HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 259 Elder Abuse Fatality Review Teams
SPONSOR(S): Children, Families & Seniors Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Children, Families & Seniors Subcommittee		Gilani	Brazzell

SUMMARY ANALYSIS

Florida has the highest percentage of senior residents in the nation, projected to increase from 20 to 25 percent (5.9 million seniors) by 2030. Mental and physical infirmities of aging and social isolation make elders vulnerable to abuse, which increases their rates of hospitalization and hastens death. One in 10 elders is abused, but incidents of elder abuse are reported in less than 5 percent of cases, primarily because the most common perpetrator is a relative, friend, neighbor, or caregiver whom the elder trusts or fears.

The Department of Children and Families (DCF) is responsible for the state's adult protective investigations. DCF investigates reports of elder abuse, including elder deaths, and facilitates supportive services to victims. In FY 2016-17, DCF received 41,192 reports of elder abuse, neglect, or exploitation and investigated 181 deaths in which the death was allegedly due to abuse or neglect.

Florida has programs to systematically review deaths due to child abuse or domestic violence. Different than protective investigations, these fatality review teams are generally established to understand the causes and incidents of deaths, identify any gaps in support and service delivery, and improve preventive interventions.

The PCS for HB 259 creates s. 415.1103, F.S., authorizing the creation of a multidisciplinary, multiagency elder abuse fatality review team (EA-FRT) in each judicial circuit to review closed cases where the death of an elderly person was alleged or found to have been caused by, or related to, abuse or neglect. EA-FRTs are housed in the Department of Elder Affairs (DOEA) for administrative purposes only. Participation in EA-FRT is voluntary and team members shall serve without compensation.

The bill includes procedures for organization and creation of an EA-FRT, appointment of EA-FRT members, and obtaining relevant records for an EA-FRT. In its review, an EA-FRT shall consider the surrounding circumstances and events leading up to a fatal incident, identify any gaps in support and service delivery, and make recommendations for systemic improvements to prevent elder abuse and deaths.

The bill requires each EA-FRT submit an annual report on its findings to DOEA by September 1 and DOEA to submit a summary report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and DCF by November 1 each year.

The bill prevents records held by an EA-FRT from being subject to discovery or introduced into evidence in any proceeding, with exceptions. The bill prohibits the testimony of EA-FRT members or participants in any proceeding, with exceptions. The bill grants EA-FRT members immunity from monetary liability and prohibits a cause of action in certain circumstances, with exceptions.

The bill amends s. 415.107(3), F.S., and authorizes DCF to release confidential and exempt adult protective investigative records to DOEA if they pertain to the death of an elderly person under review by an EA-FRT.

The bill will have an indeterminate negative fiscal impact on state government.

The bill provides an effective date of July 1, 2018.

FULL ANALYSIS

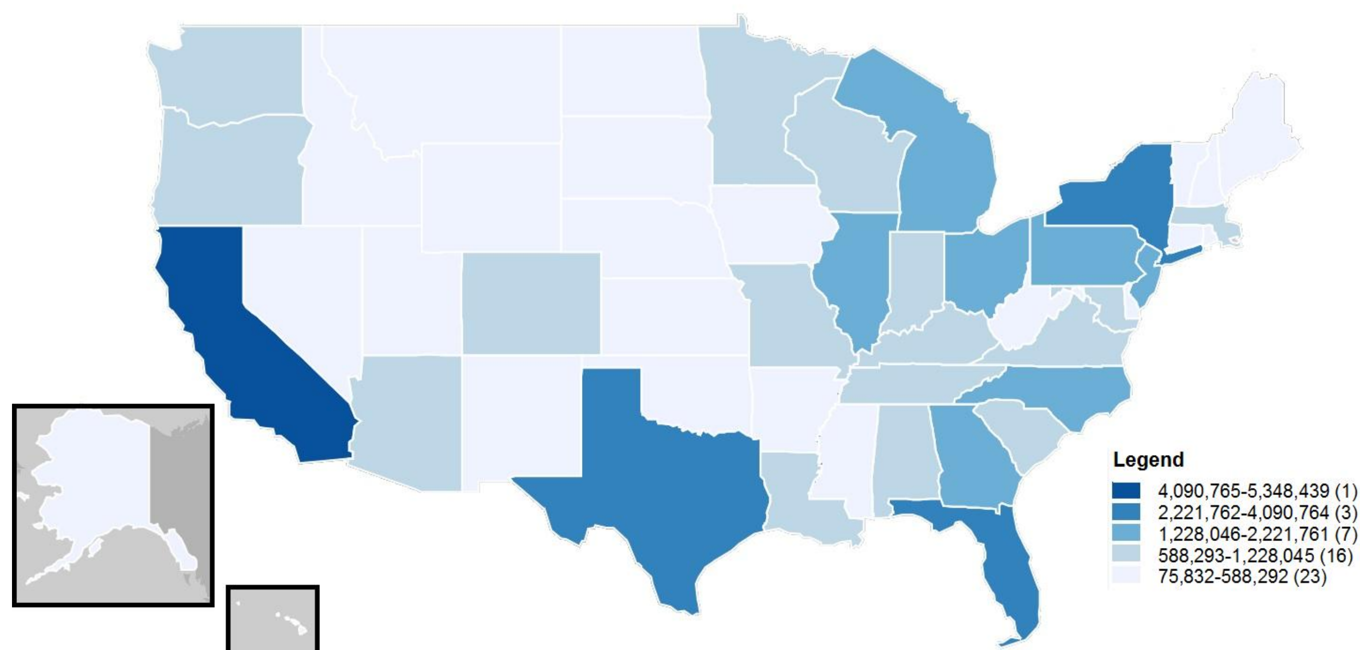
I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation:

