



# Elder Fatality Review Initiative

# 2016 Survey

- 48 respondents
  - 28 states
  - 29 counties

  - 7 state teams
  - 12 local teams
  - 1 state and local teams
  - 28 no teams

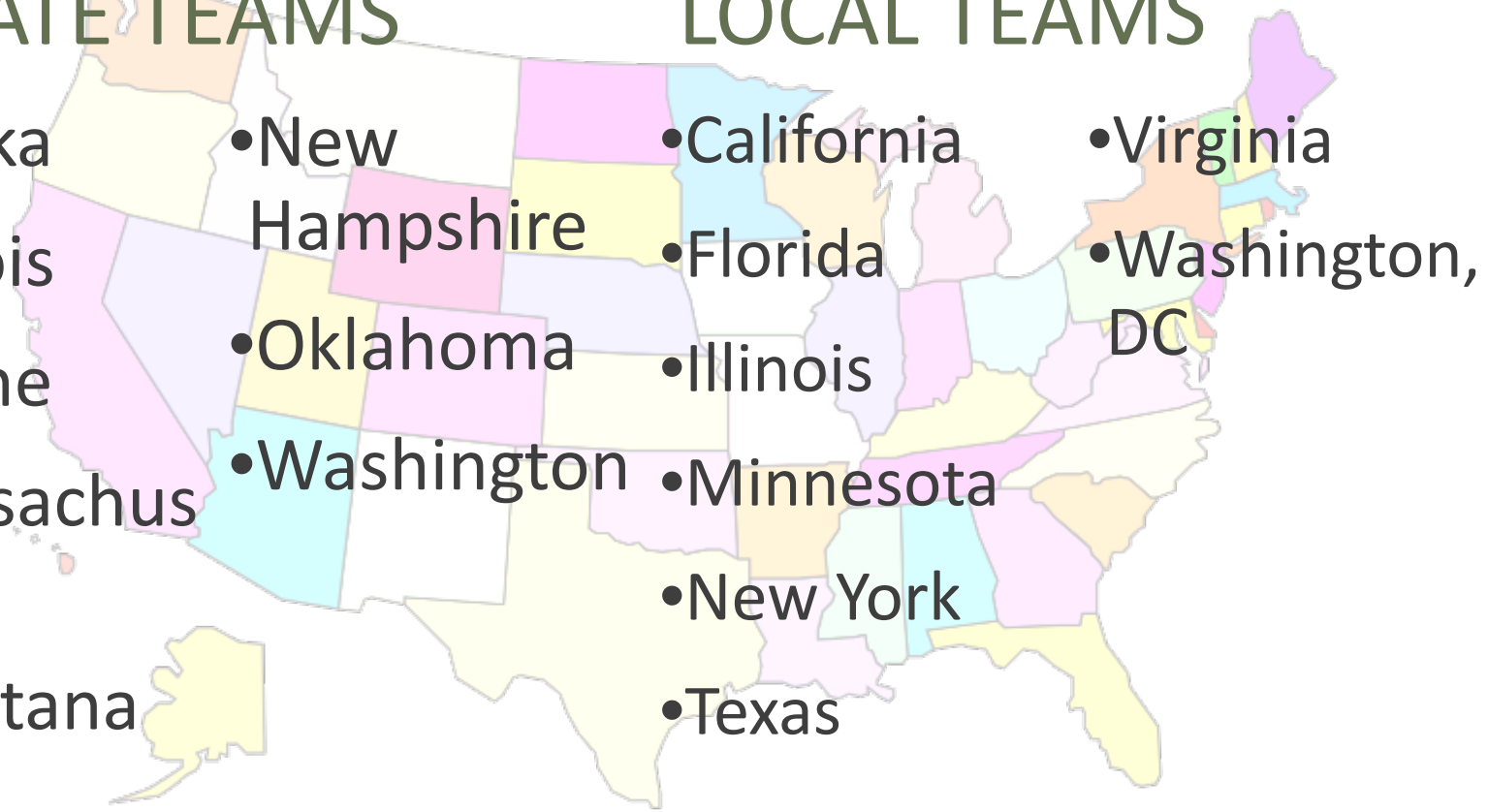
# Results

## STATE TEAMS

- Alaska
- Illinois
- Maine
- Massachusetts
- Montana
- New Hampshire
- Oklahoma
- Washington

