INVESTIGATIVE REPORT

OFFICE OF THE VETERAN ADVOCATE

Case: 2024-11-005

Lead Investigator: Nathan A. Dufault
OVA Veteran Safety Advisor

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ABOUT THE OFFICE OF THE VETERAN ADVOCATE

The Massachusetts Office of the Veteran Advocate (OVA) is an independent state agency, free of any supervision or control by any executive agency, established by the Massachusetts Legislature in 2022, codified in part as M.G.L. Chapter 115B.

The OVA is tasked with safeguarding the wellbeing, dignified treatment, rights, and benefits of veterans in the care of or receiving services from the Commonwealth. The office ensures these veterans and their families receive compassionate, timely, and effective services. It plays a crucial role in facilitating access to both federal and state benefits and in conducting comprehensive investigations to enhance the care and services provided to veterans. A main focus of the agency is to aid and coordinate with local veteran service officers to ensure that veterans receive all available state and federal benefits.

A specific responsibility of the OVA is its investigative and oversight role. Through its statutory mandates and the Code of Massachusetts Regulations,[1] the office may receive complaints and information, initiate audits and investigations, conduct inspections of facilities, and review relevant laws, legislation, regulations, and data. When necessary, the OVA makes policy recommendations to improve service delivery, address gaps in the system, and ensure compliance with existing laws.

When there is evidence of wrongdoing or failure in the provision of services to veterans, the OVA may, through its liaison requirements, refer its audit or investigative findings to the appropriate investigative, prosecutorial, or public agencies.

Through these functions, the OVA works to uphold the highest standards of care and support for veterans in Massachusetts. By conducting investigations, audits, inspections, and reviews, the OVA not only holds state agencies and private organizations accountable, but also actively seeks to improve the policies and practices that affect veterans' welfare.

This oversight role is vital to ensuring that veterans receive the dignified treatment, benefits, respect, and protections they have earned and that any systemic issues are promptly corrected.

[1] 123 CMR 2.00

INVESTIGATIVE PURPOSE AND PROCESS

The OVAs enabling statue, M.G.L. c.115B section 2, provides the OVA with authority to investigate and ensure that veterans in the care of the commonwealth or receiving services under the supervision of an executive agency or a constituent agency in any public or private facility receive humane and dignified treatment at all times with full respect for the veterans' personal dignity and right to privacy. This investigative responsibility includes a review of any fatalities, near fatalities, serious bodily harm, emotional injuries, and failure in duty to care.

The OVA is mandated to examine, on a system-wide basis, the care and services that executive and constituent agencies provide veterans. This mission is further defined by the Code of Massachusetts Regulations, 123 CMR 2.00: Investigations, Inspections, Audits, and Reviews.

The investigative purpose of the OVA is to ensure that veterans are protected from mistreatment, neglect, and violations of their rights by holding accountable the agencies and facilities responsible for their care. This oversight role is vital for maintaining transparency, ensuring compliance with state and federal laws and regulations, and promoting improvements in the quality of services provided to veterans and their families.

The investigative process at OVA is multifaceted and begins with the receipt of complaints or information from veterans, their families, or other concerned parties. Upon receiving a complaint, the OVA is authorized to initiate audits, conduct thorough investigations, and perform inspections of facilities where veterans receive care. This also includes functioning as a liaison with federal, state, and local agencies, inspection services, and public safety entities. The OVA meticulously reviews the circumstances surrounding any complaints or reports of inadequate service delivery, incidents of harm, or potential violations of veterans' rights. This includes analyzing relevant laws, policies, and practices to identify gaps or deficiencies in the existing system.

When an investigation reveals evidence of significant failures in care, negligence, or other forms of misconduct, the OVA is empowered to refer its findings to appropriate investigative, prosecutorial, or public agencies. Additionally, the office may recommend policy changes, recommend new legislation, and suggest regulatory amendments to enhance the welfare of veterans in Massachusetts.

Through this comprehensive and proactive approach, the OVA not only addresses individual cases of concern but also seeks systemic improvements to prevent future occurrences, ensuring that veterans receive the care and respect they deserve.

CONFIDENTIALITY

Confidentiality is a fundamental aspect of the Massachusetts Office of the Veteran Advocate's (OVA) investigative, assessment, review, and oversight process, ensuring the protection of personal information and the privacy of those involved in any investigation, inspection, audit, or review.

Massachusetts law mandates strict confidentiality standards for the handling of personal information including data related to veterans' health, benefits, and services in compliance with regulations such as the Massachusetts Fair Information Practices Act (FIPA) and the Health Insurance Portability and Accountability Act (HIPAA). These laws set stringent requirements for how personal information is collected, stored, and disclosed, and violations can result in legal penalties and damage to public trust.

The OVA is bound by these regulations to implement robust data security measures and protocols to prevent unauthorized access, modification, or disclosure of sensitive information. Only personnel with a direct role in the investigative process are granted access to such data, and the sharing of information is strictly limited to what is necessary to fulfill investigative or statutory purposes. Additionally, any third-party agency or entity involved must also adhere to these same confidentiality standards under Massachusetts General Laws and applicable federal statutes.

OVA further maintains internal guidelines to ensure that protected information, such as medical records, financial data, and sensitive case details, are anonymized whenever possible and that redactions are applied to reports before public dissemination. This means that information shared in reports is curated to protect the identities and personal circumstances of individuals unless disclosure is mandated by law.