As the country's "baby-boomer" population reaches retirement age and life expectancy increases, the nation's elder population is projected to increase from 49.2 million in 2016[1] to 72.8 million by 2030.[2] Florida has long been a destination state for senior citizens and has the highest percentage of senior residents in the entire nation.[3] In 2016, Florida had an estimated 4.1 million people aged 65 and older, approximately 20 percent of the state's population.[4] By 2030, this number is projected to increase to 5.9 million, meaning the elderly will make up approximately one quarter of the state's population and will account for most of the state's growth.[5,6,7]

National Distribution of Population Ages 65 and Older (2016)[8]



[1] Press Release, U.S. CENSUS BUREAU, *The Nation's Older Population is Still Growing, Census Bureau Reports* (June 22, 2017), Release Number: CB17-100, *available at*: https://www.census.gov/newsroom/press-releases/2017/cb17-100.html (last visited Jan. 3, 2018).

[2] U.S. CENSUS BUREAU, *2012 National Population Projections, Middle Series*, p.44, available at: https://www2.census.gov/programs-surveys/popproj/technical-documentation/methodology/methodstatement12.pdf (last visited Nov. 21, 2017).

[3] *Where Do the Oldest Americans Live?*, PEW RESEARCH CENTER, July 9, 2015, available at: http://www.pewresearch.org/fact-tank/2015/07/09/where-do-the-oldest-americans-live/ (last visited Nov. 18, 2017).

[4] U.S. CENSUS BUREAU, *Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States*, available at: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk (last visited Jan. 3, 2018).

[5] FLORIDA OFFICE OF ECONOMIC & DEMOGRAPHIC RESEARCH, *Population Data: 2016, 2020, 2025, 2030, 2035, 2040, & 2045, County by Age, Race, Sex, and Hispanic Origin*, pp. 89-90, available at: http://edr.state.fl.us/Content/population-demographics/data/Medium_Projections_ARSH.pdf (last visited Nov. 10, 2017).

[6] FLORIDA OFFICE OF ECONOMIC & DEMOGRAPHIC RESEARCH, *Econographic News: Economic and Demographic News for Decision Makers, 2017, Vol. 1*, available at: http://edr.state.fl.us/Content/population-demographics/reports/econographicnews-2017v1.pdf (last visited Nov. 10, 2017).

[7] *Supra* note 5, at 269-70.

[8] Map made with the U.S. Census Bureau's interactive data mapping tools using population estimation data from 2016.

Elder populations are vulnerable to abuse and exploitation due to risk factors associated with aging, such as physical and mental infirmities and social isolation.[9,10] In Florida, almost one million senior citizens are medically underserved and 1.6 million suffer from one or more disabilities.[11] According to the Department of Justice, approximately 1 in 10 seniors is abused each year in the United States, and incidents of elder abuse are reported to local authorities in 1 out of every 23 cases.[12] Elder abuse can have significant physical and emotional effects on an older adult, and can lead to premature death.[13] Abused seniors are twice as likely to be hospitalized and three times more likely to die than non-abused seniors.[14]

Elder abuse occurs in community settings, such as private homes, as well as in institutional settings like nursing homes and other long-term care facilities. Prevalent forms of abuse are financial exploitation, neglect, emotional or psychological abuse, and physical abuse; however, an elder abuse victim will often experience multiple forms of abuse at the same time.[15] The most common perpetrators of elder abuse are relatives, such as adult children or a spouse, followed by friends and neighbors, and then home care aides.[16] Research shows that elder abuse is underreported, often because the victims fear retribution or care for or trust their perpetrators.[17] Elder abuse deaths are more likely to go undetected because an elder death is expected to occur, given age or infirmity, more so than other deaths due to abuse such as a child death or a death involving domestic violence.[18] Experts believe this may be one of the reasons elder abuse lags behind child abuse and domestic violence in research, awareness, and systemic change.[19]

<u>Florida's Adult Protective Services System</u>

Chapter 415, F.S., creates Florida's Adult Protective Services (APS) under the Department of Children and Families (DCF). DCF protects vulnerable adults,[20] including elders, from abuse, neglect, and exploitation through mandatory reporting and investigation of suspected abuse.[21] This includes deaths allegedly due to abuse, neglect, and exploitation.[22] In FY 2016-17, DCF received 41,192 reports of abuse, neglect, or exploitation of persons aged 60 years or older and investigated 181 deaths in which