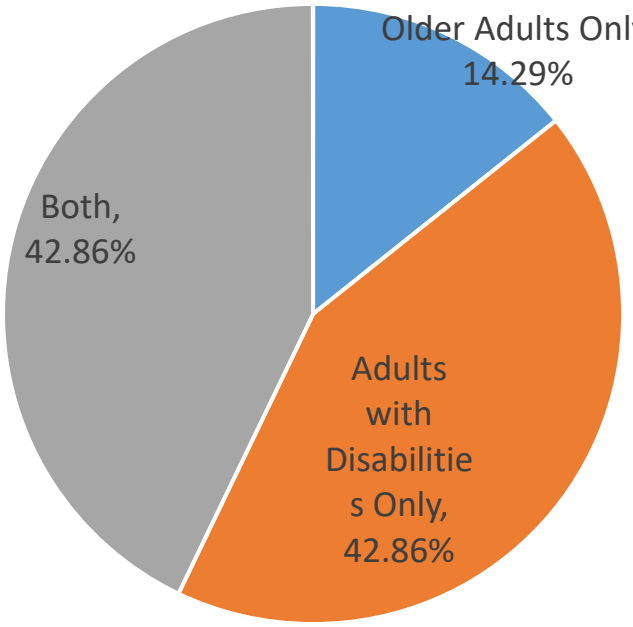
## LOCAL TEAMS

- California
- Florida
- Illinois
- Minnesota
- New York
- Texas
- Virginia
- Washington, DC