The OVA's commitment to these practices not only upholds legal obligations but also fosters a safe environment where veterans and their families can report concerns without fear of exposure or retaliation. This approach helps build trust and encourages transparency which are essential to the success of OVA's mission in serving and advocating for veterans. Moreover, maintaining confidentiality is a cornerstone of ensuring the integrity and credibility of the investigative process, protecting the rights of both veterans and employees involved.

The OVA attempts to limit the release of confidential information, thus many protected details are not included in this report.

This report may reference appendices which may or may not be released with the report due to the nature of the incident, type of information contained in the appendix, privacy concerns, or applicable laws or regulations.

LEAD INVESTIGATOR

The Massachusetts Office of the Veteran Advocate's Veterans Safety Advisor, Nathan A. Dufault, is a certified Massachusetts Emergency Medical Technician and a Pro-Board Certified Firefighter I/II with over 17 years of fire and EMS experience working in a variety of urban, suburban, and rural communities. He is also credentialed as a Fire Prevention Officer, and a Public Fire & Life Safety Educator, along with holding numerous other Fire, EMS, and public safety related certifications and credentials.

Dufault is a graduate of the Federal Law Enforcement Training Center in Glynco, GA, and the Veterans Affairs Law Enforcement Training Center in Little Rock, AR. He is also a Certified Professional Criminal Investigator (CPCI), a Certified Cyber Intelligence Investigator (CCII), and POST Certified Police Officer with over 10 years of law enforcement and investigative experience at the private, state, and federal levels conducting criminal, administrative, death, and personnel investigations.

Dufault obtained a Bachelor of Science degree in Criminal Justice from Roger Williams University and holds a certificate in Death Investigations from Texas A&M University through the Texas Forensic Science Academy.

Dufault is currently finishing a graduate program at the University of New Haven to obtain his Master of Science in Emergency Management & Public Health and is also currently enrolled at the University of Massachusetts – Lowell obtaining a Graduate Certificate in Forensic Criminology.

Dufault's experience, training, education, and life experience affords the Massachusetts Office of the Veteran Advocate and its partner agencies and organizations real depth and breadth of expertise. He brings decades of professionalism, commitment, and focus to the health, welfare, wellbeing, dignified treatment, and safety of the veterans across the Commonwealth of Massachusetts.

EXECUTIVE SUMMARY

This investigative report outlines the Massachusetts Office of the Veteran Advocate's (OVA) response to a critical incident involving the unattended death of a veteran resident at the Montachusett Veterans Outreach Center (MVOC) in Gardner, MA. The incident, reported on November 25, 2024, prompted a comprehensive investigation to assess compliance with MVOC policies and procedures and to identify potential systemic gaps in operational oversight.

The investigation began immediately following notification from MVOC leadership, with OVA investigators conducting on-site inspections, reviewing documentation, and interviewing involved personnel. Investigators meticulously analyzed incident reports, staff statements, emergency response records, and MVOC's internal policies to understand the circumstances surrounding the event. Additional efforts included liaising with local emergency services, the Office of the Chief Medical Examiner, and the U.S. Veterans Benefits Administration to gather corroborating evidence and confirm details.

Based on the findings, no fault was attributed to MVOC or its employees, and no evidence of negligence was discovered that directly contributed to this unfortunate event. The veteran's passing was determined to be consistent with his pre-existing medical conditions and no systemic or procedural failures were identified as causation factors.

Based on the findings during the investigative process, this report provides a series of targeted recommendations designed to address identified deficiencies and prevent recurrence. These recommendations emphasize implementing robust oversight mechanisms, enhancing staff training, introducing centralized compliance tracking systems, and strengthening enforcement of existing policies. Collectively, these measures aim to ensure that MVOC operates in alignment with its mission to provide a safe and supportive environment for veterans.

An advanced release copy of this report was provided to MVOC Executive Leadership to allow them a chance to respond to the OVA findings with any corrective actions taken prior to this report's official publication. In response to the OVA's findings and recommendations, MVOC promptly took steps to address each of the identified deficiencies, implementing a series of measures directly related to each specified finding to enhance compliance with organizational policies, improve staff accountability, and strengthen oversight mechanisms.[2] These corrective actions reflect MVOC's commitment to improving operational standards and fostering a safe and supportive environment for the veterans in their care.

This report underscores the importance of continuous evaluation and improvement in organizational practices to uphold the highest standards of care and service delivery for Massachusetts veterans. Through these efforts, the OVA seeks to promote transparency, accountability, and the dignity that the veterans in the Commonwealth of Massachusetts deserve.

[2] Appendix F

INTRODUCTION

On November 25, 2024, the Executive Director of the Montachusett Veterans Outreach Center, [redacted] [redacted] contacted the dedicated OVA Reporting system to report that a "Critical Incident"[3] had occurred at their housing facility located at 268 Central Street, Gardner, MA. **(Appendix A)**

Ms. [redacted] reported that a veteran, Mr. [redacted] who was a resident of their GPD[4] housing facility had passed away earlier in the afternoon, approximately around 1440. She provided the OVA with an initial incident report, and told OVA investigators that she and her staff, would be available to provide further information as required. **(Appendix A)**

MR. [redacted]

Mr. [redacted] was a graduate of Chelsea High School, Class of 1977, located in Chelsea Massachusetts. Immediately after graduation, Mr. [redacted] enlisted in the United States Navy in Boston, MA. Mr. [redacted] served honorably from August 29, 1977, until September 6, 1980, rising to the rank of E-4, Petty Officer Third Class. Mr. [redacted] separated from service out of Naval Air Station Brunswick where he was assigned to Patrol Squadron [redacted]. **(Appendix A)**

Mr. [redacted] attended the U.S. Navy's Aviation Fundamentals School, and served as a Turbo Fan Jet Engine Technician, and a System Organizational Maintenance Technician. **(Appendix A)**

Mr. [redacted] started receiving services and housing from MVOC in March of 2024. Mr. [redacted] resided at the MVOC property in Gardner since his admission.