---

[9] NATIONAL CENTER ON ELDER ABUSE, *What are the Risk Factors?*, https://ncea.acl.gov/whatwedo/research/statistics.html#risk (last visited Jan. 4, 2018).
[10] U.S. DEPARTMENT OF JUSTICE, *Elder Justice Initiative*, https://www.justice.gov/elderjustice (last visited Nov. 19, 2017). *See also*, Xing Qi Dong et al., *Elder Abuse as a Risk Factor for Hospitalization in Older Persons*, JAMA INTERN MED. 173:10 at 911-917 (2013).
[11] DEPARTMENT OF ELDER AFFAIRS, *2016 Profile of Elder Floridians,* available at: http://elderaffairs.state.fl.us/doea/pubs/stats/County_2016_projections/Counties/Florida.pdf (last visited Nov. 24, 2017).
[12] U.S. DEPARTMENT OF JUSTICE, *Elder Justice Initiative*, available at: https://www.justice.gov/elderjustice (last visited Nov. 19, 2017). *See also*, Ron Acierno et al., *Prevalence and Correlates of Emotional, Physical, Sexual, and Financial Abuse and Potential Neglect in the United States: The National Elder Mistreatment Study*, 100:2 AM. J. PUB. HEALTH, at 292-297 (Feb. 2010), available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2804623/ (last visited Jan. 3, 2018).
[13] U.S. DEPARTMENT OF JUSTICE, *Elder Justice Initiative*, https://www.justice.gov/elderjustice (last visited Nov. 19, 2017). *See also*, Mark S. Lachs et al., *The Mortality of Elder Mistreatment*, 280:5 JAMA at 428-432 (1998), available at: https://jamanetwork.com/journals/jama/fullarticle/187817 (last visited Jan. 4, 2018).
[14] U.S. DEPARTMENT OF JUSTICE, *Elder Justice Initiative*, https://www.justice.gov/elderjustice (last visited Nov. 19, 2017). *See also*, Xing Qi Dong et al., *Elder Abuse as a Risk Factor for Hospitalization in Older Persons*, JAMA INTERN MED. 173:10 at 911-917 (2013).
[15] NATIONAL CENTER ON ELDER ABUSE, *Challenges in Elder Abuse Research,* available at: https://ncea.acl.gov/whatwedo/research/statistics.html#challenges (last visited Jan. 4, 2018).
[16] NATIONAL CENTER ON ELDER ABUSE, *Who are the Perpetrators?*, https://ncea.acl.gov/whatwedo/research/statistics.html#perpetrators (last visited Jan. 4, 2018).
[17] CENTER FOR DISEASE CONTROL AND PREVENTION, *Understanding Elder Abuse*, *Fact Sheet 2016*, available at: https://www.cdc.gov/violenceprevention/pdf/em-factsheet-a.pdf (last visited Jan. 4, 2018).
[18] U.S. DEPARTMENT OF JUSTICE, NATIONAL INSTITUTE OF JUSTICE, *Elder Justice Roundtable Report: Medical Forensic Issues Concerning Abuse and Neglect*, October 18, 2000, p. 8, available at: https://www.ncjrs.gov/pdffiles1/nij/242221.pdf (last visited Jan. 4, 2018).
[19] Id. at pp. 7-10.
[20] A vulnerable adult is a person 18 years of age or older whose ability to perform normal activities of daily living or to provide for his or her own care or protection is impaired due to mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging, s. 415.102(28), F.S.
[21] S. 415.101(2), F.S.
[22] DEPARTMENT OF CHILDREN AND FAMILIES, *CF Operating Procedure No. 140-2: Adult Protective Services* (June 1, 2017), pp. 4-9 - 4-10, available at: http://www.dcf.state.fl.us/admin/publications/cfops/CFOP%20140-xx%20Adult%20Services/CFOP%20140-02,%20Adult%20Protective%20Services.pdf (last visited Jan. 4, 2018).

the death was allegedly due to abuse or neglect.[23] During that same fiscal year, DCF verified 5,423 allegations of abuse or neglect, 27 of which involved a fatality.[24] Eighty-three (83) percent of these reports were from in-home settings, which is consistent with the research findings that relatives, friends, or caregivers are the main perpetrators of elder abuse.

DCF's Adult Investigations Involving Victims Age 60+ FYs 2012-2017[25]							
FY	Reports Received [1]	Unique Reports [2]	# Verified	Deaths Reported/ Investigated [3]	# Verified	In-Home	Institutional
2016-2017	41,192	39,005	5,423	181	27	82.77%	17.23%
2015-2016	42,609	39,998	5,639	178	21	82.91%	17.09%
2014-2015	39,639	37,381	5,371	236	40	82.52%	17.48%
2013-2014	36,926	34,922	3,934	197	27	83.96%	16.04%
2012-2013	33,833	32,092	3,309	153	17	83.14%	16.86%

[1] *Reports received* ***counts Initial and Additional intakes accepted by the Hotline. There may be more than one call/reporter on the same incident.***

[2] *Unique reports* ***represents a unique count of intakes received. Multiple intakes on the same incident are not counted.***

[3] ***All reports accepted by the Hotline are investigated.***

Mandatory Reporting to the Central Abuse Hotline

DCF maintains a statewide 24/7 toll-free central abuse hotline where anyone can report known or suspected abuse, neglect, or exploitation.[26] This includes, but is not limited to, vulnerable adults. Any person that knows or has reasonable cause to suspect abuse, neglect, or exploitation of a vulnerable adult is required to immediately report this knowledge or suspicion to the central abuse hotline.[27] The hotline number must be provided to clients in nursing homes[28] and publicly displayed in every health facility licensed by the Agency for Health Care Administration (AHCA).[29] The number is also listed on the agency websites for DCF, AHCA, and the Department of Elder Affairs (DOEA). [30,31,32]

Additionally, any person who is required to investigate allegations of abuse, neglect, or exploitation, and who has reasonable cause to suspect that a vulnerable adult died as result of such harm must report that suspicion to DCF, the medical examiner, and appropriate criminal justice agency.[33] Medical examiners in turn are required to consider this information in their cause of death determinations and report their findings to DCF and the appropriate criminal justice agency and state attorney.[34]

Protective Investigations

Once DCF believes there is reasonable cause to suspect abuse or neglect of a vulnerable adult, they begin an investigation within 24 hours, to be conducted in cooperation with law enforcement and the state attorney.[35] DCF investigators determine, among other things, whether the vulnerable adult is in need of services, whether there is evidence of abuse, neglect or exploitation, the nature and extent of