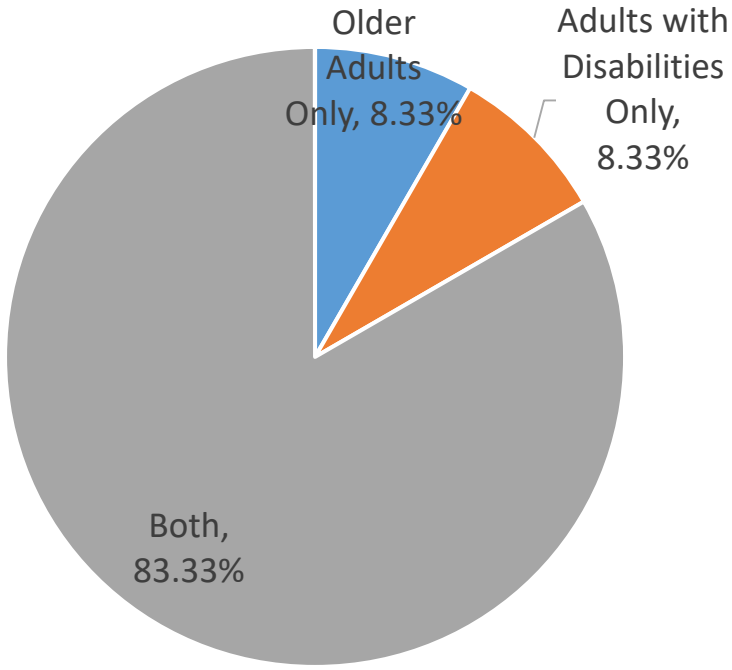


# Results – Covered Populations

## STATE TEAMS




## LOCAL TEAMS



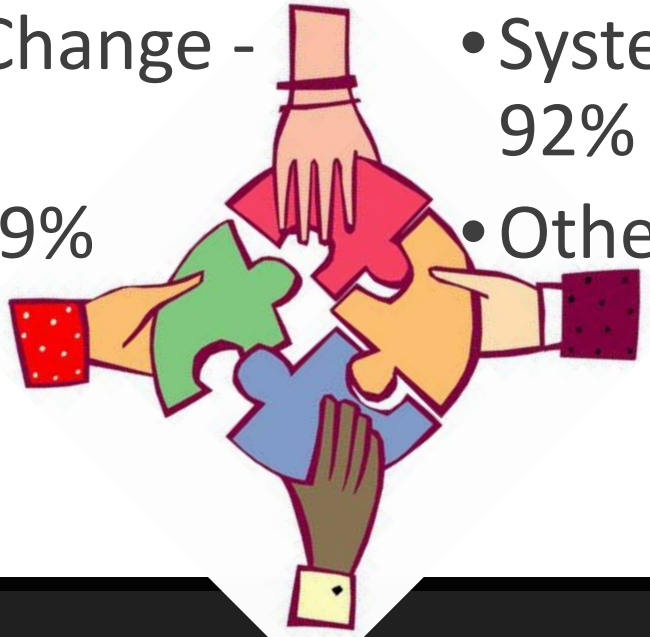
# Results – Team Purpose

## STATE TEAMS

- Prevention – 71%
- Prosecution – 14%
- Systems Change - 71%
- Other – 29%

## LOCAL TEAMS

- Prevention – 83%
- Prosecution – 50%
- Systems Change – 92%
- Other – 8%



# Results – Cases Reviewed

## STATE TEAMS

- Closed APS – 50%
- Other – 50%
  - e.g. Participants in program, unexplained deaths

## LOCAL TEAMS

- Open APS – 33%
- Closed APS – 83%
- Perpetrator has died – 8%
- Other – 58%
  - e.g. suspicious fatalities, high profile cases

# Results - Legislation

## STATE TEAMS

- Yes –57%
- No – 42%

## LOCAL TEAMS

- Yes, state – 54%
- Yes, local – 18%
- No – 36%

Legislation may include:

- Establishing teams
- Mandating reviews
- Providing confidentiality of reviews
- And other purposes

# Results – Top Participating Agencies

## STATE TEAMS

- **APS**
- Disability services
- Nurses
- Independent medical clinicians
- Public health dept.
- Others

## LOCAL TEAMS

- **APS**
- Law enforcement
- State/local district attorneys
- Aging services
- Medical examiner/coroner
- Others

# Results – Key Outcomes

## STATE TEAMS

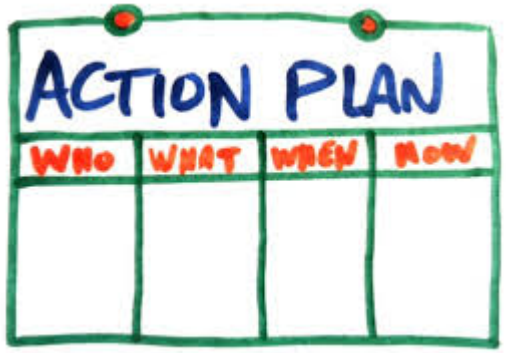
- Updates and clarifications to policies
- Trainings
- Strengthening communications and collaborations
- Corrective action plans

## LOCAL TEAMS

- Changes in communications and referrals
- Interdisciplinary teams
- New policies in participating agencies
- Additional staff

# Results – No Teams

- 28 responses
- Interest in establishing a team
  - State Team – 36%
  - Local Team – 50%
  - Have held planning meetings – 5%
  - Legislation in progress – 5%




- 74% felt there was a need for training and/or technical assistance related to fatality reviews in their state

# Elder and Vulnerable Adults Death Review

Improving our understanding of why adults die from abuse and taking action to prevent other deaths


ER SERCHOG GOFFADWRIAETH AM
GRIFFITH WILLIAMS
ANNWYL BRIOD MARGARET WILLIAMS
GLANRAFON COTTAGE, RHYDLIOS, (BRYN FFYNNON GYNT)
BU FARW CHWEFROR 13, 1962.
YN 80 MLWYDD OED.
HEFYD
MARGARET
BU FARW TACHWEDD 22, 1980.
YN 100 OED.
"YR ARGLWYDD YW FY MUGAIL,
NI BYDD EISIAU ARNAF."

