VERMONT SUPREME COURT
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Case No. 24-AP-187

Note: In the case title, an asterisk (*) indicates an appellant and a double asterisk (**) indicates a cross-appellant. Decisions of a three-justice panel are not to be considered as precedent before any tribunal.

ENTRY ORDER

DECEMBER TERM, 2024

In re Appeal of L.L.*	}	APPEALED FROM:
	}	Human Services Board
	}	CASE NO. M-11/20-759

In the above-entitled cause, the Clerk will enter:

Petitioner appeals pro se from a Human Services Board order denying her request to reopen its September 2023 decision affirming her substantiation for neglect of a vulnerable adult pursuant to 33 V.S.A. § 6906. We affirm.

The record indicates the following. In November 2020, the Department of Disabilities, Aging, and Independent Living substantiated petitioner for neglect of her adult son, T.L. Petitioner appealed this decision to the Board. The Board proceedings were delayed by extensive motion practice and multiple changes in representation for both petitioner and the Department. An evidentiary hearing was ultimately held over two days in April 2023. The following September, the Board issued a written decision affirming the Department's substantiation determination.

The Board's order included the following findings. T.L. is thirty-five years old and diagnosed with autism spectrum disorder and Landau-Kleffner Syndrome—a rare neurological disorder that results in significant communication deficits. T.L. has an athletic build and is prone to violent outbursts, destruction of property, and elopement. As a result, he requires 2:1 staffing support and 24/7 supervision. In January 2020, the probate division appointed petitioner as T.L.'s guardian.

In early 2019, petitioner contacted the executive director of Upper Valley Services (UVS) to discuss T.L.'s expected move to a new residence in Waitsfield, Vermont, and ask whether UVS could support him there. UVS agreed to try to develop a program of services for T.L. The director submitted a proposed budget to the Department which was approved near the end of 2019. UVS then began working to assemble T.L.'s program.

Petitioner and the director initially worked collaboratively to plan and develop T.L.'s program of services. However, before the anticipated implementation of the program in 2020, petitioner removed T.L. from his prior placement without UVS's agreement and brought him to the Waitsfield residence. At the time, UVS had not yet completed T.L.'s program or hired and

trained the staff necessary to provide the 24/7 care he required. The director hastily tried to secure staff to assist petitioner with T.L.'s direct care.

At this point, the previously positive working relationship between the director and petitioner broke down. UVS struggled to further develop T.L.'s program because petitioner involved herself in every aspect of all decisions relevant to his care. When UVS staff did not do exactly what petitioner wanted, there was conflict. She would not allow staff to administer medication prescribed to T.L. to assist in regulating his behavior and would not allow UVS to continue the services of its psychiatrist or permit the psychiatrist to reorder T.L.'s medications. Petitioner also refused to allow UVS to use any form of physical intervention or restraint.

Within days, it became clear to the UVS director and staff that the program was not going to work. T.L.'s behavior was volatile: he was aggressive toward staff, frequently eloped, and had a compulsion to break glass—including car windshields, windows in the home, and the oven door. Without the use of medications to assist T.L. in regulating his behavior or the ability to use physical intervention in response to those behaviors, UVS could not implement the plan of services. As a result, in April 2020, the director notified petitioner and the State that he was terminating services to T.L. in thirty days.

Around this time, T.L.'s behavior escalated. The director called the admissions department at Dartmouth Hitchcock Medical Center (DHMC) and explained that he believed T.L. was at risk. T.L. was restrained and transported by ambulance to the DHMC emergency department for evaluation and treatment. As part of his discharge planning, T.L. was prescribed medication to manage his anxiety and regulate his mood, including medication that could be administered as needed in response to crisis. However, petitioner required that staff obtain her permission before administering the medication, which she sometimes kept off-site.

In May 2020, T.L.'s behaviors escalated again, requiring staff to call police for assistance. He attempted to elope and, as he approached a neighboring property, the neighbor discharged a firearm into the air. Several days after this incident, petitioner called for an ambulance to again transport T.L. to the DHMC emergency department.

The emergency department was an overstimulating environment and being in this setting was stressful for T.L. Once his condition had stabilized, he required transition to an appropriate long-term setting with treatment and supports that could not be provided in an emergency department. Nonetheless, T.L. ultimately remained in the emergency department for seventy-eight days.

The hospital team's efforts to create a discharge plan were frustrated by petitioner's behavior. She did not seem to consider information they needed her to incorporate into her medical decisionmaking as T.L.'s guardian, disregarded discharge options presented to her, and frequently provided staff with inaccurate information about alternative discharge placements that ultimately proved infeasible.