[23] Email from Lindsey Perkins Zander, Deputy Director of Legislative Affairs, Department of Children and Families, RE: Adult Protective Services Statistics (Nov. 29, 2017) (On file with House Health and Human Services Committee staff).
[24] Id.
[25] Id.
[26] S. 415.103, F.S.
[27] S. 415.1034(1), F.S.
[28] S. 408.810, F.S.
[29] S. 400.141, F.S.; AHCA poster can be found here: https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Long_Term_Care/docs/Nursing_Homes/Posters/NURSING_HOME_POSTER_ENGLISH_LETTER.pdf (last visited Nov. 10, 2017).
[30] DEPARTMENT OF CHILDREN AND FAMILIES, *Report Abuse Neglect or Exploitation*, http://www.myflfamilies.com/service-programs/abuse-hotline/report-online (last visited Nov. 10, 2017).
[31] AGENCY FOR HEALTH CARE ADMINISTRATION, *Complaint Administration Unit*, http://ahca.myflorida.com/MCHQ/Field_Ops/CAU.shtml (last visited Nov. 10, 2017).
[32] DEPARTMENT OF ELDER AFFAIRS, *Report Elder Abuse*, http://elderaffairs.state.fl.us/doea/report_abuse.php (last visited Nov. 10, 2017).
[33] S. 415.1034(2), F.S.
[34] S. 415.1034(2), F.S.
[35] S. 415.104(1), F.S. Note, DCF does not investigate reports of elder abuse when the adult victim is determined *not* to be vulnerable under s. 415.102(28), F.S. Those elder abuse cases are the sole jurisdiction of law enforcement agencies.

any harm, and what is necessary to ensure the victim's safety and well-being.[36] DCF investigators must complete their investigations and submit their recommendations within 60 days of the initial report.[37] If DCF determines that a victim is in need of protective services or supervision, it will provide or facilitate the provision of those services to the victim.[38] If a victim dies during an open investigation, DCF investigators must verify the cause of death before closing the case to determine if the death was related to abuse or neglect.[39]

If there is a report that a death occurred due to elder abuse, neglect, or exploitation, the DCF investigator notifies the department's Registered Nurse Specialist (RNS)[40] staffing his or her region within 24 hours. If the alleged victim resided with other vulnerable adults, DCF conducts an on-site investigation to ensure the safety of these individuals as well.[41]

The DCF investigator and RNS work together to gather all relevant medical investigative information, including but not limited to medical records, the death certificate, the autopsy report, and specific questions to be included in the investigative process.[42] The DCF investigators also gather other relevant information such as copies of any related law enforcement investigations, criminal history and abuse reports relating to the alleged perpetrator, and prior adult protective services records relating to the victim or perpetrator, including the facilities where the death occurred.[43]

The DCF investigators review all of this information before making their determinations as to the cause of death and will summarize their findings in a report.[44] In these cases involving an elder abuse death, DCF designates a second party to review the DCF investigators' findings before closing the case.[45] The second party reviews the investigation process to ensure that it was thorough and that all issues were properly addressed; reviews the reports for completeness and accuracy; and documents its review for DCF's records.[46]

Adult Protection Teams

DCF is also permitted to create multidisciplinary Adult Protection Teams in each district[47] to support activities of the protective services program and provide services the team finds necessary for victims of elder abuse.[48,49] The teams can only provide these services with the consent of the vulnerable adult, the person's guardian, or court order, and should not duplicate services provided by other units or offices of DCF.[50]

---

[36] S. 415.104(3), F.S.
[37] S. 415.104(4), F.S.
[38] S. 415.105(1), F.S.
[39] DEPARTMENT OF CHILDREN AND FAMILIES, *CF Operating Procedure No. 140-2: Adult Protective Services* (June 1, 2017), p. 15-2, available at: http://www.dcf.state.fl.us/admin/publications/cfops/CFOP%20140-xx%20Adult%20Services/CFOP%20140-02,%20Adult%20Protective%20Services.pdf (last visited Jan. 4, 2018).
[40] An RNS is a Florida-licensed registered nurse who assists the DCF in its APS investigations by providing medical expertise to help inform the DCF's findings, DEPARTMENT OF CHILDREN AND FAMILIES, *CF Operating Procedure No. 140-11: Adult Protective Services Registered Nurse Sepcialist* (Oct. 21, 2011), p. 1, available at: https://www.dcf.state.fl.us/admin/publications/cfops/CFOP%20140-xx%20Adult%20Services/CFOP%20140-11,%20Adult%20Protective%20Services%20Registered%20Nurse%20Specialist.pdf (last visited Jan. 4, 2018).
[41] *Supra* note 39, at 21-1.
[42] *Supra* note 39, at 21-2.
[43] Id.
[44] *Supra* note 39, at 21-2 - 21-3
[45] *Supra* note 39, at 21-3.
[46] Id.
[47] DCF has now adopted a regional structure rather than a district-based structure.
[48] S. 415.1102(1), 415.1102(4), F.S.
[49] DCF has established 15 Adult Protection Teams statewide, varying in how often and under what circumstances they convene, Email from Lindsey Perkins Zander, Deputy Director of Legislative Affairs, Department of Children and Families, RE: Adult Protective Services Statistics (Jan. 5, 2018) (On file with House Health and Human Services Committee staff).
[50] S. 415.1102(4), 415.1102(5), F.S.