# What is Elder Death Review?

Multi-disciplinary teams of professionals that meet to share case information on fatalities in order to prevent other deaths, and to keep people safe and well.

An engaged, multidisciplinary community, telling an elder's story, one elder at a time, to understand the causal pathway that leads to the elder's death to identify pre-existing vulnerabilities and circumstances- in order to identify how to interrupt the pathway for other persons

….By generating a broad spectrum of data for an ecological understanding of the individual, community, and societal factors that interact at different levels to influence elder wellbeing.

….Then taking action to improve systems and prevent deaths.

# A simple process of sharing information to understand the WHY

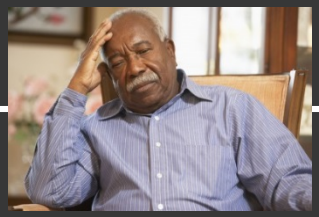
*but a complex process of group wisdom and shared responsibility for getting it right to prevent other deaths*

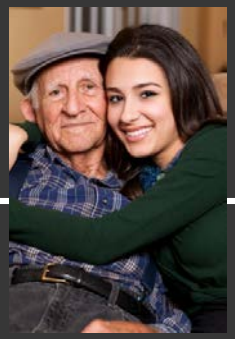
- Improve our understanding of why vulnerable adults die.
- Improving our systems to protect adults
- Taking action to prevent other deaths

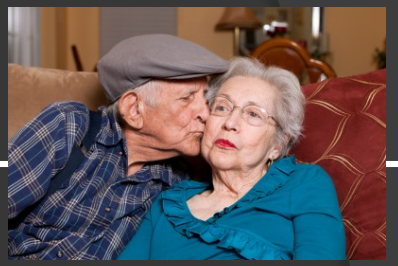
# It is Not Blaming and Shaming


Factors in the deaths are usually so multidimensional that responsibility for a death or injury doesn't belong to any one place.

# A Comprehensive Purpose







**Improved Systems**

Better Investigations

Determination of Manner/Cause

Elder Justice

Agency policies and practices

**Services**

Bereavement

Family Support

Responder Support

Meeting Basic Needs

**Prevention/Systems**

Risk Factor Analysis

Effective Recommendations

New Policies and Programs

Improving Interagency Communication, Coordination, &Collaboration

# Models Vary

- Local teams conduct intensive case reviews.
- State-only teams conduct case reviews of selected cases.
- Local teams review and send findings to a state advisory board.

# Essential Team Members

- Medical Examiner/ Coroner
- Law Enforcement
- Adult Protective Services
- Aging Services
- Prosecutor
- Gerontologists, Geriatricians and Other Health Care Providers
- Public Health
- Probate and Financial Services

# Other Team Members

- Disability Services
- Domestic Violence Program
- Elder Law
- Emergency Services (such as firefighters, emergency medical services, and other first responders)
- Facility Regulators (includes long-term care facility, assisted living facility, and hospital regulators)
- Forensic Psychiatrist
- Funeral Home Director
- Hospital Discharge Planner
- Legislator
- Long-term Care Ombudsman Program
- Medicaid Fraud Control Unit
- Mental Health Services
- Animal Control
- Community Hospital
- Clergy
- Advocacy Centers
- Tribal councils
- Ad Hoc

# Records Needed for Review


MORE IS BETTER

- Scene Investigation Information
- Medical Examiner/Coroner reports
- EMS Run reports
- APS Histories
- Guardianship/Custody Agreements
- Public Health Visits
- Medical records from hospitals/physicians
- Suicide Notes sometimes shared
- Mental Health
- Financial Records
- Court Histories
- Caretaker histories with CPS, APS, law

# The Review Meeting

- Reviewing the Cases
- Updates on past cases
- Tracking recommendations and actions
- Education on causes of deaths

# The Steps in Individual Case Review

1. Share the story
2. Investigation?
3. Services?
4. Actions for Criminal Justice?
5. What agency policies and practices need attention?
6. Modifiable risk factors?
7. What should be done for primary prevention?
8. What are our best recommendations?
9. Next steps: who will take the lead?