T.L. decompensated during his period of hospitalization, engaging in violent behavior and ceasing to interact with staff. When petitioner visited T.L., she used words and phrases that led T.L. to believe he was leaving the hospital. After T.L. heard these "trigger words," hospital staff could not redirect him and he would escalate quickly, becoming inconsolable and attempting to hurt himself and staff who tried to stop him from leaving. Staff had to intervene extensively in response, including by restraining him to his bed, because less-restrictive methods

were ineffective. Staff posted a list of the "trigger words" near T.L. as a reminder to avoid using them, but petitioner did not stop. Her presence was disruptive to T.L.'s care.

Petitioner's communication with the hospital team eventually broke down entirely and she ceased to respond. In the absence of a medical decisionmaker, DHMC could not provide a disposition plan for T.L., even as his health continued to deteriorate. As a result, DHMC filed a motion in probate court to remove petitioner as T.L.'s guardian. The motion was granted in August 2020, and the Office of Public Guardian appointed in her stead.

Based on these findings, the Board concluded that the Department demonstrated, by a preponderance of the evidence, that petitioner neglected T.L. It determined that T.L. was a "vulnerable adult" under 33 V.S.A. § 6902(14)(D) because he has a developmental disability, is largely nonverbal, and requires 24/7 care and supervision, and that petitioner was T.L.'s "caregiver" within the meaning of § 6902(2) during the relevant period because she was providing direct care when UVS initially began supporting the family and, as T.L.'s court-appointed guardian, had sole decision-making authority regarding his treatment.[*] Finally, it affirmed the Department's determination that petitioner's conduct amounted to "neglect" under § 6902(7)(A), reasoning that: (1) she was at least reckless in failing to carry out the program of care arranged with UVS when she purposely prevented staff from administering T.L.'s medication as prescribed or using any form of physical restraint, leading to episodes of unrestrained escalated behaviors that put T.L. at substantial risk of harm and resulted in his hospitalization; (2) her reckless use of language directly escalated T.L. in the hospital; and (3) while T.L. wanted to leave the hospital, petitioner's lack of cooperation and misrepresentations to the hospital staff in finding an appropriate discharge facility prolonged his stay in an overstimulating environment in which he was restrained numerous times, worsening his health over the course of his admission.

Petitioner filed a timely motion to reopen the Board's decision. Under Fair Hearing Rule 1000.4(K), a motion to reopen "shall be granted only upon a showing of good cause by the moving party." Fair Hearing Rules § 1000.4(K), Code of Vt. Rules 13 020 002, https://humanservices.vermont.gov/sites/ahsnew/files/fair-hearing-rules-1.pdf [https://perma.cc/HDS2-TNCK]. In June 2024, the Board issued an order concluding that petitioner had not shown good cause. It rejected her argument that she was not a "caregiver" under § 6902(2). The Board noted that petitioner's remaining contentions were all directed at its factual findings, but she failed to raise any objection to the hearing officer's recommended findings before the Board took them under consideration and, in any event, she had not made the requisite showing of good cause for disapproval. See Fair Hearing Rules § 1000.4(F) ("The Board shall approve the findings of the hearing officer and adopt them as the findings of the Board unless good cause is shown for disapproving them."). This appeal followed.

Petitioner does not appear to challenge any of the Board's legal conclusions on appeal to this Court. Instead, she suggests that the Board's factual findings were erroneous because they were based on evidence which she asserts should not have been credited for various reasons. This Court reviews the Board's factual findings for clear error, and thus will not set them aside where fairly and reasonably supported by any credible evidence in the record. In re E.C., 2010 VT 50, ¶ 6, 188 Vt. 546 (mem.); Hall v. Dep't of Soc. Welfare, 153 Vt. 479, 486-87 (1990).

[*] The statute the Board applied in analyzing petitioner's appeal was subsequently amended. See 2023, No. 81, § 1 (codified at 33 V.S.A. § 6902). Our citations through this order refer to the prior version of the statute.

Under this standard, transcripts of the evidentiary hearing below are necessary for informed consideration of petitioner's arguments. "[L]acking a complete record, we are unable to review the evidence to determine if it supports the [Board's] factual findings." See In re Joyce, 2018 VT 90, ¶ 21, 208 Vt. 226. Petitioner failed to order transcripts. See 3 V.S.A. § 809(f) (providing that contested hearing before administrative board "shall be transcribed on request of any party subject to other applicable provisions of law, and upon payment by the requesting party of the reasonable costs thereof"); Fair Hearing Rules § 1000.4(J) (explaining that Board's clerk shall furnish parties with transcript "at the request of either party"). As a result, petitioner has waived the arguments raised on appeal. V.R.A.P. 10(b)(1) ("By failing to order a transcript, the appellant waives the right to raise any issue for which a transcript is necessary for informed appellate review.").

Affirmed.

BY THE COURT:

Paul L. Reiber, Chief Justice

Karen R. Carroll, Associate Justice

William D. Cohen, Associate Justice