The teams can consist of anyone trained in the prevention, identification, and treatment of abuse of elderly persons, such as:

- Psychiatrists, psychologists, other trained counseling personnel;
- Police officers or other law enforcement officers;
- Medical personnel who have sufficient training to provide health services;
- Social workers who have experience or training in preventing the abuse of elderly or dependent persons; or
- Public and professional guardians under part II of chapter 744, F.S.[51]

Comparable Fatality Review Systems

Children and victims of domestic violence are individuals who are vulnerable to death by abuse. Experts believe that the current state of elder abuse research is comparable to where research on child abuse and domestic violence was a few decades ago.[52] This is in large part due to the fact that elder abuse is underreported, more undetected, and suspected less than child abuse or domestic violence.[53] Florida has programs to systematically review deaths due to child abuse or domestic violence. Different than protective investigations, these fatality review teams are generally established to understand the causes and incidents of deaths, identify any gaps in support and service delivery, and improve preventive interventions.

Florida's Child Abuse Death Review

The Child Abuse Death Review (CADR) is a statewide multidisciplinary, multiagency child abuse death assessment and prevention system.[54] The state CADR committee is housed within the Department of Health and the State Surgeon General establishes county or multicounty local CADR committees. The Surgeon General appoints membership for both state and local CADR committees.[55] State and local teams work cooperatively to review the facts and circumstances surrounding child deaths that are reported through DCF's central abuse hotline.

The purpose of the CADR system is to:

- Achieve a greater understanding of the causes and contributing factors of child abuse deaths; [56]
- Develop a communitywide approach to addressing these contributing factors; [57]
- Identify gaps and deficiencies in the system of child abuse services; and [58]
- Make and implement recommendations for changes in law, rules, and policies to support healthy development of children and reduce preventable child abuse deaths.[59]

The state CADR committee consists of a representative from each of the following:

- The Department of Health;
- The Department of Children and Families;
- The Department of Law Enforcement;
- The Department of Education;
- The Florida Prosecuting Attorneys Association, Inc.; and
- The Florida Medical Examiners Commission, whose representative must be a forensic pathologist.[60]

---

[51] S. 415.1102(1), 415.1102(2), F.S.
[52] *Supra* note 18, at 7-10.
[53] Id.
[54] S. 383.402(1), F.S.
[55] S. 383.402(2), 383.402(3), F.S.
[56] S. 383.402(1)(a), F.S.
[57] S. 383.402(1)(b), F.S.
[58] S. 383.402(1)(c), F.S.
[59] S. 383.402(1)(d), F.S.
[60] S. 383.402(2)(a)1., F.S.

Participating entities may also recommend the addition of representatives from various disciplines that work to diagnose, treat, and prevent child abuse.[61]

Local CADR committees consist of, at a minimum, representatives from each of the following:

- The state attorney's office;
- The medical examiner's office;
- The local Department of Children and Families child protective investigations unit;
- The Department of Health child protection team;
- The community-based care lead agency;
- State, county, or local law enforcement agencies;
- The school district;
- A mental health treatment provider;
- A certified domestic violence center;
- A substance abuse treatment provider; and
- Any other members that are determined by guidelines developed by the State Child Abuse Death Review Committee.[62]

CADR committees are granted access to all information and records from any state agency or political subdivision so long as the information may assist in reviewing a child's death.[63] Local committees review individual facts and circumstances of a child's death and provide the state review committee with demographic data, any gaps or deficiencies identified in the system, and recommendations for improvement.[64] The state review committee provides direction for the review system and analyzes the data and recommendations received from local review committees.[65] The state committee then submits a comprehensive annual report to the Governor and Legislature by December 1 each year.[66]

In the last fiscal year, all 22 local CADR committees used collected data to develop prevention action plans, including 194 activities designed to prevent child abuse.[67] Because drowning and asphyxia were the top causes of death in the previous year's data review, action plans included media campaigns, education, and training for safe sleep and water safety.[68] Similarly, because there is significant overlap between child maltreatment and domestic violence, substance abuse, and mental health, some action plans also addressed improvements in and increased access to parenting education, domestic violence advocates, and mental health treatment.[69]

Florida's Domestic Violence Fatality Review Teams

The state's Domestic Violence Fatality Review Teams (DV-FRT) are multidisciplinary teams that review fatal and near-fatal incidents of domestic violence, related domestic violence matters, and suicides.[70] DV-FRTs can be established at the local, regional, or state level.[71] Currently, there are 24 local DV-FRTs and one statewide team.[72] The DV-FRTs are assigned to the Florida Coalition against Domestic Violence for administrative purposes only, so the structure and activities of a team are determined at the local level.[73]

---

[61] S. 383.402(2)(a)2., F.S.
[62] S. 383.402(3)(a), F.S.
[63] S. 383.402(5), F.S.
[64] S. 383.402(3)(b), F.S.
[65] S. 383.402(2)(b), F.S.
[66] S. 383.402(4), F.S.
[67] DEPARTMENT OF HEALTH, *State Child Abuse Death Review Committee Annual Report December 2017*, p. 51, available at: http://www.flcadr.com/reports/_documents/Final_CADR_2017.pdf (last visited Jan. 4, 2018).
[68] Id.
[69] Id.
[70] S. 741.316(1), F.S.
[71] S. 741.316(2), F.S.
[72] FLORIDA COALITION AGAINST DOMESTIC VIOLENCE, *The Attorney General's Statewide Domestic Violence Fatality Review Team,* https://www.fcadv.org/projects-programs/attorney-general%E2%80%99s-statewide-domestic-violence-fatality-review-team#_ftn1 (last visited Nov. 19, 2017).
[73] S. 741.316(5), 741.316(2), F.S.