# Improving the Investigation

- Who is the lead agency?
- Was the investigation coordinated?
- Was there a comprehensive autopsy?
- Were there other investigations?
- Was the investigation adequate?
- What more do we need to know?
- What can be done to help our investigators and the system?

# Ingham County, MI
# Red Flags at Autopsy

- Decedent
- Injuries (bruises, lacerations, tears, burns, fractures) that are unexplained or untreated?
- Physically unclean or unkempt – body odor
- Apparent malnutrition or dehydration not consistent with reported natural disease(s)
- Pressure sores (decubitus ulcers)
- Evidence of restraint (marks on wrists or ankles)
- Unexplained vaginal or anal bleeding
- Living Conditions and Caregivers
- Forced isolation
- Lack of food, water, utilities
- Soiled clothing and/or bedding that seems inappropriate for the circumstances
- Filthy or unsafe living conditions
- Inappropriate medication administration (excessive number of pills or absent medication not administered as directed)
- Other Findings

# Improving Systems: Agency Policies and Practices

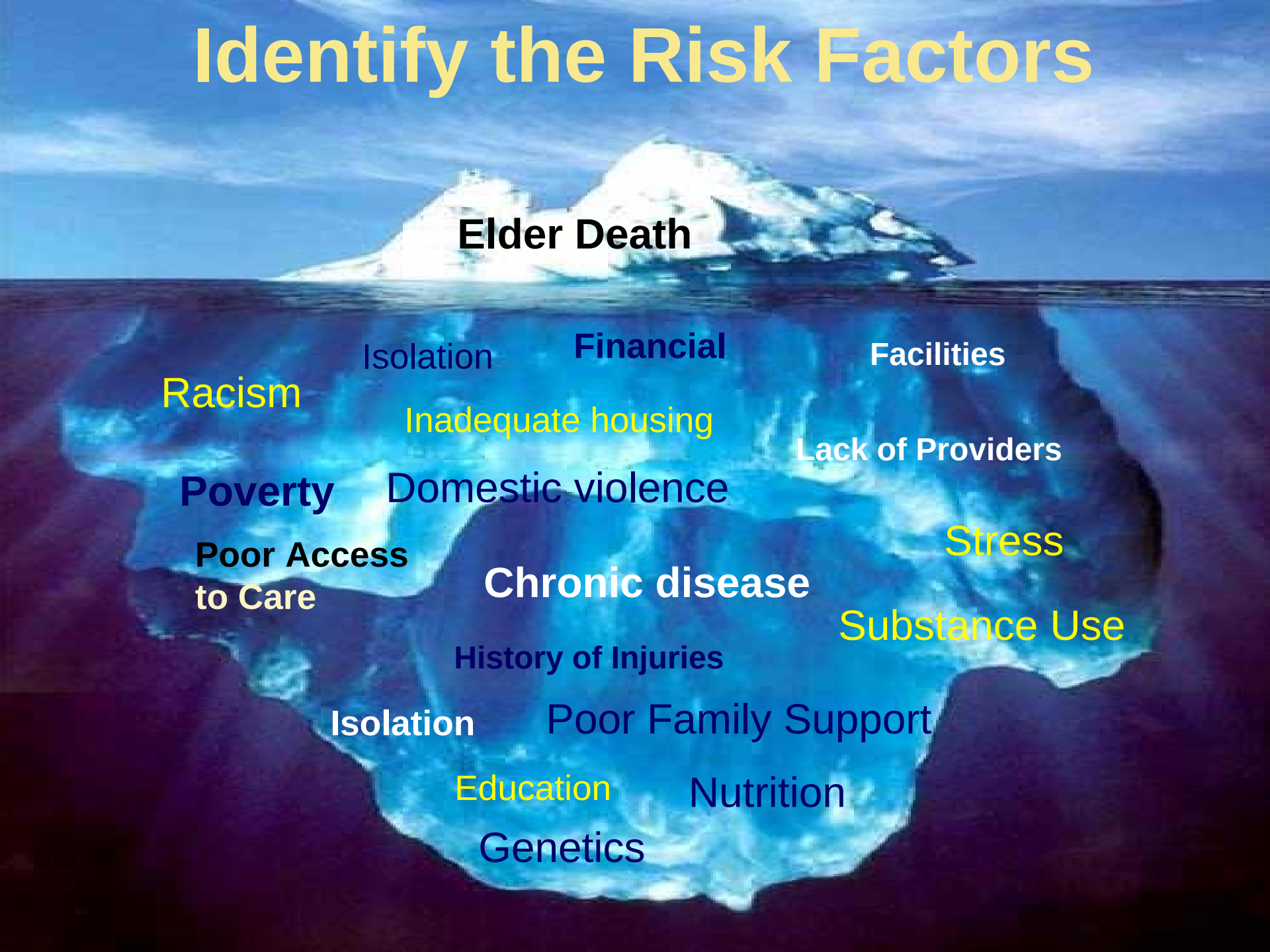
- Did agencies follow acceptable practice/policies in meeting the needs of the person before, at time of and after death?
- Are there gaps in delivery of services?
- Are there specific agency policies or practices that should be changed, improved on, implemented?
- How can we best notify the agency(ies) about our findings?