MONTACHUSETT VETERANS OUTREACH CENTER (MVOC)[5]

"The Montachusett Veterans Outreach Center provides support to military veterans and their families in need of services to develop a resilient, self-sufficient lifestyle essential to succeed in today's environment. Since its inception, the Center has been faithful to the mission, vision, and guiding principles of founder Cathy Stallings McWilliams. The MVOC offers low-income housing alternatives and residential readjustment programs, mental health counseling, case management, employment training, personal development, veterans' benefits resource assistance, medical transportation, and food assistance."

"The MVOC, located at 268 Central Street in Gardner, Ma, is home to twelve transitional veterans, single room occupancy units and seven low-income permanent housing units, a food pantry, a drop-in center, and the executive leadership and administrative offices with a dedicated staff on hand for veteran-related inquiries during business hours. The MVOC operates three additional housing off-site facilities for qualified veterans: Unity House

[3] Critical Incident: An incident where a person suffers a fatality, near fatality, serious bodily injury, emotional injury, or there is an imminent risk of harm.
[4] Department of Veterans Affairs Grants and Per Diem Transitional Housing Program
[5] https://www.veterans-outreach.org/about-us/

(15 room permanent-supportive readjustment program veterans housing), Nichols Street Apartments (12-unit low-income permanent housing), and Cathy's House, an 8-bed permanent-supportive / transitional housing program designed for women veterans."[6]

268 CENTRAL STREET – MVOC HOUSING

"The third floor of 268 Central Street offers twelve transitional single room occupancy units for male-identifying veterans as part of the congregate residential Veterans Administration Grant per Diem Service Intensive Transitional Housing program. This program is designed to help homeless and at-risk veterans overcome personal challenges and re-establish their place in society. Each resident lives and maintains their own room setting but shares common living areas and responsibilities as part of the program under the oversight of a staff case manager, wellness team, and access to the onsite comprehensive service center and food and clothing pantry."[7]

"The second floor of both 246 and 268 Central Street provides low-income permanent apartments for independent veterans looking for a more traditional tenant-landlord scenario. As separate self-contained apartments, the environment is non-gender specific. This option also provides an onsite coin-operated common laundry area and patio/balcony for residents only. Both options are ADA compliant and have controlled access as additional safety for the residents."[8]

[6] https://www.veterans-outreach.org/about-us/
[7] https://www.veterans-outreach.org/services-and-programs/housing/
[8] https://www.veterans-outreach.org/services-and-programs/housing/

OVA INVOLVEMENT

Upon notification of the Critical Incident from MVOC, OVA Investigators informed the MVOC Executive Director that they would be accepting the case and initiating an investigation into the fatality per the OVA statutory requirements as set forth in Massachusetts General Law, Title XVII, Chapter 115b, Section 2.

OVA Investigators informed the MVOC Executive Director that on November 26, 2024, they would be at the MVOC facility to begin the investigation and requested that she make herself and any MVOC staff members that were involved in the incident be present and available. **(Appendix A)**

The MVOC Executive Director was advised that the investigation would include a comprehensive review of the incident and of all pertinent MVOC policies and procedures. **(Appendix A)**

INITIAL FACT FINDING – NOVEMBER 25, 2024

Immediately upon receipt of the Critical Incident notification, OVA investigators began a review of the "Incident Report" that was provided as an attachment to the notification email by the MVOC Executive Director. **(Appendix E)**

The key information identified by OVA investigators was as follows:

- An unattended death occurred in the MVOC VA GPD housing facility
- The male party was found unresponsive during a routine room check by an MVOC Case Manager ([redacted]
- The case manager called the Executive Director who then called 911
- MVOC staff informed 911 the male party was "non-responsive and cold to the touch"
- Police Department (PD) and Emergency Medical Services (EMS) arrived and confirmed the male party's death
- Party had significant medical history to include CHF[9], COPD[10], and substance use disorder[11] (As reported by MVOC)
- PD contacted "2 medical examiners"
- Medical Examiner denied the case
- PD contacted Boucher Funeral Home at MVOCs request
- MVOC notified their contact at the US Department of Veterans Affairs

[9] Congestive Heart Failure
[10] Chronic Obstructive Pulmonary Disease
[11] Cocaine & Alcohol

MVOC SITE VISIT – NOVEMBER 26, 2024

Upon arrival at MVOC, OVA Investigators met with MVOC Executive Director [redacted] Ms. [redacted] advised that the room where the incident had occurred had been secured and un-touched since the Gardner Police Department and workers from Boucher's Funeral Home had cleared the scene. Ms. [redacted] then escorted OVA investigators to the room. Upon arrival at the room, OVA investigators took documentary photographs. **(Appendix B)**

Ms. [redacted] told investigators that when the case manager found the male party, he was kneeling on the floor in a bent forward position in between his bed and a nightstand. Upon examining the location where the party was found investigators observed a bottle of Jack Daniels Tennessee Honey Whiskey. Ms. [redacted] placed the bottle of whiskey onto the nightstand and stated that the male was a recovering alcoholic, but it was their belief that he had been "clean and sober." Ms. [redacted] removed the alcohol bottle from the room and brought it to the case manager's office. **(Appendix A)**

Ms. [redacted] provided investigators with the veterans "Universal Services Application," "Emergency Fact Sheet," and "Medical Record." Ms. [redacted] also provided a sworn written statement on the OVA Witness/Victim Statement form, recounting the events that transpired during the incident and what her involvement was. Ms. [redacted] stated that at approximately 2:40pm, she "*received a call from GPD case manager* [redacted] *stating veteran* [redacted] *was non-responsive and cold to the touch during his room check*" She stated that she "*went over immediately to meet him, confirmed no pulse and cold, and called 911*". She continued to say "*Police and EMT were deployed to site and confirmed veteran had passed. Myself &* [redacted] *provided police statements (brief) and personal contact info.*" Ms. [redacted] also stated "*Note: CPR/emergency response actions not performed because it was clear they were unnecessary"* **(Appendix A)**

Ms. [redacted] was then directed to provide digital copies of all MVOC policies and procedures to OVA Investigators for review. This was to include all policies and procedures that involve emergency response procedures, employee handbooks, and any documentation that discussed the "room check" policies. **(Appendix A)**

Ms. [redacted] then directed MVOC Case Manager [redacted] to provide OVA investigators with a statement as well. Mr. [redacted] stated "*yesterday around 1:35pm, I went upstairs to do my last check on the 3rd floor veterans before I left for the day. I knocked on the door of* [redacted] *to see how he was doing and his overall weekend but there was no answer. I walked into his room (door was unlocked) and noticed veteran in a kneeling/bent over position between his bed and a small table. I called the veteran's name again while walking towards him and still no answer. I touched the back of the veteran's elbow and noticed it was cold. I looked at the veteran's hands and feet and they was black/blue.*" **(Appendix C)**

Mr. [redacted] then stated "*I call* [redacted] *(executive director) and informed her about the situation.* [redacted] *came over and immediately called 911 after looking at the veteran."*

Mr. [redacted] stated that he then went downstairs to wait for the EMTs and the Gardner Police. He stated that once everyone arrived, he took everyone upstairs. Mr. [redacted] stated that he then went back to his office to print out paperwork for the police while [redacted] stayed in the room with the police officers. Mr. [redacted] stated that he then called the VA liaison and completed an MVOC incident report. **(Appendix C)**

After obtaining both written statements and the veteran's paperwork, OVA investigators released both Ms. [redacted] and Mr. [redacted] and advised that they would be contacted if any further information was required. Ms. [redacted] stated that she would get the policies and procedures over to investigators by the end of the day. **(Appendix A)**

GARDNER POLICE DEPARTMENT REPORT

On November 26, 2024, OVA Investigators obtained a copy of the Gardner Police Department report from the incident. The police report was completed by Officer Anthony Webb. Officer Webb states that "*at 2:42pm, Officer Neufell and I were dispatched to the Montachusett Veterans Outreach [C]enter at 268 Central Street for a report of an unresponsive male party.*" **(Appendix D)**

Officer Webb continues on to say "*Upon arrival, we met with case manager [redacted] explained to us that he went to make his last rounds before he left for the day and observed [redacted] on the floor of his room and he was unresponsive and not breathing. [redacted] told us he was cold to the touch. When [redacted] directed us to room [redacted] where [redacted] resides, we observed him to be on his knees and leaning in between his bed and nightstand. [redacted] was cold to the touch and showed clear signs of lividity and his body was in rigor. At this time, I requested paramedics. Woods paramedic, Colleen Killay, evaluated [redacted] and pronounced the time of death at 2:50pm. Executive [D]irector, [redacted] spoke to other residents and someone noticed his truck was in a different parking spot this afternoon than it was this morning. The last known time that staff saw him was on Friday evening.*" **(Appendix D)**

"[redacted] *had a list of medical conditions and prescription medications on his desk.* [redacted] *had a history of depression, COPD, AFIB, congestive heart failure, and a history of alcohol and cocaine use.* [redacted] *room was clean and well kept. There were no signs of suspicious activity in his room or on* [redacted] *person. I contacted the Medical Examiners office as well as CP AC and both agencies declined the case. The Medical Examiners office provided me with case number 2024-16465. I spoke to Laura from the ME's office and she stated Dr.* [redacted] *declined the case. l contacted CPAC and spoke to Trooper Christopher Mckenzie and he was made aware of the case as well.*" **(Appendix D)**

"*Boucher's Funeral Home arrived on scene a short time after and took custody of* [redacted] *l was able to get contact information through the VA hospital in Bedford for* [redacted] *brother,* [redacted] *I made contact with* [redacted] *and he was made aware and will follow up with the funeral home.*" **(Appendix D)**

GARDNER FIRE DEPARTMENT REPORT

On November 26, 2024, OVA Investigators obtained a copy of the Gardner Fire Department report from the incident. The police report was completed by Firefighter Michael Bergeron. The report states "*Engine 1, Paramedic 1, and paramedic 2 responded to an unresponsive party that was not breathing and cold to the touch. Upon arrival companies evaluated the patient and discovered that the patient was deceased. This became a police matter and fire and EMS companies cleared the scene.*" **(Appendix D)**

WOODS EMS INC. REPORT

On November 26, 2024, OVA Investigators obtained a copy of the Woods EMS Inc. Patient Care Report from the incident. Woods EMS Inc. is the Advanced Life Support provider for the Town of Gardner. The report was completed by Colleen Killay, Paramedic. Patient Care Report states: "*U/A @ 268 CENTRAL ST [redacted] GARDNER, PARAMEDIC 1 ARRIVES TO FIND UNRESPONSIVE 69 YO MALE PT ON KNEES WITH HEAD/SHOULDERS WEDGED FACE DOWN BETWEEN BED AND SIDE TABLE. GPD STATES THEY WERE SUMMONED BY STAFF WHO FOUND PT IN CURRENT POSITION, COLD TO TOUCH AND PULSELESS WHICH PD VERIFIED ON THEIR ARRIVAL. STAFF STATES PT LKW WAS APPROX 17:00 YESTERDAY AND HAS NOT BEEN SEEN YET TODAY. STAFF STATES PT IS NOT KNOWN TO HAVE BEEN ILL RECENTLY. PT FOUND CURRENTLY WITH COLD, MOTTLED SKIN DEPENDENT LIVIDITY NOTED TO LE BILAT, ABD. PT UE NOTED TO BE FLEXED ON BED AND SIDE TABLE RESPECTIVELY AND NOTED TO HAVE POSITIVE RIGOR MORTIS. PT WITHOUT CAROTID PULSE OR RESP DRIVE X gt; 30 SECS. PT NOTED TO BE ASYSTOLIC ON MONITOR. UNABLE TO ASSESS ANTERIOR BODY. POSTERIOR SHOWS SM ABRASION WITH SURROUNDING BRUISING WITH SOME YELLOWING TO RIGHT FLANK, NO OTHER FINDINGS. DUE TO SIGNS OF OBVIOUS DEATH, RESUSCITATIVE MEASURES WITHHELD. BODY LEFT IN CARE OF GPD X 2."* **(Appendix D)**

REVIEW OF MVOC POLICY & PROCEDURES

On November 26, 2024, the MVOC Executive Director provided OVA investigators with the MVOC "Case Manager Policies and Forms," the "Supportive Housing Handbook," and the "MVOC Employee Handbook" in digital form. These documents provided OVA investigators with an insight into the policies and procedures of MVOC and an understanding of the actions taken by their staff. **(Appendix E)**

The "Supportive Housing Handbook" page 11 outlines MVOCs proof of life checks for GPD residents. The policy states "*GPD Residents: Participate in a 9am and 9pm proof of life checks by MVOC staff, which requires the staff to enter your room and visually confirm your presence."* **(Appendix E)**

The "MVOC Employee Handbook" discuses an employee's responsibility to maintain Red Cross Certification in First Aid, CPR, NARCAN, AED, and Blood Borne

Pathogens.[12] It also states that training is offered annually to all employees at no cost. **(Appendix E)**

The "MVOC Employee Handbook" also discusses MVOCs plan/policy for "Medical Emergencies." It states, "*If a need for emergency medical assistance should develop, employees shall first call 911 and then notify the Executive Director for assistance."*[13] **(Appendix E)**

The "MVOC Employee Handbook" also discusses MVOCs plan/policy for "Other Emergencies." It states: "*In the event of other types of emergencies, such as: hostage taking or the death of clients or employee, the Executive Director shall be notified immediately and take appropriate action."*[14] **(Appendix E)**

Page 33 of the "MVOC Employee Handbook" covers employee training. It states that "*Emergency Training for employees consists of":*

- *"Twice quarterly of the Emergency Action Plan at All Staff meetings to include:*
  - *Review of 'Designated Assembly Areas'*
  - *Location of emergency evacuation routes and alternates should routes be blocked*
  - *Review of Emergency Procedures*
  - *Duties and responsibilities during an emergency*"

In addition to focusing on the areas of the MVOC Policies that were directly related to this incident, a comprehensive review of all provided handbooks, policies, and procedures was conducted.

MVOC DOCUMENTATION REQUEST

On December 4, 2024, OVA Investigators requested all current training records and copies of CPR/AED certifications for MVOC employees that were involved in the incident. MVOC's Executive Director provided appropriate documentation for all MVOC staff members. This documentation shows that all MVOC staff members are trained by the American Red Cross Training Services in Adult and Pediatric Fire Aid/ CPR/AED with Asthma and Quick-relief Medication Administration and Anaphylaxis and Epinephrine Auto-Injector Administration. **(Appendix E)**

MASSACHUSETTS OCME[15]

On December 9, 2024, OVA investigators contacted the western division of the Massachusetts Office of the Chief Medical Examiner and spoke with [redacted], Chief Investigator, regarding OCME case 2024-16465. Investigator [redacted] stated that the case was referred to them by Gardner Police Department due to being an "unattended death at a place of residence" meaning the death occurred outside of a medical care facility. Investigator [redacted] stated that the case was denied by OCME Dr. [redacted]

[12] Page 31, "Red Cross Certification Policy" – MVOC Employee Handbook
[13] Page 32, "Section 4: Additional Emergency Plans and Policies" – MVOC Employee Handbook
[14] Page 32, "Section 4: Additional Emergency Plans and Policies" – MVOC Employee Handbook
[15] Massachusetts Office of the Chief Medical Examiner

due to the conversation with on-scene GPD[16] officers. It was stated that there was "nothing obviously unnatural," the decedent had at minimum a "single chronic condition," and there were "no other reporting criteria," Investigator [redacted] advised that after the OCME declines a case, the family or facility is free to contact a funeral home for removal. **(Appendix A)**

U.S. VETERANS BENEFITS ADMINISTRATION

On December 10, 2024, OVA Investigators received notification from the United States Veterans Benefits Administration that all records and files pertaining to Mr. [redacted] had been sent USPS Certified Mail to the OVA Office in Quincy for review. **(Appendix A)**

Upon receipt of the documentation, a thorough review of applicable records was completed. This review of VBA/VHA[17] records allowed investigators to confirm the decedent's service/veteran status along with his reported medical conditions that may have been contributing factors to his death.

CONCLUSION

The Massachusetts Office of the Veteran Advocate (OVA) conducted a thorough investigation into the critical incident involving the unattended death of a veteran resident at the Montachusett Veterans Outreach Center (MVOC). This investigation encompassed on-site inspections, interviews with staff, analysis of incident reports, and a review of MVOC's internal policies and procedures. Based on the findings, no fault was attributed to MVOC or its employees and no evidence of negligence was discovered that directly contributed to this unfortunate event. The veteran's passing was determined to be consistent with his pre-existing medical conditions and no systemic or procedural failures were identified as causation factors.

While the investigation did identify areas where operational enhancements are warranted, these findings were not contributory to the incident itself. Instead, they represent opportunities for MVOC to strengthen its adherence to established policies, improve compliance tracking, and enhance oversight mechanisms. By implementing the recommendations outlined in this report, MVOC can further solidify its commitment to providing a safe and supportive environment for its residents.

The OVA acknowledges MVOC's dedication to its mission of serving veterans and recognizes the organization's responsiveness throughout this investigative process. The recommendations are provided with the intent of fostering continuous improvement and ensuring that veterans receive the highest standards of care and support. OVA remains steadfast in its role of safeguarding the dignity and wellbeing of veterans across the Commonwealth.

[16] Gardner Police Department
[17] Veteran Health Administration

INVESTIGATIVE FINDINGS & RECOMMENDATIONS

FINDING 1:

Expired/Invalid Certifications of MVOC Employees[18]

Upon review of the provided MVOC employee training records to include American Red Cross certification cards for both Adult & Pediatric First Aid/CPR/AED with Epinephrine Auto-Injector and Opioid Overdose and Naloxone Administration – Nasal Spray, it was identified that 8 out of the 19 MVOC staff members had either expired or invalid certification cards. This included the MVOC employee that was involved in this specific incident. From date of issue, American Red Cross CPR certifications are good for a period of two years.

MVOC Staff members not having a valid American Red Cross certification card is a violation of the MVOC Employee Handbook Section 3: Preventative Procedures & Safety Policies, and Section 5: Training.

The MVOC Employee Handbook, Section 3 states "*Red Cross Certification Policy: All staff must maintain Red Cross certification in Fire Aid, CPR, NARCAN, AED, and Blood Borne Pathogens. Training is offered annually at no cost to the employee."*

The MVOC Employee Handbook, Section 5 states "*The purpose of this section is to ensure that all staff and clients are provided with proper training on their roles and responsibilities in the event of an emergency."*

Section 5 continues to discuss additional MVOC employee training topics: *"Emergency training for employees consists of:*

- *Twice quarterly of the Emergency Action Plan at All Staff meetings to include:*
  - *Review of 'Designated Assembly Areas'.*
  - *Location of emergency evacuation routes and alternates should routes be blocked.*
  - *Review of Emergency Procedures.*
  - *Duties and responsibilities during an emergency.*
- *Annual training in the proper use of portable fire extinguishers for select individuals.*
- *Annual fire drills for staff in the Central Street headquarters.*
- *Annual fire drills for staff in the Fortier building.*
- *Monthly fire drills for residents at all housing facilities"*

Section 5 continues on to state "*As indicated in Section 3, all staff must maintain Red Cross certification in Fire Aid, CPR, NARCAN, AED, and Blood Borne Pathogens. Training is offered annually at no cost to the employee."*

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18 This was identified during the review of documentation (staff training records) provided by the MVOC Executive Director and was then verified through the American Red Cross website by the individual certificate number that was provided by MVOC.

RECOMMENDATION FOR FINDING 1:

SUMMARY:

It is recommended that MVOC implement a standardized tracking system to monitor the expiration dates of all staff certifications, ensuring timely renewals and compliance with American Red Cross requirements, and as required by the organization's policies, procedures, and handbooks. A digital database or software platform should be utilized to set automated reminders for upcoming expirations.

Additionally, all staff members with expired and/or invalid certifications should be prioritized for immediate re-certification. To prevent future lapses, the MVOC Executive Director should establish a policy requiring annual reviews of staff training records and certification statuses. This will ensure that certifications remain valid, maintain organizational credibility, and uphold safety standards for MVOC operations.

PROPOSED IMPLEMENTATION:

To address the issue of expired or invalid certifications among MVOC staff, it is strongly recommended that the organization (MVOC) implement a comprehensive certification compliance management program. This program should include the following elements:

1. **Incident Specific Corrective Action:**
   As a priority, MVOC should immediately address the certifications of the 8 employees identified in the investigation, including the employee involved in the specific incident. These individuals should be enrolled in the next available recertification course and restricted from roles requiring certification until their compliance is confirmed.

2. **Centralized Tracking System:**
   MVOC should establish a digital database or software platform dedicated to tracking certification records for all employees. This system should include fields for employee names, certification types, issuance dates, expiration dates, and renewal deadlines. Automated reminders should be programmed to notify employees and supervisors at least 60 days before certifications are set to expire.

3. **Mandatory Compliance Policy and Monitoring:**
   The MVOC Executive Director should reinforce the importance of maintaining current certifications by updating Section 3 and Section 5 of the MVOC Employee Handbook to include a clear compliance monitoring process. Supervisors should be tasked with conducting quarterly audits of employee certification records to ensure compliance. Staff with expired certifications should be placed on a corrective action plan, which includes mandatory recertification within 30 days.

4. **Annual Certification Renewal Training:**
   To prevent future lapses, MVOC should establish a mandatory annual certification renewal training session for all employees requiring Red Cross

certifications. This session can be coordinated to coincide with other annual training topics outlined in Section 5 of the Employee Handbook. Offering this training at no cost to employees, as stated in the handbook, will encourage participation and compliance.

5. **Enhanced Accountability Measures:**
   MVOC should establish accountability measures, such as requiring staff to sign a Certification Compliance Agreement, affirming their responsibility to maintain valid certifications. Supervisors should also acknowledge their role in monitoring and supporting their team's compliance with certification requirements.

6. **Reporting and Oversight:**
   The Executive Director should receive quarterly reports summarizing the compliance status of all staff certifications. These reports will serve as a tool for senior leadership to monitor progress, identify recurring challenges, and ensure corrective actions are implemented effectively.

7. **Update Policies and Procedures:** MVOC should update written policies and procedures to reflect new measures are implemented.

By implementing these recommendations, MVOC can address the immediate issue of policy non-compliance, establish a sustainable system to prevent future lapses, and reinforce a culture of safety and preparedness across the organization.

FINDING 2:

Failure to follow established "proof of life checks" program

The MVOC Supportive Housing Handbook (page 11, "Program Engagement Expectations") explicitly states that residents must participate in "*9 a.m. and 9 p.m. proof of life checks by MVOC staff, which requires the staff to enter your room and visually confirm your presence.*" This policy is critical to ensuring the health and safety of residents in supportive housing, particularly veterans who may be at heightened risk due to physical or mental health challenges.

Based on the statements obtained by OVA investigators and the review of the MVOC Incident Report, it was determined that this policy was not adhered to on the day of the incident. The unresponsive resident was not discovered until approximately 1:35 p.m. on November 25, 2024, when the case manager conducted what he described as his "last check on the 3rd-floor veterans." Both the case manager and the executive director confirmed during their statements that no proof of life check was conducted at 9 a.m., nor was any other check conducted prior to the 1:35 p.m. discovery. There is no record or documentation as to the exact or approximate time the last "proof of life" check had been conducted.

This lapse represents a significant failure to comply with MVOC's established procedures which are in place to safeguard the wellbeing of residents. The absence of the required proof of life checks demonstrates a breakdown in staff accountability and operational oversight.

RECOMMENDATION FOR FINDING 2:
SUMMARY:

To address the failure to adhere to the established "proof of life checks" policy, it is recommended that MVOC implement stricter operational oversight and accountability measures. Staff should receive mandatory training on the importance of proof of life checks and the procedures outlined in the MVOC Supportive Housing Handbook. A centralized logging system should be introduced to document the completion of each check, including timestamps and staff initials, to ensure compliance. Additionally, supervisory staff should conduct random audits to verify adherence to the policy.

MVOC should also consider utilizing automated or electronic check-in systems as a supplemental measure to enhance efficiency and reduce human error. This would also provide an opportunity to immediately rectify any missed checks. These corrective actions will ensure consistent execution of proof of life checks, safeguarding the wellbeing of residents and reinforcing organizational accountability.

PROPOSED IMPLEMENTATION:

To ensure adherence to the MVOC Supportive Housing Handbook policy regarding "proof of life checks," a comprehensive corrective action plan should be implemented. This plan should emphasize operational oversight, staff accountability, and process

improvement to safeguard the wellbeing of residents. The following actionable steps are recommended:

1. **Incident-Specific Corrective Action**
   Address the lapse in the 9 a.m. proof of life check identified in this investigation by issuing corrective action to the involved staff. Require an immediate review of all proof of life checks conducted on the day of the incident to identify potential systemic issues.

2. **Immediate Training and Policy Reinforcement**
   Conduct a mandatory training session for all staff involved in proof of life checks to reinforce the importance of the policy, its purpose, and its impact on resident safety. Incorporate real-world scenarios and case studies, including the current incident, to highlight the consequences of non-compliance. Require all staff to sign an acknowledgment form confirming their understanding of the policy and their responsibility to adhere to it.

3. **Implementation of a Centralized Logging System**
   Develop a standardized logging system to document the completion of all proof of life checks. Logs should include:
   - Resident names and room numbers.
   - Date and time of the check.
   - Name and signature or initials of the staff member conducting the check.

   Maintain these logs in a central location for easy access and supervisory review.

4. **Enhanced Oversight and Accountability**
   Designate a supervisor or lead staff member to conduct random spot-checks of proof of life logs to ensure compliance. Develop a clear escalation procedure for addressing missed checks, including immediate notification of supervisors and mandatory follow-up documentation. Establish a performance review metric tied to the consistent completion of proof of life checks, with consequences for repeated non-compliance.

5. **Introduction of Electronic Check-In Systems**
   Explore the use of electronic systems to enhance the efficiency and accuracy of proof of life checks. For example, implement a tablet or smartphone application that allows staff to log proof of life checks in real-time. Integrate room keycard scanners to verify and timestamp staff visits to individual rooms.

6. **Resident Engagement and Communication**
   Communicate the purpose of proof of life checks to residents, emphasizing their role in maintaining safety and wellbeing. Provide residents with clear expectations and encourage cooperation to ensure the success of the program.

Establish a feedback mechanism for residents to report concerns or suggest improvements to the program.

7. **Regular Audits and Reporting**
   Conduct monthly audits of proof of life logs to identify trends, ensure compliance, and address gaps in the process. Provide a summary report to MVOC leadership, including metrics on compliance, identified issues, and corrective actions taken.

8. **Update Policies and Procedures:** MVOC should update written policies and procedures to reflect new measures are implemented.

By implementing these steps, MVOC can ensure that the proof of life checks policy is consistently followed, reducing risks to resident safety, and reinforcing staff accountability. This comprehensive approach will help restore confidence in MVOC's ability to provide a safe and supportive environment for all residents.

FINDING 3

Presence of Alcohol in Resident's Room in Violation of MVOC Policies

The MVOC Supportive Housing Handbook[19] explicitly prohibits the presence[20] or consumption of alcohol on-site, emphasizing that its supportive housing programs are designed as sober group homes. Residents are required[21] to adhere to a zero-tolerance policy for alcohol use or possession, with violations subject to disciplinary action up to and including discharge from the program.

OVA investigators observed a bottle of Jack Daniel's Tennessee Honey Whiskey in the room of the deceased resident, during the initial site visit on November 26, 2024. The alcohol bottle was subsequently removed by the MVOC Executive Director who acknowledged that Mr. [redacted] was a recovering alcoholic.

This discovery indicates a tenant violation of policy as well as a failure to enforce MVOC's sobriety policy and raises concerns about the effectiveness of staff monitoring, observational skills, and enforcement procedures. The presence of alcohol in the decedent's room represents a significant lapse in enforcing MVOC's policies and procedures designed to maintain a sober living environment. This violation not only jeopardizes the integrity of the program but also compromises the safety and wellbeing of residents, particularly those in recovery from substance use disorders.

RECOMMENDATION FOR FINDING 3:

SUMMARY:

To address the presence of alcohol in the room of a resident, in violation of MVOC's sobriety policies, it is recommended that MVOC strengthens its monitoring and enforcement procedures, enhances resident education and accountability, and ensures staff are thoroughly trained in policy compliance. By reinforcing these measures, MVOC can create a safer, more supportive environment for residents in recovery, uphold the integrity of its programs, and prevent similar violations in the future.

PROPOSED IMPLEMENTATION:

1. **Enhanced Monitoring and Enforcement:**
   Routine Room Inspections: Staff will conduct thorough inspections of all resident rooms during routine proof-of-life checks and at other scheduled intervals.
   Inspection Checklist: Develop and implement a checklist explicitly addressing prohibited items, including alcohol, to be used during inspections.

2. **Resident Education and Accountability:**
   Policy Reinforcement: Revise resident orientation materials to include a comprehensive review of sobriety policies and their importance to community wellbeing. Conduct periodic reviews of tenant expectations and policies and

[19] MVOC Supportive Housing Handbook, Page 11
[20] MVOC Supportive Housing Handbook, Page 11 – Room Regulations
[21] MVOC Supportive Housing Handbook, Page 11 – Resident Rules and Expectations

require a policy acknowledgement.
Policy Acknowledgment: Require all residents to sign an updated policy agreement that explicitly outlines the zero-tolerance alcohol policy and potential consequences for violations.

3. **Staff Training and Oversight:**
   Targeted Training: Conduct training sessions for staff focused on identifying and responding to sobriety policy violations. This should include staff training on recognition of substance abuse indicators, and behaviors indicative of intoxication.
   Compliance Oversight: Assign a designated staff member as the Sobriety Compliance Officer to monitor enforcement efforts, provide additional oversight, and ensure staff adhere to the new protocols.

4. **Increased Communication and Reporting:**
   Incident Reporting: Require staff to immediately document and report any violations of the sobriety policy in accordance with established reporting procedures.
   Reporting Protocol: Develop a clear reporting pathway to ensure timely intervention by supervisors or directors when violations occur.

5. **Routine Audits:**
   Monthly Audits: Conduct monthly reviews of room inspection logs and compliance reports to identify trends, recurring issues, or gaps in enforcement.
   Audit Reports: Provide audit results to leadership and use the findings to guide continuous improvements in enforcement protocols.

6. **Update Policies and Procedures:** MVOC should update written policies and procedures to reflect new measures are implemented.

By implementing these steps, MVOC can proactively ensure compliance with sobriety policies, promote a safe living environment for residents, and maintain the program's mission of supporting veterans in recovery.