The DV-FRTs include, but are not limited to, representatives from the following agencies or organizations:

- Law enforcement agencies;
- The state attorney's office;
- The medical examiner's office;
- Certified domestic violence centers;
- Child protection service providers;
- The office of the court administration;
- The clerk of the court;
- Victim services programs;
- Child death review teams;
- Members of the business community;
- County probation or corrections agencies; and
- Any other persons who have knowledge regarding domestic violence fatalities, nonlethal incidents of domestic violence or suicide, including research, policy, law or other related matters.[74]

The DV-FRTs review events leading up to the domestic violence incident, available community resources, current laws and policies, actions taken by systems and individuals related to the incident and parties, and any information or action deemed relevant by the team.[75] The teams' purpose is to learn how to prevent domestic violence by intervening early and improving the response of an individual and the system to domestic violence.[76] Each team determines the number and type of incidents it will review and makes policy and other recommendations as to how incidents of domestic violence may be prevented.[77]

The Office of the Attorney General and the Florida Coalition against Domestic Violence co-chair the statewide DV-FRT, which meets quarterly to review data collected by the local teams, identify systemic gaps, and summarize its findings and recommendations for changes to the service delivery system in an annual report.[78]

Initiatives developed based on the reviews include:

- Since in 50 percent of cases reviewed, perpetrators had a prior history of domestic violence, substance abuse, or violent crimes, the statewide team developed a pilot project to train and increase coordination between local law enforcement agencies, prosecutors, judges, probation officers, and domestic violence advocates.[79,80] The purpose of this cooperation was to identify risk factors sooner, protect the victims, and prevent fatalities.[81]
- Discovering that 70 percent of victims had surviving children--some of whom even witnessed the fatal incident--the statewide team identified the need for and promoted collaboration with community partners to protect and provide services to the surviving children.[82]

[74] S. 741.316(1), F.S.
[75] S. 741.316(2), F.S.
[76] S. 741.316(2), F.S.
[77] S. 741.316(2), F.S.
[78] *Supra* note 72.
[79] FLORIDA COALITION AGAINST DOMESTIC VIOLENCE, *Faces of Fatality, Vol. VII: Report of the Attorney General's Statewide Domestic Violence Fatality Review Team* (June 2017), p. 21, *available at:* http://fcadv.org/sites/default/files/face_fatality_vii.pdf (last visited Jan. 4, 2018).
[80] FLORIDA COALITION AGAINST DOMESTIC VIOLENCE, *Faces of Fatality, Vol. VI: Report of the Attorney General's Statewide Domestic Violence Fatality Review Team* (June 2016), pp. 6-8, *available at:* http://fcadv.org/sites/default/files/FACES%20OF%20FATALITY%20VI.pdf (last visited Jan. 4, 2018).
[81] Id.
[82] *Supra* note 79.

Elder Fatality Review Teams in other States

Currently, at least 15 jurisdictions have elder fatality review teams at the state or local level.[83] For example, California, another state with a large senior population, statutorily authorized local elder fatality review teams in 2003 and now has an elder fatality review team in over 30 of its 58 counties.[84]

One of the first multidisciplinary elder fatality review teams was created in 1999, in Sacramento County, California. After years of reviewing cases, the review team noted that a common pattern of abuse involved a relative caregiver's inability to cope with the responsibility of caring for an elder whose health and mobility were rapidly deteriorating. In response, the review team created a resource guide for elder caregivers and independent elders alike, including contact information for agencies that can help with financial issues, transportation, conservatorship, home repair, medical issues, mental health issues, and other important needs.[85] Pharmacies, senior centers, medical clinics, religious centers, and other senior organizations distributed the brochure.[86]

The team also facilitated cooperation between disciplines to provide comprehensive vital services to elders in one location.[87] Acting on the review team's recommendations, the local coroner's office and adult protective services launched a project to improve communication between both agencies, the local district attorney's office implemented training and education on elder issues, and the local sheriff's department launched a volunteer program in its elder abuse unit to better detect and investigate financial fraud cases. The review team also established an interdisciplinary team of adult protective services staff and medical staff to provide intensive case management services, which has resulted in a 49 to 69 percent reduction in emergency room visits for participating elders.[88]

Soon after its inception, an elder fatality review team in Ingham County, Michigan, including police, prosecutors, adult protective services, the medical examiner, and emergency personnel, identified elder abuse in a death that law enforcement had deemed ordinary: through this multidisciplinary approach, the team determined that the elder's state caregiver had administered a lethal dose of morphine. These findings facilitated the prosecution and conviction of the perpetrator.[89]

American Bar Association's Elder Abuse Fatality Review Team Manual

In 2001, the federal Department of Justice commissioned the American Bar Association Commission on Law and Aging (ABA-COLA) to identify promising practices in the development of elder abuse fatality review teams. The ABA-COLA studied pilot programs from 8 local and state jurisdictions.[90] The ABA-COLA then created a replication manual based on these 8 programs.[91]

---

[83] NATIONAL ADULT PROTECTIVE SERVICES ASSOCIATION, *The State of Elder Fatality Reviews in the U.S.* (Webinar), available at: http://www.napsa-now.org/wp-content/uploads/2017/03/03142017-EFRT-Webinar.pdf (last visited on Nov. 19, 2017).

[84] THE NATIONAL LONG-TERM CARE OMBUDSMAN RESOURCE CENTER, *Long-Term Care Ombudsman Activities Regarding Abuse, Neglect and Exploitation*, May 10, 2011, available at: http://ltcombudsman.org/uploads/files/issues/Chart-Summary-SLTCO-FINAL-May-10.pdf (last visited Nov. 19, 2017).