# Discuss Services:

- Services that the person, family, caregivers were accessing prior to the death?
- Services provided to family members as a result of the death?
- Services provided to responders, witnesses or community members?
- Additional services that should be provided to anyone?
- Who will take the lead in following up on these service provisions?
- Does the team have suggestions to improve our service delivery systems?

# The Hard Work: Taking Action to Prevent Other Deaths

# Identify the Risk Factors



# Do Something About the Risk Factors

- **Provider training and education**
- **Home visiting**
- **Caregiver training and education**
- **Community education**
- **Improved assessments**
- **Improved financial oversight procedures**
- **Expansion of facilities**
- **Improvements to licensing**

# Outcomes from Case Reviews

- Changes to Policies and Practices
- Community and State Task Forces
- Improvements to Facilities
- Elder Abuse Legislation
- Suicide Ideation Training
- Revisions to Mental Health Service Plans
- Family and Community Support
- PTSD Services

# San Diego County Success Stories

- **Case review has prompted further investigation of cases**
- **Data collection and analysis of trends used to compile DVRT reports**
- **We typically learn something from each death review – to the point that we can recommend changes in policy or procedure for law enforcement, first responders, ER departments, SNF and RCFEs**.

- **San Diego APS has created our Acutely Vulnerable Adult Protocol, (AVA). An internal workgroup meets every other month to review concerning open cases involving our most vulnerable clients who are unable to advocate for themselves.**

- **San Diego APS has also created a Cross Regional Committee, comprised of APS, PG/ PA, SDRC, LE, PERT, and other community members as appropriate to the cases being reviewed. This committee meets on the alternate months from AVA to review any difficult and challenging current APS cases.**

# You Can Work to Build a Team

- Designate an organizer and chair.
- Identify and contact core team members.
- Develop confidentiality and memorandum of agreement documents.
- Understand your local responses to a death: who does what when?
- Develop a process for identifying deaths.
- Decide on your time frame.
- Decide on the types of deaths to review.
- Select a meeting location.
- Set your first organizational meeting.
- Conduct a practice review(s) if necessary
- Worry about funding later.

