to the need for prompt corrective action.

INCAPACITATED AND VULNERABLE ADULT FATALITY REVIEW COMMITTEE

Co-Chairs

Elizabeth Fenner-Lukaitis*
Acute Care Services Coordinator
Bureau of Mental Health Services

Rachel Lakin*
Adult Protective Services Administrator
Department of Health and Human Services

Vanessa Blais*
Director of Policy and Planning
NH Council on Developmental Disabilities

Vicki Blanchard, BS, NRP, IC*
Captain, Clinical Systems
NH DOS, Division of Fire Standards and Training & EMS

Matthew Boucher
National Certified Guardian
Office of Public Guardian

Francesca Broderick, JD (alt.)
Attorney
Disabilities Rights Center - NH

Susan Buxton
State Long-Term Care Ombudsman
Office of the Long-Term Care Ombudsman

Janet Carroll, RN, CEN, SANE – A/P
Dartmouth Hitchcock Medical Center
NH Coalition Against Domestic and Sexual Violence

Tiffany Crowell
Nurse Administrator
Bureau of Developmental Services

Officer Steven Duquette
Senior Service Officer
Manchester Police Department

Jennie Duval*
Chief Medical Examiner
Office of the State Medical Examiner

Kristie Holtz (alt.)
Unit Chief of Certification
Bureau of Licensing and Certification

Detective Rochelle Jones
Portsmouth Police Department

Kelly Keefe (alt.)
Bureau of Health Facilities Administration
Department of Health and Human Services

Julie Lane (alt.)
Assistant Administrator
Adult Protective Services, NH BEAS

Stuart Lewis, MD *
Associate Professor Medicine, Geisel School
Dartmouth-Hitchcock Medical Center

Josanne Mirolo, *Staff Assistant* *
Office of Victim/Witness Assistance
NH Attorney General's Office

Sunny Mulligan Shea, Victim Advocate*
Elder Abuse and Exploitation Unit
NH Attorney General's Office

*= denotes Executive Committee Member

Dr. Thatcher Newkirk
Geriatric Psychiatrist
New Hampshire Hospital

Stephanie Patrick (alt.)
Executive Director
Disabilities Rights Center

Officer Jacqueline D. Pelletier
Goffstown Police Department

Isadora Rodriguez-Legendre, MSW
Executive Director
NH Council on Developmental Disabilities

Sergeant Justin Rowe
State of NH Coordinator for
Amber/Blue/Silver Alert Programs
NH State Police

Lynda Ruel, Director*
Office of Victim/Witness Assistance
NH Attorney General's Office

Bernie Seifert
Deputy Director
National Alliance on Mental Illness of New Hampshire (NAMI)

Doreen Shockley
Manager, Bureau of Licensing and Certification
Department of Health and Human Services

Joi Smith
Program Director
New Hampshire Coalition Against Domestic and Sexual Violence

Kerri Swenson (alt.)
Mental Health Systems Administrator
Bureau of Mental Health Services

I. INTRODUCTION

The abuse of incapacitated and vulnerable adults is a serious problem, both locally and nationally. However, the responses of the justice, health, and social services systems to incapacitated adult abuse lag far behind their responses to the similar problems of child abuse or domestic violence. Fatality review teams for child abuse and domestic violence have had an impact in improving systems' responses to the victims of those similar forms of abuse.

The Incapacitated and Vulnerable Adult Fatality Review Committee (IVAFRC) or "Committee" is a group of professionals from different organizations, agencies and branches of government that convenes regularly to review cases where an incapacitated or vulnerable adult has died. The theory underlying the fatality review process is that if we are able to understand why and how a death occurred, we can learn important lessons to help prevent future deaths. The review process affords the Committee with the opportunity to develop recommendations intended to improve the statewide provision and coordination of services for incapacitated and vulnerable adults and their families. By statute, the primary emphasis is on reviewing selected deaths of incapacitated and vulnerable adults who are receiving, were recently receiving, or potentially should have been receiving services from the mental health system (including NH Hospital), the Area Agency system (which services individuals with developmental disabilities or acquired brain injuries), the elderly service system, licensed care and treatment facilities, or were reported to the Bureau of Elderly and Adult Services as victims of abuse, neglect or exploitation under RSA 21-M (IV).

II. HISTORICAL BACKGROUND

In 2007, House Bill 862-FN, sponsored by State Representatives Schulze, MacKay, Donovan, Emerson, French and Senator Fuller Clark was introduced to establish a committee to study the incidence and causes of deaths of incapacitated adults. (See Appendix A) The purpose of the proposed committee was, among other things, to recommend policies, practices, and services that will promote collaboration and reduce preventable fatalities among incapacitated adults.

On January 1, 2008, NH RSA 21-M:16 took effect, creating the Incapacitated Adult Fatality Review Committee. The Committee, administratively attached to the Attorney General's office, exemplifies New Hampshire's strong tradition of multidisciplinary cooperation and its commitment to improving the State's ability to protect its most vulnerable citizens.

The authority and objectives of the Committee are defined in the statute and incorporated into the Committee's mission statement. The meetings and records of the Committee are exempt from the provisions of RSA 91-A (Right-to-Know Law). The Committee adheres to strict confidentiality standards and does not identify reviewed cases. Additionally, Committee members

sign a confidentiality agreement that prohibits any unauthorized dissemination of information beyond the purpose of the review process as a condition of membership. This also allows participants to engage in an open and honest discourse.

III. FATALITY REVIEW

MEMBERSHIP

The Attorney General appoints members of the Committee. By statute, the members must be drawn from the health care field, organizations with expertise in services provided to incapacitated and vulnerable adults, law enforcement, organizations or individuals who advocate for or provide legal representation for incapacitated and vulnerable adults and may include such other members as the Attorney General determines will assist the Committee in fulfilling its objectives.

A review of the membership list reflects representation from the following: law enforcement, victim services, health care (medical and mental health), Office of the Chief Medical Examiner, Department of Health and Human Services, Bureau of Elderly and Adult Services, Office of The Long Term Care Ombudsman, attorneys, disability rights advocates, emergency management services, home care providers, public guardians, and members of public and private organizations that advocate for, and serve the needs of, incapacitated and vulnerable adults.

The unique make-up of committee members is key to the Committee's success. Committee members are volunteers and do not receive pay for their mileage or time to participate. Their presence on the Committee exemplifies their compassion, their professionalism, and their professional and personal commitment to improving the lives of our incapacitated and vulnerable adult population as well as the system that serves them.

These members come together every other month to review deaths with the hope of improving the State's ability to meet the needs of its most vulnerable citizens.

CONFIDENTIALITY AGREEMENT

Pursuant to RSA 21-M: 16, VIII, the meetings and records of the Committee are exempt from the provisions of RSA 91-A ("Right-To-Know-Law"). Because certain information shared at committee meetings is confidential, all members of the Committee must sign a confidentiality agreement that prohibits any unauthorized dissemination of information beyond the purpose of the review process as a condition of membership. (See Appendix B)

In addition to individual confidentiality agreements, the heads of the New Hampshire Attorney General's Office, the New Hampshire Department of Health and Human Services, and the New Hampshire Department of Safety have signed an interagency agreement. (See Appendix C)

CASE REVIEW PROTOCOL

1. The IVAFRC will review data regarding certain deaths of New Hampshire incapacitated and vulnerable adults as defined in N.H. RSA 21-M:16.

2. The Committee's review of a case shall not be initiated until any related criminal action has been finally adjudicated at the trial court level.

3. Comprehensive, multidisciplinary review of specific cases may be initiated by the Department of Justice, the Department of Health and Human Services, the Department of Safety, or by any member of the Incapacitated and Vulnerable Adult Fatality Review Committee (IVAFRC).

4. Once the IVAFRC Executive Committee identifies a case for review, the IVAFRC Chairperson or Staff Assistant will send case information to IVAFRC members in a sealed envelope marked "Confidential" prior to the scheduling of the case for review at an IVAFRC meeting. The envelope may contain, among other things, the following information: name of victim and perpetrator (if applicable), name of facility or address of residence where death occurred, deceased's date of birth, and deceased's date of death.

5. The IVAFRC members should gather necessary information pertaining to the specific case and report this information and their organization's involvement or non-involvement during the IVAFRC meeting.

6. At the IVAFRC meeting, members will review the facts and information gathered for each case and identify any policies and procedures that could be strengthened or implemented, or measures that could have been taken to prevent the death from occurring.

7. The Committee shall make a biennial report, on or before the first day of November each year and send to the speaker of the House of Representatives, the President of the Senate, the Attorney General and the Governor. This report will describe any trends and patterns of deaths or serious injury or risk factors, together with any recommendations for changes in law, policy, and practice that will prevent deaths and related serious occurrences. The Committee may also issue special reports when doing so is necessary to alert authorities or the public to the need for prompt corrective action.

8. Each Committee member representing a discipline or agency will designate an alternate member from their discipline or agency and will ensure that one member will be present at every meeting.

9. Confidentiality agreements are required of any individual participating in any IVAFRC meeting.

10. Written materials from the meeting, such as case summaries or notes pertaining to the case, will be collected by the Staff Assistant or the Chair at the end of the meeting and destroyed. Use of recording equipment is not allowed.

11. The IVAFRC Executive Committee, comprised of members of the IVAFRC, assesses case information for review by the IVAFRC and performs other business as needed.

12. The IVAFRC will convene every other month at times published by the Executive Committee.

13. The Committee may invite non-member guests to observe and participate in a review. Invited guests shall be required to sign a confidentiality agreement.

IV. REVIEW AND ANALYSIS OF DATA

In 2021, the Committee met five times and reviewed four cases. The cases reviewed encompassed fatalities attributable to various manners of death including accidental deaths, and homicides, including justifiable homicide, and related to smoke inhalation and asphyxiation, and perpetrators with a history of mental illness. One case review took place over the course of two meetings.

In 2022, the Committee met six times and reviewed five cases. The cases reviewed encompassed fatalities attributable to manners of death including suicide, homicide and accidental death, and related to wandering, self-neglect and perpetrators with cognitive impairments. The July meeting was the first in person committee meeting to be held since the beginning of the Covid-19 pandemic and was used to reflect on cases reviewed by the Committee since January 2021, to review, revise and update recommendations, and also for two presentations.

The Committee aims to pair educational presentations along with the case reviews to inform the Committee about the prevalence of the issue(s) being discussed, services available, possible barriers, and other issues pertaining to the case. These educational presentations help to facilitate future meaningful discussions and can offer the Committee useful tools and information that they can not only bring back to colleagues and practitioners, but also disseminate further to multidisciplinary collaborators.

The Committee hosted the following educational presentations throughout 2021:

HOARDING DISORDER

Dr. Thatcher Newkirk of New Hampshire Hospital presented on Hoarding Disorder at our January 2021 meeting. Hoarding Disorder is a condition about which little is currently known and is in the early stages of study. Hoarding Disorder is a disorder most often categorized as an obsessive-compulsive or related disorder and which may be identified by a persistent difficulty discarding or parting with possessions regardless of value, due to a perceived need to save such items. A person with hoarding disorder experiences distress at the thought of getting rid of items.

There are typically signs of the disorder at a young age, between the ages of 10-15, and indicators become clearly visible around the age of 30, worsening with age. Many (89-90%) show an excessive acquisitiveness and others (10-20%) never get rid of anything. The result is an accumulation that clutters and interferes with living areas.

Like most mental disorders, hoarding disorder is some combination of genetic predisposition and environment, however not much information is available about what specific genes may be related to its development or what environments predispose people to it. About 50% of cases report relatives with hoarding behaviors, suggesting that there may be a genetic component. Though seemingly more common in men, women are more likely to seek help. Sometimes hoarding symptoms can start after an individual experiences significant stress.

As older adults often have greater symptom severity, hoarding disorder can present special concerns for elderly patients. It may be a sign of developing dementia or brain dysfunction and the clutter associated with hoarding disorder can contribute to risks such as falls and food contamination, can interfere with medication management, and may cause first responders to have difficulty with access. There are some estimates of a 5-year mortality rate of 50%.

As part of our case review process the Committee was able to examine the dangers of hoarding as it related to an accidental fire death.

THE ROLE OF THE LOCAL HEALTH OFFICER

Sophia Johnson from the Department of Public Health Services presented on the Role of the Local Health Officer at our January 2021 meeting. Local Health Officers are appointed municipal officials whose role is to ensure sanitary conditions are present in rental homes, neighborhoods, schools and other public or private locations. They investigate, enforce and resolve local public health issues, with a focus on the assessment of environmental hazards that include air, water, waste, housing, septic and other nuisances. The authority of local health officers derives from NH RSA 128 (Chapter 128 TOWN HEALTH OFFICERS) and NH RSA 147 (Chapter 147 NUISANCES; TOILETS; DRAINS; EXPECTORATION; RUBBISH AND WASTE).

Common duties of Health Officers are in the below table.

Public Health Topic	Health Officer Involvement
Nuisances	Conduct sanitary investigations into complaints and nuisances that may endanger public health. These may include garbage, insects, unsanitary living conditions, rodents, and safe drinking water inspections.
Septic Systems	Inspect septic systems to determine if a system has failed.
Rental Housing	Enforce minimum standards for rental housing, including: safe drinking water; availability of hot water; garbage control; properly functioning septic systems; vermin control; adequate heat; and that walls and roofs don't leak.
Drinking Water	Test any public/private water supply suspected of being unsafe.
School Health and Sanitation Inspections	Inspect public and private school facilities to certify they meet specific criteria by the Department of Education.
Childcare/Foster Homes	Inspect/approve facilities used to provide childcare and the homes of those serving as foster parents to ensure they meet local health codes.

Health Officers are often called into situations where abuse and neglect are present. They have the authority to assess and enforce conditions related to health and sanitation that may relate to neglect including, but limited to rental housing standards, public health nuisances and hazardous and dilapidated buildings. Health Officers are encouraged to report concerns of abuse or neglect.

Health Officers are also often called to assess sanitation for homes with clutter or hoarding and have the authority to assess and enforce health 'nuisances' under NH RSA 147. Such nuisances are defined either as private nuisances or public health nuisances, which are those that extend beyond the property. Examples are noxious noises, odors, septic, rats, pests and similar things which affect nearby people. Health Officers are encouraged to work with social services to determine how much of the problem is environmental, as opposed to situational or mental health related.

Health Officers are supported by the Health Officer Liaison Program at the New Hampshire Department of Public Health Services, through the Health Officer Liaison Unit, which consists of one part-time position and a supervisor, who support 234 towns across the state. The Unit helps local municipalities by ensuring and processing appointments of local health officials on behalf of DHHS Commissioner in accordance with state law, by helping to facilitate communication between health officers, the New Hampshire Health Officers Association and state officials, by providing case-specific technical assistance including phone consults to expand the capacity of local health officials to respond to complex environmental health situations, and by providing training opportunities that increase health officers' knowledge, skills and ability to respond to environmental threats and concerns, which includes maintaining the Health Officer Manual. The Unit is funded by a CDC Block Grant and uses available funds to support municipalities and state agencies.

The work of Health Officers and Health Officer inspections can help prevent circumstances from arising which contribute to incapacitated and vulnerable adult fatalities, such as the accidental fire death reviewed, and help connect citizens services which may better fit their needs.

AMERICAN RED CROSS – SMOKE DETECTOR INSTALLATION PROGRAM AND EMERGENCY PREPAREDNESS TRAINING

In our July 2021 meeting, Abigail Kelly from the American Red Cross Northern New England Region presented on *Sound the Alarm* and the Smoke Detector Installation Program as part of their Home Fire Campaign, as well as on Disaster and Emergency Preparedness.

The Home Fire Campaign is a fire prevention campaign that can help save lives by installing free smoke alarms in homes that don't have them, and by educating people about home fire safety. American Red Cross will *Sound the Alarm* by educating people about home fire safety and preparing people to act quickly through the Home Fire Campaign, which includes tips on escaping from a home fire including a Home Fire Escape Plan and smart habits that can prevent a fire from starting, including tailored information on how to protect a home and reduce fire risks. Two important steps are emphasized in helping to prepare a family against a home fire, which are to practice a 2-minute fire escape drill and to test smoke alarms monthly.

The Smoke Detector Installation Program works to help make homes safer by installing free smoke alarms in homes that don't have them. By requesting an installation, a trained Red Cross team member will go out to a home to install smoke detector, provide education on the best locations in the home to place a smoke detector and how to test them monthly to ensure they are working.

In the Northern New England Region, the American Red Cross have installed over 30,000 smoke detectors, helped create over 9,000 Home Fire Escape Plans and helped to make more than 10,000 households safer. The Home Fire Safety Program was implemented with the aim to reduce fire-related deaths and injuries. Such prevention tools and fire safety awareness education can help to mitigate the risk of fire-related fatalities.

Also presented was information on Disaster and Emergency Preparedness, to help understand, prepare for, and respond appropriately to emergencies. The American Red Cross recommend three steps for disaster and emergency preparedness. The first is preparing an emergency supply kit, with essential items needed for the family in the case of an emergency, the second is to make a disaster preparedness plan with the household to discuss and prepare for the types of emergencies that may be experienced, and third is to be informed and to learn about what disaster are most likely to occur in the area and what to do to stay safe.

WANDERING

Committee member Vanessa Blais from the New Hampshire Council on Developmental Disabilities presented on the topic Wandering to the Committee at our November 2021 meeting to provide information on safety preparedness for children and adults.

Wandering, sometimes referred to as elopement, is when someone leaves a safe space or area or a responsible caregiver. Some children and adults with intellectual or developmental disabilities are at risk of wandering, as well as adults who have a brain injury, dementia, or other cognitive disabilities. Reasons for wandering can include enjoyment of running and exploring or enjoying being chased, to get to a place of interest (pool, train station, playground), to leave a stressful situation or to go see something of interest (a dog being walked down the street). Wandering can be a concern due to safety issues such as roads/traffic, getting lost, open water and Stranger Danger. When Wandering results in a lethal outcome, between 70-90% of the time it is due to drowning. 50% of parents who have faced this problem reported that they received no guidance from anyone in preventing or addressing their child's wandering behaviors.

There are steps that can be taken to help mitigate the risk of danger to loved ones who wander.

Plan
• Watch the person's behaviors and record patterns, places of interest, routes, etc.
• Have a clear, written emergency plan (involve the individual in the plan where possible)
• Mark key places and routes on a neighborhood map
• Keep information about the person up to date (photo, description), note any special needs. Keep copies of this information in the home, car glove box, child's back-pack, with local services, etc.
• Secure your home (fences, locks, home security system)
• Keep identification on the person (ID bracelet, information card, lanyard) This information can include disclosure that the person is prone to wandering and how they may react to being approached. This can sometimes help the wanderer stay calm by knowing that someone can help them with the use of this information
Prevent
• Notice signs that may cause wandering before it happens
• Be alert about the person's location
• Provide a safe, comfortable environment and avoid sensory that makes the individual anxious
• Inform neighbors and school workers about tendency to wander
• Alert first responders and provide information to them for their records
• Teach safety skills - Responding to safety commands "stop" (use of stop signs on doors or fence gates) - Identifying people who can help - Stating name and important information - Swimming, crossing streets, using cross walks

It is also important to engage the community, such as local police, neighbors, local shop keepers, schools, local bus drivers, staff of favorite places. The more people who are aware that a person is prone to Wandering, the more support and help available in keeping them safe.

Through the course of recommendations that were worked through by the Committee, following a case review which pertained to an accidental death that involved wandering, we found a number of safety programs specific to adults with intellectual, developmental or cognitive disabilities are available in New Hampshire communities, based out of local police departments. An example is Manchester Police Department's Just in Case Program, which can be utilized by emergency services to identify incapacitated and vulnerable adults registered with the program so that responders can better respond to an individual's needs during an encounter, or in the event someone wanders and becomes disoriented, and be provided with important information such as emergency contact information and any pertinent medical information.

The Committee hosted the following educational presentations throughout 2022:

THE NEW HAMPSHIRE RAPID RESPONSE ACCESS POINT AND 988

In conjunction with a suicide case reviewed by the Committee in January 2022, the New Hampshire Department of Health and Human Services (DHHS) presented on New Hampshire Rapid Response Access Point (NHRRAP). As part of the 10-Year Mental Health Plan, DHHS launched the NHRRAP program on January 1, 2022 to address a number of behavioral health issues.

The New Hampshire Rapid Response Access Point (NHRRAP) is a centralized contact center available 24-hours a day, seven days a week, including holidays, by phone, text or chat to anyone in the state of New Hampshire who is experiencing a crisis. The caller defines the crisis and it can include but is not limited to mental health and substance use concerns. The phone number brings callers to the Access Point (AP) managed by Beacon Health Options. Seventy-five percent (75%) of the calls are resolved by talking to the AP. If desired by the caller, they can be offered "same day/next day" appointments at the mental health center in the region in which the caller resides.

If the caller needs, or wants, an in-person response, the AP will deploy a Rapid Response (RR) team from the mental health center. The RR team consists of a master's level clinician and a Peer (defined as a person with lived experience), who will either meet with the person at their residence, or at a location of the caller's preference (a park, a public setting, etc.). A safety assessment is conducted prior to deployment to ensure the safety of the team and the caller.

If a team is not available at the time of the deployment, efforts are made to find a team from another mental health center. The response time is under an hour, so alternate teams are deployed

only if they are within a fifty-mile radius. There are times that telehealth is used if a local team is unavailable and/or the caller prefers it to an in-person session.

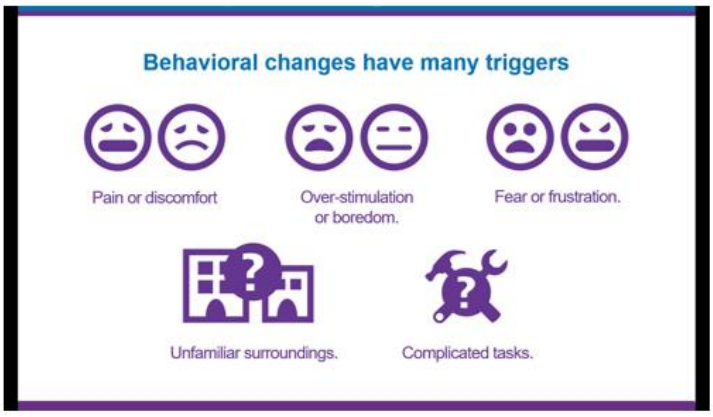
A goal of the NHRRAP is to decrease the number of people who are in New Hampshire's hospital emergency departments as an emergency department is not an ideal environment for someone who is experiencing a behavioral health crisis. Meeting the person in their environment can decrease an escalation of symptoms that could result in an inpatient psychiatric hospitalization.

In July 2022, the nationwide launch of 988 took place, which is a number that can be called for behavioral health needs rather than 911. 988 is an easy to remember number and will connect the caller to 24/7 support for mental health-related distress or a suicidal crisis. Residents of New Hampshire are encouraged to use the NHRRAP number (1-8333-710-6477) to ensure a dedicated NH response. Both NHRRAP and 988 aim to connect those in crisis with trained and caring staff who can provide phone support and problem solving along with a wealth of resources to help resolve a behavioral health crisis.

THE ALZHEIMER'S ASSOCIATION – UNDERSTANDING AND RESPONDING TO DEMENTIA-RELATED BEHAVIORS

Melissa Grenier from the Alzheimer's Association's Massachusetts-New Hampshire Chapter, presented to the Committee on understanding and responding to Dementia-related behaviors at the July 2022 meeting.

When interacting with people with dementia it is important to identify and understand behaviors as behaviors are a form of communication. Behaviors are typically not spontaneous and let us know something is wrong. While some dementia-related behaviors can be upsetting, people with dementia are typically not violent. Some common dementia-related behaviors are anxiety, agitation, confusion, suspicion, aggression, hallucinations, delusions, repetition and wandering. The behavior that is seen can often depend on which part of the brain is damaged by dementia, which can impact how a person acts and how they respond to their environment, and their behaviors may change over time. Such behavioral changes may have triggers, such as pain or discomfort or fear.



To mitigate such triggers, it is important to identify and understand the behaviors, which can help when interacting with or caring for a person with dementia. Observation and attention can help to detect what may trigger certain behaviors, such as who, what, when, where, and how the behavior occurred.

When learning about behaviors it can be useful to start first with the physical needs of the person with dementia, ascertain whether they are in pain, hungry or thirsty, or have physical stimulus such as the temperature, lighting or loud noises that are bothering them. Next address emotional needs they may have, such as boredom, loneliness or confusion, which can also be contributing factors. Afterwards it is beneficial to reassess and plan for next time – what changes helped and what didn't? How and where can you make adjustments, to the environment or the approach, which can help prevent triggers which impact behavior? Such information should be communicated to others who care for or interact with the person with dementia to best provide for their needs.

Learning about behaviors can also improve the safety of the person with dementia, as many changes that occur in the brain in a person with dementia can impact safety. Changes in body function and physical abilities, altered sensory perception system, confusion and short-term memory loss, their way-finding ability declines, executive functions (problem-solving, awareness, judgment, reasoning, forming concepts and thinking abstractly) are impaired, and there are also changes in thinking, such as delusions or hallucinations, suspicious thinking, and fearfulness, that can all impact the safety of the person with dementia.

There are preventative measures which can be taken by a caregiver or person interacting with a person with dementia which can help to improve their safety and further help to reduce the risk of behavioral triggers. Maintaining a routine during the day can create a sense of safety and security for the person with dementia, providing opportunities for physical activity and meaningful engagement, creating a care team with formal or informal supports can all reduce common triggers and further modifying, removing or avoiding items that cause distress or confusion to the person with dementia (ex. mirrors, clutter, areas with poor lighting) can also help. Caregivers or people interacting with a person with dementia should also address pain, poor sleep or other conditions which may increase the likelihood of behaviors such as anger, aggression, or resistance.

Other safety hazards when caring for or interacting with a person with dementia should also be considered. Locking up medications, alcohol, chemicals, sharp objects, or other items that could pose a threat to the person with dementia or others, removing firearms or ammunition from the premises, and ensuring 911 or another person can be reached for assistance if needed, including having a safe location to make a 911 call or for personal safety, all should be taken into account, for both the person with dementia and the person who cares for or provides for them. As dementia progresses, the person living with the disease will become increasingly less able to modify their approach or environment to fit their needs, so their caregivers and people interacting with them are in the best position to learn about their behaviors and address their needs, make improvements which contribute to their safety and comfort, and overall contribute to their quality of life.

This presentation provided key information to the Committee for consideration in future case reviews, such as an accidental death that involved wandering which was reviewed in the following Committee meeting. It also gave further insight to multidisciplinary team members on how to interact with a person with dementia and de-escalate a response.

Disaster Behavioral Health Response Team - Redefining Resilience

Jennifer Schirmer and Skyler Conway from the Department of Health and Human Services Disaster Behavioral Health Response Team (DBHRT) joined the Committee in July 2022 to present on the topic of redefining resilience, to acknowledge the importance of stress and stress responses and how they impact us, in our first in person meeting since the beginning of the Covid-19 pandemic. Having experienced the Covid-19 pandemic, as well as the ways in which it impacted our work and the work of multidisciplinary team members, especially in the direct services community, resilience has become an ever more useful tool to help us adapt and perform when faced with difficult or challenging circumstances.

In order to understand stress and look at it from a different perspective, the Committee were walked through the mechanics of stress, how it works, and how to identify stress responses. Stress responses can manifest as both physical and emotional responses, from thoughts and feelings to their corresponding physical reactions. These responses are the body's way of providing us with information and recognizing and understanding stress responses is critical.

In attending to stress responses, and the information they provide us, we can take a purposeful pause and intentional breath, and decide how to use this information we are being provided with. Recognizing stress responses as helpful information being given to us by our body can aid in measuring our response to demanding circumstances. Understanding a reaction to an event, acknowledging the response may be a stress reaction, and contemplating which response or action is best to take knowing this information, can lead to better flexibility and adaptation and thus improved resilience.

The New Hampshire Missing Vulnerable Adult Alert Program

The New Hampshire State Coordinator for Amber/Silver/Blue Alert Systems at New Hampshire State Police, Sgt. Justin Rowe, presented at our September 2022 meeting on the state Missing and Vulnerable Adult Alert Program.

A Missing Vulnerable Adult Alert is an alert that is issued by New Hampshire State Police Headquarters Communications after it has been confirmed that a person meeting the statutory criteria is missing. NH RSA 106-J outlines the Missing Adult Program and Missing Vulnerable Adult Alert, NH RSA 106-J:3 establishes the criteria used to determine whether a missing person classifies as a Missing Vulnerable Adult. Though sometimes reference is made to "Silver Alerts", these are not a separate alert system, but fall under the Missing Vulnerable Alert Program.

NH RSA 106-J:3(iii)

III. " Missing vulnerable adult " includes, but is not limited to, a missing adult who:
(a)(1) Is 18 years or older;
(2) Whose whereabouts are unknown;
(3) Whose last known whereabouts at the time he or she is reported missing is in New Hampshire; and
(4) Whose disappearance poses a credible threat to the safety and health of the person, as determined by a local law enforcement agency; and
(b)(1) Who has a mental or cognitive disability, such as dementia;
(2) Who has an intellectual or developmental disability;
(3) Who has a brain injury; or
(4) Who has another physical, mental, or emotional disability.

The Caregiver, as outlined in NH RSA-J(i) is any individual duly designated as a caregiver for a person who needs care assistance as a vulnerable adult, which can include, but is not limited to a relative or a paid caregiving professional, provides confirmation to local law enforcement that the vulnerable adult is missing and has an impairment. A Missing Vulnerable Adult Alert is sent to designated media outlets only and is not broadcast across the state's Emergency Alert System. A designated media outlet is any outlet on a statewide distribution list who had provided their contact information to New Hampshire State Police Communications. These may include radio, TV and other media outlets who may issue the alert at designated intervals.

To activate the Missing Vulnerable Adult Alert, a local law enforcement agency will have received a report of a missing vulnerable adult whose identifying and descriptive information, as well as information relative to the vulnerable adult's impairment, has been provided by the vulnerable adult's family, legal guardian or caregiver. This information is used to complete a missing person report within 48 hours which is entered into the National Crime Information Center (NCIC). If the missing vulnerable adult alert report meets the statutory criteria the law enforcement agency will contact New Hampshire State Police Headquarters Communications and request activation of the Missing Vulnerable Alert Plan. When a person goes missing it is important to report them as missing without delay.

The alert will include all appropriate information that may assist in the safe recovery of the missing vulnerable adult and a statement instructing anyone with information related to the missing vulnerable adult to contact their local law enforcement agency. A local law enforcement agency who locates a missing vulnerable adult shall notify New Hampshire State Police that the missing vulnerable adult has been located as soon as possible and the local law enforcement agency is responsible for notifying NCIC as soon as the missing vulnerable adult is located or returned. The alert will be cancelled as soon as New Hampshire State Police receive notification that the missing person has been located or returned but will remain active until that time.

This presentation was presented in conjunction with a case review which involved a missing vulnerable adult and for whom the alert had been activated.

THE OFFICE OF PUBLIC GUARDIAN

Matthew Boucher from the Office of Public Guardian presented to the Committee at the November 2022 meeting on the duties and responsibilities of public guardians.

The Office of Public Guardian (OPG) was established as a non-profit agency in 1983 and began contracting with the state to provide services throughout New Hampshire to individuals with intellectual disabilities, mental illness, progressive cognitive loss due to dementia or other neurological disorders and traumatic brain injuries. With experience in legal, ethical and treatment issues affecting people with incapacitating conditions, the OPG has served over 4000 people.

As a Guardian, one must know the person they have guardianship over as well as possible in order to make informed decisions. Guardians must be thoroughly familiar with their authority and responsibilities as outlined in the guardianship order from the court, as well as the limitations of that authority. Their actions must be consistent with New Hampshire law, promote the development of maximum self-reliance, and advocate for rehabilitative rather than custodial care of each person they serve. Guardians adhere to the guidelines outlined in the Model Code of Ethics for Guardians, adopted by the National Guardianship Association, which outlines the decision-making process to be followed by guardians, and strive to follow the National Guardianship Association's best practice standards for guardians to guide their day-to-day activities.

A Guardian shall exercise extreme care and diligence when making decisions on behalf of a person under guardianship. All decisions are to be made in a manner which protects the civil rights and liberties of the ward and maximizes their opportunities for growth, independence and self-reliance. There are two different standards which are used by Guardians when making decisions.

SUBSTITUTED JUDGMENT STANDARD
• This decision-making standard represents the decision the person would have made themselves if capable. • In order to make an informed decision based on this standard, the Guardian must learn as much as possible about the lifestyle, values and preferences of the person both past and present. • This standard promotes the self-determination, independence, and individual rights of the person. • This standard should be used unless the person's preferences cannot be determined or unless following the person's wishes would be likely to cause substantial harm.

BEST INTERESTS STANDARD
• This decision-making standard is used when the person either never had capacity, or their preferences cannot be determined, or following the person's wishes would lead to a substantial harm. • This standard is guided by what a "reasonable person" would decide in the situation. • The Guardian should consider the least intrusive, least restrictive, and most normalizing course of action available. • This standard focuses on the protection of the individual. • Guardians must be very vigilant when using this standard to avoid imposing their own values and biases when making a decision.

The fiduciary relationship between a Guardian and the individual imposes a duty of trust and confidentiality. The Guardian owes undivided loyalty to the person and must avoid even the appearance of a conflict of interest in any business transaction or activity related to guardianship. The Guardian's decision-making authority cannot be delegated. They must try to protect the legal rights of the person against infringement by others, including filing claims or lawsuits when necessary. In a guardianship over the estate, the person's assets must be kept safe and not commingled with any of the guardian's accounts. All pertinent information must be provided to the individual unless doing so would be likely to cause substantial harm.

Part of the Guardian's role is to ensure that the person is living in the most appropriate, least restrictive environment that addresses their wishes and needs. This is usually at home, or in a community setting near family and friends. A Guardian would only authorize a move to a more restrictive setting after reviewing all reasonable options for increased support in the current environment and making an independent determination that the move is necessary in order to meet the needs of the person. When considering involuntary or long-term placement of the person in an institutional setting, the basis of the Guardian's decision shall be to minimize the risk of substantial harm to the person, to obtain the most appropriate placement possible, and to secure the best treatment.

This related to another aspect of the Guardian's role, which is their responsibility to promote the health and well-being of the person. To do this the Guardian must stay informed about the person's status and needs and advocate for opportunities in all areas of life important to the person, taking into account their interests and abilities. The Guardian will consider the recommendations of professionals to determine whether the current or proposed treatment services are appropriate and with cooperatively with individuals and organizations in ensuring the person receives proper care, treatment, and services consistent with their wishes or best interests. The Guardian will utilize the standards for decision-making and the principles of informed consent when consenting to or refusing to consent to medical and other professional care and treatment.

Informed consent is a person's voluntary agreement to allow something to happen that is based on a full disclosure of facts needed to make the best decision possible. It requires adequate information, voluntary action and a lack of coercion. The Guardian stands in the place of the person and is entitled to the same information and freedom of choice the person would receive if the were not legally incapacitated. The Guardian should have adequate information on the risks and benefits of the proposed action as well as possible alternatives and should consider a second opinion where appropriate, as well as input from caregivers, family and ethics committees. No decision is made until all questions are answered in understandable terms.

The needs of the person under guardianship are best met when the guardian, service providers, family and friends strive to work together cooperatively and respectively. Everyone on the "team" has an important role. The Guardian is the independent decision maker and the only person with that authority and responsibility. A Guardian who is not a family member should not provide direct services to the person, but monitors the services provided to ensure appropriate care and treatment. Public guardianship contracts in New Hampshire specifically forbid providing direct services. Because of this Guardians rely on service providers to be their "eyes and ears" and share information about the individual, and to be a resource regarding services, providers and facilities available in a given community. Though others on the care team may be answerable to multiple others, the Guardian answers only to the person and the probate court and the difference in roles can sometimes lead to conflict, despite the shared goal of supporting the individual. Guardians work collaboratively with services agencies to ensure the needs of the individual are met to the greatest extent possible.

With the remit of the Committee being to review fatalities involving incapacitated and vulnerable adults, the OPG presentation on Guardianship provided the Committee with key information on the role and responsibilities of a public guardian. Learning more about the decision-making models utilized and the emphasis given to promoting the self-reliance and independence of persons under a guardianship helped to provide context for a case reviewed which involved a guardian, and further demonstrated to the Committee the importance of collaborative efforts with direct services team members in facilitating successful care of incapacitated and vulnerable adults across the state.

V. RECOMMENDATIONS AND RESPONSES

The purpose of recommendations made during a review is to take case-specific facts and create broader recommendations for system improvement. Recommendations fall into three broad categories: **Training, Public Awareness or Policy.** Each recommendation is assigned to the appropriate committee member responsible for taking the recommendation back to the agency that is capable of responding to and/or implementing the recommendation. It is the committee member's role to provide the response back to the Committee. Resource constraints may sometimes hinder the ability of the agency to act on the recommendation. The specific recommendations and system or institutional responses follow.

PUBLIC AWARENESS RECOMMENDATIONS	
To increase public awareness of smoke and carbon monoxide detector safety encourage all Bureau of Elderly and Adult Services (BEAS) involved home care providers to incorporate this topic into their discussions and practices, ask the New Hampshire Medical Society to encourage Primary Care Providers (PCPs) to enquire about smoke and carbon monoxide detectors with their patients (do they have one, do they know how to check if it is working or change the batteries without assistance?).	This information was passed on to the Bureau Chief and the CFI Administrator at BEAS and the New Hampshire Medical Society agreed to share this message with providers.
Educate individuals and organizations on the resources and programs available through the American Red Cross (ex. Home Care Association, Bureau of Developmental Services Area Agencies, senior centers, etc.)	Information about American Red Cross resources and programs were shared with all Community Mental Health Centers (CMHCs) and was also distributed to BDS.
Explore whether there is a listing of types of residences and their staffing levels for the patients leaving the emergency department/hospital. Speak with housing representatives within the Department of Health and Human Services (DHHS) to determine what exists.	The Bureau of Mental Health Services (BMHS) advised that there are 11 Community residences throughout the state, managed by CMHCs. There is at least one community residence in each region, with the exception of regions 9 and 10 which cover the Dover and Derry catchments respectively. BMHS has contracted with each of the 10 CMHCs to manage two housing voucher programs for homeless individuals with SMI/SPMI who are ready to live independently in the community, which are the Housing Bridge Subsidy Program, and the Integrative Housing Voucher Program. Access to

	these programs can be gained by calling any of the 10 CMHCs and requesting to speak to the Housing Specialist. The BMHS has also contracted with NFI North, Inc. to provide fully staffed Transitional Housing Services Programs, with priority for individuals being discharged from NHH. NFI has programs in Concord, Bethlehem, Bradford, Manchester and Ashland; this is a 76-bed program across New Hampshire. Any individual experiencing homelessness or imminent homelessness across the state is advised to call 211 to gain access to referrals for all housing programs managed through NH DHHS, Bureau of Housing Support.
Educate the public on the risk of strangulation, not just as it relates to domestic violence cases. Share information provided by a Domestic Violence Fatality Review representative on the dangers of strangulation.	The information on strangulation was shared with CHMCs, and internal groups within DHHS.
Explore whether New Hampshire Firearms Safety Coalition can help address the concern of persons with dementia having access to firearms, and whether they can include persons with dementia as at risk of having access to firearms, in addition to individuals who are thought to be suicidal.	The New Hampshire Firearms Safety Coalition agreed that this was an important population to add/include as an example of when to decrease access to firearms.
Increase the number of senior police officers on the IVAFRC – identify officers from other departments, reach out to department supervisors to identify suitable candidates and reach out to prospective candidates.	An officer from Goffstown Police Department, and representatives from Merrimack County Sheriff's Office and New Hampshire State Police all joined the committee during 2022.

Raise awareness about the Just in Case Program.	Committee members shared information about the Just in Case Program amongst the Committee and with the ten Community Mental Health Centers, some of the psychiatric hospitals in New Hampshire, and with staff internally at DHHS. Adult Protective Services staff met with Manchester PD to learn more about the program and will be working to bring information about it to other police departments they interact with.
Reach out to news agencies about airing a short information piece on the Just in Case Program.	A committee member connected with Channel 9 news through their agency's communications team who in September 2022 ran a highlight on Manchester Police Department's Just in Case Program to raise awareness for the initiative in which surrounding towns can also participate.
Encourage the marketing of 988 and NHRRAP to middle age and older adults.	This was shared with the Communications sub-committee of 988.
Share information more broadly about the NH Rapid Response Access Point (NHRRAP) and 988.	Adult Protective Services received training on NHRRAP. NAMI NH has offered a webinar on the NHRRAP (it is recorded and available on their website) and offered a workshop at their annual conference in April 2022. They also included a section on NHRRAP in CIT training for first responders, as well as engaging in promotional activities such as sharing NHRRAP and 988 upcoming events on social media and distributing NHRRAP cards at fairs and events. Other committee members shared information with groups outside of mental health centers including the DHHS Suicide Prevention Integration Team. It was also shared internally at DHHS and the Bureau of Licensing and Certification.

Disseminate information on wandering to Centers for Health and Aging and provide education to hospital emergency departments and the New Hampshire Fish & Game department on resources for people who wander and their families.	Information on wandering was sent out, training was offered to the Fish & Game Department and a committee member reached out to hospital emergency departments to encourage them to give families information on wandering, particularly when a person who has wandered is being returned
Confirm with medical centers and CHMCs that there are policies and procedures in place regarding communication of care plans to minimize risk.	A committee member confirmed that all medical centers and CHMCs should have existing communication policies in place that relate to patient care.
Support education on initial missing person's report and the importance of there being no delay in reporting. Committee members to share and distribute an information piece to agencies such as FAST and AARP who may further spread the message that there should be no delay in reporting a missing person.	A committee member is writing a short article for the Commission on Aging Newsletter Aging Matters. This article will be disseminated to StayConnectedNH. A Committee member will also be doing a Coffee and Conversation segment with AARP (currently scheduled for February 2023) to further raise awareness.

TRAINING RECOMMENDATIONS	
Encourage Adult Protective Services (APS) to incorporate awareness around smoke and carbon monoxide detector safety into their safety assessment and provide information about the Smoke Detector Installation Program to their clients.	APS had a representative from American Red Cross present to their staff and information about smoke and carbon monoxide detector awareness and smoke detector installation has been incorporated into trainings.
Increase awareness of the opportunity for Counseling on Access to Lethal Means (CALM) training, share information with the Committee on how to access the training.	Information on CALM training was shared with the Committee.
Have a presentation to Committee on 988, NHRRAP and 211.	A presentation was given to the Committee in January 2022.

Provide preparedness training or a presentation to hospital staff on what to do in an active shooter situation. Manchester Police Department can provide training.	Granite State Healthcare Coalition (GSHC) work directly with hospitals and healthcare providers to provide emergency preparedness training activities including active shooter preparedness. Information about other trainings available were passed on to GSHC as additional training resources.
Investigate the resources and training opportunities around hoarding in order to broaden education around the dangers of hoarding within the community. Identify training funds or virtual trainings available.	A committee member met with the Investigation and Compliance Specialist for Manchester City Fire Department to discuss fire safety issues in the center of Manchester, which often involves visiting homes that raise concern due to signs of hoarding. This position is only on temporary funding but there is hope the city will be able to keep the position once the funding ends. Another committee member shared that there is a class for people with hoarding disorder that runs twice a year from the Dartmouth Health Aging Resource Center and is conducted by Lora Gerard.
Explore the possibility of providing education about resources and referrals to APS or places of transition. Discuss with Bureau of Drug and Alcohol Services to see whether a conversation with the county jail superintendents would be possible.	A meeting with the Director of the Bureau of Drug and Alcohol Services and the two committee co-chairs was held. Follow up activities included offering the county jail superintendents a training on the array of mental health and substance use services available.
Increase awareness of the role of a Guardian as well as the range of alternate options to guardianship available.	In process – Committee member will check with law schools who run classes on elder law and similar regarding possible clinics related to guardianship and alternatives, connect them with presenters from OPG and also possibly APS.

Find out what resources or programs the Alzheimer's Association has that may be of assistance when a person is at risk of harming others.

The Alzheimer's Association presented at the July 2022 meeting.

In addition to improving safety through prevention (removing dangerous items such as firearms from the environment), considering housing options for significant behaviors (such as short-term inpatient psychiatric stay) and ensuring that there is an accurate dementia or Alzheimer's diagnosis as much as possible and taking steps to learn and diffuse the persons behaviors, the Alzheimer's Association provides a 24/7 helpline which allows care providers (family members or professionals) to contact them to discuss and troubleshoot issues. Trained clinicians can work with callers to address their specific needs, provide general information or to request a Care Consultation, which is a free, in-depth meeting to dive deeper into areas of particular concern or multiple issues that need to be addressed. The Alzheimer's Association also provide education programming that helps care providers learn about improving communication skills and understanding and responding to dementia-related behaviors, which are available at no charge, as well as online in pre-recorded programs.

POLICY RECOMMENDATIONS

Discuss with the Geriatric Emergency Department at Dartmouth Hitchcock Medical Center (DHMC) and Dartmouth Geriatric Residency Program in Concord what they can do to include more awareness around smoke and carbon monoxide detector safety among their patients.

DHMC Lebanon has received funding to be credentialed in Geriatric Emergency Medicine – one of only a few locations in the country currently. As part of this project, they will have Geriatric Nurses assigned to do screening questions. The nurse manager on that team will add screening questions related to smoke and carbon monoxide detectors. If they find a patient needs help with getting either set up, they will make a call to the fire departments. This information was also shared with Community Health nurses to add to their screening as well.

Explore the practice of discharge before probably cause hearings and Friday afternoon discharges, speak with social work department at New Hampshire Hospital (NHH) to confirm the process.	Discharge planning from NHH occurs based on the clinical assessments of the patient, resulting recommendations and patient and guardian participation. IEA hearings are to determine if a patient's situation met the legal standard of involuntary emergency admission. The hearing is not to determine the minimum length of stay, as that is a clinical decision. NHH Social Work staff contact the mental health center on the first business day of the patient's admission to begin collaboration with outpatient providers to start discharge planning discussion. Efforts are made, regardless of the day of the week, for NHH staff to have a phone conversation with the outpatient provider. The patient has a right to be discharged once the attending prescriber and team determines they no longer require acute inpatient involuntary treatment. If that determination is made on a Friday, the mental health center is contacted again to set up aftercare appointments as soon as possible. For numerous clinical reasons, this does not always allow for 24-hour notice, and it is inappropriate to extend hospitalization through the weekend if not clinically necessary. This would also prevent acute patients in emergency departments from being admitted to NHH due to lack of bed availability.
Create an appropriate pathway for placement when a person with dementia has committed a serious crime.	Department of Justice workgroup met twice in 2022 to investigate updating/reviewing existing policies to streamline this process. This is currently an internal workgroup but may look to inviting the participation of other agencies in future.
Committee member to check in with Bureau of Developmental Services (BDS) to ensure the developmental services community are aware of 988 and have a seat at the planning table.	There is no representative at the Bureau of Developmental Services who is a part of the 988 implementation program.

Local law enforcement agencies create their own program for incapacitated and/or vulnerable persons such as the Just in Case Program. Committee members to reach out to local law enforcement agencies and provide promotional video and materials for reference to other agencies and find out whether their local police department has a similar program in place.	Information shared by Committee members with local police departments. Members found other agencies which run similar programs. Hooksett Police Department have two programs which provide assistance to seniors, the "R U OK" Program which provides daily check-ins with seniors and a call out to their address if no response is received and "Operation Safe Return Program" which operates similarly to Manchester PD's Just in Case Program and offers a registry to appropriate candidates whose information can be shared with emergency personnel when needed. Derry Police Department work with *SafetyNet Tracking Systems* to help care for and locate a person with a cognitive condition in the event of wandering. The person wears a bracelet which features a radio frequency transmitter that emits a continuous signal and is connected to a database with key information about the person to assist with search and rescue efforts. Conway Police Department sponsors "Project Good Morning" which is designed to assist the senior citizens of their community who live alone continue to live an independent lifestyle. Registrants of the program only need to be a resident of Conway and provide some basic information as part of their application. Each morning the program member calls the Conway PD between 8:00 AM and 10:00 AM. In the event a member does not call in by 10:00 AM dispatch will attempt to call the member. If contact cannot be made, a patrol unit will respond to the residence to conduct a welfare check. Surrounding towns not within the jurisdiction of Conway may also join the program as long as an agreement is reached with the Chief of Police of that town that their agency respond in the vent contact is not made by telephone. Currently the towns of Bartlett and Jackson are also participating in Project Good Morning along with Conway.
Improve and increase the direct services workforce.	In process – Committee member to reach out to Alliance for Healthy Aging to find out whether there is any legislative work taking place to help tackle this issue.

GENERAL IVAFRC POLICY STATEMENTS

1. The IVAFRC acknowledges the extreme challenges long-term care facilities have faced over the course of the COVID-19 pandemic - the challenges of staffing for the facilities impacted, the compounded grief of the many deaths in these settings, and the stress for both residents and staff. Our sympathies are with the many family members who lost loved ones as a result of the pandemic.

2. The IVAFRC recognizes the need for expanded services and supports for the population diagnosed with dementia and other cognitive impairments who have engaged in criminal activity. The existing penal system is not able to provide the needed supports and services to individuals diagnosed with dementia and other cognitive impairments and long-term care facilities are not equipped to deal with potential violent behavior.

3. The IVAFRC recognizes the impact of chronic staff shortages on the ability to hire, retain, train, and adequately compensate qualified staff in direct services. We appreciate every staff member who works with the incapacitated and vulnerable population. These personnel often are not highly paid and have difficult responsibilities.

4. The IVAFRC supports the Department of Health and Human Services efforts to increase the variety of residential options for individuals with multiple intellectual and/or mental health diagnoses with challenging or high-risk behaviors

5. The IVAFRC recognizes the need for multidisciplinary cooperation in working to prevent incapacitated and vulnerable adult fatalities across the state.

VI. CONCLUSION

The New Hampshire Incapacitated and Vulnerable Adult Fatality Review Committee is instrumental in the State of New Hampshire's effort to reduce or prevent deaths of some of its most vulnerable citizens. The Committee recognizes that the education provided, and the recommendations made have been viewed as valuable by the organizations and agencies dedicated to the services for New Hampshire's incapacitated and vulnerable adult populations.

Identifying issues which impact the incapacitated and vulnerable adult population, distinguishing system changes which could help to minimize these issues and raising awareness among multidisciplinary team members of services and resources available can all contribute to a reduction in incapacitated and vulnerable adult fatalities across the state.

Though meeting the needs of the incapacitated and vulnerable adult population can be challenging due to a system which is already over-burdened and underfunded, there are competent, professional, and caring service providers working to mitigate the risk of unnecessary and premature deaths. We honor these professionals for their ongoing dedication.

TITLE I
THE STATE AND ITS GOVERNMENT

CHAPTER 21-M
DEPARTMENT OF JUSTICE

[RSA 21-M: 16 effective July 24, 2018.]

21-M: 16 Incapacitated and Vulnerable Adult Fatality Review Committee Established. –

I. There is hereby established the incapacitated and vulnerable adult fatality review committee (committee) which shall be administratively attached, under RSA 21-G:10, to the department of justice.

II. The attorney general shall appoint members and alternate members to the committee. The members of the committee shall include individuals representing the health care field, organizations with expertise in services provided to incapacitated and vulnerable adults, law enforcement, organizations or individuals who advocate for or provide legal representation for incapacitated and vulnerable adults, and such other members as the attorney general determines will assist the committee in fulfilling its objectives. The terms of the members shall be 3 years; provided, that the initial members shall be appointed to staggered terms. Members shall serve at the pleasure of the attorney general.

III. The committee shall:

(a) Recommend policies, practices, and services that will promote collaboration among service providers for, and reduce preventable fatalities among, incapacitated and vulnerable adults.

(b) Evaluate policies, practices, interventions and responses to fatalities among incapacitated and vulnerable adults and offer recommendations for any improvements in those interventions and responses.

(c) Determine and report on trends and patterns of incapacitated and vulnerable adult deaths in New Hampshire.

(d) Evaluate and report on high risk factors, current practices, gaps in systematic responses, and barriers to safety and well-being for incapacitated and vulnerable adults in New Hampshire.

(e) Educate the public, policy makers, and budget authorities about fatalities involving covered incapacitated and vulnerable adults.

(f) Recommend improvements in the sources of data relative to preventing fatalities among incapacitated and vulnerable adults.

(g) Identify and evaluate the prevalence of risk factors for preventable deaths in the population of incapacitated and vulnerable adults.

IV. For the purposes of this section, "incapacitated adult" means:

(a) Adults who are clients of the area agency system pursuant to RSA 171-A or RSA 137-K at the time of the person's death or within one year of the person's death.

(b) Adults who are patients at the New Hampshire hospital or any other designated receiving facility or whose death occurs within 90 days following discharge, who are on conditional discharge, or who are applicants for or clients of the community mental health center system under RSA 135-C:13 and RSA 135-C:14 at the time of death or within one year of death.

(c) Adults who are receiving services pursuant to RSA 161-E and RSA 161-I.

(d) Adults who are participants in programs or residents of facilities specified in RSA 151:2, I(a), (b), (d), (e), or paragraph IV-a, or RSA 161-J, or within 90 days of discharge from such a facility.

(e) Adults who were in need of any of the services defined in subparagraphs (a)- (d) and paragraph IV-a at the time of their death.

IV-a. For the purposes of this section, "vulnerable adult" means an adult who was the reported victim of abuse, neglect, self-neglect, or exploitation which was reported to the department of health and human services pursuant to RSA 161-F:46, where the report was determined to be unfounded and was filed within 6 months prior to death, where the report was determined to be founded and was filed within 3 years prior to death, or where the report was pending at the time of death.

V. The committee shall adopt a protocol defining which deaths shall be reported to the committee and subject to review, and which deaths may be screened out for review, such as deaths where the cause is natural, expected, and non-preventable. The committee shall also determine whether it is appropriate to have different types of review, such as comprehensive or more limited reviews depending on the incident under review or the purpose of the review. The protocol shall also define the character of the contents of the committee's annual report, required under paragraph VII.

VI. The committee's review of a case shall not be initiated until such time as any related criminal action has been finally adjudicated at the trial court level. Records of the committee, including testimony by persons participating in or appearing before the committee and deliberations by committee members relating to the review of any death, shall be confidential and privileged and shall be protected from direct or indirect means of discovery, subpoena, or admission into evidence in any judicial or administrative proceeding. However, information, documents, or records otherwise available from original sources shall not be construed as immune from discovery from the original sources or used in any such civil or administrative action merely because they were presented to the committee, and any person who appears before the committee or supplies information as part of a committee review, or who is a member of the committee, may not be prevented from testifying as to matters within his or her knowledge, but such witness may not be asked about his or her statements before the committee, participation as a member of the committee, or opinions formed by him or her or any other member of the committee, as a result of participation in a review conducted by the committee.

VII. The committee shall make a biennial report, on or before the first day of November of each even-numbered year, beginning on November 1, 2020 , to the speaker of the house of representatives, the president of the senate, and the governor describing any trends and patterns of deaths or serious injuries or risk factors, together with any recommendations for changes in law, policy, and practice that will prevent deaths and related serious occurrences. The committee may also issue special reports when doing so is necessary to alert authorities or the public to the need for prompt corrective action.

VIII. The meetings and records of the committee shall be exempt from the provisions of RSA 91-A. The committee's reports shall not include any private or privileged information. Members of the committee may be required to sign a confidentiality agreement that prohibits any unauthorized dissemination of information beyond the purpose of the review process as a condition of membership.

Source. 2007, 256:1, eff. Jan. 1, 2008. 2016, 59:7, eff. July 4, 2016. 2018, 59:1, eff. July 24, 2018.

CONFIDENTIALITY AGREEMENT FOR THE NEW HAMPSHIRE INCAPACITATED AND VULNERABLE ADULT FATALITY REVIEW COMMITTEE.

The purpose of the New Hampshire Incapacitated and Vulnerable Adult Fatality Review Committee is to conduct a full examination of incapacitated and vulnerable adult fatalities. In order to assure a coordinated response that fully addresses all systemic concerns surrounding incapacitated and vulnerable adult fatality cases, the New Hampshire Incapacitated and Vulnerable Adult Fatality Review Committee must have access to all existing records on each case. This includes social service reports, court documents, police records, autopsy reports, mental health records, hospital or medical related data and any other information that may have a bearing on the involved incapacitated adult, family and perpetrator, if applicable.

Records of the committee, including testimony by persons participating in or appearing before the committee and deliberations by committee members relating to the review of any death, shall be confidential and privileged and shall be protected from direct or indirect means of discovery, subpoena, or admission into evidence in any judicial or administrative proceeding. However, information, documents, or records otherwise available from original sources shall not be construed as immune from discovery from the original sources or used in any such civil or administrative action merely because they were presented to the committee. Any person who appears before the committee, supplies information as part of a committee review, or who is a member of the committee may not be prevented from testifying as to matters within his or her knowledge. Such witness may not be asked about his or her statements before the committee, participation as a member of the committee, or opinions formed by him or her or any other member of the committee, because of participation in a review conducted by the committee.

The meetings and records of the committee shall be exempt from the provisions of RSA 91-A. The committee's reports shall not include any private or privileged information.

With this purpose in mind, I the undersigned, as a representative of: _____

agree that all information secured in any review will remain confidential and not be used for reasons other than that which was intended. No material with case identifying information will be taken from the meeting.

Name: _____

Authorized Signature: _____

Witness: _____

Date: _____

INTERAGENCY AGREEMENT TO ESTABLISH THE NEW HAMPSHIRE ELDERLY INCAPACITATED ADULT FATALITY REVIEW COMMITTEE

This cooperative agreement is made between the New Hampshire Department of Justice, the New Hampshire Department of Health and Human Services and the New Hampshire Department of Safety.

WHEREAS, the parties hereto are vested with the authority to promote and protect the public health and to provide services which improve the well-being of incapacitated and vulnerable adults; and

WHEREAS, under RSA 125:9 II, the Department of Health and Human Services – Division for Public Health has the statutory authority to: "Make investigations and inquiries concerning the causes of epidemics and other diseases; the source of morbidity and mortality; and the effects of localities, employment, conditions, circumstances, and the environment on the public health;" and

WHEREAS, under RSA 161-F, the Department of Health and Human Services – Bureau of Elderly and Adult Services, has the responsibility to protect the well-being of elder and incapacitated adults; and

WHEREAS, the objectives of the New Hampshire Incapacitated and Vulnerable Adult Fatality Review Committee are, as specified by the statute, agreed to be:

1. *Recommend policies, practices, and services that will promote collaboration among service providers for, and reduce preventable fatalities among, incapacitated adults.*
2. *Evaluate policies, practices, interventions and responses to fatalities among incapacitated adults and offer recommendations for any improvements in those interventions and responses.*
3. *Determine and report on trends and patterns of incapacitated adult deaths in New Hampshire.*
4. *Evaluate and report on high risk factors, current practices, gaps in systematic responses, and barriers to safety and well-being for incapacitated adults in New Hampshire.*
5. *Educate the public, policy makers, and budget authorities about fatalities involving covered incapacitated adults.*
6. *Recommend improvements in the sources of data relative to preventing fatalities among incapacitated adults.*
7. *Identify and evaluate the prevalence of risk factors for preventable deaths in the population of incapacitated adults.*
8. *Development and dissemination of an annual report to state officials describing any trends and patterns of deaths or serious injuries or risk factors, together with any recommendations for changes in law, policy, and practice that will prevent deaths and related serious occurrences and special reports when doing so is necessary to alert authorities or the public to the need for prompt corrective action.*

WHEREAS, all parties agree that the membership of the New Hampshire Incapacitated and Vulnerable Fatality Review Committee needs to be comprehensive and to include at a minimum,

representation from the following disciplines: law enforcement, judiciary, medical, mental health, public health, child protection services, consumer advocacy organizations, with specific membership from designated agencies to include, but not to be limited to: the Office of the Chief Medical Examiner, the New Hampshire Department of Justice, the New Hampshire Department of Safety and the New Hampshire Department of Health and Human Services; and

WHEREAS, the parties agree that meetings of the New Hampshire Incapacitated and Vulnerable Fatality Review Committee will be held no fewer than six (6) times per year to conduct reviews of fatalities:

NOW, THEREFORE, it is hereby agreed that the following agencies will cooperate with the New Hampshire Incapacitated and Vulnerable Adult Fatality Review Committee under the official auspices of the New Hampshire Department of Justice, subject to the renewal of this Interagency Agreement. Records of the committee, including testimony by persons participating in or appearing before the committee and deliberations by committee members relating to the review of any death, shall be confidential and privileged and shall be protected from direct or indirect means of discovery, subpoena, or admission into evidence in any judicial or administrative proceeding.

The meetings and records of the committee shall be exempt from the provisions of RSA 91-A. The committee's reports shall not include any private or privileged information.

All members of the New Hampshire Incapacitated and Vulnerable Adult Fatality Review Committee will sign a confidentiality statement that prohibits any unauthorized dissemination of information beyond the purpose of the review process. The New Hampshire Incapacitated and Vulnerable Adult Fatality Review Committee shall not create new files with specific case-identifying information. Non-identified, aggregate data will be collected by the Committee. Case identification will only be utilized in the review process in order to enlist interagency cooperation. No material may be used for reasons other than that for which it was intended. It is further understood that there may be individual cases reviewed by the Committee which will require that a particular agency be asked to take the lead in addressing a systemic or quality of care issue based on that agency's clear connection with the issue at hand.

Attorney General	Date
Commissioner, Health and Human Services	Date
Commissioner, Department of Safety	Date