[85] SACRAMENTO COUNTY DISTRICT ATTORNEY'S OFFICE, *County of Sacramento Elder Death Review Team 2012 Report*, p. 5, available at: http://www.sacda.org/files/7414/2671/1371/2012_EDRT_Annual_Report.pdf (last visited Jan. 4, 2018).

[86] SACRAMENTO COUNTY DISTRICT ATTORNEY'S OFFICE, *County of Sacramento Elder Death Review Team 2008 Report*, p. 5, available at: http://www.sacda.org/files/5514/2671/1055/2008_EDRT_Report_Final.pdf (last visited Jan. 4, 2018).

[87] SACRAMENTO COUNTY DISTRICT ATTORNEY'S OFFICE, *County of Sacramento Elder Death Review Team 2015 Report*, p. 2-3, available at http://www.sacda.org/files/9914/2671/1266/EDRT_2015_Report_FINAL.pdf (last visited Jan. 4, 2018).

[88] *Supra* note 86.

[89] Chisun Lee, A.C. Thompson, and Carl Byker, *Gone Without a Case: Suspicious Elder Deaths Rarely Investigated*, FRONTLINE PBS, https://www.pbs.org/wgbh/frontline/article/gone-without-a-case-suspicious-elder-deaths-rarely-investigated/ (last visited Jan. 4, 2018).

[90] Houston, Texas; Maine; Orange County, California; Pima County, Arizona; Pulaski County, Arkansas; Sacramento, California' San Diego, California; and San Francisco, California.

[91] Lori A. Stiegel, J.D., *Elder Abuse Fatality Review Teams: A Replication Manual*, AMERICAN BAR ASSOCIATION COMMISSION ON LAW & AGING, available at: https://www.americanbar.org/content/dam/aba/administrative/law_aging/fatalitymanual.authcheckdam.pdf (last visited Jan. 4, 2018).

The manual cites important factors for a successful review team: subject matter expertise and influence of membership, access to relevant records, confidentiality of review team meetings and records, and purpose and structure for the review process.

Pilot programs were generally to:

- To improve the systems that caused, contributed to, or failed to prevent the death, and thereby ensure that services are provided to elder abuse victims to help to prevent similar deaths in the future; or
- To determine whether law enforcement investigation and prosecution of alleged perpetrators is appropriate, and supporting those efforts.

The manual recommends that review teams include representatives from agencies or organizations that can provide insight into the systems and issues affecting elders, elder abuse, and elder fatalities, such as Adult Protective Services, the Attorney General's Office, elder lawyers, forensic pathologists, medical examiners, geriatricians, health providers, or victim assistance programs.

On the premise that lack of awareness may lead investigators and other professionals to miss signs of abuse and neglect in cases where abuse truly is present, the manual recommends broadening the scope of eligible cases to include fatalities where a history of elder abuse existed or elder abuse was suspected to be a contributing factor, even if not verified to be the cause of death.

The pilot programs studied by the ABA generally required legislative authorization to access the otherwise confidential records that were necessary for effective review of their cases. Similarly, confidentiality of review meetings and records allowed for open communication and rapport between members.

On October 20, 2017, the Department of Justice announced more than $3.42 million in funding to respond to elder abuse and victims of financial crimes, which included funding to the ABA-COLA to enhance and evaluate elder abuse fatality review teams.[92]

Effect of the Bill:

<u>Elder Abuse Fatality Review Teams</u>

The PCS for HB 259 creates s. 415.1103, F.S., authorizing the creation of a multidisciplinary, multiagency elder abuse fatality review team (EA-FRT) in each judicial circuit to review elderly persons' deaths alleged or found to have been caused by, or related to, abuse or neglect. The teams are housed in the Department of Elder Affairs (DOEA) for administrative purposes only.

Membership and Organization

An EA-FRT may include, but is not limited to, representatives from public and private entities that study, treat, investigate, or prevent elder abuse, including but not limited to law enforcement agencies, health and social services agencies, healthcare practitioners, and nonprofit organizations.[93] Participation in an EA-FRT is voluntary and members serve without compensation or reimbursement for per diem or travel

---

[92] Press Release, DEPARTMENT OF JUSTICE, *Justice Department Invests $3.42 Million in Fight Against Elder Abuse and Financial Exploitation* (Oct. 20, 2017), available at: https://www.justice.gov/opa/pr/justice-department-invests-342-million-fight-against-elder-abuse-and-financial-exploitation (last visited Jan. 4, 2018).

[93] Specifically: law enforcement agencies; the state attorney; the medical examiner; a county court judge; Adult Protective Services; the Aging and Disability Resource Center; the State Long-Term Care Ombudsman Program; the Agency for Health Care Administration; the Office of the Attorney General; the Office of the State Courts Administrator; the clerk of the court; a victim services program; an elder law attorney; emergency services personnel; a certified domestic violence center; an advocacy organization for victims of sexual violence; a funeral home director; a forensic pathologist; a geriatrician; a geriatric nurse; a geriatric psychiatrist or other individual licensed to offer behavioral health services; a hospital discharge planner; a public guardian; and/or other persons who have knowledge regarding fatal incidents of elder abuse, domestic violence, or sexual violence, including knowledge of research, policy, law, and other matters connected with such incidents or who are recommended for inclusion by the review team.

expenses. Members or the entities whom they represent bear the administrative costs of operating the EA-FRT.