# Learn your Systems: Who Does What When a Vulnerable Adult Dies?

- The 911 Call or Family at Hospital
- The Emergency Response: EMS, Fire, Police
- Health Care: Hospitals, physicians, public health
- The Investigation: Police, ME/Coroner, APS, courts
- Probate
- Notification and Death Certification
- Bereavement Services: public health, non profit groups
- Critical Incident Debriefing
- Services for the Family and Community
- Burial
- Prosecution/Adjudication
- Follow Up Services

# Decide on Your Leadership

Your Team Coordinator.

Your meeting facilitator/chair

Your team reporter

*These can be different people*

# The Team Manager

- Identifying deaths
- Obtaining records
- Recruitment of members
- Meeting logistics
- Case reports
- Follow up and tracking of actions
- Liaison with state

# Types of Deaths to Review

- Age
- Cause of Death
- Residence
- Cases under APS, investigation or litigation

# Identifying Deaths

Make friends with your

-Medical Examiner/Coroner

-Register of Deeds/County Clerk

-Hospitals Records

-Law Enforcement

-APS and Aging Services

Read the obituaries.

# Confidentiality: What Do your Laws Allow?

Access to case records and the sharing of information

Members sign statements as do all guests.

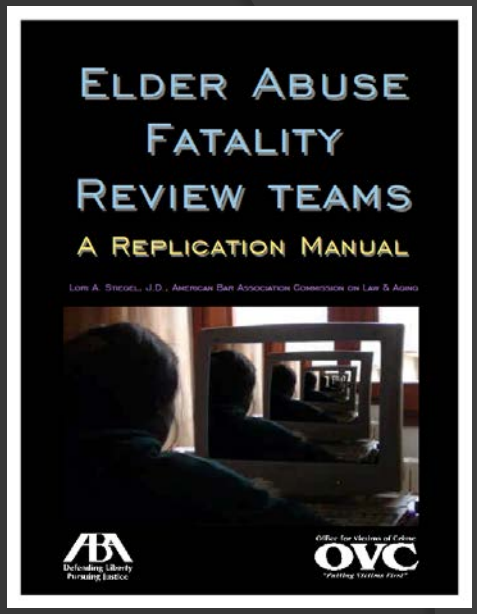
# What Can You Do?

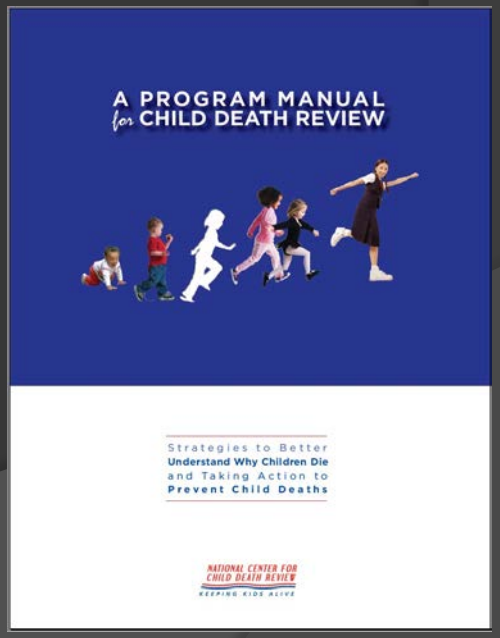
- Work for legislation or policy to establish the structures.
- Ask us for assistance.
- Work to organize a team
- Participate on a Review Team
- Encourage your staff to participate if they were working a case
- Share your case records
- Offer your Expertise & Resources
- Offer to Assist with Data analysis and reports

# Resources

***apps.americanbar.org****/aging/publications/docs/fatality****manual****.pdf*

www.childdeathreview.org



# *Next Steps*

◊ Release Report from National APS Survey

◊ Launch EFR Listserv

◊ Additional Webinars

◊ Convene National Advisory Committee

◊ Session(s) at NAPSA Conference

# *Next Steps*

◊ Obtain Funding for National EFR TA Center

◊ Follow-up National Survey (complete scan)

◊ Repository of Resources & Info re EFRs

◊ Communities of Practice

◊ TA to states & Communities

◊ National Database

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