Any person eligible to participate in an EA-FRT may initiate its establishment in his or her judicial circuit by requesting DOEA to call the first organizational meeting of the team. The Secretary of DOEA, or his or her designee, appoints the team members in consultation with the relevant public and private entities. Members serve for staggered two-year terms and may be reappointed for up to three consecutive terms. At an initial EA-FRT meeting, members choose two members to serve as co-chairs and may reelect them by a majority vote for up to two consecutive terms.

After its initial meeting, EA-FRTs determine their local operations, including the process for case selection and meeting schedule; however, EA-FRTs must limit their review to closed cases and meet at least once in each fiscal year.

Review Process

An EA-FRT's review includes consideration of the events leading up to a fatal incident, available community resources, current law and policies, and the actions taken by public and private systems and individuals related to the fatal incident.

In its review, an EA-FRT must identify any gaps, deficiencies, or problems in the delivery of services that related to the fatal incident. Whenever possible, an EA-FRT should develop a communitywide approach to address these causes and contributing factors identified in its review. Lastly, an EA-FRT must develop practice standards and recommend changes in law, rules, and policies to support the care of elderly persons and prevent elder abuse deaths.

Records

An EA-FRT may access information that is publicly available or voluntarily provided by a victim's family. Additionally, a team may ask DOEA to obtain the following records on its behalf:

- Information and records held by a criminal justice agency, not including active criminal intelligence or investigative information;[94]
- Information and records from DCF's adult protective investigations;[95] and
- An autopsy report from the medical examiner's office, not including photos and videos or audio recordings of the autopsy.[96]

The bill prohibits an EA-FRT or its members from disclosing any information that is confidential pursuant to law.

Annual Reports

Each EA-FRT team must prepare an annual report which includes, but is not limited to:

- Descriptive statistics of cases reviewed, including demographic information of the victims and caregivers, and the causes and nature of deaths;
- Current policies, procedures, rules, or statutes that the review team identified as contributing to the incidence of elder abuse and elder deaths, and recommendations for system improvement and needed resources, training, or information dissemination to address those identified issues;
- Any other recommendations to prevent elder abuse deaths based on an analysis of the data and information presented in the report; and

---

[94] Records from criminal justice agencies are public. However, active criminal intelligence and active criminal investigative information are confidential and exempt pursuant to s. 119.011(3), F.S.

[95] DCF adult protective investigation records are confidential and exempt. Section 2 of this bill amends s. 415.107(3), to grant an EA-FRT access to these records.

[96] Autopsies are public records. However, s. 406.135 makes confidential and exempt any photographs or video or audio recording of an autopsy held by the medical examiner's office.

- Any steps the review team or private or public entities took to implement necessary changes and improve the coordination of services and reviews.

Each EA-FRT must submit this report to DOEA by September 1 each year. DOEA will summarize all of these reports into one final report and submit it to the Governor, the President of the Senate, the Speaker of the House of Representatives, and DCF by November 1 each year.

Discovery, Testimony, and Immunity

The bill prevents information or records obtained by an EA-FRT from being subject to discovery or introduced into evidence in any civil, criminal, administrative, or disciplinary proceeding. However, if information or records are available from another source and are not otherwise immune from discovery or introduction into evidence, then this immunity does not apply to those records or information simply because an EA-FRT obtained or reviewed them.

Similarly, the bill prohibits a person who has attended an EA-FRT meeting or participated in EA-FRT activities from testifying in any civil, criminal, administrative, or disciplinary proceeding as to records or information produced or presented to an EA-FRT in the course of its duties. However, this does not prevent any EA-FRT member or meeting attendee from testifying as to matters that are otherwise within his or her knowledge.

The bill provides EA-FRT members with immunity from monetary liability and prohibits a cause of action against them for matters that were in the performance of their duties as an EA-FRT member. However, this immunity will not apply if the member acted in bad faith, with wanton and willful disregard of human rights, safety, or property.

Access to DCF Adult Protective Investigation Records

The bill amends s. 415.107(3), F.S., to narrow the public records exemption for records and reports created by DCF's adult protective investigations. The bill authorizes DCF to release to DOEA records related to the death of an elderly person under review by an EA-FRT.

B. SECTION DIRECTORY:

Section 1: Creates s. 415.1103, F.S., relating to elder abuse fatality review teams.
Section 2: Amends s. 415.107(3), F.S., relating to the confidentiality of reports.
Section 3: Provides for an effective date of July 1, 2018.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

See Fiscal Comments.

D. FISCAL COMMENTS:

The bill creates an indeterminate negative fiscal impact on agencies and organizations that participate in an EA-FRT. However, such participation is voluntary.

The bill creates an indeterminate negative fiscal impact on the Department of Elder Affairs (DOEA). The bill requires DOEA to organize initial EA-FRT meetings, appoint members, obtain records on behalf of an EA-FRT, and prepare an annual summary report. If any EA-FRT's are established, DOEA staff responsibilities would increase, with the level of increase depending on the number of EA-FRT's established and their degree of activity. Additionally, DOEA may need to develop a secure method to transmit confidential and exempt records to an EA-FRT. DOEA states that without knowing how many teams will be established, the amount of records DOEA will have to obtain, and whether any technology would need to be developed, the negative fiscal impact on DOEA is indeterminate.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. The bill does not appear to affect county or municipal governments.

2. Other:

A tied bill, HB 261, makes certain records held or created by elder fatality review teams confidential and exempt. It also allows a team to close portions of its meetings wherein the members discuss confidential or exempt information or reveal the identity of an elder abuse victim.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES