


How Elder/Adult Abuse Fatality Review Teams Benefit APS Professionals and Improve Victim Services

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HOW ELDER/ADULT ABUSE FATALITY REVIEW TEAMS BENEFIT APS PROFESSIONALS AND IMPROVE VICTIM SERVICES

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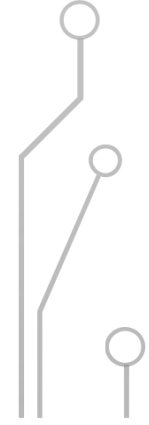
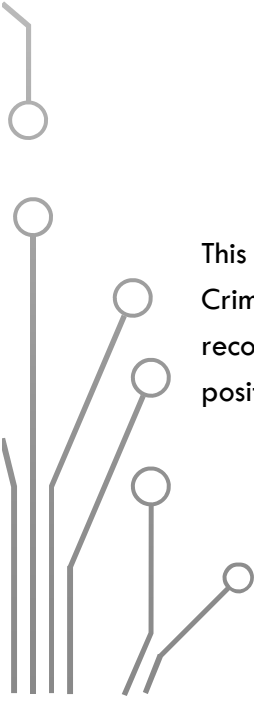
USDOJ OFFICE FOR VICTIMS OF CRIME-FUNDED PROJECT

Purposes:

(1) Update and expand the initial EAFRT capacity-building work of ABA COLA
Elder Abuse Fatality Review Teams: A Replication Manual (2005)

https://www.americanbar.org/groups/law_aging/resources/elder_abuse.html

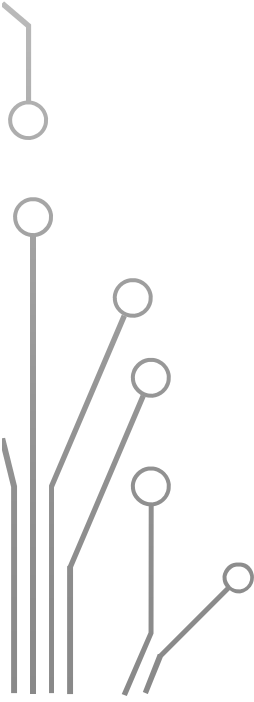
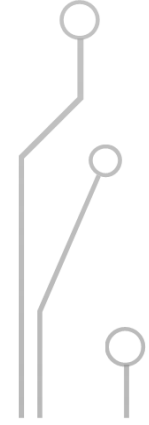
(2) Evaluate the impact of EAFRTs on victim services



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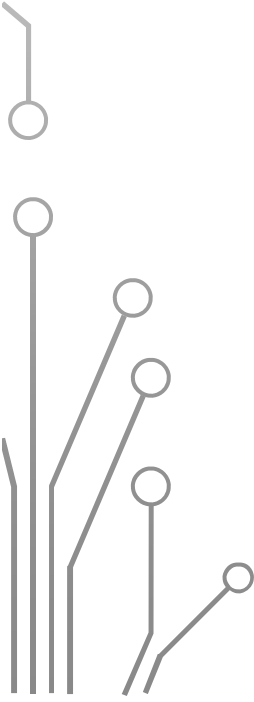
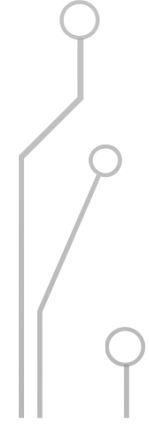
EAERT PURPOSE

- Examine deaths of individuals that may be caused by or related to elder/adult abuse *for the purpose of identifying system gaps and improving victim services*
 - Some EAERTs also help assess whether case merits criminal prosecution
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EFRT HALLMARKS

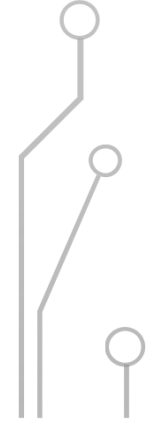
Two hallmarks enable open and safe discussion of system gaps:

- avoiding “blame and shame”
 - maintaining the confidentiality of team discussions and documents
- 
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EFRT HALLMARKS

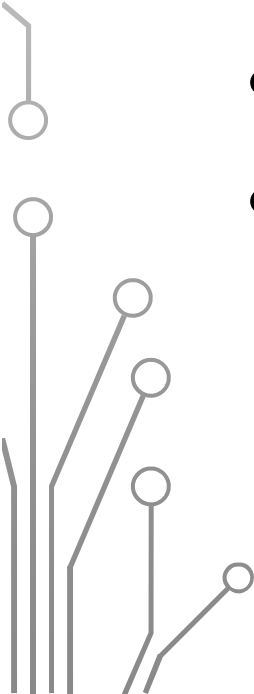


Team characteristics and practices vary on:

- Authorizing legislation
 - Mission
 - Leadership and membership
 - Types of cases reviewed
 - Policies and procedures for case reviews
 - What records are made of discussions
 - What data are collected
 - What reports and recommendations are issued and to whom
- 
- 



EAFRT OUTCOMES


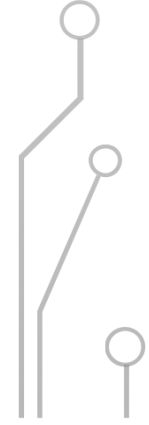
Changes in laws, policies, practices, programs, or protocols to improve delivery of victim services?

- Short-term
 - Intermediate
 - Long-term
- 
- 
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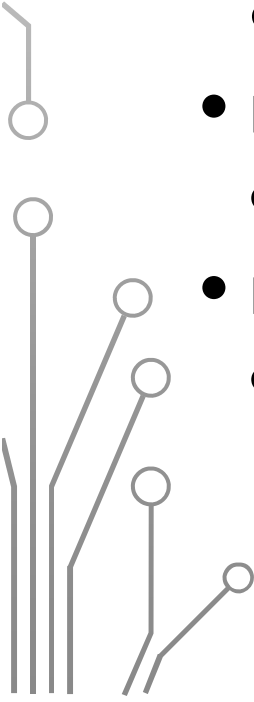
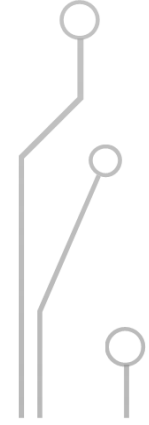
EAFRT EVALUABILITY ASSESSMENT

Criteria:

- Clearly discernable & measurable action
 - Clearly discernable process for executing action
 - Clearly discernable & measurable impact/outcome
 - Ability to determine that action preceded outcome
 - Process allows plausible link between action & outcome
 - EAFRT has met at least six times
- 
- 



EAFRT RECOMMENDATIONS

- Outcome findings and evaluability assessment will inform project recommendations on EAFRT characteristics, data collection, and processes for linking team purposes, actions, and impact/outcomes
 - Reason #1: To facilitate future rigorous evaluation of EAFRT effectiveness
 - Reason #2: To inform OVC on opportunities to improve EAFRT efforts nationally
- 
- 



ADDITIONAL INFORMATION

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ELDER ABUSE FATALITY REVIEW TEAMS A REPLICATION MANUAL

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ABA
Defending Liberty
Pursuing Justice

Office for Victims of Crime
OVC
"Putting Victims First"

ELDER ABUSE FATALITY REVIEW TEAMS

A REPLICATION MANUAL

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The Office for Victims of Crime is a component of the Office of Justice Programs, which also includes the Bureau of Justice Assistance, the Bureau of Justice Statistics, the National Institute of Justice, and the Office of Juvenile Justice and Delinquency Prevention.

The materials contained herein represent the opinions of the authors and should not be construed to be those of the American Bar Association unless adopted pursuant to the bylaws of the Association. Nothing contained herein is to be considered as the rendering of legal advice for specific cases, and readers are responsible for obtaining such advice from their own legal counsel. These materials and any forms and agreements herein are intended for educational and informational purposes only.

All appendices herein that were not developed by the ABA are reprinted with permission of the documents' authors. The documents developed by the elder abuse fatality review teams are provided as examples of tools that teams can use and their inclusion in this manual is not intended as an endorsement of their contents. The opinions, findings, and conclusions expressed in those team documents are those of their authors and do not necessarily represent the official position or policies of the ABA or the U.S. Department of Justice.

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I. About the American Bar Association Commission on Law and Aging

The mission of the American Bar Association Commission on Law and Aging (ABA-COLA) is to strengthen and secure the legal rights, dignity, autonomy, quality of life, and quality of care of elders. It carries out this mission through research, policy development, technical assistance, advocacy, education, and training.

Established in 1979, the ABA-COLA consists of a 15-member interdisciplinary body of experts in aging and law, including lawyers, judges, health and social services professionals, academics, and advocates. With its professional staff, the ABA-COLA examines a wide range of law-related issues, including legal services to older persons; health and long-term care; housing needs; professional ethical issues; Social Security, Medicare, Medicaid, and other public benefit programs; planning for incapacity; guardianship; elder abuse; health care decision-making; pain management and end-of-life care; dispute resolution; and court-related needs of older persons with disabilities. The ABA-COLA's work has led to publications, research, conferences, and demonstration projects of considerable value to the American Bar Association and the public at large.

Since 1993, the ABA-COLA has conducted research projects, sponsored and implemented conferences, and developed curricula on elder abuse for judges and court staff, lawyers, and victim services professionals. It has been a partner in the National Center on Elder Abuse, a national training and technical assistance center, since 1998.

II. About the National Adult Protective Services Association

The National Adult Protective Services Association (NAPSA), formerly known as the National Association of Adult Protective Services Administrators (NAAPSA), was formed in 1989 in order to provide state Adult Protective Services (APS) program administrators and their staff with a forum for sharing information, solving problems, and improving the quality of services for vulnerable adults. NAPSA has since expanded its membership to include local APS line staff, supervisors, and supporters of APS and the victims they serve. NAPSA is a national non-profit organization with members in every state.

NAPSA conducts national research on issues relating to the delivery of adult protective services, provides training and technical assistance to APS professionals, provides information to the public on issues relating to elder and vulnerable adult abuse, exploitation, and neglect, and serves as an advisor on national policy issues relating to protective services for adults.

Since 1998, NAPSA has been a partner in the National Center on Elder Abuse. In addition to partnering with the ABA-COLA on this fatality review team project and other grant projects, it has also worked with state and other national organizations, such as the Wisconsin Coalition Against Domestic Violence, the California District Attorneys' Association, and the National Organization of Victim Assistance, on joint grant projects benefiting victims of elder and vulnerable adult abuse.

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IV. Acknowledgements

Many individuals and organizations contributed to this project in crucial ways. Each of them deserves recognition and a great deal of gratitude.

The members of the eight elder abuse fatality review teams (EA-FRT, which will be used to refer to one team or multiple teams) that are discussed in this manual—in Houston, Texas; Maine; Orange County, California; Pima County, Arizona; Pulaski County, Arkansas; Sacramento, California; San Diego; and San Francisco—are trailblazers for undertaking this challenging work and sharing their experiences and materials to benefit others. Their contributions to this manual and the elder abuse field are invaluable.

The representatives of the eight teams who attended the April 2004 meeting in Washington, D.C., deserve special thanks for taking the time to do that on short notice and for making the meeting so enlightening.

The National Adult Protective Services Association (NAPSA), through its executive director Joanne Marlatt Otto, made significant contributions to the project by providing excellent advice and support throughout, especially during the demonstration project site visits; promoting the project and concept of EA-FRT to NAPSA members and others; sponsoring and participating in several workshops at NAPSA and other conferences; and drafting some sections of the manual and reviewing and commenting on all of it.

The project advisory committee members (listed previously) provided very valuable guidance, resources, and feedback on this replication manual. Their suggestions strengthened the manual immeasurably.

The National Association of Victims of Crime Act Assistance Administrators supported the project by sponsoring a workshop on elder abuse and fatality review teams at its 2004 National Training Conference.

Participants at the workshops held at NAPSA and other conferences and in dialogues on the Elder Abuse and Elder Abuse Fatality Review Teams listserves offered useful questions and feedback, which strengthened the project and the replication manual.

The members of the ABA-COLA provided helpful guidance and support to the project.

The staff of the ABA-COLA—especially director Nancy Coleman, researchers Julia Bueno and Ellen VanCleave, office managers Julie Pasatiempo and Sonia Arce, and administrative assistant Trisha Bullock—provided invaluable support and encouragement. The ABA-COLA's editor, Jamie Philpotts, edited and produced the manual and designed the cover, illustrating the reflection that EA-FRT undertake as part of their work.

Finally, the Office for Victims of Crime at the U.S. Department of Justice deserves gratitude for recognizing the importance of this project and funding it. Special thanks are due to program manager Meg Morrow for her unflagging interest in and support of the project. Meg was more than a grant monitor; she contributed to the project's success by ensuring that project staff was aware of useful resources and had opportunities to promote the project and the concept of EA-FRT.

V. Using the Replication Manual

There are a variety of ways to establish and maintain an EA-FRT. These methods can reflect or be adapted to the needs and resources of the jurisdiction. In other words, teams have the flexibility to develop policies, procedures, and protocols that work for the members of their team; that meet the needs of their jurisdiction; and that comply with their state's law. As a result, this replication manual does not provide step-by-step instructions on how to develop and maintain an EA-FRT. Instead, the manual raises the issues and challenges that a team may face and shares ideas for addressing them that have been used by an existing EA-FRT or by child abuse or domestic violence fatality review teams. Think of this manual as a collection of recipes for the same type of food, rather than as an instruction manual for putting together a mechanical object. You can follow the recipe developed by one team or you can create your own recipe using ideas borrowed from other teams.

This replication manual does not and was not intended to provide guidance to other types of entities on how to conduct elder abuse fatality reviews. There are some general elder abuse multidisciplinary teams that look at cases in which victims have died. There are some domestic violence fatality review teams or domestic violence programs that review the deaths of older women who experienced domestic violence. There are some human services agency internal quality assurance committees that review elder deaths. The absence of those entities from this manual should not be interpreted as minimizing the value of the work that they do. They are not discussed in this manual simply because they are not EA-FRT, meaning that they either are not focused on elder abuse fatality review or they are not a multidisciplinary team. And while individuals and agencies interested in conducting elder death reviews through those other types of teams and committees may be able to learn useful things from this manual, providing guidance to them is not the goal of this manual.

This manual also provides examples and analyses of key documents that the EA-FRT have prepared, such as mission statements; memoranda of understanding, policies and procedures, or protocols; confidentiality forms; and data collection forms. It includes the Maine team's report; copies of the fatality review team laws from California, Maine, and Texas; and materials on avoiding vicarious traumatization.

The manual is organized in a generally chronological fashion. It begins with background information on the need for EA-FRT, the project that led to this manual, and the history of the fatality review team concept. It then discusses the various issues that must be considered and decisions that must be made by those who wish to start an EA-FRT. Next, it focuses on the actions that occur once a team has been established: conducting case reviews, collecting data, and developing periodic reports or stand-alone recommendations. It then addresses the steps that must be taken to sustain the team. The manual concludes with information about resources, a list of references, and the appendices referenced in the previous paragraph.

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The contents of this replication manual, in whole or part, excluding the materials contained in the appendices, may be reprinted and adapted in print and electronic form without the permission of the American Bar Association by individuals and organizations for use in developing an EA-FRT, provided that the materials are used for information, noncommercial purposes only, and any copy or adaptation of the materials or portion thereof acknowledges original development and publication by the American Bar Association.

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VII. The Need for Elder Abuse Fatality Review Teams

Elder abuse is a serious and growing problem. However, the responses of the justice, health, and social services systems to elder abuse lag far behind their responses to the similar problems of child abuse or domestic violence. Research indicates that elder abuse hastens mortality (Lachs, M.S., C.S. Williams, A. O'Brien, et al., August 5, 1998, "The Mortality of Elder Mistreatment," *Journal of the American Medical Association*, Vol. 280, No. 54: 428-432). Anecdotal evidence indicates that it often directly causes an older person's death. Fatality review teams for child abuse and domestic violence have had an impact in improving systems' responses to the victims of those similar forms of abuse. Yet EA-FRT are only just starting to develop.

In 1998, the participants at a focus group convened by the Office of Justice Programs at the Department of Justice (DOJ) on crime victimization of older persons recommended that DOJ support technical assistance "to coordinate development of ... older person fatality review teams" (Office of Justice Programs, March 30, 1998, *Focus Group on Crime Victimization of Older Persons: Recommendations to the Office of Justice Programs*, Washington, D.C.: U.S. Department of Justice, 19). Three years later, DOJ, through its Office for Victims of Crime, funded the ABA-COLA to implement a project titled "Promising Practices in the Development of Elder Abuse Fatality Review Teams" in order to develop such technical assistance. This replication manual is the final product of that project, which is described below. The ABA-COLA conducted the project with the assistance of NAPSA.

The goal of the project was to expand the fatality review team concept to deaths resulting from or related to elder abuse in order to foster examination of and improvement in the responses of adult protective services, law enforcement officers, prosecutors, victim assistance providers, health care providers, and others to the growing numbers of victims of elder abuse. This goal was met through the following objectives:

- (1) Funding four demonstration projects and conducting other assessment activities to identify promising practices that support communities in establishing and continuing EA-FRT
- (2) Using the seed money as an incentive to ensure that victim services providers and other pertinent systems are involved in the four demonstration projects
- (3) Developing and disseminating a replication guide and presenting workshops at relevant conferences in order to encourage communities to adopt the EA-FRT concept and the promising practices identified by the demonstration projects.

The project demonstrated that the agencies and disciplines participating on an EA-FRT experience many benefits. One of the primary advantages is that the EA-FRT raises the awareness of agency administrators and, ultimately, the community about the seriousness and potential lethality of elder abuse. The work of the team encourages policymakers, program administrators and workers, and the public to question whether an older person's death was caused by or related to elder abuse, and to decide how to set protections and reforms in place that will help prevent similar deaths in the future and help to ensure that victims of elder abuse receive the services they need. Certainly older people die, but an EA-FRT questions whether the elder should have died in that manner or at that particular time. The existence of the EA-FRT

VII. The Need for Elder Abuse Fatality Review Teams

sends a message that the premature and/or unexplained death of an older person will be taken just as seriously as that of a younger adult or a child.

Another benefit of participation is that many of the EA-FRT members bring high levels of knowledge and expertise to the discussions. Team members, thus, have an opportunity to educate each other on a number of complex issues. During visits to the demonstration sites, nearly every team member interviewed indicated that networking and learning about other systems was a significant benefit of team participation. These experiences raise the level of sophistication and effectiveness of each system's response to victims of elder abuse.

Data generated by the teams may also prove invaluable in several ways. First, it can be used to educate the public about the potential deadly outcome of elder abuse. Second, it can help to identify patterns—known as lethality factors—of both perpetrator behavior and victims' situations that contribute to untimely deaths. This knowledge may eventually be used to more accurately predict risk, resulting in earlier intervention and, in some cases, preventing death.

The possibility of effecting systems change is another exciting benefit of participation on an EA-FRT. Working together, professionals have a much better window into “big picture” issues that affect service delivery. As they identify gaps or breakdowns in systems, they may use their collective wisdom and professional credibility to advocate for improvements in state statutes; agency structures, procedures and/or leadership; funding; and heightened community awareness. The opportunity to act as effective change agents can be energizing for all the team members.

Finally, participation on an EA-FRT can provide members with psychological support in dealing with emotionally charged situations. By being able to share their grief and rage regarding the untimely death of an abused elder, members strengthen their bonds with other team members, work more cooperatively, and decrease professional burn out.

VIII. Project Background

There were three phases to the project: assessing needs, selecting the demonstration projects, and learning from the demonstration projects. Each phase is described below.

(A) Assessing Needs

In order to assess the needs and activities of the field, encourage state APS administrators to support the project, and buttress the project's multidisciplinary nature, the ABA-COLA worked with NAPSA to design and conduct a survey of state APS administrators. The survey asked about the following issues:

- Whether an EA-FRT existed in the state at either the state or local level
- Whether there were or had been any ad hoc groups that functioned as an EA-FRT
- Whether an EA-FRT was currently in development or under consideration
- Whether there was interest in seeing an EA-FRT established in their jurisdiction
- The barriers, real or perceived, to EA-FRT development in their jurisdictions
- The technical assistance and support they would need from the ABA-COLA and NAPSA to support development of an EA-FRT in their jurisdiction.

Thirty-one of the fifty-one state APS administrators responded to the survey. Five administrators indicated interest in establishing an EA-FRT. None of the respondents indicated that an EA-FRT currently existed in their state, although three indicated a history of ad hoc teams that had, among other things, examined deaths related to elder abuse. In one state, the APS administrator served on the statewide domestic violence fatality review team.

Respondents were asked to suggest what technical assistance they would need to support the development of an EA-FRT in their jurisdiction. They requested exactly the type of resources and technical assistance that this project was designed to provide:

- Replication guide/tool kits for promising practices
- Models for development
- Protocols and policies
- Teleconferences and training on how to establish an EA-FRT
- Strategies for and linkages to other groups

VIII. Project Background

- Guidelines for identifying cases.

Additionally, respondents were asked to identify real or perceived barriers to EA-FRT development. The barriers identified included:

- Lack of funding, resources, and support
- Confidentiality
- Turf issues
- Need for statutory or regulatory changes
- Lack of support and commitment from law enforcement, prosecutors, and/or medical examiners
- Need to determine case review criteria
- Potential for negative media coverage on some cases.

Most of these challenges were experienced by the demonstration projects and are examined in this manual.

(B) Selecting the Demonstration Projects

In order to solicit and select the four demonstration projects, ABA-COLA and NAPSA staff developed an informal request for proposal (RFP) that was disseminated to 13 entities and individuals. These included the existing EA-FRT, APS administrators in states where either the APS administrator or others had expressed interest in starting a team, and other individuals who had contacted the project director in response to earlier project publicity or related activities. The RFP solicited the following information:

- Where the team was in the implementing or planning phase
- What entities were or would be involved in the team
- What the team would propose to do with the \$5,000 in seed funding
- What the purpose of the team was or would be (systems change, determining whether cases should be prosecuted, or both)
- Whether the team was or would be located in a rural or urban jurisdiction.

Eleven jurisdictions responded to the RFP. Their applications were analyzed and discussed by ABA-COLA and NAPSA staff. The staff decided to eliminate the existing teams so that the team development process could be watched from its beginning stages. Houston, Texas, Maine (statewide), Orange County, California, and Pulaski County, Arkansas, were chosen from the remaining seven applicants because of the

strength of their proposals, their geographic diversity and mix of rural and urban settings, and their differences in leadership and programmatic structure. Each proposal contained at least one unique feature, as discussed below. Information about each team's leadership, membership, purpose, and case review process is provided elsewhere in this manual.

- The Houston team was developed by the Texas Elder Abuse and Mistreatment (TEAM) Institute, which is a project of the Baylor College of Medicine and the Texas APS program. The unique feature of this proposal was the link between the EA-FRT and a team of geriatric practitioners with expertise in elder abuse.
- The Pulaski County team was developed by the state APS administrator. The unique features of this proposal were the leadership of APS and the participation of the Pulaski County coroner, who has been examining all deaths in nursing homes in Pulaski County since 1999.
- The Maine team was developed by the Office of the State Attorney General and the APS program. The support of the attorney general and the fact that this was a statewide team were the unique features of this proposal.
- The Orange County team was developed by the Vulnerable Adult Specialist Team (VAST) at the University of California at Irvine Medical Center. The VAST has many similarities to Houston's TEAM Institute, so the unique feature of this proposal was that the UCI Medical Center had just received a grant to establish the nation's first forensic center on elder abuse and the EA-FRT and the forensic center were to be linked in several ways.

(C) Learning from the Demonstration Projects

Information was gathered from the demonstration projects throughout the course of the project by semi-annual progress reports, dialogue on the elder abuse fatality review team listserv that was developed for the project, receiving and responding to requests for technical assistance, and a site visit to each demonstration project. The site visits entailed interviewing as many team members as possible and observing a team meeting.

During the site visits, numerous team members stated that they would like to have a conference with members from other teams. Project resources were not sufficient to support a conference, but project staff conducted a 1.5-day meeting in April 2004 for representatives of the four demonstration projects and the teams from Pima County, Arizona, Sacramento, California, San Diego, and San Francisco (those teams started before or at about the same time as the demonstration projects). The meeting allowed the newer teams and project staff to learn about the experiences of the older teams. A tremendous amount of information was shared and this manual was strengthened significantly as a result.

IX. History and Purpose of Fatality Review Teams

The fatality review team (FRT) concept was developed by the medical profession or the automobile industry, depending on the history one reads. Regardless of its origin, the concept involves bringing together a group of professionals to examine deaths that result from or relate to a certain cause, in order to improve the thing or system that caused, contributed to, or failed to prevent the death and, thus, prevent similar deaths in the future. This means that the primary goal of an EA-FRT is the improvement of services to victims so that they receive the services and interventions they need.

Hospital physicians use the “Morbidity and Mortality Review” process to examine what went wrong with a medical procedure and determine how the same problem could be avoided in the future. Car manufacturers examine accident-related deaths or injuries to learn how to design and build a safer car. Service providers in the child abuse and, more recently, domestic violence fields analyze deaths that were caused by abuse or deaths of persons who were known victims of abuse previously in order to change the systems’ response to victims and avoid similar outcomes. (Websdale, Neil, Michael Town, and Byron Johnson, 1999, “Domestic Violence Fatality Reviews: From a Culture of Blame to a Culture of Safety,” *Juvenile and Family Court Journal*, Vol. 50, No. 2 (Spring): 61.)

Subsumed within the broad goal of examining deaths in order to improve systems and prevent similar deaths in the future are many other goals and objectives. These may include:

- Collecting data
- Determining common lethality factors
- Identifying and prosecuting the deaths that were caused by the problem under review.

The following definitions of “child fatality review teams” and “domestic violence fatality review” provide guidance about the purposes of those teams.

The National Center on Child Fatality Review defines child fatality review teams as

multi-agency, multi-disciplinary teams that review child deaths from various causes, often with an emphasis on reviewing child deaths involving caretaker abuse and/or neglect. The scope of cases reviewed is determined by each team, with some reviewing all child deaths from all causes or all [c]oroner child deaths under age 18, while others limit their review to cases fitting into a pre-determined protocol, often based on cause of death or age of the child. Benefits of child fatality review include improved inter-agency case management, identification of gaps and breakdowns in agencies and systems designed to protect children, and the development of data information systems that can guide the formation of protocols and policy for agencies that serve families and children. The common goal for all teams is the prevention of child death and injury.

The National Center on Child Fatality Review, *A ‘How To’ Guide for Child Fatality Review Teams*, p. 3, The National Center on Child Fatality Review, <http://www.ican-ncfr.org>. Accessed June 29, 2004.

IX. History and Purpose of Fatality Review Teams

The National Domestic Violence Fatality Review Initiative defines domestic violence fatality review as the

deliberative process for identification of deaths, both homicide and suicide, caused by domestic violence, for examination of the systemic interventions into known incidents of domestic violence occurring in the family of the deceased prior to the death, for consideration of altered systemic response to avert future domestic violence deaths, or for development of recommendations for coordinated community prevention and intervention initiatives to eradicate domestic violence. This deliberative process can be formal or informal, relatively superficial, offering basic demographic details of victims and perpetrators, or very detailed.

National Domestic Violence Fatality Review Initiative, n.d., “Key Questions – What is a Domestic Violence Fatality Review?,” <http://www.ndvfri.org/> Accessed May 2, 2005.

As noted earlier, fatality review teams in some communities also examine deaths for the purpose of recommending or supporting law enforcement investigation and prosecution of alleged perpetrators. They may do this instead of or in addition to examining systemic problems. Nonetheless, even teams that focus only on investigation and prosecution often end up developing ideas for system change. The reasons why some teams decide to consider prosecution and the pros and cons for their decision are discussed below in the “Team Purpose” [section X \(C\)](#).

There are two hallmarks of successful fatality review teams. Open and honest discussion of system flaws and ideas for fixing those flaws cannot be fostered without them. The first is a culture of avoiding “blame and shame.” The second is an environment that treats team discussions as confidential and prohibits their disclosure outside the team. These characteristics and the steps that teams take to imbue the team culture with them are discussed in detail in “Creating a Culture of Avoiding ‘Blame and Shame,’” [section X\(F\)](#), and “Elder Abuse Fatality Review Team Laws: Authorization and Confidentiality,” [section X\(I\)](#).

X. Developing An Elder Abuse Fatality Review Team

(A) Introduction

Several critical issues are faced immediately when a decision is made to form an EA-FRT. These issues include the team’s jurisdiction (local, regional, or statewide), its leadership and members, and its purpose. Considering these issues sparks the “chicken or the egg” dilemma, because each, to a certain extent, drives the other.

Other issues do not arise immediately, but they must be addressed before a team can start reviewing cases. These issues include creating a culture of avoiding “blame and shame”; preparing policies and procedures, protocols, or memoranda of understanding; deciding what to call the team; and, most importantly, ensuring that necessary confidential information can be shared and obtained and that confidential information and team deliberations and products are protected from voluntary or involuntary disclosure outside of the team.

As state law may provide direction on these issues, persons interested in establishing an EA-FRT should ascertain whether any laws in their state mandate or authorize the establishment of an EA-FRT. For example, the state may have laws authorizing or mandating child abuse or domestic violence fatality review teams that also explicitly or implicitly authorize elder abuse teams. A state’s adult protective services law or some other statutory provision that authorizes the establishment of elder abuse multidisciplinary case review teams may be broad enough to allow interested agencies to create an EA-FRT. If a state already has an EA-FRT, it is likely that a current state law allows that type of team.

It is also worthwhile to determine whether an existing elder abuse multidisciplinary case review team is reviewing deaths caused by or related to elder abuse. Likewise, a jurisdiction’s domestic violence FRT may be reviewing deaths of older victims of domestic violence.

If current state law neither authorizes nor mandates an EA-FRT, then it is probable that potential team members will determine that a new law is necessary before a team can review cases. The reasons for enacting such a law are discussed below in “Elder Abuse Fatality Review Team Laws: Authorization and Confidentiality,” [section X\(I\)](#).

(B) Selecting the Team’s Jurisdiction

An EA-FRT may be local or statewide in its jurisdiction. In many areas, the team’s founders will not face the question of what the team’s jurisdiction should be because state law will have made that determination already by authorizing only a statewide team or only local teams. In other areas, however, that issue will have to be considered. The team’s jurisdiction will affect decisions on leadership, membership, and purpose. Alternatively, decisions about purpose and membership may influence decisions about jurisdiction. The population, size, geographic nature, and resources of a state or community may help to determine the jurisdiction of a team. For example, the population of Orange County, California, is equivalent to the population of Colorado and greater than the population of Maine. The founders of the Orange County team never contemplated a statewide team, whereas the founders of the Maine team never

considered having local teams. The founders of the Colorado team, which was developed toward the end of this project, spent significant time contemplating whether to have local teams or a state team.

Decisions about the team's jurisdiction should be based on the needs and interests of the agencies seeking to establish the team and their history of collaborating on other teams and initiatives. Other more tangible considerations include population size; transportation times and distances; whether the jurisdiction is urban, rural, or mixed; and the resources of participating agencies. Another important factor may be the size and distribution of the elderly population within a state. The founders of the Maine team decided that in their rural state of 1.3 million people, where the state agencies' staff all know each other and work together regularly, and where the population centers are not spread out, a statewide team made the most sense. Houston, Texas, and the California counties, on the other hand, all urban communities with populations ranging from 800,000 people to 4 million people located in large and diverse states, never considered the possibility of anything but a local team.

Members of statewide teams are more likely to represent state or regional agencies. In addition, a statewide team will naturally focus on statewide practices and systems. Local teams, on the other hand, will represent local agencies and be more likely to address local practices and systems. Of course, state practices and systems impact local practices and systems, and vice versa. It is also possible to have a hybrid team of sorts, as is the situation in Pulaski County, Arkansas. Pulaski County is the location of Little Rock, the state's capital. The team is led by the state APS administrator and has other members who represent state agencies, but it also has members from local agencies, including the coroner's office, the prosecutor's office, and the domestic violence and victim services programs.

(C) Team Purpose

A new EA-FRT must determine its purpose early in its development phase, because its purpose will affect some of the other decisions a team must make, particularly those related to membership and case review. As discussed previously, the various goals of an EA-FRT can be boiled down to one or both of the following purposes.

- Examining deaths that resulted from or were related to elder abuse in order to improve the system(s) that caused, contributed to, or failed to prevent the death and thereby ensure that services are provided to elder abuse victims that help to prevent similar deaths in the future while recognizing and acknowledging that not all deaths are preventable and that the perpetrator is ultimately responsible for the death.
- Some teams have a different purpose in addition to or in lieu of system change: examining deaths known or suspected to be related to elder abuse for the purpose of determining whether law enforcement investigation and prosecution of alleged perpetrators is appropriate and supporting those efforts. Even teams that devote their efforts to the second purpose end up recognizing system flaws and developing ideas for system change.

So how does a fledgling team decide what its purpose will be?

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Determining the team's purpose is, unfortunately, not just an easy decision about reaching one or two worthy goals. It is a complicated matter that involves assessing state law(s), considering issues of confidentiality and access to information, and balancing the possibility of interfering with the investigation and prosecution of open cases with the possibility of encouraging involvement by and assisting law enforcement agencies and prosecutors. Each of these issues is discussed in detail in "Team Purpose," [section X\(C\)](#). But the Houston and Pima County teams illustrate how some of these factors affect a team's decision about its purpose. The Houston team decided to adopt both purposes in the hope that the second purpose would encourage law enforcement and prosecution agencies to become involved in the team. The Pima County team only addresses investigation and prosecution because the state does not have a law that allows team members to share relevant information for any other purpose.

The "Team Purpose Chart" provided at [Appendix A](#) indicates the purpose identified by each of the eight EA-FRT. More information can be gleaned from the "Team Mission Statements Chart" provided at [Appendix B](#), which reproduces the mission statements of some of the different teams.

(D) Team Leadership

An EA-FRT will face questions about its leadership early in its development, as well as following changes in composition or circumstance. There are several issues to consider when selecting a team leader. These include:

- The clout and credibility needed to establish and manage the team and to promote implementation of the team's recommendations
- The ability to devote the time necessary to lead the team
- The ability to recruit members for the team
- Meeting facilitation skills
- The ability to deal with team members who do not fulfill their responsibilities and other problems that may arise.

Team members have indicated that it is also helpful if the team leader has a sense of humor. The use of humor at team meetings should be approached with caution, however, and is discussed in detail in "Supporting Team Members and Avoiding Vicarious Traumatization," [section XIV\(B\)](#).

According to a recent study by the National Center on Elder Abuse, there are several activities necessary to support an elder abuse multidisciplinary team. Some of these activities may be delegated to other team members or a team administrator (see "Determining the Costs of and Funding the Team," [section XIV\(C\)](#)), but the team leader is ultimately responsible for ensuring these activities are fulfilled. These activities may include:

- Recruiting and orienting team members

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- Negotiating memoranda of understanding
- Arranging the meeting location
- Producing and sending out meeting announcements, agendas, and minutes
- Preparing team materials, including confidentiality agreements, data collection forms, case review forms, policies and procedures, and annual reports
- Selecting cases for review and ensuring that review documents are provided, collected, and destroyed
- Serving as a team spokesperson proactively or in response to contacts from policymakers or the media.

Teaster, Pamela and Lisa Nerenberg. n.d. "A National Look at Elder Abuse Multidisciplinary Teams." National Center on Elder Abuse. <http://www.elderabusecenter.org/pdf/publication/mdt.pdf>. Accessed May 2, 2005.

There is no one appropriate leader for a fatality review team. Analysis of the team's needs and the political circumstances in its jurisdiction should help determine the person or agency best suited to lead the team. As a result, fatality review teams have used an array of approaches to meet the challenges of selecting a team leader. The eight EA-FRT discussed in this manual illustrate some of these approaches.

Some of the teams have a chairperson, while others have co-chairpersons. The teams that have opted to use co-chairpersons usually have done that in order to have the enhanced clout and credibility provided by having representatives of two agencies serving as team leaders. But they have realized that another benefit to having co-chairpersons is that the team can continue to function in the short- or long-term absence of one of the co-chairs. As it can be challenging to find one person who has all the skills required of a team leader, another advantage to having co-chairs is that the individuals may bring complementary skills to their shared efforts to lead the team.

The teams are diverse in their leadership. APS administrators chair the Pulaski County, Sacramento, and San Diego teams. A regional APS administrator (there is no state APS administrator) and an investigator with the state attorney general's office co-chair the Maine team. A geriatrician and a deputy medical examiner co-chair the Orange County team. A geriatrician and an assistant district attorney co-chair the Houston team. A deputy attorney general and a law enforcement officer co-chair Pima County's team. And a deputy district attorney and a deputy medical examiner co-chair the San Francisco team.

A team's leadership is likely to alter over time because of changing circumstances. A team's leader may change jobs or face new job responsibilities that preclude him or her from continuing to serve in the leadership role. Alternatively, a team may decide to rotate its leaders in order to bring fresh ideas to the table, prevent burnout, or share the workload. A team should anticipate the possibility of a leadership change and make every attempt to plan for that possibility in order to ensure that team functions continue smoothly if a change occurs. The Houston team's "Policies and Procedures," which is provided at [Appendix C](#), limits the terms of its co-chairs and provides a process for selecting new leadership. But there

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is not always an opportunity to plan for a leadership change, as illustrated by situations in Pima County and San Francisco, where a co-chairperson of each team suddenly had to step down because of an internal job transfer. Teams may want to assess whether it is the culture of any of their member agencies to regularly rotate staff and, if so, consider that fact when making decisions about team leadership.

(E) Team Members

An EA-FRT will undoubtedly face several challenges related to membership in both its initial and later phases. These may include the following issues:

- Identifying the appropriate agencies and disciplines to include as team members
- Identifying the appropriate representative of those agencies or disciplines to have on the team and, on occasion, determining whether having a specific individual is more important than having the agency or discipline that individual represents
- Determining whether to exclude certain industries, agencies, disciplines, or individuals from team membership
- Overcoming the reluctance or refusal of agencies, disciplines, or individuals to participate on the team
- Adding new members to the team after its initial phase, either because of job turnover at the agency they represent or because the team decides to add more agencies, disciplines, or individuals to the team
- Recognizing and addressing the fact that EA-FRT members lack the clout or ability to effect the policy or program changes recommended by the team.

Elder abuse and other FRT have responded to these challenges in a variety of ways. Each issue will be discussed separately below.

(1) Identifying Appropriate Agencies and Disciplines to Include As Team Members or Consultants

There are numerous agencies and disciplines that an EA-FRT should or could have as members or consultants. A state law authorizing the establishment of an EA-FRT may provide guidance on the agencies or disciplines that could or should be included as team members. Potential team members or consultants include representatives of the following disciplines or agencies (in alphabetical order):

- Adult Protective Services
- Aging Services (a state office on aging, an area agency on aging, or a state or local provider of direct services)

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- Animal Protection (such as the Humane Society)
- Attorney General
- Coroner
- County Counsel (or other lawyer representing a local jurisdiction or pertinent local agency)
- 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 Pathologist
- Forensic Psychiatrist
- Forensic Toxicologist
- Funeral Home Director
- Geriatrician
- Gerontologist
- Hospital Discharge Planner
- Law Enforcement (police and sheriffs)
- Legislator
- Long-term Care Ombudsman Program
- Medicaid Fraud Control Unit
- Medical Examiner
- Mental Health Services
- Nursing (including geriatric nurse practitioners)

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- Other Health Care Providers (such as a general medical doctor, dentist, geriatric nurse practitioner, etc.)
- Pharmacologist
- Probation and Parole
- Prosecution
- Public Guardian and/or Conservator
- Public Health Agency
- Social Security Administration
- Sexual Assault Program
- Victim Assistance Program (see explanation below)
- Vital Statistics.

Several of the eight teams have members who previously served or currently are serving on either a child abuse FRT or a domestic violence FRT. Each team indicated how important and useful it was to have a member with that expertise. Members indicated that their colleagues with FRT experience helped them work through the process of developing policies and procedures, protocols, or memoranda of understanding; conducting case reviews; and, perhaps most importantly, staying or getting back on track when the team's progress was stymied by the emotional difficulty that the inexperienced members faced in doing fatality review work for the first time. Having team members from other types of FRT may also have another benefit: those members may serve as liaisons to the other teams when there are cases that overlap, such as when a spouse abuses and kills his spouse and his spouse's older parent.

Some of the teams have opted to involve consultants to supplement the expertise brought by team members. Generally, consultants are used on an ad hoc basis. For example, the San Diego team invited staff from the Vital Statistics office to attend a team meeting and to explain the work of the office and its relationship to the team's work. Another example would be when a team in a jurisdiction that has multiple law enforcement agencies asks representatives from agencies that are not represented on the team to attend a meeting because the team is reviewing a case in which those agencies were involved. Another example of the need to use consultants occurred in Maine, where state law proscribed the number of members allowed to serve on the team and the agencies or disciplines that they may represent. After the team determined that it needed information from additional disciplines to do its work, it had to resort to adding the representatives of those disciplines as consultants in order to overcome the statutory restrictions.

The "Team Composition Chart" provided at [Appendix D](#) indicates the agencies and disciplines comprising each of the eight EA-FRT. The chart also shows whether the representatives are team members or consultants.

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As the Office for Victims of Crime funded this project, the ABA-COLA staff required the four demonstration projects to include representatives of victim assistance programs as team members or to make every attempt to do so. All the teams except one were successful. That team had problems for two reasons:

- The team did not understand what the ABA-COLA staff meant by “victim assistance programs” and thought that APS staff and domestic violence advocates fulfilled that requirement. This problem demonstrated that project staff needs to explain what it means by “victim assistance programs.” Certainly APS, domestic violence programs, sexual assault programs, and other disciplines that may be involved in an EA-FRT provide services to victims. But “victim assistance programs” (which may also be known as “victim services programs,” “victim-witness programs,” or by other names) refer to programs that provide an array of direct services to victims of crime; they may be funded through the federal Victims of Crime Act (see description in “Determining the Costs of and Funding the Team,” [section XIV\(C\)](#) for more information). These programs may be housed in a prosecutor’s office, a law enforcement agency, or a community-based organization. Their staff members have a wealth of knowledge about the impact of crime on victims, the needs of crime victims, and the array of services that may be available to fill those needs.
- After the first problem was resolved, the team approached the victim assistance program but was unable to recruit a member for the EA-FRT. In the county where the team is located, the victim assistance program is part of the district attorney’s office and the victim services provider who assists elder abuse victims works for the deputy district attorney, who was already a member of the team. Either the district attorney’s office did not wish to have two members of its staff participate on the team or it believed that the deputy district attorney could adequately represent the viewpoint of the victim advocate.

Project staff believes that it is critical to include a victim assistance program representative on the EA-FRT even if he or she is part of an agency that is already represented. A victim services provider brings to the team a distinct perspective and expertise about victim issues, needs, and services that are not duplicated by a prosecutor or law enforcement colleague. Additionally, as discussed in “Determining the Costs of and Funding the Team,” [section XIV\(C\)](#), including a victim services program on the EA-FRT may benefit a team’s effort to educate the state victim assistance program administrator about the goal of the team and to obtain funding from the state victim assistance program for implementation of the team’s recommendations.

(2) Determining Whether to Exclude Certain Industries, Agencies, Disciplines, or Individuals from Team Membership

Teams have also faced the issue of whether to exclude certain agencies, disciplines, or individuals from membership. Usually the concern has related to entities or individuals who are connected to or thought to be aligned with the long-term care industry because elder abuse and neglect are widespread problems in nursing homes, assisted living facilities, and board and care homes. It is important that team members discuss and reach consensus on this issue because of its potential for divisiveness. Teams may also want to consider an idea that one team has implemented. Recognizing that persons with experience in the long-term care industry can bring valuable knowledge to the table, this team has found ways of involving individuals who are retired from careers in the long-term care industry and who are now perceived to have a balanced approach to addressing the need for improved services for elder abuse victims in all settings.

(3) Identifying the Appropriate Agency or Discipline Representatives to Serve on the Team

After identifying the agencies or disciplines that should serve on the EA-FRT, teams face the challenge of finding one or more individuals to represent the specific agency or discipline. Ideally, the representative has a thorough knowledge of the system represented and its relationship to victims and the other entities comprising the EA-FRT, can collaborate with other team members, and can make the time to attend team meetings and fulfill other team responsibilities. But what if the ideal representative does not exist? What if the agency wants to designate or has designated as its member an individual who does not work well with other team members, who cannot or will not engage in the team process or, even worse, who tries to sabotage the team? When asked these questions, team members from the four demonstration sites usually indicated that it was more important to have the right individual on the team than it was to have the wrong person with an agency's or discipline's "blessing." Team members expressed their belief that the right individual would overcome the obstacles and sooner or later bring the agency or discipline around to supporting the team. They understood, however, that this strategy could result in a short-term loss of clout with the particular agency or discipline. Team members also recognize that sometimes the person most suitable for participation simply cannot undertake that responsibility because of job commitments or political reasons.

Some teams have acknowledged that all EA-FRT members are busy and will have occasions when they cannot attend team meetings and, as a result, have required or allowed agencies participating on the team to designate an alternate representative. This practice helps to ensure continuity in team meetings and better-informed team members. If a team adopts this practice, it should discuss whether the member and alternate can attend a meeting simultaneously and, if so, how any voting or consensus building matters should be handled.

(4) Overcoming the Reluctance or Refusal of Agencies, Disciplines, or Individuals to Serve on the Team

The demonstration sites had only a few experiences with agencies or disciplines that were reluctant or that refused to join the EA-FRT. More common was the experience of gaining an entity's commitment to participate, only to have the entity's representative attend only one meeting or none at all. Both problems seemed to occur most often, but not always, with law enforcement agencies and prosecutors' offices. Sometimes the cause of the problem appeared to be related to agency staffing and an individual's job responsibilities. Other times it seemed to be caused by turf problems. Patience, persistence, resourcefulness, or some combination thereof often led to the problem's resolution. Sometimes a personnel change—for example, the departure of an agency director who refused to name a representative to the team—fixed a problem. Sometimes team leaders had to make repeated attempts to convince an agency or individual to join the team. And there were times when team leaders were unable to recruit a representative from the most politically appropriate organization and instead had to find a team representative from another agency through "back channels." To illustrate, one team decided that it wanted to have a representative from a certain professional membership organization, as it believed that the organization would have clout among its members. The organization's representative failed to participate, however, and after repeated attempts to involve the organization the team members concluded that they would have to invite a specific individual to represent that profession on the team. That plan worked, and the individual has proved to be a valuable team member even though he does not represent his professional organization.

X. Developing An Elder Abuse Fatality Review Team

Recognizing that the team members interviewed had overcome barriers to joining an EA-FRT, project staff asked them what impediments their colleagues in other jurisdictions might experience and how those impediments could be overcome. Team members shared the following ideas (these are not in any particular order):

- Lack of time. All of the potential team members are likely to be extremely busy. Many work for agencies that are chronically and woefully understaffed. They have little time to prepare for and attend EA-FRT meetings. To overcome this obstacle, potential participants should be informed of how team membership can result in the development of better and more efficient services or the improved identification of criminal cases. As team members learn about the roles of other agencies and form personal relationships with representatives of other disciplines, they are able to avoid duplication of effort and make more appropriate referrals—all of which save time. Additionally, team leaders must be sensitive to members' time constraints and keep meetings focused and start and end meetings on time.
- Lack of objectivity and potential for harming other work relationships. Many team members travel in the same circles, participating together on other teams, boards, task forces, advisory committees, etc. They may work together regularly to provide direct services to elder abuse victims. As a result of these important connections, team members may lack objectivity about the work performed by their colleagues. They may fear that their EA-FRT work will be perceived as criticism and will harm their working relationships and, ultimately, the older persons they serve. Team members suggested that the methods used to avoid a culture of “blame and shame” (see “Creating a Culture of Avoiding ‘Blame and Shame,’” [section X\(F\)](#)) could help alleviate these problems.
- Uncertainty about the work of EA-FRT. The concept of an EA-FRT is new to most of the agencies, disciplines, and individuals working in the field of elder abuse. Potential members may need education about the goal and operations of the team and what their role would be. This will be particularly important for representatives of agencies that customarily close cases upon the death of a client and for other potential members who may not see the value in examining the death of an individual when they can instead be focusing their energies on people who are alive and who need their attention and assistance.
- Fear of being criticized and blamed. If potential members are familiar with situations in which another type of FRT has criticized and blamed team participants for deaths and system failures, they or their program administrators may be reluctant to join an EA-FRT that may do the same thing to them. Education and a strong expression of the intent to avoid “blame and shame” by the team leader and other participants may help surmount this concern.
- Concern that information shared at team meetings will be disclosed and used outside team meetings. Potential participants may fear that otherwise confidential information shared with team members during meetings may be voluntarily or involuntarily disclosed outside of the meeting. Such disclosures could have serious negative outcomes to participating agencies and disciplines, including political consequences and litigation. It could also have criminal or civil consequences for the person(s) making the disclosure. Team leaders should stress the statutory protections that a team has or is developing against voluntary or involuntary disclosure of confidential information and team deliberations and records and against the ability of the media, lawyers, or others to

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subpoena team information. Even if statutory protections exist or are in development, but especially if they are not, leaders should also stress the importance of having a team culture—demonstrated by written documents such as policies, protocols, or memoranda of understanding—that make it unthinkable for any team member to voluntarily disclose confidential information or team deliberations and records. See “Elder Abuse Fatality Review Team Laws: Authorization and Confidentiality,” [section X\(I\)](#).

- Concern about upsetting public officials who think that elder abuse is not a problem. It is not unusual for public officials to say that elder abuse is not a problem in their state or community. Potential participants and program administrators may be concerned about political ramifications if the EA-FRT develops reports and recommendations stating that elder abuse does exist and that problems with system responses are causing older citizens to die prematurely. Team leaders may need to remind potential participants and program administrators that the political repercussions may be worse if the systemic problems are not fixed and the public, media, and policymakers learn that the agency turned down the opportunity to participate on a team that sought to fix those problems.
- Intimidation about other team members. Some potential participants may find the thought of participating on an EA-FRT with doctors, lawyers, medical examiners, and others to be intimidating. They may question their qualifications to serve on the team, particularly if they do not have advanced degrees. Team leaders need to advise those participants that their knowledge and experience is critical to the team. Team leaders may need to demonstrate to the potential participants that the background information on victims, perpetrators, and services that they bring to the table will be invaluable to the team’s work.
- Concern about looking at pictures of injured, dead victims. Some potential members may be reluctant to participate in a process that may necessitate their looking at terrible pictures of injured, dead victims. They may fear that the tragic stories they hear will be emotionally distressing. To overcome these concerns, team leaders should talk about the benefits of EA-FRT participation. They could also advise the potential member that the focus of the team is on systemic responses to victims, and that the team member can discuss those issues without having to look at disturbing photographs. The team leader could talk about how the team will address the problem of vicarious traumatization (see “Supporting Team Members and Avoiding Vicarious Traumatization,” [section XIV\(B\)](#)). The team leaders could also acknowledge that the deaths discussed by the team might well be tragic, but that the process of sharing that information and doing something so that the individual’s death is not in vain may help compensate for the tragedy.

(5) Adding New Members to An Existing Team

Each of the teams faced the challenge of adding new members after the team’s start-up phase, either because of job turnover at a member agency or because the team decided to add more agencies, disciplines, or individuals to the team. Adding new members to a team raised the following two issues:

- Orienting new members. When project staff visited the demonstration sites, some of the later-joining team members indicated that they would have benefited from a more thorough orientation to the team’s work and culture. An orientation is particularly important if a team does not keep

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detailed minutes of meetings, but is very useful for any new member even if the team maintains detailed minutes and written policies and procedures. An informal meeting or a telephone conversation between a team's leader(s) and new members prior to the new members' first meeting will allow review and discussion of the team's purpose, history, policies and procedures, and culture.

- Developing a process for adding new members. A greater challenge concerns the need for team members to be aware of and to reach consensus about the addition of new members to the team. The experience of one team illustrates the problem and offers a solution. That team decided to add a new member to the team to fill a knowledge gap. A member who missed the meeting where that decision was made objected to the new individual as soon as she learned of the decision. An invitation to join the team had already been extended to the new individual, however. As a result of this experience, the team decided to revise its process to ensure that any potential new member would be vetted by all team members, including anyone who missed a meeting where the new member was discussed, before an invitation would be issued to the proposed new member.

(6) Ensuring the Team Has the Clout to Effectuate Its Recommendations

A common problem with FRT is that the individuals who are most knowledgeable about services and best able to review cases and formulate recommendations may not be the individuals who have the clout or ability to effectuate the changes suggested by the team. Elder abuse and domestic violence teams have suggested some potential solutions to this problem.

- A strong connection to or sponsorship by a policymaker with clout and credibility, preferably the highest level person possible. An example is the Maine EA-FRT, which is sponsored by and housed in the office of the state attorney general, who is a highly respected public official and former state legislator.
- A close connection between the EA-FRT and an entity such as a coordinating council that includes policymakers and other people with influence. The Orange County EA-FRT, which has several members who also serve on the county's elder abuse coordinating council (and other multidisciplinary collaborations on elder abuse), illustrates this idea.
- A bi-level FRT where the level responsible for reviewing cases and developing recommendations is composed of front-line workers or program administrators and the level responsible for issuing the recommendations and seeking to implement them is composed of agency directors and other policymakers. The domestic violence FRT in Miami-Dade County, Florida, operates this way.

(F) Creating a Culture of Avoiding “Blame and Shame”

Avoiding a culture of “blame and shame” is one of the two hallmarks of a successful FRT. Open and honest discussion of system flaws and ideas for fixing those flaws cannot occur unless team members feel confident that they or their agencies or disciplines will not be publicly criticized and embarrassed.

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Creating a team culture that is about systems change instead of “blame and shame” is extremely challenging. But it can and must be done. Participants from domestic violence teams and the eight elder abuse teams have offered the following suggestions for creating that culture:

- From the beginning, the team’s attitude and approach must indicate its desire to adopt a culture of avoiding blame and shame.
- The team’s approach should focus on gaps in the system and better ways of doing the work, rather than on problems and who did something wrong.
- It helps to take the attitude that everyone is learning how to serve elder abuse victims and, therefore, everyone “drops the ball” occasionally.
- The group needs to anticipate difficult situations and make plans to deal with them, always reflecting concern for preserving the integrity of the team.
- This approach should be reflected in the wording of the team’s mission statement, policies and procedures statement, memoranda of understanding, report, and any other documents it develops.
- Team members need to be trustworthy and willing to be self-critical and to truly share the philosophy of the team.
- The team should honor and support its members for having the courage to do fatality review work.
- The team should insist on agency accountability and allow members “to take ownership if their agency messed up.”

(G) Policies and Procedures/Memoranda of Understanding

Fatality review teams find it is useful to create statements of team policies and procedures (sometimes known as protocols) or to have member agencies enter into memoranda of understanding with each other in order to memorialize their understanding of the roles and responsibilities of member agencies and their representatives. Developing these tools causes team members to think and make decisions about the many sensitive and difficult matters that are discussed elsewhere in this manual. Following these tools will help team members understand their responsibilities to the team and ensure consistency in their approach to such matters as case review, transition of leaders and members, and maintaining a culture that avoids “blame and shame.”

An analysis of the documents submitted by four of the EA-FRT indicates that those teams treat statements of policies and procedures and memoranda of understanding (MOU, also known as memoranda of agreement or MOA) in a similar manner. To illustrate, the MOU used by the Orange County and San Diego teams (which are almost identical because the Orange County team modified the San Diego team’s form) contain sections titled “Protocols” and “Policies and Procedures.” The Houston and Maine documents are referred to as “policies and procedures.” The four documents have the following categories in common (although they do not necessarily use the same words to label the categories):

- Goals/Mission/Purpose/Philosophy
- Team Composition/Members
- Confidentiality
- Meeting Procedures
- Case Review Process
- Team Reports/Recommendations
- Data Collection and Handling

Although the documents have commonalities, they vary widely in the level of detail they provide and the way they organize that detail. To make it easier for readers to understand and compare that detail, project staff prepared a list of the key headings and subheadings for the Houston, Maine, and Orange County documents. That list is provided at [Appendix C](#). The documents themselves are also provided at [Appendix C](#). The San Diego MOU is not attached because it is almost identical to the Orange County MOU.

(H) What to Call the Team

Several of the elder abuse teams have used different words for their names. For example:

- Sacramento, San Diego, San Francisco, and Orange County each adopted the name Elder Death Review Team (EDRT)
- Pima County's team is called the Pima County Death Analysis Review Team (PC DART). Maine's team borrowed that idea and decided to name itself the Maine Elder Death Analysis Review Team (MEDART)
- After realizing that the acronym for its elder abuse fatality review team (EAFRT) could be pronounced as "effort," the Houston team decided to adopt EFFORT as its name.

Does it really matter what a team names itself? None of the teams have reported experiencing any confusion about their work as a result of using words other than fatality review team in their names. Nonetheless, a team that is contemplating different terminology may want to consider that the words "fatality review team" and "death review team" have historical context and recognized meaning in other relevant fields. State law, whether governing elder abuse, domestic violence, or child abuse teams, may also provide some guidance for decisions about a team's name.

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(I) Elder Abuse Fatality Review Team Laws: Authorization and Confidentiality

(1) Introduction

Among the first issues faced by people who want to develop an EA-FRT is whether there needs to be a law governing the functions of the team. Fatality review teams can and do operate in the absence of a state law that authorizes their work. The Pima County and Pulaski County EA-FRT are examples of such teams. But an authorizing law may define the team's purpose and membership and address other important issues, the most critical of which is confidentiality. In order to function, team members must have access to information that would otherwise be deemed confidential. A team must keep that information confidential. Although, as explained previously, a team culture of confidentiality can be fostered and maintained through policies, protocols, and memoranda of understanding, it can help to have statutory protection against involuntary disclosure of team deliberations and records through subpoenas, discovery, or other legal processes. This section will discuss those three issues separately in [section I\(3\)](#) below. It will conclude with a brief discussion of the impact of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(2) Authorizing a Team's Operation

The importance of having a law is illustrated by the experience of the Sacramento and Maine teams. The Sacramento team was the first EA-FRT to develop. Team members originally thought that the provisions of California's law governing child abuse and domestic violence FRT also authorized and protected their work. It was ready to begin reviewing cases when the Sacramento County Attorney's Office declared that the law did not specifically authorize an EA-FRT and that such a law was necessary. The team's efforts ground to a halt. Team members drafted legislation, the bill was enacted quickly and without controversy, and the team finally was able to review cases. The Maine team, subsequently, had a virtually identical experience, except that it was the state attorney general's office that concluded that a new law was necessary and also developed the legislation. The Houston team was more fortunate, as Texas already had a law authorizing various types of FRT, including elder abuse. The other California teams (Orange County, San Diego, and San Francisco) benefited from the path blazed by the Sacramento team.

Legal authority, in addition to dealing with the issues of confidentiality and information access and disclosure that are discussed below, can have other important benefits. For example, the laws in California, Maine, and Texas define the purpose of an EA-FRT, thus relieving team members from having to make decisions about the role of their team. Also, a law may provide suggestions or even requirements for team members. The California and Texas laws offer suggestions for possible members, while the Maine law mandates that the team will have 13 members and indicates who they will be.

Laws may also address other issues that will help a team work through its developmental stage. These issues might include selection and role of officers, terms of membership, and frequency of meetings. Authorizing laws may allow or require teams to prepare periodic reports and indicate to whom those reports may or must be disseminated. They may designate a governmental entity that is responsible for oversight of the EA-FRT. The Texas law, which is a generic FRT law, even creates a new reporting requirement. It requires any person, including a health care provider, who knows that a death resulted or may have resulted from suicide, family violence, or abuse to report that death immediately to the medical examiner's office in the county where the death occurred or, if there is no medical examiner, to a justice of peace in that county. Tex. Health & Safety Code Ann. §§ 672.012 (West 2003). After receiving such a

report, the medical examiner's office or justice of peace may conduct an inquest and must report the death to either the fatality review team or to the team's county oversight entity. Tex. Health & Safety Code Ann. §§ 672.013 (West 2003).

There have been situations, however, when authorizing laws have proved to be too narrow or proscriptive in certain aspects. One example is Maine's statute, which limited the team members to a certain number and to certain disciplines and prevented the team from expanding its membership to include representatives of important professions. Authorizing laws might also limit the range of cases that a team could examine, precluding it from reviewing important issues. This means that it is important to enact an authorizing law that gives an EA-FRT the authority and resources it needs to do its job, yet is flexible enough to allow the team to determine and include what members it needs and review the cases it deems to be most relevant.

(3) Confidentiality: Enabling Team Members to Share and Access the Information Needed to Conduct Reviews

An EA-FRT cannot fulfill its purpose unless its members can share and access information about the decedent, the suspected perpetrator, or system responses that would otherwise be deemed confidential. Without the fullest possible picture of the circumstances surrounding the death that is under review, a team cannot accurately analyze the systemic response and develop appropriate recommendations. This issue is very complex because, as discussed in an excellent article titled "Confidentiality and Fatality Review," there is a "web of law" governing confidentiality that includes federal laws and state laws and is supplemented by professional ethical codes and personnel ethical codes. That article is provided in [Appendix E](#), with the permission of its author, Robin Hassler Thompson (a member of the project's advisory committee) and the National Domestic Violence Fatality Review Initiative, which published the article in its *Fatality Review Bulletin*.

Each team has developed a confidentiality form and has implemented other practices to ensure that team members, consultants, and guests understand the importance of protecting confidential information and team deliberations. Those practices include having members sign the form when they join the team or at each meeting, having consultants and visitors sign the form, limiting distribution of case-related documents, collecting those documents after each meeting, and destroying extra copies of the documents. The "Team Confidentiality Practices Chart" provided at [Appendix F](#) indicates the practices of each team. The confidentiality forms used by the teams are also included in [Appendix F](#).

It is beyond the scope of this project and manual to analyze and provide legal advice about the many federal and state laws that comprise the "web of law" that Thompson writes of and determine how they will specifically impact an EA-FRT. That is a task for an attorney general of a state or the counsel of a jurisdiction that wishes to establish an EA-FRT. Instead, this manual will raise issues and discuss the approaches taken by the legislatures in California, Maine, and Texas. Copies of their laws are provided in [Appendix G](#).

California's law (Cal. Penal Code §§ 11174.4 *et seq.* (West 2003)) allows team members to share information about the decedent that would otherwise be deemed confidential, privileged, or prohibited from disclosure. The law, however, does not require any individual or agency to disclose that information. The law specifies the types of information that may be disclosed, which includes medical information, mental

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health information, criminal history information, information provided to probation officers in the course of their duties, records relating to in-home supportive services, and information about elder abuse reports and investigations except for the identification of the individual who reported the suspected abuse of the decedent.

Maine's law (Me. Rev. Stat. Ann. tit. 5, § 200-H (West 2003)) gives team members the authority to access information and records, notwithstanding any other provision of law, by making an oral or written request to any person who possesses information or records needed by the team. It also protects the individuals who are disclosing the information to the team from civil or criminal liability for doing so.

Texas's law (Tex. Health & Safety Code Ann. §§ 672.001 *et seq.* (West 2003)) authorizes the team to request certain types of information pertaining to the decedent; this information may include medical, dental, and mental health records and state or local government agency records including birth certificates, investigative data from law enforcement or the medical examiner, parole and probation information and records, and APS information and records. Team members are prohibited, however, from obtaining original or copies of medical or mental health records pertaining to the decedent's family, caregiver, guardian, or the suspected perpetrator. The team can have access to information about those individuals if the information was obtained during the course of an investigation by a state or local government agency. In addition to a copy of Texas's FRT law, [Appendix G](#) provides a copy of a synopsis of the law that the Harris County (Houston) Domestic Violence Coordinating Council Adult Violent Death Review developed in order to make it easier for team members to understand and follow the law. Other teams may want to develop something similar.

Several of the eight teams have indicated that it would be useful to have the legal authority to subpoena records related to a death they are reviewing. They reported that they have particularly had problems accessing information from banks. States may want to consider these problems when drafting new laws or amendments pertaining to the authority of an EA-FRT.

(a) Impact of the Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) poses new challenges to EA-FRT as they face issues of confidentiality and access to information and records that are otherwise deemed confidential. For purposes of this discussion, the relevant goal of HIPAA and its privacy regulations (45 C.F.R. pts. 160 and 164) is the security and privacy of patient's health data. As was the case with the earlier section on sharing of and access to information, it is beyond the scope of this project and manual to analyze and provide legal advice about the implications of HIPAA on the work of an EA-FRT. Suffice it to say that HIPAA raises significant issues that must be addressed by each state and, probably, local jurisdictions that have or want to establish a team. States are working to determine whether APS and other agencies are a "covered entity" that must comply with HIPAA's provisions limiting the disclosure of "personal health information" (PHI). So far, the conclusions reached about APS vary, often depending on the legal authority and role of the APS program and whether it is part of a larger government agency that has other programs that fit the definition of a "covered entity." But the analysis of whether APS or any other agency is a covered entity is only the first of several complex issues that must be considered. Additionally, there are exceptions provided in HIPAA enabling covered entities to disclose PHI about a person reasonably believed to be a victim of abuse, neglect, or domestic violence to a protective services agency if disclosure is authorized by a legal requirement, permission, or a statute or regulation. There is an explicit exception for "reporting of disease or injury, child abuse, birth, or death, or for the conduct of

public health surveillance, investigation, or intervention.” While this might cover reports of death that are related to elder abuse, it is uncertain how this exception will apply to the work of an EA-FRT. The complexity of these issues is illustrated in a paper titled “*The Impact of HIPAA on Child Abuse and Neglect Cases*” by Howard Davidson, director of the American Bar Association Center on Children and the Law. The paper may be downloaded from the National Center on Child Fatality Review Web site at http://www.ican-ncfr.org/library/HIPAA_ABA_Analysis.doc. Accessed May 3, 2005.

(4) Confidentiality: Protecting Confidential Information and Team Deliberations and Records from Voluntary and Involuntary Disclosure to Third Parties

An EA-FRT can no more function effectively if it voluntarily or involuntarily discloses confidential information or team deliberations and records than it can if it is unable to access confidential information. Legal authorization to share confidential information will be meaningless and disregarded if EA-FRT members cannot trust their fellow team members to maintain the confidentiality of information shared with the team or if the team’s deliberations and records can be subpoenaed or discovered in a legal proceeding brought by a third party. The team will lack credibility if it is perceived by member agencies or outsiders as a tool for law enforcement and regulatory agencies, prosecutors, or civil lawyers to gather otherwise confidential information about the circumstances surrounding an older person’s death. The problems resulting from voluntary or involuntary disclosure of confidential information used by the team or the team’s own deliberations about that information have as much potential to destroy a team as does playing the “blame and shame game” (see “Creating a Culture of Avoiding ‘Blame and Shame,’” [section X\(F\)](#)). Once again, the approaches taken by the legislatures in California, Maine, and Texas will be used to illustrate how those states have attempted to prevent these problems. The statutes from those three states may be found in [Appendix G](#).

California’s law provides that information shared by other members of a team is confidential. It also states that oral or written communications of team members and documents shared within or produced by the team are confidential and not subject to disclosure or discovery by a third party. Likewise, the law protects from disclosure or discovery any oral or written communications or documents that were provided by a third party to the EA-FRT or shared between a third party and the team.

Maine’s law states that the proceedings and records of the EA-FRT are protected from subpoena, discovery, or introduction into evidence in a civil or criminal action.

Texas’s law contains several pertinent provisions. It prohibits team members from disclosing confidential information; it also declares that disclosure of confidential information is a Class A misdemeanor. It prohibits team members from disclosing team deliberations and actions unless necessary to carry out the team’s purpose and duties. It states that the information and records acquired by the team are confidential and exempt from disclosure under the state’s open records law unless necessary to carry out a team’s purpose and duties. The law says that team meetings are not subject to the open meetings law, but the team may ask a non-member who has information about a fatality to attend a meeting.

(a) *Releasing Periodic Reports or Stand-alone Recommendations*

The release of periodic reports or stand-alone recommendations by a team presents a different situation. Each of the laws clearly states in some fashion that the team has the legal authority to issue periodic reports or stand-alone recommendations. The California law simply provides that the team may

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disclose its recommendations upon completion of a review at the discretion of a majority of the team members. In Maine, the attorney general is required to disclose the team's recommendations if the team requests disclosure. In Texas, teams are required to submit a report in every even-numbered year to the Texas Department of Family and Protective Services, formerly known as the Department of Protective and Regulatory Services, and the department is required to make those reports available to the public. The law also provides that a team's report or statistical compilation of data reports is a public record that is subject to the state's open records law. The Maine team issued its first report in June 2004, the Houston team did the same in September 2004, and the Sacramento team released its first report in January 2005. None of the other EA-FRT had developed a report or stand-alone recommendations at the time this manual was written. None of those teams experienced a problem with a higher-level government official quashing or interfering with the issuance of the report or recommendations. The statutory language in Maine and Texas would appear to anticipate and prevent this possibility. Other states may want to consider adopting comparable provisions. For additional information about reports and recommendations, see "Developing Periodic Reports or Stand-alone Recommendations," [section XIII](#). For specific statutory language, see [Appendix G](#).

XI. Conducting Reviews

Decisions about the types of cases to review and the processes for conducting those reviews are among the most important and challenging that an EA-FRT will make. The range and difficulty of these decisions illuminates the most significant differences between EA-FRT and domestic violence or child abuse FRT: (1) many more deaths occur among the elderly than among younger adults or children, so there are many more potential cases to review, (2) the expectation that older persons will die means that their deaths are rarely questioned, (3) there is almost a complete lack of science to determine whether an older person's death was caused by elder abuse, and (4) elder abuse can occur in a broader range of situations than either domestic violence or child abuse.

(A) Open vs. Closed Cases

Teams that are determining whether investigation or prosecution of a case is warranted will obviously be reviewing open criminal cases. But teams considering system change must decide whether they want to review open cases, closed cases, or both.

There are two benefits to reviewing only closed cases. First, the possibility that the team will interfere with or affect an ongoing criminal investigation or prosecution is avoided. Second, it decreases the chance that the team's members or records of its deliberations will be subpoenaed or otherwise sought for use in the criminal proceeding.

The "Team Open or Closed Cases Chart" provided at [Appendix H](#) indicates for each of the eight teams whether it is reviewing open or closed cases.

(B) Cases in Which the Alleged Perpetrator Has Died

Some domestic violence FRT take an even more narrow approach and only review homicide-suicide cases or other cases in which the alleged perpetrator has died. Other domestic violence teams have opted to review those types of cases in the early stages of the team's existence and then expanded the range of cases they reviewed as they grew more comfortable with the process. The rationale for these decisions is that a dead alleged perpetrator can neither be prosecuted nor take legal action against a team.

(C) Types of Deaths Reviewed

As noted earlier, the fact that older people are more likely to die than younger people and that their deaths are rarely questioned, combined with the lack of scientific research about elder abuse, means that it is very difficult to determine that someone died due to elder abuse. If reviews are limited only to cases in which elder abuse was known to be the cause of death, there may be very few cases to review. But if a team decides to consider cases in which the deceased person was known to be a victim of some form of elder abuse or in which elder abuse was suspected as the cause of death, the teams' experiences indicate that there will not be any shortage of cases to review.

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Teams must also decide whether they want to review deaths occurring in domestic settings, institutional settings, or both. The “Team Types of Abuse Chart” provided at [Appendix I](#) indicates the decisions made by the eight EA-FRT.

(D) Elder Abuse or Adult Abuse Deaths

Some of the programs that are likely to participate on an EA-FRT, particularly the APS and Long-term Care Ombudsman programs, may or do serve adults age 18 or older who meet certain criteria in addition to older persons. As a result, those programs may want to review deaths caused by or related to adult abuse and not limit reviews to elder abuse. To illustrate, the Houston EA-FRT decided to expand its purview from elder abuse to adult abuse at the behest of APS, which investigates allegations that vulnerable or dependent adults have been abused. The “Team Elder or Adult Abuse Chart,” provided at [Appendix J](#), indicates whether the teams are reviewing cases of elder abuse, adult abuse, or both.

Review of adult abuse deaths is a worthy undertaking, but a team that does that is not an EA-FRT and may have to do some things differently than an EA-FRT might do. For example, there would probably be additional agencies to include on the team.

(E) Deciding Which Deaths to Review

Once a team determines the types of cases it will review, it faces decisions about selecting cases from within those categories. How will appropriate cases for review be identified? Who will identify cases for the team to review?

Most of the teams have indicated that they would like to develop criteria for case selection. But none of the teams—all of which are young and lack experience reviewing cases—have developed those criteria yet. Nonetheless, there are valuable lessons to be learned from their experiences to date.

Each of the demonstration projects expressed surprise at how long it took to work through the initial steps of team development. They indicated that some members expressed frustration that the team was not yet reviewing cases. To alleviate this frustration, between the fifth and eighth month of its existence, each team began reviewing long-closed cases that had disturbed one or more team members for some time. These reviews had a second benefit as they enabled team members to assess whether the procedures and protocols they were developing actually worked in practice.

The teams differ in their answer to the question of who will identify cases for review. For example, the Houston and Pulaski County teams only review cases that are brought to the table by the medical examiner and coroner, respectively. The Maine and Orange County teams, on the other hand, allow any member to recommend a case for review. In Sacramento, the team briefly reviews all deaths of APS clients and determines which deserve in-depth review.

(F) Process for Reviewing Cases

An EA-FRT must establish a process for conducting case reviews and follow it consistently in order for its work to have credibility. If the process does not work, the team should formally revisit and revise its policies and protocols, rather than just stop following them. Developing a process for case reviews necessitates making decisions about the following issues.

- Will members be expected to review their own agency's records in order to learn about and discuss their agency's role in the victim's life? Multiple systems may be involved with an elder abuse victim prior to the victim's death. Full analysis of the systems' involvement and the ways in which the involved systems related (or did not relate) to each other and the victim is the richest source for developing recommendations. But teams can and do function even when each system has not determined its own level of involvement through internal review of its own case files. There may be legal or policy reasons to limit the internal review by every participating system. Some of the teams have developed case review worksheets for use by an agency during its internal review process. Those worksheets are provided in [Appendix K](#).
- Will documents related to the case be disseminated prior to the meeting? If so, how? If documents are not disseminated before the meeting, will they be shared at the meeting? If so, how (e.g., one copy for each participant or one set of copies that is circulated among the participants)? Will shared documents be collected at the end of the meeting? If so, what precautions should be taken to ensure that all copies are retrieved? Will duplicate copies be destroyed? If so, by whom and when?

The answers to these questions will be dependent on, or at least influenced by, state law(s) and regulations, agency procedures, and professional codes of ethics. As long as team, agency, and/or client confidentiality is protected, there is no right or wrong way to approach the issue of document dissemination. Team members need to be sensitive to the problems associated with using electronic communications such as e-mail or fax machines. The "Team Confidentiality Practices Chart," provided at [Appendix F\(1\)](#), indicates what each of the eight teams does about document dissemination, collection, and destruction.

- Who will present the case? In what level of detail and for how long? Generally the person who brings the case to the table will present it to the team and then either that member or the chairperson will facilitate the team's discussion. The length and level of detail of the case presentation may depend on whether each agency has conducted an internal review, whether case documents are disseminated and when dissemination occurred, and the amount of time that the team wants to spend reviewing each case.
- How much time will the team spend reviewing each case? Will reviews be completed at one meeting or will they occur over the course of multiple meetings? There are no right answers to these questions. Some FRT examine one case per meeting. Others review a case over the course of two or more meetings. Many child abuse teams review multiple cases at each meeting. Some cases will take longer to review than others.

XI. Conducting Reviews

A related issue is whether the team will allow decisions to be revisited by members who were absent from the meeting at which the cases were discussed. One team faced that problem after reviewing its first case. At the next meeting, the members who had been absent for that review began to discuss the case during the team's review of the previous meeting's minutes. The team decided that cases should not be revisited at a subsequent meeting unless a member believed that the meeting minutes did not accurately reflect the earlier discussion.

- How will teams make decisions? The process for making decisions about cases does not necessarily have to be the same as the process for making decisions about members, policies and protocols, etc. Will team members vote or will they attempt to reach consensus? If they vote, must there be a quorum present at the meeting? Will the majority rule or must a higher percentage of members agree? At the time of the visits to the demonstration projects, most of the teams had adopted (although not always consciously) a consensus approach.
- Will meeting minutes be kept? If so, with what level of detail? Some teams keep no minutes, others keep detailed minutes, and still others keep minutes that indicate action items and notices of the next meeting. To answer these questions, a team should consider its need to maintain confidentiality and prevent disclosure of team information, its need to keep members informed of team activities and decisions, and its need to develop recommendations and a periodic report.

(G) Tools for Reviewing Cases

Teams may find it useful to develop a case chronology to guide review of the case and to help identify interventions or missed opportunities for intervention that may signal potential recommendations for system change. A chronology does not need to be a complex document. For example, the Hennepin County, Minnesota, domestic violence FRT uses a three-column chart with the headers of “date, agency, and event” to set forth the events that occurred in a case. In that county, a law clerk at one of the member agencies reviews all available documents and prepares the chronology for team members, who read the chronology before the case review meeting and usually review their own agency's documents in order to be prepared to answer questions or fill in missing information related to their agency's role.

That methodology would not work, obviously, for a team that does not share its documents prior to a meeting or at all. Such a team could still prepare a chronology by having team members develop a chronology of the involvement of their organization or discipline with the person whose death is being reviewed and then combining those charts into one.

XII. Collecting Data

One of the most important benefits of an EA-FRT is its ability to collect critical data about victims that may go far in helping to identify general risk factors and specific lethality factors for elder abuse. Identification of risk and lethality factors would help legislators, policymakers, program administrators, and front-line workers make decisions about program resources, program design, intervention approaches, and responses to individual victims.

Six of the eight EA-FRT have developed a data collection form. There are many commonalities among the forms, but also significant differences. The forms elicit an extensive range of information about:

- Victims, including personal, medical, and legal/financial information and contacts with the social services, health care, and criminal justice systems and with other pertinent agencies
- Perpetrators, including personal information and contacts with the criminal justice system
- Risk Factors, including the relationship between the victim and perpetrator, presence of weapons and history of other violence and abuse, and history of substance abuse
- Circumstances of the victim's death or the incident related to the victim's death
- Process of investigating the victim's death
- Case review process used by the team
- Recommendations developed by the team.

To benefit teams that wish to create a data collection form or revise an existing form, [Appendix L](#) provides the six data collection forms, a series of charts prepared by project staff to categorize the contents of those forms, and a memorandum explaining the contents of those charts and how they were developed.

The data collected by the EA-FRT can be a rich resource for researchers. Some of the teams are already working with researchers who are analyzing the data gathered by the EA-FRT.

XIII. Developing Periodic Reports or Stand-alone Recommendations

Fatality review teams generally produce reports containing a description of the team's work and its recommendations on a periodic basis. These reports may be disseminated to state legislators, agency leadership and other policymakers, other relevant organizations, and the media. Publicity surrounding the release of a team's report provides an excellent opportunity to educate the public and other professionals about the problem of elder abuse and to elicit support for the team's recommendations.

The Maine EA-FRT released its first report in June 2004. A copy is provided at [Appendix M](#) for reference purposes. The Houston team released its first report in September 2004, as part of the Houston/Harris County Adult Violent Death Review Team 2004 report; it may be found online at <http://www.hd.co.harris.tx.us/dv/DVReports/AVDRT%202004%20Report.pdf>. Accessed May 3, 2005. The Sacramento team issued its first report in January 2005; it can be accessed at <http://www.sacdhhs.com/CMS/download/pdfs/HHS/EDRT%20Annual%20Report%20Final%20January%202005.pdf>. Accessed May 3, 2005. Additionally, several domestic violence and child abuse FRT reports are available on the Internet. Domestic violence team reports may be found on the Violence Against Women Online Resources Web site at <http://www.vaw.umn.edu/> by using the search function to find documents related to fatality or death review. Child fatality review team reports may be accessed on the Web site of the National Center on Child Fatality Review, <http://www.ican-ncfr.org>.

Due to the nature of fatality review work, there are issues related to the release of team reports or stand-alone recommendations that should be examined before any decision to release information is made. A team should consider the possibility that its recommendations may be politically sensitive and may face resistance from agencies that participate on the team, policymakers, the long-term care industry, or other groups that serve older people, or even the public. Teams that are sponsored by a government agency should discuss the risk that a high-level administrator may try to block release of the report if it calls for controversial, unpopular, or expensive changes to agency programs. Ideally, these issues will be discussed early in the team's development and decisions will be reflected in the team's MOU, policies, procedures, or protocols.

If the team decides to issue a report or stand-alone recommendations, members should designate one or two members to serve as the team's spokesperson, agreeing that any media or other inquiries to other members will be referred to the spokesperson(s). Designation of one or two members as spokespersons is useful for responding to any media or other inquiries about the team, even before it issues a report or stand-alone recommendations.

XIV. Sustaining the Team

(A) Introduction

All of the EA-FRT are too new to provide any guidance on what works to sustain a team over the long term. But lessons learned from child abuse FRT and domestic violence FRT indicate that the keys to surviving, thriving FRT are:

- Maintaining a culture of avoiding “blame and shame”
- Protecting confidential information and team deliberations and records from voluntary and involuntary disclosure outside the team
- Supporting the team members who do this difficult work, so that they do not experience vicarious traumatization
- Determining the costs of and funding the team
- Seeing that the team’s work has made a difference in the systems’ ability to respond to elder abuse victims.

The first two keys have been discussed previously. The third and fourth keys are discussed below. The fifth is self-explanatory.

(B) Supporting Team Members and Avoiding Vicarious Traumatization

In her materials provided at [Appendix N](#), Trudy Gregorie, a nationally recognized victim advocate (and advocate for providers of victim services) writes that participation on an EA-FRT may pose significant emotional and psychological challenges. She describes how the attention paid to deaths, many of which were terrible and preventable, can cause EA-FRT members to “experience grief and rage, become numb emotionally, lose focus and energy, and burn out,” possibly causing them to leave the team or their job. She notes that these reactions are called “vicarious traumatization,” “compassion fatigue,” or “secondary traumatic stress,” and states that these are terms that describe “a process whereby trauma counselors and other helpers who are exposed to trauma or its effects experience disruptive and painful psycho-social effects [that] may persist and intensify over time.” The effects of vicarious traumatization have been compared to the effects of post-traumatic stress disorder. How can team members protect themselves from or deal with vicarious traumatization? Is the use of “black humor” by team members appropriate?

The materials provided at [Appendix N](#) provide information on the warning signs of vicarious traumatization and suggest ways in which individuals may prevent or respond to the problem. These excellent materials also contain references to resource books and Web sites, and should be shared with team members.

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But the materials do not suggest ways by which teams, as an entity, can deal with the circumstances that may lead members to experience vicarious traumatization. EA-FRT members, however, have shared some ideas:

- Some amount of humor, including “black humor,” can be a good release and an important coping skill for team members. Its use can also indicate a strong level of comfort and trust among team members. But the use of humor may seem inappropriate or insensitive to some team members, particularly those who may join a team after it has existed for a while, or guests.
- Emotional reactions to case presentations, such as grimaces or groans, may be useful to other team members who use the reaction of other team members to judge how bad a case is. But such reactions may also be viewed as inappropriate. Even worse, they may be misinterpreted as being reactions about an agency’s response to the victim, rather than about what happened to the victim. Team members suggested that it is important for members to discuss whether emotional reactions are appropriate. If the team decides that they are, then members need to be careful to react only to the experience of the victim, rather than to the response of the agency to the victim. As an alternative, team members suggested that other times and means of reacting to cases that do not jeopardize the cohesiveness of the team should be provided.
- An alternative process for enabling emotional reactions to cases may be a debriefing process at a designated time. For example, a team could decide that emotional reactions during case presentations and discussions are inappropriate, but set aside a time period at the end of the discussion or each meeting to allow members to share and examine their emotional reactions to the victim’s situation.
- It is critical for team members to discuss the affect of vicarious traumatization, in general, and the use of humor and emotional reactions to case presentations, in particular. To build a strong EA-FRT, members must have the opportunity to share their views about sensitive and appropriate reactions to the cases under discussion and to reach consensus about these practices.
- As new members join the team, whether they are new representatives from an agency that has been on the team or representatives from an agency new to the team, they need to be advised about the results of earlier discussions about these issues. Additionally, earlier decisions may need to be re-visited, so that new members are provided with an opportunity to share their views about the use of humor and emotional reactions to case presentations.

(C) Determining the Costs of and Funding the Team

Fatality review teams can and do operate with little to no actual funding, relying instead on donations of time and support from members. But the work of an EA-FRT has a variety of costs associated with it. One cost is the time that already-overworked professionals spend reviewing cases and attending meetings. There may be costs for travel to and meals at meetings. Other costs are associated with coordination efforts, copying and disseminating cases and other materials, and producing and disseminating recommendations and/or an annual report. Members of new teams may want to travel in order to meet with and observe existing teams. Attendance at pertinent training programs may be useful. Teams may want to buy computers or other equipment for use when coordinating team events and at team meetings. Teams may

need to buy supplies or even some research (for example, to determine the number of elder deaths in the team's jurisdiction and how many of those deaths were of former or present APS clients). How can a team, which is usually so reliant on voluntary contributions of time from its members, determine its actual costs? How can agencies that comprise an EA-FRT, most, if not all, of which are already under-funded and short-staffed, meet the financial costs of the team?

Each of the four demonstration projects received \$5,000 from the ABA-COLA and was allowed to use that money as the team saw fit. Each team reported that the funding was useful, but it did not cover all of the team's costs or fulfill all of its needs. The functions for which funding is especially needed include coordinating the team, producing and disseminating team recommendations or an annual report, and implementing the team's recommendations. This section will examine why those functions need to be funded and then provide some suggestions for obtaining such funds. This section will also discuss the importance of collecting information about and placing a value on the time of team members and other in-kind contributions made by the agencies they represent.

The Houston team applied its seed money toward a coordinator, whose role was to organize and notify members of the team meetings; take, prepare, and disseminate minutes; and copy and collect materials. The other teams used their money for a variety of things, including a laptop computer for use at team meetings, letterhead and other supplies, and travel to observe other fatality review teams. Those three teams and the other teams that the project did not support subsequently expressed the need for a team coordinator. Each said that a part-time person would suffice. Several teams are considering the option of sharing the costs of a team coordinator with other multidisciplinary teams or FRT in their jurisdiction. The teams recognize, however, that such an arrangement may raise management issues related to supervising the coordinator, allocating time among the various teams, and paying employee benefits for the coordinator.

An EA-FRT may need funding to produce and distribute its periodic report or stand-alone recommendations. Team reports are discussed in detail in "Developing Periodic Reports or Stand-alone Recommendations," [section XIII](#), but their costs are the focus of this paragraph. As a team's recommendations relate to system change, it is likely that the team will want to disseminate its report to legislators, agency heads, other policy makers, advocacy groups, and the media. It is important, therefore, that reports and stand-alone recommendations be well written and professional in appearance. Teams may need financial resources to pay someone to write or edit the report and/or design its layout. Teams also may require financial resources in order to print and distribute the report.

Several teams have reported that they need funds to implement their recommendations for system change. It is likely that many of a team's recommendations, such as those relating to enhancing public awareness, training, developing or improving services, or conducting more autopsies when older people die under certain circumstances, will have associated costs.

Currently, the resources of funding agencies (governmental and non-governmental) are stretched very thin. Compounding the problem is the fact that elder abuse is not perceived as a high priority problem by very many funding agencies. It seems likely that both of those circumstances will change over time. In the meanwhile, some potential funding options do exist.

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- The federal Victims of Crime Act (VOCA), which is administered by the Office for Victims of Crime (OVC), an entity of the U.S. Department of Justice, Office for Justice Programs, is a possible source of funding for EA-FRT activities, although restrictions on VOCA funds make it more likely that these funds might support implementation of some team recommendations rather than team operations.

The VOCA created the Crime Victims Fund to support a wide array of state and local programs that assist crime victims and compensate victims for financial losses that they experience due to the crime. The Fund is not tax supported; its assets are derived from “fines, penalty assessments, and bond forfeitures collected from convicted federal offenders.” The OVC supports “state compensation and assistance services for victims and survivors of domestic violence, sexual assault, child abuse, drunk driving, homicide, and other crimes.” “Funding History.” U.S. Department of Justice’s Office for Victims of Crime, http://www.ojp.usdoj.gov/ovc/publications/factshts/companassist/fs_000306.html#1 Accessed June 3, 2004.

A majority of the monies from the Fund are allocated to the states (including the District of Columbia and territories) and can only be used for programs providing direct services or compensation to crime victims (some of the Fund is used for national scope demonstration and technical assistance projects, such as the ABA-COLA project that has resulted in this replication manual). Specific information about how the Fund is allocated can be found in OVC’s fact sheet titled “Victims of Crime Act Crime Victim’s Fund,” which may be found online at <http://www.ojp.usdoj.gov/ovc/publications/factshts/vocacvf/fs000281.pdf> Accessed June 9, 2005. Direct services may include but are not limited to crisis intervention, emergency shelter, emergency transportation, counseling, and criminal justice advocacy. The VOCA Fund cannot be used for crime prevention activities. OVC provides guidelines to the States for the use of VOCA funds, but State agencies may choose to support a more narrow range of activities. States and territories are required to give priority to programs serving victims of domestic violence, sexual assault, and child abuse. Additional funds must be set aside for underserved victims, such as survivors of homicide victims and victims of drunk drivers. OVC does include older persons in its definition of “underserved victims.”

These restrictions on the Fund may limit a team’s ability to use Fund monies to develop and operate an EA-FRT. It may, however, be possible to obtain Fund monies to support actions that would implement a team’s recommendations to create or enhance direct services for elder abuse victims or for training of certain disciplines about services for elder abuse victims. For example, if an EA-FRT determined that elder abuse victims were dying because of a lack of housing options other than remaining at home with the abuser or going to a nursing home, it might seek victim assistance program funding for an emergency shelter. It would be worthwhile for existing or developing teams to reach out to their State victim assistance program administrator, as early as possible, to educate the victim assistance program administrator about the team’s goal and activities, stressing that the ultimate goal of the EA-FRT is to change systems in order to improve the delivery of services to victims of elder abuse. An effort to inform the State victim assistance program administrator about the goal of the EA-FRT can only be enhanced by the presence of a victim services provider on the team (see [section X\(E\)\(1\)](#) for information about including a victim services provider on the team).

The OVC Web site provides a wealth of information about the activities it supports. It also contains a directory of state victim assistance programs; that URL is http://www.ojp.usdoj.gov/ovc/help/voca_links.htm. Accessed May 2, 2005.

- Another possible source of funding for an EA-FRT is the Edward Byrne Memorial Justice Assistance Grant Program (JAG Program), which was enacted in 2004 and combined the Edward Byrne Memorial State and Local Law Enforcement Assistance Grant Program and the Local Law Enforcement Block Grant Program. The Bureau of Justice Assistance (BJA), another entity of the U.S. Department of Justice, Office of Justice Programs, administers the JAG Program. BJA awards JAG Program funds to states and local governments to “support a broad range of activities to prevent and control crime and to improve the criminal justice system” in the following purpose areas:
 - Law enforcement programs
 - Prosecution and court programs
 - Prevention and education programs
 - Corrections and community corrections programs
 - Drug treatment programs
 - Planning, evaluation, and technology improvement programs.

This and additional information about the JAG Program may be found on the BJA Web site at <http://www.ojp.usdoj.gov/BJA/grant/jag.html>. Accessed on April 29, 2005.

- The Violence Against Women Act (VAWA) programs administered by the Office on Violence Against Women (OVW) at the U.S. Department of Justice may be a source of funding, particularly for implementing some of the recommendations made by an EA-FRT. There are two possible ways in which VAWA funding might be obtained.

The OVW uses VAWA funds to make formula grants to states and territories under the STOP (Services, Training, Officers, Prosecutors) Violence Against Women Formula Grant Program. The state dollars are administered by a state agency and are used to “promote(s) a coordinated, multidisciplinary approach to improving the criminal justice system’s response to violence crimes against women” by encouraging “the development and strengthening of effective law enforcement and prosecution strategies to address violent crimes against women and the development and strengthening of victim services in cases involving violent crimes against women,” http://www.ojp.usdoj.gov/vawo/stop_grant_desc.htm, accessed on April 29, 2005. One of the program priorities is the “support (of) safety audits and fatality review teams at the state and local levels to develop and implement more effective police, court, and prosecutor policies, protocols, and orders,” http://www.ojp.usdoj.gov/vawo/stop_grant_desc.htm, accessed on April 29, 2005. A list of the state agencies that administer STOP Violence Against Women Formula Grant Program funds may be found online at <http://www.ojp.usdoj.gov/state.htm>, accessed on April 29, 2005. It is important to recognize that an EA-FRT may face two challenges if it seeks STOP program funds to support its work. First, not all elder abuse deaths are caused by or related to domestic violence and sexual assault. Second, VAWA funds are already supporting domestic violence FRT in some communities, so an attempt to gain funding may place an EA-FRT in competition with an existing domestic violence FRT.

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The second funding possibility under VAWA is much more limited in terms of the dollars available, but at the same time it is more closely related to the work of an EA-FRT. It is the Training Grants to Stop Abuse and Sexual Assault Against Older Individuals or Individuals with Disabilities Program that is administered by OVW. As of the date of this writing, this program is currently being revamped and the information on the OVW Web site is no longer accurate. Programs interested in funding through this program should monitor the OVW Web site, <http://www.ojp.usdoj.gov/vawo/about.htm>. Accessed on April 29, 2005.

- The federal Older Americans Act provides some funding through State Units on Aging (including the District of Columbia and territories) for “activities to develop, strengthen, and carry out programs for the prevention and treatment of elder abuse, neglect, and exploitation (including financial exploitation)” 42 U.S.C. § 3058i. http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse_usc&docid=Cite:+42USC3058i. Accessed May 2, 2005. The statute indicates that these activities may include:
 1. Public education and outreach to identify and prevent elder abuse, neglect, and exploitation
 2. Coordinating the services provided by area agencies on aging with services instituted under the state APS program, state and local law enforcement systems, and courts
 3. Promoting the development of information and data systems, including elder abuse reporting systems, to quantify the extent of elder abuse, neglect, and exploitation in the state
 4. Conducting analyses of state information concerning elder abuse, neglect, and exploitation and identifying unmet service, enforcement, or intervention needs
 5. Conducting training for individuals, including caregivers, professionals, and paraprofessionals on the identification, prevention, and treatment of elder abuse, neglect, and exploitation
 6. Providing technical assistance to programs that provide or have the potential to provide services for victims of elder abuse, neglect, and exploitation and for family members of the victims
 7. Conducting special and on-going training for individuals who serve victims of elder abuse, neglect, and exploitation, on the topics of self-determination, individual rights, state and federal requirements concerning confidentiality, and other topics determined by a state agency to be appropriate
 8. Promoting the development of an elder abuse, neglect, and exploitation system consistent with requirements set forth in the Older Americans Act.

The fourth activity and, possibly, the sixth and the eighth seem to be potential sources of funds for conducting an EA-FRT. The first, second, third, fifth, seventh, and, again, the sixth activities seem to have promise for supporting actions to implement a team’s recommendations.

In some states, the elder abuse program dollars are retained at the state level and used to support statewide activities, such as program coordination and training. In other states, the dollars are allocated to the area agencies on aging and used for local activities. Teams that are interested in pursuing these funds should learn more about how their state has allocated and used this money in the past. This information can be obtained from the director of the state's office on aging. A directory of state office on aging directors is available on the Web site of the National Association of State Units on Aging at http://www.nasua.org/SUA_members.cfm.

- An appropriation for an EA-FRT by a state legislature or the governing authority of a local jurisdiction should be considered. If a team can demonstrate that monies spent on its work create new services or efficiencies in existing services that will save the state or county money, success will be more likely.
- Foundations that focus their initiatives on a particular state or community may be a logical funding source for a state or local EA-FRT. The Foundation Center's Web site (<http://fdncenter.org/>) provides a lot of useful information, some of it free. Searching the Internet for information about foundations in your state or community is also likely to be fruitful.
- Imposing small fees or surcharges on services has become a popular way of raising funds for special programs or services. Such a fee or surcharge could be used to support the work or recommendations of an EA-FRT. Team members suggested the possibility of establishing surcharges for death certificates or cremating bodies. Another suggestion was to look at whether a jurisdiction required in-person filing of any documents and, if so, to propose a fee for the privilege of instead filing those documents by fax that would be devoted to supporting the EA-FRT.
- Donated in-kind services may help an EA-FRT conduct some of its work, particularly in relation to producing a periodic report. For example, college internship programs might provide students who could design a team database or Web site, or help write, edit, or design a report in exchange for class credit and/or work experience. Printing companies, graphic designers, or Web site or software designers might be willing to donate their services in exchange for free publicity.

Regardless of the funding source that an EA-FRT decides to pursue, it will be important for it to make every attempt to determine the actual costs of administering the team. These costs include the time that team members spend participating in team meetings, reviewing cases, and writing recommendations and reports. Other expenses associated with team participation, such as photocopying and mailing documents or transportation costs, should be calculated even if the member or the member's employer contributes those expenses. The value of other in-kind contributions, such as those discussed previously, should also be determined. It is critical to gather and calculate cost data so that it is available when a funding proposal is written. Even if a funding proposal does not seek resources to pay team members for their time, the value of their time can be used to leverage monies from a funding agency or to meet a requirement for in-kind match.

XV. Resources

(A) Resources on Elder Abuse Fatality Review Teams

(1) American Bar Association Commission on Law and Aging

Contact Information:

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ABA-COLA Web site: <http://www.abanet.org/aging>

The American Bar Association Commission on Law and Aging will continue to provide technical assistance and training about EA-FRT upon request. Staff created and administered an EA-FRT listserv as part of the OVC project and will continue to do so after the project concludes. The listserv welcomes members who are members of EA-FRT or who work for organizations that are seriously interested in establishing an EA-FRT. For additional information about EA-FRT or the listserv, contact Lori Stiegel as shown above.

(2) State and Local Elder Abuse Fatality Review Teams

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XV. Resources

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(B) Resources on Domestic Violence Fatality Review and Child Fatality Review

The federal government funds national training and technical assistance centers on the issues of domestic violence fatality review and child fatality review. The Web sites of those organizations are listed below:

- National Domestic Violence Fatality Review Initiative, <http://www.ndvfri.org>
- National Center on Child Fatality Review, <http://www.ican-ncfr.org/>

Domestic violence team reports may be found on the Violence Against Women Online Resources Web site at <http://www.vaw.umn.edu/> by using the search function to find documents related to fatality or death review. Child fatality review team reports may be accessed on the Web site of the National Center on Child Fatality Review, <http://www.ican-ncfr.org>. There is, of course, much more than team reports on those Web sites. It is highly unlikely that all available team reports, whether on domestic violence or child fatality, can

be found on these Web sites, however. It may be advisable to conduct searches of the Internet to find other reports. To illustrate, on May 2, 2005 a Google search using the words “domestic violence fatality review team reports” resulted in 73,500 “hits,” among which were domestic violence and child FRT reports, articles, press releases, statutes and summaries of statutes, legislation, and more.

(C) Resources for Information on the Dying Process

Some team members have found it helpful to learn more about the dying process. Team members suggested contacting hospice programs for written information or inviting a hospice doctor to make a presentation to the team. Also recommended was the book *How We Die: Reflections on Life's Final Chapter* by Sherwin B. Nuland (Vintage Books, 1995).

(D) Resources on Elder Abuse

(1) Key National Resources on Elder Abuse

- Administration on Aging, U.S. Department of Health & Human Services, Washington, DC 20201, (202) 619-0724, Web site: <http://www.aoa.gov>
- American Association of Retired Persons, 601 E Street, NW, Washington, DC 20049, (800) 424-3410, Web site: <http://www.aarp.org>
- American Bar Association Commission on Law and Aging, 740 Fifteenth Street, NW, Washington, DC 20005, (202) 662-8690, Web site: <http://www.abanet.org/aging>
- Clearinghouse on Abuse and Neglect of the Elderly, University of Delaware, Department of Consumer Studies, Newark, DE 19716 (302) 831-3525, on-line annotated database: <http://db.rdms.udel.edu:8080/CANE>
- National Adult Protective Services Association, 1900 13th St., Suite 303, Boulder, CO 80302, (720) 565-0906, Web site: <http://www.apsnetwork.org/About/policy.htm>
- National Center on Elder Abuse, 1201 15th Street NW, Suite 350, Washington, DC 20005, (202) 898-2578, Web site: <http://www.elderabusecenter.org>
- National Clearinghouse on Abuse in Later Life, a project of the Wisconsin Coalition Against Domestic Violence, 307 S. Paterson, Suite 1, Madison, WI 53703, (608) 255-0539, Web site: <http://www.ncall.us>
- National Committee for the Prevention of Elder Abuse, 1612 K Street, NW, Suite 400, Washington, DC 20006, (202) 789-0470, Web site: <http://www.preventelderabuse.org>

XV. Resources

(2) The Elder Abuse Listserve

The elder abuse listserv provides practitioners, administrators, educators, health professionals, researchers, lawyers, law enforcement officers, prosecutors, judges, and policy makers who are concerned about elder abuse with a FREE forum for raising questions, discussing issues, and sharing information and best practices. The goal of the listserv is to enhance (1) efforts to prevent elder abuse, (2) the delivery of adult protective services and (3) the response of the justice, social services, and health care systems to victims of elder abuse. The ABA Commission on Law and Aging sponsors and manages the listserv for the National Center on Elder Abuse (NCEA). To subscribe, complete the online subscription request form provided on the NCEA Web site at

<http://www.elderabusecenter.org/default.cfm?p=listservesubscribeform.cfm>. For more information about the listserv, visit <http://www.elderabusecenter.org/default.cfm?p=listserve.cfm>. If you do not have Internet access, then send a request to the list manager, Lori A. Stiegel, at lstiegel@staff.abanet.org. Your request must include the following information in the text of your e-mail: your e-mail address, your name, your job title, your profession, your employer/agency's name (if appropriate), your mailing address, your telephone number, and a statement of your interest/expertise in adult protective services/elder abuse.

(3) Useful Publications on Elder Abuse

- *Our Aging Population: Promoting Empowerment, Preventing Victimization, and Implementing Coordinated Interventions – A Report of Proceedings* is a 300-page long summary of a symposium co-sponsored by the Department of Justice and the Department of Health and Human Services. The document may be downloaded in PDF from http://www.ojp.usdoj.gov/docs/ncj_186256.pdf or ordered for \$15.00 from the National Criminal Justice Reference Service (NCJRS), P.O. Box 6000, Rockville, MD 20849-6000, 800-851-3420 or 301-519-5500, TTY Service for the Hearing Impaired (toll free): 1-877-712-9279 (local): 301-947-8374. The NCJRS reference number for the document is NCJ 186256.
- *Abuse and Neglect of Older People* is the title of the Summer 2000 special issue of *Generations*, the journal of the American Society on Aging (ASA). It can be obtained from ASA, 833 Market Street, Suite 511, San Francisco, CA 94103-1824, (415) 974-9600, <http://www.generationsjournal.org>
- *The Journal of Elder Abuse and Neglect* is the nation's only peer-reviewed journal devoted to the problem of elder abuse. For more information about the journal, contact the National Committee for the Prevention of Elder Abuse, 1612 K Street, NW, Suite 400, Washington, DC 20006, (202) 682-4140, Web site: <http://www.preventelderabuse.org>.

Victimization of the Elderly and Disabled is a newsletter devoted to the subject of abuse of older persons and persons with disabilities. For information about this newsletter, contact the Civic Research Institute, 4478 U.S. Route 27, P.O. Box 585, Kingston, NJ 08528, (609) 683-4450, e-mail: order@civics-researchinstitute.com.

(E) Resources on Collaboration

Two resources on collaboration and team-building that EA-FRT members might find useful include:

- Drummond, Anita, Carroll Ellis, Melissa Hook, Morna Murray, and Anne Seymour, “Essential Skills for Leaders: Collaboration and Team Building.” The National Victim Assistance Academy Advanced Topic Series Workbook. U.S. Department of Justice Office for Victims of Crime. <http://www.ojp.usdoj.gov/ovc/assist/leadership/files/chapter4.pdf>. Accessed May 1, 2005.
- “What Does It Take to Make Collaboration Work? Lessons Learned Through the Criminal Justice System Project.” U.S. Department of Justice National Institute of Justice. <http://ncjrs.org/pdffiles1/jr000251c.pdf>. Accessed May 1, 2005.

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All appendices herein that were not developed by the ABA are reprinted with permission of the documents' authors. The documents developed by the EA-FRT are provided as examples of tools that teams can use and their inclusion in this manual is not intended as an endorsement of their contents. The opinions, findings, and conclusions expressed in those team documents are those of their authors and do not necessarily represent the official position or policies of the ABA or the U.S. Department of Justice.

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Appendix A
Team Purpose Chart

Team	Systems Change	Prosecution
Houston, Texas	X	X
Maine	X	
Orange County, California	X	
Pima County, Arizona	X	X
Pulaski County, Arkansas	X	
Sacramento, California	X	X
San Diego, California	X	
San Francisco, California	X	X

Appendix B
Team Mission Statements Chart

Team	Has Mission Statement?	Wording
Houston, Texas	Y	<p>Harris County Domestic Violence Coordinating Council Adult Violent Death Review Team (AVDRT) in accordance with Chapter 672 of the Health and Safety Code has been established to conduct a system-wide review of selected cases of adult unexpected deaths that have been caused by interpersonal violence including family violence, suicide, neglect, or abuse occurring in Houston and Harris County. The Elder Abuse Fatality Review Team (EFFORT), a subcommittee of the AVDRT, will focus on the unexpected deaths of elderly and/or disabled adults. The purpose of the EFFORT is to refine and coordinate an intervention effort with the purpose of improving services, decreasing the incidence of preventable elder deaths, and increasing the prosecution of perpetrators.</p>
Maine	Y	<p>The Maine Elder Death Analysis Review Team (MEDART) will examine deaths, and cases of serious bodily injury, associated with suspected abuse or neglect of the elderly and vulnerable adults. The purpose of MEDART is to review deaths related to abuse and neglect, and to identify whether systems that have the purpose or responsibility to assist or protect victims were sufficient for the particular circumstances or whether such systems require adjustment or improvement. MEDART will foster system change that will improve the response to victims and prevent similar outcomes in the future.</p> <p>MEDART recognizes that the responsibility for responding to and preventing fatalities related to abuse or neglect of the elderly and vulnerable adults lies within the community and not with any single agency or entity. It is further recognized that a careful examination of the fatalities provides the opportunity to develop education, prevention, and strategies that will lead to improved coordination of services for families and our elder population.</p>
Orange County, California	Y	<p>Through education of appropriate agencies and the community, the goal of the Elder Death Review Team is to prevent deaths due to elder abuse.</p>

Pima County, Arizona	Y	<p>The Pima County Death Analysis Review Team (PC DART) will examine deaths associated with suspected vulnerable adult/elder abuse and/or neglect.</p> <p>We recognize the responsibility for responding to and preventing vulnerable adult/elder abuse and neglect fatalities lies within the community and not with any single agency or entity. We further recognize that a careful examination of the fatalities provides the opportunity to develop education, prevention, and if necessary prosecution strategies that will lead to improved coordination of services for families and our elder population.</p>
Pulaski County, Arkansas	Y	<p>The Pulaski County Elder Fatality Review Team is a multi-agency, multi-disciplinary team that will review vulnerable adult deaths from various causes, with an emphasis on the review of deaths involving caregiver abuse and/or neglect and self-neglect. The scope of cases reviewed will be limited to cases fitting a pre-determined protocol, based on cause of death. Possible benefits of an elder fatality review include improved inter-agency case management, identification of gaps and breakdowns in agencies and systems designed to protect this population, and the development of data information systems that can guide the formation of protocols and policy for agencies that serve the elderly.</p>
Sacramento, California	Y	<p>The Sacramento Elder Death Review Team will examine deaths associated with suspected elder abuse and/or neglect.</p> <p>We recognize the responsibility for responding to, and preventing, elder abuse and neglect fatalities lies within the community, and not with any single agency or entity. We further recognize that a careful examination of the fatalities provides the opportunity to develop education, prevention and, if necessary, prosecution strategies that will lead to improved coordination of services for families and our elder population.</p>
San Diego, California	Y	<p>It is the mission of the EDRT to review suspicious deaths associated with suspected elder abuse and/or neglect, identify risk factors for such deaths, maintain statistical data concerning such deaths and facilitate communication among agencies involved with elder</p>

		deaths in order to improve systems gaps in delivery services.
San Francisco, California	N	N/A

Appendix C

Team Policies & Procedures, Memoranda of Understanding, and Protocols

1. Key Headings and Subheadings.

Although the following documents have commonalities, they vary widely in the level of detail they provide and the way they organize that detail. To make it easier for readers to understand and compare that detail, this appendix contains a list of the key headings and subheadings for the Houston, Maine, and Orange County documents.

2. Harris County Domestic Violence Coordinating Council Adult Violent Death Review Team (AVDRT), Elder Abuse Fatality Review Team (EAFRT) called EFFORT Policies and Procedures (Houston, Texas)
3. Maine Elder Death Analysis Review Team Policy Manual
4. Interagency Agreement Between UCI College of Medicine, The County of Orange Sheriff-Coroner Department, Social Services Agency, District Attorney, Health Care Agency- Older Adult Services, The Long-Term Care Ombudsman, and Community Care Licensing (Orange County, California)

Harris County Domestic Violence Coordinating Council Adult Violent Death Review Team (AVDRT), Elder Abuse Fatality Review Team (EAFRT) called EFFORT Policies and Procedures (Houston, Texas) Key Headings and Subheadings

- Purpose and Goals
 - Purpose
 - Goals
- Team Membership
 - Team Leadership
 - EFFORT Coordinator
 - The Roles of Team Members
- Team Procedures
 - Meeting of a Review Team
 - Reviewable Deaths
 - Information Sharing
 - Confidentiality
 - Obtaining the Names for Team Reviews
 - Adult Death Information and Distribution for a Review Meeting
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 - Record Keeping
- Procedures for Conducting an Elder Death Review Meeting
 - Members Agree to Confidential Discussions
 - Members Provide Information

- Data Collection and Time Required for Reviews
- Record Meeting Issues
- Follow-up Reviews
- Referrals for Survivors
- Agency Conflict Resolution
- Media Relations
- Maintaining a Review Team
 - Respect Team Agreements
 - Participate and Be Prepared for Meetings
 - Keep Regular Schedules for Meetings
 - Provide an Educational Element to Team Meetings
 - Use the Professional Associations Represented on Teams
 - Periodic Review of the Team's Purpose and Objectives
 - Team Membership is a Long Term Commitment

Maine Elder Death Analysis Review Team Policy Manual Key Headings and Subheadings

- Introduction
- Mission Statement
- Composition
- Meetings; Officers
- Powers and Duties
- Access to Information and Records
- Confidentiality
- Reporting of Findings of Facts and Recommendations
- Annual Report
- Case Review Procedure
- Authorization
- Confidentiality Agreement

Interagency Agreement Between UCI College of Medicine, The County of Orange Sheriff-Coroner Department, Social Services Agency, District Attorney, Health Care Agency- Older Adult Services, The Long-Term Care Ombudsman, and Community Care Licensing (Orange County, California) Key Headings and Subheadings

- Background
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- Policies and Procedures
 - Member Selection and Roles
 - Process for Selection and Screening of Cases for Review
 - Case Review Criteria
 - Administrative Procedure for Reports and for Follow-up/Evaluation Reports
- Withdrawal of Parties from EDRT

Harris County Domestic Violence Coordinating Council Adult Violent Death Review

Team (AVDRT)

**Elder Abuse Fatality Review Team (EAFRT) called EFFORT
Policies and Procedures**

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- I. Purpose and Goals
- II. Team Membership
- III. Team Procedures
- IV. Procedures for Conducting An Elder Death Review Meeting
- V. Agency Conflict Resolution
- VI. Media Relations
- VII. Maintaining a Review Team

I. Purpose and Goals

A. Purpose

Harris County Domestic Violence Coordinating Council Adult Violent Death Review Team (AVDRT) in accordance with Chapter 672 of the Health and Safety Code has been established to conduct a system-wide review of selected cases of adult unexpected deaths that have been caused by interpersonal violence including family violence, suicide, neglect, or abuse occurring in Houston and Harris County. The Elder Abuse Fatality Review Team (EFFORT), a subcommittee of the AVDRT, will focus on the unexpected deaths of elderly and/or disabled adults. The purpose of the EFFORT is to refine and coordinate an intervention effort with the purpose of improving services, decreasing the incidence of preventable elder deaths, and increasing the prosecution of perpetrators.

B. Goals

1. To bring together an interdisciplinary team (IDT) composed of a public health professional, a victim witness professional, a representative of the Texas Department of Protective and Regulatory Services, a medical examiner, a geriatrician, law enforcement, and a nurse;
2. To conduct formal, confidential, and systematic evaluation and analyses of cases of interpersonal violence occurring in Houston and Harris County, focusing on the flow of each case through the various agencies in the system to identify areas for improvement or strengthening of agency contacts and interagency response;
3. To evaluate policies, protocols and practices to identify gaps in service within agencies and the community;
4. To build a database for analysis of aggregate population data of deceased persons and perpetrators;
5. To disseminate information on prevention strategies through an annual quantitative and qualitative report to the Adult Violent Death Review Team (AVDRT) and as required to the Texas Department of Protective and Regulatory Services and to the community at large;
6. To promote cooperation, communication, and coordination among agencies involved in responding to unexpected deaths;
7. To develop an understanding of the causes and incidence of deaths caused by interpersonal violence in Houston/Harris County where the review team is located;
8. To advise the legislature, appropriate state agencies, and local law enforcement agencies on changes to law, policy, or practice that will reduce the number deaths attributed to violence;
9. To identify research questions that need investigation to inform decision making to end violence against elders; and

10. To identify interventions that are applicable to informing health professionals and the public about violence against elders.

II. Team Membership

Team members are representatives from the medical community, the legal community, and agencies who are responsible for adult fatality investigations.

- A criminal prosecutor involved in prosecuting crimes involving family violence;
- A homicide detective;
- A medical examiner;
- A medical forensic professional, such as a forensic nurse specialist or a death scene investigator;
- Elder abuse and neglect specialists including APS, physicians, and nurses;
- A public health professional;
- A representative(s) of family violence shelter/center providing services to the county;
- The victim witness advocate in the county prosecutor's office;
- A representative from the community supervision and corrections department; and
- A designated representative(s) from AVDRT

Also, team members may be selected according to community resources and needs. These members must reflect the geographical, cultural, racial, ethnic, and gender diversity of the county or counties represented. Also, members under this section should have experience in abuse, neglect, suicide, family violence, or elder abuse. They may include any of the following:

- A representative of the Department of Protective and Regulatory Services engaged in providing adult protective services;
- A representative from the Texas Department of Criminal Justice Parole Division;
- A mental health services provider;
- Additional representatives from area law enforcement agencies within the boundaries of Harris County, including but not limited to homicide detectives; and
- A representative from a local battering intervention program.

A. Team Leadership

EFFORT Team leadership is comprised of 2 CO-CHAIRS and 2 COORDINATORS.

The team shall appoint a presiding EFFORT chair candidate and an EFFORT co-chair candidate. The co-chairs will assume responsibility for the administration of the team operations, including the selection of the annual report committee members with the input of the EFFORT coordinator. The report committee shall be composed of no less than 3 and no more than 4 members.

The co-chairs may be any of the team members and serve in accordance with the EFFORT policies and procedures. Co-chairs will serve alternating two-year terms. One current co-chair will serve from January 1, 2004 – to January 2005. At that time, a co-chair will be elected to begin a full 2-year term. The remaining co-chair will serve from January 1, 2004 – January 1, 2006, when his/her term will expire and another co-chair selected.

B. EFFORT Coordinator

The team shall appoint an *EFFORT* coordinator. The duties of a coordinator include:

1. Coordinate information from all members to generate a case list for review.
2. Disseminate the case lists to all EFFORT members at least one month prior to the team meeting in which the cases will be discussed.
3. Collect and maintain a secure environment for the confidential file information.
4. Provide statistical, non-confidential, information to the team and to other agencies by request.
5. Oversee the production and dissemination of the EFFORT report.
6. The coordinator will maintain a record of issues from team discussions.
7. The coordinator(s) will be selected for 2-year terms beginning January 1, 2004.

C. The Roles of Team Members

The roles of the team members can be flexible to meet the needs of a particular community. The individual abilities of members should be used to form the most effective team possible.

Each member provides the team with information from their records, serves as a liaison to their professional counterparts, provides definitions of their profession's terminology, interprets the procedures and policies of their agency, and explains the legal responsibilities or limitations of their profession. They

also assist in making referrals for services or providing direct aid to surviving family members.

All team members must have a clear understanding of their own and other professionals' and agencies' roles and responsibilities in response to elder fatalities. Additionally, members need to be aware of and respect the expertise and resources offered by each profession and agency. The integration of these roles is the key to a community having a well-coordinated elder fatality response system.

1. Criminal Prosecutor

Prosecutors educate the team on criminal law and provide information about criminal and civil actions taken against those involved in the elder fatalities reviewed. They also provide the team with explanations regarding when a case can or cannot be pursued and information about previous contacts with family members and criminal prosecutions of suspects in an elder death.

2. Law Enforcement

Law enforcement members provide information on criminal investigations of elder deaths reviewed by the team. They also check the criminal histories of the adult and/or family members and suspects in the elder death cases. To ensure sufficient representation, both the sheriff's department and the police department are needed as team members. The law enforcement team members act as liaisons between the team and other local law enforcement departments. They assist with persuading officers from other agencies to participate in reviews when there is a death in that jurisdiction. Law enforcement officers are usually the best-trained team members on scene investigations and interrogations, essential skills required in determining how an elder died. Their expertise provides useful information and training to other members.

3. Medical Examiner

When reviewing a violent death, the medical examiner provides the team with copies of preliminary scene investigation forms, information regarding how the determination of cause and manner of death was reached, and a copy of the full autopsy report when available.

The medical examiner also assists the team because of their access to records from the other investigating agencies and because of their ongoing working relationship with law enforcement, EMS, hospitals, and APS.

4. **Public Health Professional**

Public health agencies facilitate and coordinate preventive services needed to assist the community with education and community awareness programs. Public health members provide the team with vital records, epidemiological profiles of families for early risk detection, and help educate members on the public health services available in the county. Public health doctors or nurses help identify public health issues that arise in adult deaths and also provide medical explanations to the team. If the adult was treated in a local public health facility, they can provide medical histories and explanations of previous treatment.

5. **Department of Family and Protective Services providing Adult Protective Services (APS)**

The APS member has the legal authority and responsibility to investigate and provide protection to elders and vulnerable adults that might be at risk. As a team member, they provide detailed information on the family and the worker's investigation into the abuse and neglect that may have occurred within the home. APS members also have prior agency contact information including 1) reports of neglect or abuse and 2) APS services previously or currently being provided to the family.

They may be able to provide the team with information regarding the family's history and the psychosocial factors that influence family dynamics such as unemployment, divorce, previous deaths, history of domestic violence, history of drug abuse, and previous abuse or neglect. Their knowledge on issues related to elder abuse and neglect cases is essential to an effective team.

6. **Mental Health Services Provider**

The mental health representative provides information and insight regarding psychological issues related to the adult, the family, the perpetrator, and the event that caused the elders' death. They make suggestions when counseling or other mental health service referrals may be appropriate.

7. **A Representative of Family Violence Shelter/Center Providing Services to the County**

A Family Violence Center representative provides information and insight regarding the elder, family, or perpetrator's request for or use of services offered by the agency. The representative from the agency checks the agencies records for use of services including hotline services, shelter services, non-residential services, transitional services, or other services that the client may have requested. The information they provide to the team includes dates of service, length of service, types of service offered, and termination of agency services.

8. **Victim Witness Advocate**

A representative from the Harris County District Attorney's Office Victim Witness Program provides information and insight regarding Crime Victims Compensation requested and/or received by the complainant and interaction the complainant had with their program.

9. **Medical forensics specialist**

The medical forensics specialist provides expert information on scene investigations that may help in determining elder abuse or neglect.

10. **Elder abuse medical specialist**

A geriatrician or geriatric nurse practitioner provides invaluable information on the complexities surrounding the medical treatment of cases reviewed. They will be able to identify subtle signs that may indicate foul play.

11. **A representative from the Texas Department of Criminal Justice – Parole Division**

A representative from the Parole Division can provide his/her professional insight and knowledge as each case is reviewed. They also provide information from their agency/organization for relevant cases.

Member Designees and Meeting Attendance

Team members may designate another representative of their agency to replace them at meetings they are unable to attend. Team members must recognize the need to attend meetings regularly to offer the expertise and knowledge that initially determined their selection.

Members Agree to Confidential Discussions

Key to the successful operation of a fatality review team is ensuring the confidentiality of both the information brought to the meetings and the team's deliberations. Prior to each EFFORT meeting, members must sign a confidentiality agreement. Information and records acquired by a review team in the exercise of its purpose and duties are confidential and exempt from disclosure under the open records law and may only be disclosed as necessary to carry out the review team's purpose and duties. Therefore, a member of the review team may not disclose any information that is confidential. If a person discloses information made confidential, they have committed a Class A misdemeanor. Any member who violates confidentiality will be removed from the team.

Therefore it is essential members abide by the confidentiality procedures established by and for the committee. A template of the confidentiality agreement may be found in Appendix D.

III. Team Procedures

A. Meeting of a Review Team

A meeting of a review team is closed to the public and not subject to the open meetings law, Chapter 551, Government Code. A review team may request the attendance, at a closed meeting, of a person who is not a member of the review team and who has information regarding a fatality resulting from family violence, suicide, or abuse. The attendance of a person who is not a member of the team must be cleared in advance with the presiding officer and the coordinator. Except as necessary to carry out a review team's purpose and duties, members of a review team and persons attending a review team meeting may not disclose what occurred at the meeting.

The Harris County EFFORT Team meets monthly.

B. Reviewable Deaths

A reviewable death is one in which:

1. The deceased is an adult from one of the following categories:
 - Disabled adults 17 to 54 years
 - Older and disabled adults 55-64 years
 - Elderly adults 65+ years
2. The injury that resulted in death occurred within the limits of the City of Houston or within the boundaries of Harris County.
3. The death resulted from injuries sustained during interpersonal violence related to intimate partner violence, family violence, suicide, or abuse, or resulted from neglect of an incapacitated adult.

C. Information Sharing

1. Teams are not a mechanism for criticizing or second-guessing any agency's decision. They are a mechanism for the essential information sharing required if the system's response to adult fatalities is to be improved.
2. A team may request information and records regarding a deceased adult as necessary to carry out the purpose and duties of the team. Background and current information from the records of team members and other sources may be needed to assess circumstances of the death.

3. Team members should use the knowledge and expertise provided in the confidential forum to gather additional input for pending investigations.
4. A standing request for records and information may be developed by the team to facilitate the gathering of information required to conduct a death review. It should be addressed to the “custodian of the records” or the agency director and include the review team authorizing statute, information regarding the team operation and purpose, and a copy of the team’s interagency agreement. These requests are particularly useful for acquiring information from agencies that do not have a representative on the team. Some teams have numerous hospitals in the counties covered by the teams; this request would enhance the team’s ability to gather required medical information.
5. When reviewing deaths of elders who were or are residents of another county, team members should contact the corresponding agency and request information regarding the deceased adult for the review.

D. Confidentiality

1. Records acquired by the team to conduct a review are exempt from disclosure under the Open Records Law, Chapter 552 of the Government Code.
2. Data collected and information retrieved regarding the death of an adult at a review team meeting are confidential.
3. A report or statistical compilation of a review team is a public record subject to the Open Records Law, Chapter 552 of the Government Code, if it does not permit the identification of an individual.
4. A team member may not disclose any information that is confidential.
5. Information, documents, and records of the team are confidential and are not subject to subpoena or discovery and may not be introduced into evidence in any civil or criminal proceedings.
6. Information that would otherwise be available from other sources is immune because it was included in a review team meeting.
7. The adult protective services member of a team may not disclose information from the Texas Department of Family and Protective Services records that would identify an individual who reported an allegation of abuse and/or neglect.

E. Obtaining the Names for Team Reviews

1. The death certificate is the basis for review because it is the legal document required to certify death and to bury a body. The Medical Examiner’s Office shall provide copies of the death certificates, preliminary investigative reports, and final autopsy reports to the EFFORT coordinator. If the death certificate is unavailable from the Medical Examiner’s Office, the Bureau of Vital Statistics in the Texas Health Department, the City of Houston Bureau of

Vital Statistics, or local registrar's offices may be requested to provide one to the EFFORT coordinator.

2. To obtain names for review meetings, the EFFORT coordinator may contact the local registrars. Most counties have more than one registrar; and each city in a county may have its own office of vital statistics, with the county clerk recording deaths for unincorporated areas. The State Registrar can supply presiding officers with a list of local registrars for their area.

F. Adult Death Information and Distribution for a Review Meeting

The EFFORT coordinator compiles summary information, most of which is available from the death certificate and the medical examiner's records, for each death to be reviewed. It is a requirement that team members search their files and obtain the necessary data for a review.

For confidentiality purposes, **the death certificates are not distributed to the members.**

G. Adult Fatality Summary Information

1. Deceased adult name.
2. Adult's race or ethnicity, age, and gender.
3. Adult's date of birth and date of death.
4. Cause of death—may be pending when the list is initially written. Cause of death is the specific reason the elder died: blunt force head injury, gunshot, etc.
5. Manner of death—is the category of the death, homicide, suicide, accident, or undetermined.

H. Record Keeping

The team will not maintain records of case discussions. Basic information will be kept for purposes of informing the team members of the deaths to be reviewed; and the data collection form is returned to the EFFORT coordinator at the conclusion of the review. The team's EFFORT coordinator maintains a list of issues raised during the meetings.

IV. Procedures for Conducting An Elder Death Review Meeting

A. Members Agree to Confidential Discussions

Each member agrees to keep meeting discussions and information confidential. This is essential for each agency to be able to fully participate in the meetings.

The AVDRT coordinator should keep a confidentiality agreement, signed by team members and required for other meeting attendees, at each meeting.

B. Members Provide Information

Each team member provides information from their agency's records.

C. Data Collection and Time Required for Reviews

Deaths will vary in the amount of time required for completion of a review. Each member presents their agency's investigation and/or historical information on the cases and families. To ensure an adequate review has been conducted and the appropriate questions asked, the data collection form serves as the agenda for a review. Not all questions are applicable for each death. Some information may be unavailable. The lack of information regarding the circumstances of a death serves the team by focusing their attention on what information was needed but unavailable. This heightened awareness may lead to improved prevention efforts and services.

D. Record Meeting Issues

The EFFORT coordinator maintains a record of issues discussed by the team during case review meetings.

E. Follow-up Reviews

Cases may need to be discussed at more than one meeting for several reasons: the results of the investigations are incomplete at the first review, members may wish to obtain additional information from their agency, a team member with significant information is absent, or the case continues to progress and needs to be updated.

F. Referrals for Survivors

Referrals for appropriate services for survivors are an opportunity for the team to assess and address an immediate need. The team member, professionally associated with the agency that is providing or knowledgeable about the service, usually handles referrals. Any team member may assist with making a referral. The team should discuss which agency will handle the referral and note when the referral has been completed.

V. Agency Conflict Resolution

Participating agencies may have individuals with concerns or disagreements regarding specific cases. Reviews are not opportunities for others to criticize or second guess an agency's decision regarding a case. Issues with the procedures or policy of a particular agency are sometimes identified; however, that agency's team

member is responsible for any further action taken on the issue by his or her agency.

Teams are not peer reviews. They are designed to look at the system issues, not the performance of individuals. The team review is a professional process aimed at improving the system that responds to adult deaths.

When conflict continues to occur among members, the presiding officer should intervene at the meeting to allow the review to progress. By contacting the members outside the meeting, the presiding officer may discuss the issues and assist with resolving the conflicts. Sometimes disagreement is both productive and appropriate, but disruption of the review is not acceptable. Members should always be encouraged to conduct the reviews in a professional manner.

VI. Media Relations

Media are an essential part of the communication strategies of an elder fatality review team, providing an outlet for information about the status of elderly violence rates in the community and facilitating education of the public regarding prevention issues. A positive relationship with the media should be established and fostered by media relations specialists, typically public information officers from participating agencies. Individual members other than the co-chairs should not consent to media interviews concerning EFFORT without the knowledge and agreement of the team.

VII. Maintaining a Review Team

A team follows three stages of development to achieve its goal of reducing the number of preventable elder deaths in the community: organizational, operational, and the implementation of prevention efforts and strategies from team findings. Once a team has been established and the procedures for operation are thoroughly understood, maintenance of the team is essential. The following are recommendations for maintaining a functional review team:

A. Respect Team Agreements

For the team to operate effectively, it is essential that team agreements be recognized and followed by the members.

B. Participate and Be Prepared for Meetings

Reviews require the regular attendance and participation of **EFFORT** members. A quorum of members is required to be present for the review of a case to proceed. A quorum is defined as the presence of the chair or co-chair, the coordinator or a substitute, a representative from the Harris County District Attorney's Office, a representative from the law enforcement agency that handled or investigated the case, a medical examiner, APS, and an geriatric medical specialist. If a quorum is not present, the case will be held over for

review at the next meeting of the team. Additionally, participants in review should become acquainted with the questions on the data collection forms to facilitate their own record preparation.

C. Keep Regular Schedules for Meetings

Establishing regularly scheduled meetings provides members with the ability to make long-term schedule plans and allows for better attendance. Canceling scheduled meetings diminishes the team's ability to gather information and hinders the cooperative networking of the members. A team can only achieve its objectives by meeting routinely and regularly.

D. Provide An Educational Element to Team Meetings

Keeping members informed of team-related training, changes in laws regarding their professions, and new adult death or injury prevention programs should be an integral part of the operations of every review team. Periodically scheduling brief presentations and providing informative handouts will enhance the team's ability to accomplish its objective. Also, an effort should be made to regularly contact other teams for suggestions and input on innovative team efforts.

E. Use the Professional Associations Represented on Teams

Professional associations can answer questions regarding many aspects of the responsibilities and statutes that govern a profession.

F. Periodic Review of the Team's Purpose and Objectives

A periodic review of the stated purpose of the team and its goals will provide direction to the team and remind members why the team was originally formed.

G. Team Membership Is a Long-term Commitment

The team is a panel of professionals dedicated to establishing a better understanding of the causes of elder deaths in their community. Discovering the patterns that cause or contribute to preventable elder deaths is an on-going process. Patterns change over time within a community. The aggregate knowledge acquired and shared by team members provides the team structure for achieving effective results.

By participating on a team, local professionals with the responsibility of the protection, health, and safety of their community communicate a pledge to better understand deaths from interpersonal violence and to support the necessary steps to eliminate obstacles hindering their integrated response.

MAINE ELDER DEATH ANALYSIS REVIEW TEAM POLICY MANUAL

LAST REVISION:

September 16, 2004

I. INTRODUCTION

In 2003, the Maine Elder Death Analysis Review Team, known herein as either “MEDART” or “*the Team*,” was established by the Maine Legislature under the auspices of the Office of the Attorney General in accordance with 5 M.R.S.A. §200-H. MEDART is charged with examining deaths and cases of serious bodily injury associated with suspected abuse or neglect of elderly and vulnerable adults. MEDART, whose membership includes representation from state, local and county law enforcement, prosecutors, victim advocates, healthcare facility licensing and certification, adult protective services, and mental health, meets monthly to review selected cases. The purpose of the review is to identify whether systems that have the purpose or responsibility to assist or protect victims were sufficient for the particular circumstances or whether such systems require adjustment or improvement. MEDART seeks to foster system change that will improve the response to victims and prevent similar outcomes in the future.

MEDART was chosen early on as one of four “*elder fatality review teams*” in the United States to serve as a pilot program for a Department of Justice funded initiative managed by the American Bar Association’s Commission on Law and Aging. The goal of the pilot program is to expand the fatality review team concept, and to develop and disseminate a replication and best practices guide. For its role in the program, the team received \$5000 in “*seed money*” to help defray set up costs.

II. MISSION STATEMENT

The Maine Elder Death Analysis Review Team (MEDART) will examine deaths, and cases of serious bodily injury, associated with suspected abuse or neglect of the elderly and vulnerable adults¹. The purpose of MEDART is to review deaths related to abuse and neglect, and to identify whether systems that have the purpose or responsibility

¹ An adult, age 18 to 59 or older, who needs protections and programs that are the same as, or similar to, protections and programs for elder adults, including an adult who, due to developmental, cognitive, psychological, physical, or other type of disability, is unable to protect him/herself from abuse, neglect, or financial exploitation or is unable to provide or obtain essential care or services.

to assist or protect victims were sufficient for the particular circumstances or whether such systems require adjustment or improvement. MEDART will foster system change that will improve the response to victims and prevent similar outcomes in the future.

MEDART recognizes that the responsibility for responding to and preventing fatalities related to abuse or neglect of the elderly and vulnerable adults lies within the community and not with any single agency or entity. It is further recognized that a careful examination of fatalities provides the opportunity to develop education, prevention, and strategies that will lead to improved coordination of services for families and our elder population.

III. COMPOSITION

- a) The membership of the Maine Elder Death Analysis Review Team is set by statute and includes the following:
 - i) The Chief Medical Examiner, ex officio;
 - ii) The Director of Investigations for the Office of the Attorney General, ex officio;
 - iii) The Director of the Division of Licensing and Certifications within the Department of Human Services, ex officio;
 - iv) The Director of the Healthcare Crimes Unit within the Office of the Attorney General, ex officio;
 - v) The Director of Community Resource Development within the Department of Human Services, Bureau of Elder and Adult Services, ex officio;
 - vi) The Director of the Adult Protective Services program within the Department of Human Services, Bureau of Elder and Adult Services, ex officio;
 - vii) The Director of Adult Mental Health Services within the Department of Behavioral and Developmental Services, ex officio;
 - viii) The executive director of the long-term care ombudsman program, as established in 22 M.R.S.A. § 5106(11-C), ex officio;
 - ix) A representative of victim services, appointed by the Attorney General;

- x) A commanding officer of the Criminal Investigation Division within the Department of Public Safety, Bureau of the State Police, appointed by the Attorney General;
 - xi) A prosecutor, nominated by a statewide association of the prosecutors and appointed by the Attorney General;
 - xii) A police chief, nominated by a statewide association of chiefs of police, and appointed by the Attorney General; and,
 - xiii) A sheriff, nominated by a statewide association of sheriffs and appointed by the Attorney General.
- b) An ex officio member may appoint a designee to represent the ex officio member on the team. A designee, once appointed, qualifies as a full voting member of the team who may hold office and enjoy all the other rights and privileges of full membership on the team. All of the appointed members of the team serve for a term of three years. Any vacancy on the team must be filled in the same manner as the original appointment, but for the unexpired term.² It is the policy of the Maine Elder Death Analysis Review Team that each member shall designate an alternate member who will represent the appointee in the case of the appointee's absence. An alternate member qualifies as a full voting member of the team in the absence of the appointee. It is also the policy of the Maine Elder Death Analysis Review Team that upon request of the membership, the chair may call upon subject matter experts so that they may assist members with the review of facts and development of recommendations. These persons shall be subject to a confidentiality agreement outlined within this policy.

IV. MEETINGS & OFFICERS

- a) The team shall meet at such a time or times that may be reasonably necessary to carry out its duties, but it shall meet at least once in each calendar quarter at such a place and time as the team determines, and it shall meet at the call of the chair.

² 5 M.R.S.A. § 200-H(1)

The Attorney General shall call the first meeting before January 1, 2004. The team shall organize initially and thereafter annually by electing a chair and a vice-chair from among its members.³ It is the policy of MEDART that the membership shall meet every first Tuesday of the month at 10 a.m. at the Office of the Attorney General, Augusta, Maine, but shall recess during the months of July and August.

- b) It is the policy of MEDART that the chair shall perform all duties required by law and preside at all meetings of the team. The Chair shall rule on issues of evidence, order, and procedure and shall take other such actions as are necessary for the efficient and orderly conduct of hearings unless directed otherwise by the majority of the team.
- c) It is the policy of MEDART that the vice-chair shall serve in the absence of the chair and shall have all the powers of the chair during the chair's absence, disability, or disqualification.
- d) It is the policy of MEDART that the vice-chair shall also serve as secretary and, to the extent possible, may delegate this responsibility to available staff members from participating agencies. The secretary, subject to the direction of the chair and the team, shall keep minutes of all team proceedings. The secretary shall collect and disseminate all relevant case review materials to team members. The secretary shall oversee the collection and disposition of all case review materials upon completion of the review. The secretary shall also keep records of all correspondence, findings, and recommendations prepared by the team.

V. POWERS AND DUTIES

- a) The team shall examine deaths and serious injuries associated with suspected abuse or neglect of elderly or vulnerable adults. The purpose of such

³ 5 M.R.S.A. § 200-H(3)

examinations is to identify whether systems that have the responsibility to assist or protect victims were sufficient for the particular circumstances or whether such systems require adjustment or improvement. The team shall recommend methods of improving the system for protecting persons from abuse and neglect, including modifications of statutes, rules, training and policies and procedures.⁴

VI. ACCESS TO INFORMATION AND RECORDS

- a) In any case subject to review by the team, upon oral or written request of the team, notwithstanding any other provision of law, any person that possesses information or records that are necessary and relevant to the team shall as soon as practicable provide the team with the information and records. Persons disclosing or providing information or records upon request of the team are not criminally or civilly liable for disclosing or providing information or records in compliance with this subsection.⁵

VII. CONFIDENTIALITY

- a) The proceedings and records of the team are confidential and are not subject to subpoena, discovery or introduction into evidence in a civil or criminal action. The Office of the Attorney General shall disclose conclusions of the review team upon request, but may not disclose information, records, or data that are otherwise classified as confidential.⁶ In addition to those provisions set forth by law, it is the policy of the team that each member or others participating in case reviews shall adhere to the terms set forth in a confidentiality form signed by each team member or other participant prior to a case review.

VII. REPORTING OF FINDINGS OF FACT AND RECOMMENDATIONS

⁴ 5 M.R.S.A. § 200-H(4)

⁵ 5 M.R.S.A. § 200-H(5)

⁶ 5 M.R.S.A. § 200-H(6)

- a) It is the policy of the Maine Elder Death Analysis Review Team that a report shall be delivered in a timely fashion to the Attorney General upon completion of each review. The report shall include, but is not limited to, a case summary, findings of fact, and recommendations. The report shall not contain the name of the decedent or any other personally identifying information.

IX. ANNUAL REPORT

- a) It is the policy of the Maine Elder Death Analysis Review Team that a report shall be delivered in a timely fashion to the Attorney General upon completion of each calendar year. The report shall include, but is not limited to, a statement by the Chair, a list of current members, case summary information, and the team's observations, recommendations and progress to date.

X. CASE REVIEW PROCEDURE

- a) Criteria: It is the policy of the Maine Elder Death Analysis Review Team that members may refer cases to the team for review that involve death or serious injury associated with suspected abuse or neglect of elderly adults and vulnerable adults. Additionally, cases may be referred by healthcare providers, protective service agencies, law enforcement, family members through a team member, and regulatory agencies.
- b) Case Information: It is the procedure of the Maine Elder Death Analysis Review Team that once a case is selected for review, the Chair, Vice-Chair, or a designee shall collect and disseminate records to all appointees or their designees. The records shall be in a sealed envelope marked "confidential." Upon receipt, team members shall gather all information relevant to his or her organization's involvement or non-involvement in the case. Reports or other documents related to the review should be forwarded to the Chair or Vice-Chair as soon as possible, prior to the upcoming review, so that they may be disseminated to other team

members. In the event that an appointee or designee can not attend a scheduled case review meeting, he or she shall forward all documents to his or her alternate member. At the conclusion of each case review, the Vice Chair shall collect all case review records in a method that ensures no documents remain in circulation. Those records shall then be destroyed.

- c) Review Procedure: The Chair shall lead the case review process. In the absence of the Chair, the Vice-Chair shall lead the process. Each review shall include a report by the Chair regarding any concerns about the current case, the names of any witnesses, and other pertinent information as it relates to the review. Team members shall review the facts and information gathered for each case and identify whether systems that have the responsibility to assist or protect victims were sufficient for the particular circumstances or whether such systems require adjustment or improvement. The team shall recommend methods of improving the system for protecting persons from abuse and neglect, including modifications of statutes, rules, training, and policies and procedures.

VI. AUTHORIZATION

This policy was voted upon and enacted by the duly appointed membership of the Maine Elder Death Analysis Review Team on October 5, 2004.

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

G. Steven Rowe
Attorney General



Phone: 207-626-8520
Fax: 207-287-3120

MAINE ELDER DEATH ANALYSIS REVIEW TEAM

Maine Office of the Attorney General
Six State House Station, Augusta, Maine 04333-0006

Confidentiality Agreement

I, _____, as a member of the Maine Elder Death Analysis Review Team, or as a participant in its proceedings, agree to keep confidential, in accordance with 5 M.R.S.A. § 200-H(6), the proceedings of the team and the records, information, or data associated with the proceedings. I agree to return to the team chairperson or designee, at the conclusion of a meeting of the team, all records, information, or data that are related to any proceeding of the team.

Date: _____

(Signature)

Printed Name: _____

**INTERAGENCY AGREEMENT BETWEEN UCI COLLEGE OF MEDICINE,
THE COUNTY OF ORANGE SHERIFF-CORONER DEPARTMENT,
SOCIAL SERVICES AGENCY, DISTRICT ATTORNEY, HEALTH CARE
AGENCY- OLDER ADULT SERVICES, THE LONG-TERM CARE OMBUDSMAN,
AND COMMUNITY CARE LICENSING**

Background. In February 2001, California counties were authorized by Senate Bill 333, Chapter 301, to establish interagency elder death review teams to ensure that incidents of elder abuse or neglect are recognized and that agency involvement is reviewed to develop recommendations for policies and protocols for prevention and intervention initiatives to reduce the incidence of elder abuse and neglect. This Memorandum of Understanding establishes the County of Orange Elder Death Review Team (EDRT), which is a collaboration between UCI College of Medicine, the County of Orange Sheriff-Coroner Department, the County of Orange Social Services Agency, District Attorney, Health Care Agency- Older Adult Services, the Long-Term Care Ombudsman, and Community Care Licensing.

Purpose. It is the mission of the EDRT to prevent deaths due to elder abuse through education of appropriate agencies and the community. To this end, the EDRT will review suspicious deaths associated with suspected elder abuse and/or neglect, identify risk factors for such deaths, and maintain statistical data concerning such deaths. The meetings will serve to facilitate communication among agencies involved with elder deaths in order to improve system gaps in the delivery of services.

The ultimate goal of the EDRT is to decrease the number of deaths in Orange County due to elder abuse as a result of physical abuse, neglect or self-neglect and to identify the role of elder abuse and/or neglect as contributory factors to such deaths.

The EDRT is a multi-disciplinary team that will review suspicious deaths that are no longer under investigation in Orange County in accordance with a pre-determined set of protocols and procedures. Information gathered by the EDRT and any recommendations made by the team shall be used by the team member agencies to develop education, prevention, and improve prosecution strategies.

The short, intermediate, and long-term goals of the Orange County EDRT are as follows:

SHORT TERM (July 2003-July 2005)

- 1) Create a manual that will serve as roadmap for Elder Death Review Team and will outline criteria for the types of cases the team will review.
- 2) Select team members will travel to other death review teams around the country to identify components that could be successfully incorporated into this team's process.
- 3) To educate ourselves, the Death Review Team will begin to review known suspicious elder abuse deaths.
- 4) Team members will educate themselves about the current processes of investigating suspicious elder deaths and the participation of different agencies.
- 5) The team will identify areas in the process needing improvement and prioritize these needs.

- 6) The team will develop initial plans for quality improvement in the process.
- 7) If patterns are identified in these deaths, the team will attempt to develop proposed criteria for what may constitute a suspicious death.
- 8) From the experiences gained from the initial cases, further research questions will be developed.

INTERMEDIATE TERM (July 2005-2008)

- 1) The team will implement and test the criteria developed for what constitute a suspicious death.
- 2) The team will begin to implement the planned improvement changes.
- 3) The team will develop research questions coming out of the first two years of experience and start collecting data to answer these questions. These include demonstration of the impact of the team and validation of the proposed criteria.
- 4) The team will develop training manuals for the respective agencies and disciplines on how to investigate these deaths.

LONG TERM (after 2008)

- 1) The team ultimately seeks to promote changes in policies and procedures of governmental and private agencies to close service gaps.
- 2) The team will work towards improving communication and cooperation between the agencies involved in the prevention of elder abuse deaths.
- 3) The team will educate our community at large about elder abuse and identification of risk factors for premature death.
- 4) The team will promote the funding of research on the detection and prevention of elder abuse deaths from governmental and private agencies.

Protocols. It is the intent of each entity to work in a cooperative manner.

3.1 Recommendations. The EDRT will review cases and ultimately will produce recommendations to assist local agencies in identifying and reviewing elder abuse, neglect, or self-neglect related deaths, including homicides, and facilitating communication among the various agencies involved with elder abuse. The intent is to assure that incidents of elder abuse are recognized and that agency involvement is reviewed to develop recommendations for policies and protocols, improvements in the processes by which organizations address and respond to elder abuse.

Caution and care are needed to ensure that the primary objective of improving and facilitating communications amongst the various agencies is fulfilled. Recommendations made by the EDRT shall be carefully worded to assure that they are not interpreted as a finding of failure to provide services.

3.2 Confidentiality. All communications among EDRT members or communications by EDRT members with a third party, and any written communication shared within the EDRT or produced by the EDRT, and any oral or written communication or document provided to an EDRT member are and shall remain confidential and may not be disclosed outside the EDRT unless authorized or required by law.

Each individual participant in the EDRT shall sign an agreement that he/she will abide by the confidentiality laws and will not discuss EDRT confidential information outside the

meetings or the purview of team operations, nor disclose documents (either generated by the EDRT or obtained from third parties) to third parties. All permanent team members shall sign a confidentiality agreement.

3.3 Membership. The core of the EDRT will include individuals who serve as permanent members on the team, combined with temporary members who represent specific agencies or disciplines for certain case reviews. Elder abuse/neglect death reviews can be attended by specific agencies as allowed by law.

Permanent Members, for all cases: UCI College of Medicine, the County of Orange Social Services Agency- Adult Protective Services, District Attorney, Sheriff-Coroner Department, Health Care Agency- Older Adult Services, the Long-Term Care Ombudsman, and Community Care Licensing.

Ad Hoc Members: Public Guardian/Public Administrator, local law enforcement; the City Attorney; emergency first-responders, emergency room staff, Regional Center; Alcohol & Drug Services; Probation/Parole; community-based service organization(s) and others as needed and as allowed by law.

Policies and Procedures will be developed to include issues such as

- Member selection and roles
- Process for selection and screening of cases for review
- Case review criteria
- Administrative procedure for reports (statistical data, case summary, recommendations, etc.) and for follow-up/evaluation reports

Withdrawal of parties from EDRT. Any party to this agreement may terminate their participation by providing written notice to the chair.

**Appendix D
Team Composition Chart**

M = member C = consultant

Discipline	Houston, Texas	Maine	Orange County, California	Pima County, Arizona	Pulaski County, Arkansas	Sacramento, California	San Diego, California	San Francisco, California
Adult Protective Services	M	M	M	M	M	M	M	M
Aging Services		M					M	M
Animal Protection								
Attorney General		M		M	M	M		
Coroner			M		M	M		
County Counsel						C		M
Disability Services				M	M	M		
Domestic Violence Program	M				M			
Elder Law								
Emergency Services						M		M
Facility Regulators		M	M		M	M		
Forensic Pathologist								
Forensic Psychologist or Psychiatrist								C
Forensic Toxicologist								
Funeral Home Director								

Discipline	Houston, Texas	Maine	Orange County, California	Pima County, Arizona	Pulaski County, Arkansas	Sacramento, California	San Diego, California	San Francisco, California
Geriatrician	M	C	M	M		M		M
Gerontologist			M				M	
Hospital Discharge Planner								M
Law Enforcement	M	M	M	M	M	M	M & C	M
Legislator							C	
Long Term Care Ombudsman Program		M	M			M	M	M
Medicaid Fraud Control Unit		M				M		
Medical Examiner	M	M		M		M	M	M
Mental Health Services		M	M					
Nursing	M			M	M	M		
Other Health Care Providers				M	M	M		C
Pharmacologist								
Probation and Parole								
Prosecution	M	M	M	M	M		M	M
Public Guardian and/or Conservator						M	C	
Public Health Agency	M							C
Social Security Administration								

Discipline	Houston, Texas	Maine	Orange County, California	Pima County, Arizona	Pulaski County, Arkansas	Sacramento, California	San Diego, California	San Francisco, California
Sexual Assault Program								
Victim Assistance Program	M	M			M			
Vital Statistics							C	

M = member C = consultant

Appendix E “Confidentiality and Fatality Review”

Confidentiality and Fatality Review

Robin H. Thompson, Esq.

Consultant, National Domestic Violence Fatality Review Initiative (NDVFRI)

This article first appeared in *Fatality Review Bulletin* published by the National Domestic Violence Fatality Review Initiative. <http://www.ndvfri.org/docs/Newsletter3.doc>. Accessed May 2, 2005. It is reprinted with permission of the author and NDFVRI.)

Ralph Bonifay fatally shot his wife Miranda Bonifay, and then immediately turned the gun on himself. The crimes occurred as she was leaving work for the day. Their 8-year-old daughter, Lila, awaited her mother at school. Miranda worked for the State, and Ralph was in the military. Four months prior to the murder-suicide, Miranda had moved out and was living with friends. Miranda had recently placed Lila in a private school, directions to which were found in Ralph’s pocket when police searched his body. Ralph had been arrested off the base for domestic violence seven months before he killed Miranda. He pled to supervised probation and was ordered to attend both a batterers intervention program (BIP) and substance abuse treatment, as well as to submit to random drug and alcohol tests. The local newspaper reported that Miranda had obtained a protection order against Ralph from the local circuit court both for herself and Lila three months after his arrest. The protection order judge ordered Ralph to turn over his “personal” (non-military issue) guns to the sheriff and to attend the local BIP. The order also provided for “no violent contact” and granted Ralph contact with Miranda “so long as it was regarding the child.” Miranda filed for divorce one month before her death; she was represented by counsel. Among other things, autopsy results showed that Miranda was two months pregnant and that at the time of his death, Ralph had a blood alcohol level of .12, significantly above the legal limit.

A fatality review team looking at the life of the Bonifay family would have access to a great deal of public information relating to Miranda, Ralph and Lila, even absent specific fatality review team statutory authority.¹ This could include:

- Media accounts (newspapers, television, radio, etc.)
- Protection order documents (petition, ex parte order, final order, history of violations and enforcement)
- Criminal histories (arrest and disposition data, on both adults)
- Police files (closed files of homicide/suicide investigations, arrest report and investigation)
- Medical examiner’s report, if available
- Court records in the divorce (petition, docket, preliminary determinations regarding child custody, financial affidavits)
- Concealed weapons permit data

¹ Each state has unique laws and interpretations of them. This discussion presumes laws that are common to a majority of jurisdictions.

- Reports to animal control (if pets were harmed)
- Statements from her employer, friends, family
- Statements from his friends, family

However, the team would likely *not* have access to the following non-public information, such as:

- Substance abuse treatment histories
- Lila’s school records
- Probation records (attendance and compliance at BIP, drug and alcohol test results, treatment history)
- Military records regarding Ralph, Miranda and Lila, as he was an active service member
- Contacts with local domestic violence or sexual violence programs
- Mental health records
- Attorney client or other privileged communications, such as clergy
- Physical health records (family physician, Miranda’s obstetrician/gynecologist, dentist)
- Autopsy reports, including photographs
- Gun purchase and background check records

How effective can a fatality review be if some of the information is confidential and the team cannot have complete access to it? When does the team cross the line into discovering or discussing information that is private and should be kept out of the public eye? What impact will the disclosure of information to a fatality review team have on a domestic violence victim’s desire to access a shelter, to call law enforcement or to hire a lawyer? Laws regarding an individual’s right to privacy and the public’s right to know attempt to balance these interests. Often positioned between these two interests is the work of the domestic violence fatality review team. When teams meet, they process all levels of information – some public, some private and some in between. It is essential that the fatality review teams respect both the privacy of the persons whose lives, and deaths, it studies.

Teams also must respect the public’s “right to know” and should deliver to the public information about what a community should do to intervene in and prevent domestic violence, including domestic violence homicides. Finally, team members must remember to respect the work of the team, its member agencies and organizations and their team review activities.

The laws regarding confidentiality and information used by a fatality review team differ widely across state and tribal lines. Generally, this information falls into two major categories. First, there is information relating to the lives and deaths of the people the team is reviewing. Second, there is information regarding the fatality review process itself such as its members, deliberations, findings, work products and reports. All of this information can be both public and non-public. State and federal laws, rules, regulations, and codes govern the confidentiality of both personal, case-specific information and information concerning fatality review team processes. It almost goes without saying that

a fatality review team should examine these laws and rules prior to beginning a review to be in compliance with them as it begins work, however, doing so is not as straightforward as it seems.

*The web of law governing confidentiality*²

A. Federal Law

1. Substance Abuse

Federal laws that specifically deal with information sought by a fatality review team preempt state law and will govern the team's request for data.³ In the scenario above, Ralph was ordered by the court to undergo substance abuse treatment and to submit to random drug testing. While a fatality review team could know the terms of punishment from an order in the public record, Federal law bars disclosure of information by either the probation department or the substance abuse program as to whether or where Ralph sought or obtained treatment. Nor could the team know the results of his treatment, as there are also strict limits on both disclosure and redisclosure of substance abuse treatment information.⁴ The intent of the Federal law (and similar State laws) is to protect the privacy of patients and so promote treatment.⁵ Probation officers who are members of a fatality review team can provide a great deal of information, nonetheless. For instance, they could state whether Ralph kept his appointments with the probation officer or was violated for any reason. They might also describe contacts with Miranda and whether they told her of Ralph's terms of probation and served as resource for her.

2. Domestic violence shelter records and location

Federal law also mandates that state family violence prevention and services programs hold client records and shelter address information confidential.⁶ "Shelter" means what is commonly understood as a local domestic violence program and includes an array of services such as emergency shelter, non-residential counseling, and children's programming. Many state laws mirror this requirement and so also would prohibit a domestic violence center representative from disclosing information relating to a particular client.

² The author and the National Fatality Review Initiative welcome commentary to this article, particularly additional laws and issues regarding confidentiality not mentioned here.

³ For example, with substance abuse treatment, "state confidentiality law may be more restrictive than but may not override the Federal regulations. Where State law is not stricter and conflicts with the Federal regulations, State law must yield." Lopez, F., *Confidentiality of Patient Records for Alcohol and Other Drug Treatment*, TAP Series 13, US Dept. of HHS, p.2. (last reprint 1999).

⁴ 42 U.S.C.A. s.290dd-2 (2002).

⁵ Lopez, p.1.

⁶ 42 U.S.C.A. s. 10402(a)(2)(E) (2002).

3. Military

The military keeps information about service personnel confidential to the public.⁷ Therefore, Ralph's interactions with his command, attendance at family advocacy programs (that include the military's equivalent of batterer intervention programs), prior violence or criminal record while in the service, military protection orders or any other information regarding Ralph would not be available to a team as a matter of law. It is possible, however, that fatality review teams can receive information regarding military personnel if they make a request to the proper authorities, on a case-by-case basis.⁸

4. First Amendment

State and Federal Constitutions also prohibit forced disclosure of sources of information from the media under the first amendment right of freedom of the press.⁹ If the local paper conducted an investigation and learned key information about this case, the reporter could not be forced to reveal her or his sources. However, it may benefit a team to speak with any investigative reporters who covered this murder-suicide to see what information they are willing to share, including ideas about possible reforms.

⁷ Federal Privacy Act, 5 USC 552a, and (2) exception 6 under the Freedom of Information Act (FOIA), 5 USC 552(b)(6). Those laws cover active duty personnel, civil service employees, and the family members of active duty personnel and would include personnel, medical, Family Advocacy Program, and law enforcement records, which are governed by exception 7 of the FOIA. The person whose record is being sought can give consent, and in the case of a minor, the guardian can give consent.

⁸ A fatality review team could try to obtain information regarding active duty personnel (including information after a death) in several ways. They can make a request in writing for the release of records under the civil law enforcement activity (exception 7) of the Privacy Act of 1974. A team also could ask a court to issue an order for the records under exception 11 of the Privacy Act. See <http://www.dtic.mil/whs/directives/> for further information (go to Department of Defense (DoD) directives 5400.7 and 5400.11). However, neither of these paths appears feasible for most teams as the team's work is not "law enforcement" and as courts rarely, if ever, order records for teams – team members and others produce information voluntarily. The fatality review team can also contact the Freedom of Information Act (FOIA) office where the active duty person was most recently assigned, and discuss how to access the records. The chair should include a copy of any laws or other information that legitimates or authorizes the fatality review team to act. Note that teams may be referred to the Staff Judge Advocate (SJA) at the installation and might wish to call that office for help. Another resource regarding the DoD and Freedom of Information and Privacy Programs is Mr. Vahan Moushegian, Director of the Defense Privacy Office, Washington, 703/607-2943.

⁹ *Branzburg v. Hayes*, 408 U.S. 665 (1972); see also s. 90.5015, Fla. Stat., Florida's qualified reporter privilege.

B. State Law

1. Privileged Information

State laws regulate and “privilege” a host of communications between people in specific relationships to one another. Generally, confidentiality laws are broader than the statutory grant of privilege. Some of the privilege-protected relationships include attorney-client, physician and psychotherapist-patient,¹⁰ clergy, and domestic violence and/or sexual violence counselor-client. There can be exceptions, most commonly relating to child and elder abuse, neglect and maltreatment that pierce these privileges and allow disclosure. Except in these isolated instances, only the holder of the privilege can waive it. For example a client can waive attorney/client-privileged information by knowingly divulging it to a third party. In fatality review matters, it is rare to have access to this protected information and revealing it can subject the discloser of the information to civil and criminal liability.¹¹

2. Domestic Violence Records and Child Abuse Investigations

State law can also provide for confidentiality of information, such as records of a domestic violence program, from discovery except under specific circumstances.¹² States also seal child abuse investigations.¹³ In the Bonifay scenario, a member of the local domestic violence center who sits on the fatality review team could not disclose conversations with Miranda or even state whether she contacted the domestic violence program for help. Local domestic violence program often are troubled by this law, as they may want to give the team information about a former client, but cannot do so without running afoul of state and federal law.

Some domestic violence programs have considered asking clients to waive domestic violence counselor-client privilege as well as state confidentiality protections. This would give the domestic violence program permission to share information about the clients in

¹⁰ See *Tarasoff v. Board of Regents of the University of California*, Cal. Rptr. 14, No. S.F. 23042 (Cal. Sup. Ct., July 1, 1976) 131, where the court held that a psychologist had a duty to warn his patient’s intended victim, whom his patient later killed. This case carves out an exception for psychologists, and arguably other professionals, who also may have a “duty to warn.” It is very relevant to fatality review deliberations when the team asks whether anyone knew the victim was in lethal danger and if they acted on that information.

¹¹ See *Privacy Surviving Death*, below, for further discussion of privileges.

¹² For instance, s.39.908, Fla. Stat. (2002) that provides “information about domestic violence center clients may not be disclosed without the written consent of the client... information about a client or the location of a domestic violence center may be given by center staff or volunteers to law enforcement, firefighting, medical or other personnel...”. Some might interpret this section to allow a domestic violence center to ask a client to sign a waiver stating that, in the event of her death, any information held by the domestic violence program about her could be disclosed.

¹³ E.g., s.39.908(3)(b), Fla. Stat. (2002) where it states that restrictions on disclosure or use of information about domestic violence center clients does not apply in cases of child or elder abuse.

the event of their death.¹⁴ This could allow a program to speak openly about a client, provided the waiver was valid, i.e., given knowingly and willingly. However, the use of a waiver is controversial and strongly opposed by some advocates. They question whether such a waiver could be truly informed and free of coercion and whether someone in crisis could understand all of the implications of signing it. They are also concerned that such waivers put the interests of the domestic violence organization and the fatality review team above those of the client being served.

Although the law prohibits them from disclosing case-specific information, domestic violence programs can play a critical role in the operation and success of fatality review teams. They can respond to hypothetical questions posed by team members and explain how their program might respond. They also are key interpreters of information received by the team regarding victim or perpetrator conduct and will likely be instrumental in promoting reforms suggested by the team. Moreover, in cases of near-lethal violence, they could reveal information in instances where a victim has waived the domestic violence counselor-client privilege or consented to its release. Similarly, it is very important that child abuse investigators are present at domestic violence fatality review team meetings. Not only might they also be key interpreters of information the team receives, but they may also be members of local child death review teams. Child death review and local domestic violence teams may have liaison relationships with one another and combine meetings to discuss instances where both adults and children died.

3. Privacy surviving death

Laws differ on how they treat an individual's privacy upon death and whether the "right to publicity" tort claims extend past death. Laws may protect the right to privacy of a decedent absolutely. For instance, if the law says that *only* the client can waive the privilege, and that client dies without doing so, the lawyer or other party to the privileged conversation is forever barred. However, some laws, such as those governing substance abuse treatment laws, have been interpreted to allow surviving family members, such as a spouse, to assert or waive privileges held by the person during his or her life. Still other laws or privacy-related causes of action may provide that the right to privacy is personal and ends with a person's life because *that person* can no longer suffer harm.

There are other issues regarding the use of information concerning a decedent that teams should note. In one case, a court found a spouse, child, parent or sibling could sue in tort for the reckless infliction of emotional distress if a decedent-relative's privacy is egregiously violated and they suffer harm on account of this violation.¹⁵ Privacy rights,

¹⁴ See note 12 and Washington State Domestic Violence Fatality Review Project (206) 389-2515.

¹⁵ *Williams v. City of Minneola*, 575 So. 2d 683 (Fla. 5th DCA 1991) where the court found that the decedent's mother and sister could bring an action for intentional infliction of emotional distress against the City of Minneola when City police officers showed a video autopsy of the decedent at an officer's home in "a party atmosphere where the

and the right to sue, may be spelled out in state statute, but most of the law around privacy after death has been developed over time by case law.

Therefore, if Miranda disclosed information to her lawyer and to the counselor at the domestic violence center, could that information be disclosed by either of those individuals after Miranda's death? The U.S. Supreme Court recently has held that the attorney-client privilege survives the death of client, except under very limited circumstances, so the attorney could not speak.¹⁶ The same rules would also apply to confidentiality considerations, so that an attorney's work product would also remain confidential. Some of the same issues regarding attorney-client privilege, such as the client's expectation that information would remain confidential unless waived, would apply to the domestic violence counselor. Fatality review teams should carefully research their state laws, rules and professional codes on this topic and set out guidelines for their members as to information they can disclose.

4. Fatality Review Legislation and Team Agreements

States that have enacted legislation governing fatality review team operation have passed laws that deal with some or all of the above issues in a variety of ways.¹⁷ For instance, California has one of the most expansive laws, which allows the fatality review team to receive (but not compel) medical, mental health, elder abuse, child abuse, firearms and probation reports, criminal histories, juvenile court proceedings, and lawyer – client, physician – patient, psychotherapist-patient, sexual assault victim-counselor information.¹⁸ Other states, like Florida, have a much more narrow view. However, Florida law still allows the fatality review team access to information that is usually shielded from public view, such as open law enforcement investigation files, but it does not allow teams access to privileged information¹⁹ nor give the team power to subpoena records as does Delaware.²⁰

Laws regulating fatality review teams and the information that the team uses and produces also lay out what is public and what is not. This includes:

- Membership (names, address and other contact information, attendance records)
- Meetings, deliberations

audience joked and laughed.” *Minneola*, 685. The decedent was a 14 year-old boy who had died of a drug overdose.

¹⁶ *Swidler & Berlin v. United States*, 524 U.S. 399 (1998) where the Court ruled that notes taken by a private attorney consulted by deputy White House counsel Vince Foster, after Foster committed suicide were protected by attorney – client privilege.

¹⁷ Domestic Violence Fatality Review State-by-State Matrix, National Fatality Review Initiative (2002).

¹⁸ Cal. Penal Code ss 11163.3-.6 (2002).

¹⁹ s. 741.3165, Fla.Stat. (2002).

²⁰ 13 Del. C. s. 2105 (2002).

- Working documents (notes, meeting minutes, communications between members, case summaries, data collection forms, interview notes, report drafts)
- Final reports
- Member statements, observations, comments during reviews
- Public access to meetings themselves

Teams also set out their own terms regarding confidentiality in “Confidentiality Agreements” that members and participants are required to sign.²¹ These agreements bar discussion and disclosure of fatality review team matters outside of the team and team meeting.

C. Professional codes of conduct

Codes of conduct for professionals such as psychotherapists, lawyers, mediators, health care providers and substance abuse providers deal with confidentiality and provide sanctions for violating these codes. These restrictions are usually very strong, because people will not seek out services from these professionals if they believe what they disclose will not be held private. This is in addition to criminal and civil liability that is provided by state law. Professional code sanctions can include suspension or permanently barring that individual from practice. In the above case, Miranda’s therapist might have valuable insights into both her and into Ralph’s state of mind prior to the homicide, but sharing that information could result in that therapist losing his license to practice, depending on what the psychotherapist’s professional code and state law would allow.

D. Personal ethics

Fatality review teams are collegial bodies and members often support one another both in and outside of team meetings. A fatality review team’s “no shame – no blame” philosophy requires members to trust one another and to not point fingers. Furthermore, team members must sign confidentiality agreements that prohibit disclosure of information beyond the four walls of a team meeting. What happens when a fatality review team member breaches that confidentiality based on ethical or moral reasons? He or she may believe such a breach is necessary in order provide the team with information because without this information, the community cannot hold another member accountable? In the above scenario, what if that the court’s order was the fifth in a series of “no violent contact” orders where death or serious injury followed – and that the issuing judge who sits on the team maintains and that “parents always must be able to talk about children together” and that, moreover, “no violent-contact orders” are the best ways to protect women? Assuming all interventions failed, could the personal ethics of team members demand that they speak out to the community? When, if ever, should one’s own sense of “what is right” override confidentiality proscriptions? These are difficult questions that teams should process before and during their work, perhaps seeking the advice of counsel, other teams and the NDVFRI before acting.

²¹ See Washington State Domestic Violence Fatality Review Project (206) 389-2515 and other examples available at www4.nau.edu/sbs/ndvfri.

E. Conclusion: Just because you can, should you?

No one in the community might have known that Miranda was pregnant when she died, until the autopsy was performed. If that information was shared in a fatality review team meeting, the team might have knowledge that even her family and close friends lacked. This is the type of information that should be treated with great sensitivity, and thought should be given to its overall relevance. Teams should carefully consider the impact that their discovery and use of information will have on the victim, the perpetrator, children and others in their lives, as well as upon the systems they are seeking to reform. Teams should carefully consider, and regularly revisit, their use of information and their mission. They should understand that the information they obtain, and their use of it, could affect the decision of a potential victim to access services -- if they think their doing so will be detailed in a report or the newspaper. Teams should reflect on their own roles as caretakers of highly personal data and realize that fatality review process confers rights, honors, duties, and privileges to investigate, discover and make conclusions based upon a death which is, after all, one of the most intimate moments of a person's life.

Appendix F
Team Confidentiality Practices Chart and Team Confidentiality Forms

1. Team Confidentiality Practices Chart
2. Houston, Texas, Confidentiality Agreement
3. Maine Confidentiality Agreement
4. Pima County, Arizona, Confidentiality Agreement
5. Pulaski County, Arkansas, Confidentiality Agreement
6. San Diego, California, Confidentiality Statement
7. San Francisco, California, Confidentiality Form

(NOTE: The Orange County, California, team's confidentiality form is not included in this Appendix; it is part of the MOU that team members sign and that MOU is provided in Appendix C.)

Team Confidentiality Practices Chart

Team	Has Confidentiality Agreement Form	Members Sign Form When They Join Team	Members Sign Form at Each Meeting	Guests or Consultants Sign Form at Meeting	Documents are Generally Distributed Prior to Meeting	Documents are Generally Distributed at the Meeting and not Prior to it	Documents Collected at End of Meeting	Documents Destroyed After Meeting
Houston, Texas	X		Confidentiality agreement repeated on sign-in form	X		X, but only 1 set of documents which are then circulated	X	
Maine	X	X		X	X		X	X
Orange County, California	X	X	Confidentiality agreement repeated on sign-in form	X		X, but only given to specific disciplines for review	X	X
Pima County, Arizona	X	X		X	X		X	X
Pulaski County, Arkansas	X	X		X		X	X	X
Sacramento, California	X	X		X		X	X	X
San Diego, California	X	X		X		X	X	X
San Francisco, California	X		Confidentiality agreement repeated on sign-in form	X		X	X	X



**Houston EFFORT Team - Elder Abuse Fatality Review Team
Confidentiality Agreement
Meeting Date:**

Team reviews are closed to the public and not subject to open meetings law. In no circumstances should any team member or meeting attendee disclose any team information regarding teamwork product or fatality case identifiers outside the team other than for the legitimate conduction of EFFORT review activities, and pursuant to team confidentiality guidelines.

The undersigned agree to abide by the terms of this confidentiality agreement.

Name	Signature	Agency	Telephone	E-mail Address

G. Steven Rowe
Attorney General



Phone: 207-626-8520
Fax: 207-287-3120

MAINE ELDER DEATH ANALYSIS REVIEW TEAM

Maine Office of the Attorney General
Six State House Station, Augusta, Maine 04333-0006

Confidentiality Agreement

I, _____, as a member of the Maine Elder Death Analysis Review Team, or as a participant in its proceedings, agree to keep confidential, in accordance with 5 M.R.S.A. § 200-H(6), the proceedings of the team and the records, information, or data associated with the proceedings. I agree to return to the team chairperson or designee, at the conclusion of a meeting of the team, all records, information, or data that are related to any proceeding of the team.

Date: _____

(Signature)

Printed Name: _____

Pima County Death Analysis Review Team Confidentiality In The Case Review Process

Confidentiality Issues

PIMA COUNTY DEATH ANALYSIS REVIEW TEAM, PC DART, members recognize that although confidentiality is essential to the PC DART process, the overall goal is to strengthen system policies and procedures, to identify prevention measures to stop future incidents of elder abuse – related injuries and deaths and to develop information to support prosecutions of elder abuse. This confidentiality is based upon the Arizona law.

Confidentiality must be approached on two levels: team confidentiality and member confidentiality. Team confidentiality includes all activities that occur during an PC DART meeting. Written information will be disseminated, reviewed, collected at the end of the meeting, and shredded.

Any information shown or discussed within an PC DART meeting must not be discussed with anyone outside the group. The only exception to this is in the event PC DART information is necessary to further an administrative, civil or criminal investigation.

On an individual member level, PC DART members must keep any information that is given out about specific cases confidential. PC DART should not share or speak about case information with anyone else including others in their organization. Information should not leave the room.

Confidentiality Agreement

I, as a member of the Pima County Death Analysis Review Team agree to keep confidential all information disseminated prior to or discussed at the PCDART meetings. I understand that any oral or written communication or a document shared within or produced by the PCDART or provided by a third party to the PCDART is confidential.

I also agree to return to the Chairperson of the PCDART, all outside case information received prior to, or in any meeting involving decedents, at the end of that meeting.

Date

Printed Name

Signature

Breaching Confidentiality

There will be no breaches of confidentiality. Should a breach of confidentiality be discovered, it will be investigated by the PCDART chairperson. If substantiated, the member responsible will be asked to resign from the team.



Pulaski County Elder Fatality Review Team Confidentiality Agreement

The effectiveness of this team's work to review vulnerable adult deaths of various causes with a focus on cases of abuse and neglect is conditioned upon the confidentiality of the review process and the information shared. I agree to adhere to the following confidentiality terms:

- All information obtained from social service reports, court documents, police records, coroner and autopsy reports, mental health records, hospital or medical related data and any other information that may have a bearing on the involved decedent or decedents and family will remain confidential. I agree that all discussions and information obtained in the review process will remain strictly confidential and will not be used for any purpose outside the purpose of this review process.
- I will store all materials with identifying information in a locked and secure centrally located setting and will return to the appropriate agency upon completion of case review.
- I will notify the Fatality Review Team Chair if I am subpoenaed or court ordered for information in my capacity as member of the Pulaski County Fatality Review Team.
- I agree that any information pertinent to review cases will only be discussed or released in aggregate form outside of the review Team process, in accordance with established guidelines. Communications, oral and written, and documents relating to the review process shall remain confidential and not subject to disclosure.
- I agree that any public presentations of case illustrations will have all identifiable characteristics removed in accordance with established guidelines.
- I agree that if in the course of the review, there is information that may be indicative of a new crime or mandated reportable event, the Team leader or designated member will report promptly to the most appropriate authority.
- I agree that violation of this agreement may result in my removal from the Review Team.

Name and Title _____

Agency Name _____

Signature _____

Date _____

7/2/03

**COUNTY OF SAN DIEGO
ELDER DEATH REVIEW TEAM (EDRT)**

CONFIDENTIALITY STATEMENT

The purpose of the County of San Diego Elder Death Review Team (EDRT) is to conduct a full examination of suspicious deaths associated with suspected elder abuse and/or neglect. In order to assure a coordinated response that fully addresses all systemic concerns surrounding these fatality cases, the EDRT must have access to all existing records on each person's death. This includes social services reports, court documents, police records, autopsy reports, mental health records, education records, hospital or medical related data, and any other information that may have a bearing on the intimate relationship violence victim and his/her family.

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

Agency's Name

agree that all information secured in this review meeting will remain confidential as required by Penal Code section 11174.7 and any other applicable state or federal law, and will not be used for reasons other than that which it is intended. No material will be taken from the meeting with case identifying information.

Print Name

Signature

Date

Witness 4/03

**SAN FRANCISCO CITY AND COUNTY
ELDER DEATH REVIEW TEAM**

CONFIDENTIALITY AGREEMENT

Date: _____

I, as a member of, or as a participant on, the San Francisco City and County Elder Death Review Team, agree to keep confidential all information disseminated prior to or discussed at the Death Review Team meetings. I understand that any oral or written communication, or any document, shared within or produced by the Elder Death Review Team, or provided by a third party to the Elder Death Review Team, is confidential and not subject to disclosure or discovery by a third party.

I also agree to return to the Chairperson of the Elder Death Review Team, all outside case information received prior to or during any meeting involving decedents, at the end of that meeting.

<u>NAME</u>	<u>AGENCY</u>	<u>SIGNATURE</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____

Appendix G

State Laws

1. California
2. Maine
3. Texas
4. Houston EA-FRT Statutory Synopsis

West's Annotated California Codes Currentness

Penal Code (Refs & Annos)

Part 4. Prevention of Crimes and Apprehension of Criminals (Refs & Annos)

Title 1. Investigation and Control of Crimes and Criminals (Refs & Annos)

Chapter 2. Control of Crimes and Criminals (Refs & Annos)

Article 2.7. Elder Death Review Teams (Refs & Annos)

§ 11174.4. Definitions

<Text of section as added by Stats.2001, c. 301 (S.B.333), § 2.>

The following definitions shall govern the construction of this article, unless the context requires otherwise:

(a) "Elder" means any person who is 65 years of age or older.

(b) (1) "Abuse" means any of the conduct described in Article 2 (commencing with Section 15610) of Chapter 11 of Part 3 of Division 9 of the Welfare and Institutions Code.

(2) Abuse does not include the use of any reasonable and necessary force that may result in an injury used by a peace officer acting within the course of his or her employment as a peace officer.

<For another section of the same number, added by Stats.2002, c. 1064 (A.B.2442), § 1, see Penal Code 11174.4, ante.>

§ 11174.5. Authority to establish interagency elder death team and to establish protocols

(a) Each county may establish an interagency elder death team to assist local agencies in identifying and reviewing suspicious elder deaths and facilitating communication among persons who perform autopsies and the various persons and agencies involved in elder abuse or neglect cases.

(b) Each county may develop a protocol that may be used as a guideline by persons performing autopsies on elder adults to assist coroners and other persons who perform autopsies in the identification of elder abuse, in the determination of whether elder abuse or neglect contributed to death or whether elder abuse or neglect had occurred prior to but was not the actual cause of death, and in the proper written reporting procedures for elder abuse or neglect, including the designation of the cause and mode of death.

§ 11174.6. County elder death review team; membership

County elder death review teams may be comprised of, but not limited to, the following:

- (a) Experts in the field of forensic pathology.
- (b) Medical personnel with expertise in elder abuse and neglect.
- (c) Coroners and medical examiners.
- (d) District attorneys and city attorneys.
- (e) County or local staff including, but not limited to:
 - (1) Adult protective services staff.
 - (2) Public administrator, guardian, and conservator staff.
 - (3) County health department staff who deal with elder health issues.
 - (4) County counsel.
- (f) County and state law enforcement personnel.
- (g) Local long-term care ombudsman.
- (h) Community care licensing staff and investigators.
- (i) Geriatric mental health experts.
- (j) Criminologists.

(k) Representatives of local agencies that are involved with oversight of adult protective services and reporting elder abuse or neglect.

(l) Local professional associations of persons described in subdivisions (a) to (k), inclusive.

§ 11174.7. Confidentiality of oral or written communications or documents shared or produced by elder death review team; third parties; discretion to waive confidentiality of team recommendations

(a) An oral or written communication or a document shared within or produced by an elder death review team related to an elder death review is confidential and not subject to disclosure or discoverable by another third party.

(b) An oral or written communication or a document provided by a third party to an elder death review team, or between a third party and an elder death review team, is confidential and not subject to disclosure or discoverable by a third party.

(c) Notwithstanding subdivisions (a) and (b), recommendations of an elder death review team upon the completion of a review may be disclosed at the discretion of a majority of the members of the elder death review team.

§ 11174.8. Sharing of information by organization represented on elder death review team with other team members; confidentiality; disclosure of written and oral information to team; voluntariness of disclosure; types of information to be disclosed

(a) Each organization represented on an elder death review team may share with other members of the team information in its possession concerning the decedent who is the subject of the review or any person who was in contact with the decedent and any other information deemed by the organization to be pertinent to the review. Any information shared by an organization with other members of a team is confidential. The intent of this subdivision is to permit the disclosure to members of the team of any information deemed confidential, privileged, or prohibited from disclosure by any other provision of law.

(b) (1) Written and oral information may be disclosed to an elder death review team established pursuant to this section. The team may make a request in writing for the information sought and any person with information of the kind described in paragraph (3) may rely on the request in determining whether information may be disclosed to the team.

(2) No individual or agency that has information governed by this subdivision shall

be required to disclose information. The intent of this subdivision is to allow the voluntary disclosure of information by the individual or agency that has the information.

(3) The following information may be disclosed pursuant to this subdivision:

(A) Notwithstanding Section 56.10 of the Civil Code, medical information.

(B) Notwithstanding Section 5328 of the Welfare and Institutions Code, mental health information.

(C) Notwithstanding Section 15633.5 of the Welfare and Institutions Code, information from elder abuse reports and investigations, except the identity of persons who have made reports, which shall not be disclosed.

(D) State summary criminal history information, criminal offender record information, and local summary criminal history information, as defined in Sections 11075, 11105, and 13300.

(E) Notwithstanding Section 11163.2, information pertaining to reports by health practitioners of persons suffering from physical injuries inflicted by means of a firearm or of persons suffering physical injury where the injury is a result of assaultive or abusive conduct.

(F) Information provided to probation officers in the course of the performance of their duties, including, but not limited to, the duty to prepare reports pursuant to Section 1203.10, as well as the information on which these reports are based.

(G) Notwithstanding Section 10825 of the Welfare and Institutions Code, records relating to in-home supportive services, unless disclosure is prohibited by federal law.

(c) Written and oral information may be disclosed under this section notwithstanding Sections 2263, 2918, 4982, and 6068 of the Business and Professions Code, the lawyer-client privilege protected by Article 3 (commencing with Section 950) of Chapter 4 of Division 8 of the Evidence Code, the physician-patient privilege protected by Article 6 (commencing with Section 990) of Chapter 4 of Division 8 of the Evidence Code, and the psychotherapist-patient privilege protected by Article 7 (commencing with Section 1010) of Chapter 4 of Division 8 of the Evidence Code.

§ 11174.9. County use of team information and recommendations to improve protection and coordination of services for families and elder population

Information gathered by the elder death review team and any recommendations made by the team shall be used by the county to develop education, prevention, and if necessary, prosecution strategies that will lead to improved coordination of services for families and the elder population.

Current with urgency legislation through Ch. 44 & Res. Ch. 1 of 2004 Reg.Sess., Ch. 1 (end) of 3rd Ex.Sess., Chs. 1 & 2 (Prop. 57) & Res. Ch. 1 (Prop. 58) of 5th Ex.Sess., & Props. 55 & 56
END OF DOCUMENT

Maine Revised Statutes Annotated Currentness
Title 5. Administrative Procedures and Services
Part 1. State Departments
Chapter 9. Attorney General

→§ 200-H. Maine Elder Death Analysis Review Team

There is created, within the Office of the Attorney General, the Maine Elder Death Analysis Review Team, referred to in this section as 'the team.'

1. Composition. The team is composed of 13 members as follows:

- A.** The Chief Medical Examiner, ex officio;
- B.** The Director of Investigations for the Office of the Attorney General, ex officio;
- C.** The Director of the Division of Licensing and Certification within the Department of Human Services, Bureau of Medical Services, ex officio;
- D.** The Director of the Health Care Crimes Unit within the Office of the Attorney General, ex officio;
- E.** The Director of Community Resource Development within the Department of Human Services, Bureau of Elder and Adult Services, ex officio;
- F.** The Director of the Adult Protective Services program within the Department of Human Services, Bureau of Elder and Adult Services, ex officio;
- G.** The Director of Adult Mental Health Services within the Department of Behavioral and Developmental Services, ex officio;
- H.** The executive director of the long-term care ombudsman program, as established in Title 22, section 5106, subsection 11-C, ex officio;
- I.** A representative of victim services, appointed by the Attorney General;
- J.** A commanding officer of the Criminal Investigation Division within the Department of Public Safety, Bureau of the State Police, appointed by the Attorney General;
- K.** A prosecutor, nominated by a statewide association of prosecutors and appointed by the Attorney General;

L. A police chief, nominated by a statewide association of chiefs of police and appointed by the Attorney General; and

M. A sheriff, nominated by a statewide association of sheriffs and appointed by the Attorney General.

2. Designees; terms of office. An ex officio member may appoint a designee to represent the ex officio member on the team. A designee, once appointed, qualifies as a full voting member of the team who may hold office and enjoy all the other rights and privileges of full membership on the team. All of the appointed members of the team serve for a term of 3 years. Any vacancy on the team must be filled in the same manner as the original appointment, but for the unexpired term.

3. Meetings; officers. The team shall meet at such time or times as may be reasonably necessary to carry out its duties, but it shall meet at least once in each calendar quarter at such place and time as the team determines, and it shall meet at the call of the chair. The Attorney General shall call the first meeting before January 1, 2004. The team shall organize initially and thereafter annually by electing a chair and a vice-chair from among its members. The vice-chair shall also serve as secretary.

4. Powers and duties. The team shall examine deaths and serious injuries associated with suspected abuse or neglect of elderly adults and vulnerable adults. The purpose of such examinations is to identify whether systems that have the responsibility to assist or protect victims were sufficient for the particular circumstances or whether such systems require adjustment or improvement. The team shall recommend methods of improving the system for protecting persons from abuse and neglect, including modifications of statutes, rules, training and policies and procedures.

5. Access to information and records. In any case subject to review by the team, upon oral or written request of the team, notwithstanding any other provision of law, any person that possesses information or records that are necessary and relevant to a team review shall as soon as practicable provide the team with the information and records. Persons disclosing or providing information or records upon request of the team are not criminally or civilly liable for disclosing or providing information or records in compliance with this subsection.

6. Confidentiality. The proceedings and records of the team are confidential and are not subject to subpoena, discovery or introduction into evidence in a civil or criminal action. The Office of the Attorney General shall disclose conclusions of the review team upon request, but may not disclose information, records or data that are otherwise classified as confidential.

CREDIT(S)

2003, c. 433, § 1.

5 M. R. S. A. § 200-H, ME ST T. 5 § 200-H

Current through 2003 First Special Session of the 121st Legislature

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END OF DOCUMENT

Vernon's Texas Statutes and Codes Annotated Currentness

Health and Safety Code (Refs & Annos)

Title 8. Death and Disposition of the Body (Refs & Annos)

▣ Subtitle A. Death

→ Chapter 672. Adult Fatality Review and Investigation (Refs & Annos)

§ 672.001. Definitions

In this chapter:

(1) "Abuse" means:

(A) the negligent or wilful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting emotional or physical harm leading to death; or

(B) sexual abuse of an adult, including any involuntary or nonconsensual sexual conduct that would constitute an offense under [Section 21.08, Penal Code](#), or Chapter 22, Penal Code.

(2) "Autopsy" and "inquest" have the meanings assigned by [Article 49.01, Code of Criminal Procedure](#).

(3) "Family violence" has the meaning assigned by [Section 71.004, Family Code](#).

(4) "Health care provider" means any health care practitioner or facility that provides medical evaluation or treatment, including dental and mental health evaluation or treatment.

(5) "Review" means a reexamination of information regarding a deceased adult from relevant agencies, professionals, and health care providers.

(6) "Review team" means an unexpected fatality review team established under this chapter.

(7) "Unexpected death" includes a death of an adult that before investigation appears:

(A) to have occurred without anticipation or forewarning; and

(B) to have been caused by suicide, family violence, or abuse.

§ 672.002. Establishment of Review Team

(a) A multidisciplinary and multiagency unexpected fatality review team may be established for a county to conduct reviews of unexpected deaths that occur within the county. A review team for a county with a population of less than 50,000 may join with an adjacent county or counties to establish a combined review team.

(b) The commissioners court of a county may oversee the activities of the review team or may designate a county department to oversee those activities. The commissioners court may designate a nonprofit agency or a political subdivision of the state involved in the support or treatment of victims of family violence, abuse, or suicide to oversee the activities of the review team if the governing body of the

nonprofit agency or political subdivision concurs.

(c) Any person who may be a member of a review team under Subsection (d) may initiate the establishment of a review team and call the first organizational meeting of the team.

(d) A review team may include:

- (1) a criminal prosecutor involved in prosecuting crimes involving family violence;
- (2) a peace officer;
- (3) a justice of the peace or medical examiner;
- (4) a public health professional;
- (5) a representative of the Department of Protective and Regulatory Services engaged in providing adult protective services;
- (6) a mental health services provider;
- (7) a representative of the family violence shelter center providing services to the county;
- (8) the victim witness advocate in the county prosecutor's office;
- (9) a representative from the battering intervention and prevention program for the county; and
- (10) a community supervision and corrections department officer.

(e) Members of a review team may select additional team members according to community resources and needs.

(f) A review team shall select a presiding officer from its members.

(g) Members selected under Subsection (e) must reflect the geographical, cultural, racial, ethnic, and gender diversity of the county or counties represented.

(h) Members selected under this section should have experience in abuse, neglect, suicide, family violence, or elder abuse.

[§ 672.003. Purpose and Powers of Review Team](#)

(a) The purpose of a review team is to decrease the incidence of preventable adult deaths by:

- (1) promoting cooperation, communication, and coordination among agencies involved in responding to unexpected deaths;
- (2) developing an understanding of the causes and incidence of unexpected deaths in the county or counties in which the review team is located; and
- (3) advising the legislature, appropriate state agencies, and local law enforcement agencies on changes to law, policy, or practice that will reduce the number of unexpected deaths.

(b) To achieve its purpose, a review team shall:

- (1) develop and implement, according to local needs and resources, appropriate protocols;
- (2) meet on a regular basis to review fatality cases suspected to have resulted from suicide, family violence, or abuse and recommend methods to improve coordination of services and investigations between agencies that are represented on the team;
- (3) collect and maintain data, as appropriate; and
- (4) submit the report required under Section 672.008.

§ 672.004. Duties of Presiding Officer

The presiding officer of a review team may:

- (1) send notices to the review team members of a meeting to review a fatality involving suspected suicide, family violence, or abuse;
- (2) provide a list to the review team members of each fatality to be reviewed at the meeting; and
- (3) ensure that the review team operates according to the protocols developed by the review team.

§ 672.005. Review Procedure

(a) The review team of the county in which the event that was the cause of the unexpected death occurred, as stated on the death certificate or as otherwise indicated by the medical examiner or justice of the peace notified of the death, may review the death.

(b) On receipt of the list of fatalities under Section 672.004, each review team member shall review available records for information regarding each listed unexpected death.

§ 672.006. Access to Information

(a) A review team may request information and records regarding adult deaths resulting from suicide, family violence, or abuse as necessary to carry out the review team's purpose and duties. Records and information that may be requested under this section include:

- (1) medical, dental, and mental health care information; and
- (2) information and records maintained by any state or local government agency, including:
 - (A) a birth certificate;
 - (B) law enforcement investigative data;
 - (C) medical examiner investigative data;
 - (D) juvenile court records;
 - (E) parole and probation information and records; and
 - (F) adult protective services information and records.

(b) On request of the presiding officer of a review team, the custodian of the relevant information or records relating to the deceased adult shall provide the information or records to the review team. A law enforcement agency or a medical examiner may decline to provide investigative data to a review team until after the conclusion of the investigation.

(c) This section does not authorize the release of the original or copies of the mental health or medical records of any member of the deceased adult's family, the guardian or caretaker of the deceased adult, or an alleged or suspected perpetrator of family violence or abuse of the adult that are in the possession of any state or local government agency as provided in Subsection (a)(2). Information relating to the mental health or medical condition of a member of the deceased adult's family, the guardian or caretaker of the deceased adult, or the alleged or suspected perpetrator of family violence or abuse of the deceased adult acquired as part of an investigation by a state or local government agency as provided in Subsection (a)(2) may be provided to the review team.

(d) This section does not authorize any interference with a criminal investigation, inquest, or autopsy.

§ 672.007. Meeting of Review Team

(a) A meeting of a review team is closed to the public and not subject to the open meetings law, Chapter 551, Government Code.

(b) This section does not prohibit a review team from requesting the attendance at a closed meeting of a person who is not a member of the review team and who has information regarding a fatality resulting from suicide, family violence, or abuse.

(c) Except as necessary to carry out a review team's purpose and duties, members of a review team and persons attending a review team meeting may not disclose what occurred at the meeting.

§ 672.008. Report

(a) Not later than December 15 of each even-numbered year, each review team shall submit to the Department of Protective and Regulatory Services a report on deaths reviewed.

(b) Subject to Section 672.009, the Department of Protective and Regulatory Services shall make the reports received under Subsection (a) available to the public.

§ 672.009. Use of Information and Records; Confidentiality

(a) Information and records acquired by a review team in the exercise of its purpose and duties under this chapter are confidential and exempt from disclosure under the open records law, Chapter 552, Government Code, and may only be disclosed as necessary to carry out the review team's purpose and duties.

(b) A report of a review team or a statistical compilation of data reports is a public record subject to the open records law, Chapter 552, Government Code, as if the review team were a governmental body under that chapter, if the report or statistical compilation does not contain any information that would permit the identification of an individual and is not otherwise confidential or privileged.

(c) A member of a review team may not disclose any information that is confidential under this section.

(d) A person commits an offense if the person discloses information made confidential by this section. An offense under this subsection is a Class A misdemeanor.

§ 672.010. Civil Liability for Disclosure of Information

Subject to the limits described in Section 101.023(b), Civil Practice and Remedies Code, a team organized pursuant to this chapter, or any member thereof, may be civilly liable for damages caused by the disclosure of information gathered pursuant to an investigation if such disclosure is made in violation of Section 672.007 and Section 672.009.

§ 672.011. Governmental Unit

Subject to Section 672.010, a review team established under this chapter is a local governmental unit for purposes of Chapter 101, Civil Practice and Remedies Code.

§ 672.012. Report of Unexpected Fatality

(a) A person, including a health care provider, who knows of the death of an adult that resulted from, or that occurred under circumstances indicating death may have resulted from, suicide, family violence, or abuse, shall immediately report the death to the medical examiner of the county in which the death occurred or, if the death occurred in a county that does not have a medical examiner's office or that is not part of a medical examiner's district, to a justice of the peace in that county.

(b) The requirement of this section is in addition to any other reporting requirement imposed by law.

§ 672.013. Procedure in the Event of Reportable Death

(a) A medical examiner or justice of the peace notified of a death under Section 672.012 may hold an inquest under Chapter 49, Code of Criminal Procedure, to determine whether the death was caused by suicide, family violence, or abuse.

(b) Without regard to whether an inquest is held under Subsection (a), the medical examiner or justice of the peace shall immediately notify the county or entity designated under Section 672.002(b) of:

- (1) each notification of death received under Section 672.012;
- (2) each death found to be caused by suicide, family violence, or abuse; or
- (3) each death that may be a result of suicide, family violence, or abuse, without regard to whether the suspected suicide, family violence, or abuse is determined to be a sole or contributing cause and without regard to whether the cause of death is conclusively determined.

§ § 672.014 to 672.021. Renumbered as V.T.C.A., Health & Safety Code § § 166.045 to 166.051 and amended by Acts 1999, 76th Leg., ch. 450, § 1.03, eff. Sept. 1, 1999

Current through the end of the 2004 Fourth Called Session
END OF DOCUMENT

Synopsis: Health and Safety Code (Section III)

Chapter 672

Adult Fatality Review and Investigation

Glossary of Terms (Section 672.001)

1. Abuse - the negligent or willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting emotional or physical harm leading to death; or sexual abuse of an adult (Appendix B Sexual Assault).
2. Autopsy - a post mortem examination of the body of a person, including X-rays and an examination of the internal organs and structures after dissection, to determine the cause of death or the nature of pathological changes that may have contributed to the death.
3. Family violence - an act by a member of a family or household against another member of the family or household that is intended to result in physical harm, bodily injury, assault, or sexual assault or that is a threat that reasonably places the member in fear of imminent physical harm, bodily injury, assault, or sexual assault, but does not include defensive measures to protect oneself. (Family Code Section 71.004).
4. Inquest - an investigation into the cause and circumstances of the death of a person, and a determination, made with or without a formal court hearing, as to whether the death was caused by an unlawful act or omission.
5. Health care provider - any health care practitioner or facility that provides medical evaluation or treatment, including dental and mental health evaluation or treatment.
6. Review - means a reexamination of information regarding a deceased **adult** from relevant agencies, professionals, and health care providers.
7. Review Team - an unexpected **Fatality Review Team** established under this chapter.
8. Unexpected death - a death of an **adult** that before investigation appears to:
 - a. Have occurred without anticipation or forewarning; and
 - b. Have been caused by suicide, family violence, or abuse.

Establishment of a Review Team (Section 672.002)

1. **Who has oversight of the Review Team?** The county commissioners court oversees the activities of the Review Team, or designates a department. They may also appoint a nonprofit agency or political subdivision of the state involved in support or treatment of victims if the party agrees to do so.
2. **Who can belong to a Review Team?** A Review Team may include a:
 - a. Family violence criminal prosecutor
 - b. Peace officer
 - c. Justice of the peace or medical examiner
 - d. Public health professional
 - e. Representative of the Department of Family and Protective Services, Adult Protective Services
 - f. Mental health services provider
 - g. Representative of the family violence shelter center
 - h. Medical examiner investigator
 - i. The victim witness advocate in the county prosecutor's office
 - j. A representative from the battering intervention and prevention program for the county
 - k. Community supervision and corrections department officer

Members of a Review Team may select additional team members according to community resources and needs. All members must reflect the geographical, cultural, racial, ethnic, and gender diversity of the county or counties represented.

3. **How is a Review Team governed?** Members elect a presiding officer. Members should have experience in abuse, neglect, suicide, family violence, or elder abuse.

Purpose and Powers of Review Team (Section 672.003)

1. **What is the purpose of a Review Team?** The purpose of a **Review Team** is to decrease the incidence of preventable **adult** deaths by:
 - a. Promoting cooperation, communication, and coordination among agencies
 - b. Developing an understanding of the causes and incidence of unexpected deaths in the county or counties in which the **Review Team** is located;
 - c. Advising the legislature, appropriate state agencies, and local law enforcement agencies on changes to law, policy, or practice that will reduce the number of unexpected deaths.
2. **What does a Review Team do?**
 - a. Develops and implements appropriate protocols according to local needs and resources.
 - b. Meets on a regular basis to **review fatality** cases suspected to have resulted from suicide, family violence, or abuse;
 - c. Recommends methods to improve coordination of services and investigations between agencies that are represented on the team;
 - d. Collects and maintains data, as appropriate; and
 - e. Submits a report to the Department of Family and Protective Services by December 15 in even numbered years (**Section 672.007**)

Duties of the Presiding Officer (Section 672.004)

1. **What duties are the responsibilities of the Presiding Officer?**
 - a. Sends notice of meetings
 - b. Provides a list of fatalities to be reviewed
 - c. Ensures that the Review Team operates according to the policies and procedures

Review Procedure (Section 672.005)

1. **What procedure does the Review Team follow?**
 - a. The Review Team reviews the list of fatalities provided by the presiding officer
 - b. Each **Review Team** member reviews available records for information regarding each listed unexpected death.

Access to Information (Section 672.006)

1. **How can the Review Team access data?** A **review team may** request information and records regarding **adult** deaths resulting from suicide, family violence, or abuse. Records and information that may be requested under this section include:
 - a. Medical, dental, and mental health care information;
 - b. Information and records maintained by any state or local government agency, including:
 - c. A birth certificate;
 - d. Law enforcement investigative data;
 - e. Medical examiner investigative data;
 - f. Juvenile court records;
 - g. Parole and probation information and records; and
 - h. Adult protective services information and records.
2. **Who requests the records?** The presiding officer can request the records from the appropriate agency. On request of the presiding officer, the custodian of the relevant information or records **shall** provide the information or records to the review team. A law enforcement agency or a medical examiner may decline to provide investigative data to a **review** team until after the conclusion of the investigation.
3. **What records are not accessible by the Review Team?**
 - a. The Review Team **cannot** access the original or copies of the mental health or medical records of any member of the victim's family, the guardian or caretaker, or an alleged or suspected

- perpetrator of family violence or abuse that are in the possession of any state or local government agency; **however**,
- b. This information can be reviewed if it is acquired during an investigation by a state or local government agency.
 - c. The Review Team **cannot** interfere with a criminal investigation, inquest, or autopsy.

Meeting of Review Team (Section 672.007)

1. What are the rules governing the meeting of the Review Team?

- a. Meetings are closed to the public, but others can attend if the Review Team invites that person and he/she has information pertinent to the fatality.

Use of Information and Records; Confidentiality (Section 672.009 and 672.010)

1. What are the rules regarding confidentiality?

- a. Information is confidential and exempt from disclosure under the open records law.
- b. A report of a **review** team or a statistical compilation of data reports is a public record subject to the open records law. The report or statistical compilation cannot contain any information that would permit the identification of an individual and is not otherwise confidential or privileged.
- c. Information or notes from discussions at the meetings may not be disclosed.
- d. A Review Team member or guest commits a misdemeanor offense if the person discloses information made confidential by this section.
- e. A Review Team, or any member of the team, may be civilly liable for damages caused by the disclosure of confidential information.

Governmental Unit (Section 672.011)

1. Is a Review Team a governmental unit?

- a. Yes, it is a local governmental unit.

Report of Unexpected Fatality (Section 672.012)

1. Who must report an unexpected fatality?

- a. A person, including a health care provider, must report a suspicious adult death to the county medical examiner.

Appendix H
Team Open or Closed Cases Chart

Team	Open Cases	Closed Cases
Houston, Texas	X	X
Maine		X
Orange County, California		X
Pima County, Arizona	X	
Pulaski County, Arkansas		X
Sacramento, California	X	X
San Diego, California		X
San Francisco, California	X	

Appendix I
Team Types of Abuse Chart

Team	Domestic Abuse	Institutional Abuse
Houston, Texas	X	X
Maine	X	X
Orange County, California	X	X
Pima County, Arizona	X	X
Pulaski County, Arkansas	X	X
Sacramento, California	X	X
San Diego, California	X	X
San Francisco, California	X	X

Appendix J
Team Elder or Adult Abuse Chart

Team	Elder Abuse	Dependent Adult Abuse
Houston, Texas	X	X
Maine	X	X
Orange County, California	X	
Pima County, Arizona	X	X
Pulaski County, Arkansas	X	X
Sacramento, California	X	
San Diego, California	X	
San Francisco, California	X	

**Appendix K
San Diego Elder Death Review Team Case Review Worksheet**

The San Diego team uses the following case review worksheet in addition to the data collection form that is provided in Appendix L. According to a team member, prior to EA-FRT meetings the team coordinator sends to each team member the data collection form with the name of the victim whose death will be reviewed. The coordinator asks each member to search through their agency's databases to research their agency's involvement with the victim. The coordinator enters the data submitted by the team members onto the case review worksheet. That worksheet, with the data entered, is shown at the meeting on a Power Point slide. Additional information is added during the meeting as each team member shares more details. The case review worksheet is mostly used to collect the demographic information and other data that is useful statistically, and for developing recommendations.

Victims Name: _____ Victims DOB: _____ Suspect's Name: _____ Suspect's DOB: _____ Suspect's Relationship to the Victim: _____ ME CC#: _____
--

**COUNTY OF SAN DIEGO
ELDER DEATH REVIEW TEAM**

Worksheet

Prior to the death, was the victim known to your agency? Yes No
 If yes, how many times was this individual's case opened?

**PLEASE PROVIDE THE FOLLOWING INFORMATION FOR THE LAST THREE
CASES
MOST RECENT FIRST**

Date of Contact	Nature of Contact
_____	_____
_____	_____
_____	_____

FOR MOST RECENT CONTACT

Was case active at time of decedent's death? Yes No

If no, date case closed: ____/____/____

Date Hotline called: ____/____/____

Hotline called by: ____ Family ____ Medical Personnel ____ Neighbor ____ Friend
____ Care Provider ____ Other

Triage Categorization: ____ Imminent Danger ____ Significant Risk of Imminent Danger
____ Other

Was Triage appropriate? Yes No If yes, please comment

Was contact made with victim/family? Yes No If yes, date ____/____/____

Region, which made most recent contact: East County Metro North County South Bay

Most recent contact made with: Victim Family Other

Assessment Findings:

What was the nature and extent of the agencies' intervention?

Were standards met for the following:

Frequency of contact: Yes No

Risk Assessment conducted: Yes No

For the most recent Agency contact (within last 12 months) were any agency standards not met?

All were met Not met

Comments:

Did your agency make a suggestion/referral that was not followed by victim/family?

Yes No Unknown

If yes, please explain

Did your agency conduct an investigation following the death? Yes No

If yes what were the findings

The victim is survived by:

Spouse Former Spouse Significant Other Other Close Relatives

Close Friends of Either Sex

Adult Children

Others

If victim was a resident of San Diego County: Date of residency (if known) ____/____/____
or # of years _____

Was victim currently living with any family members? Yes No Unknown

If yes: Spouse Daughter Son Other

Were there any other unrelated persons living in the home? Yes No Unknown

If yes, who

Were there major family stressors, i.e.: illness, substance abuse, etc? Yes No Unknown

If yes, please explain

Was there any incidence of abuse/neglect in the home? Yes No Unknown
Details

Was chemical abuse associated with the decedent's living environment? Yes No
 Unknown
If yes, users Decedent Spouse Adult Child Other

Was there any intervention for the family members following the death of the decedent? Yes
 No Unknown
If yes, by whom?

Decedent's estimated annual income: Unknown
 Less than \$10,000 \$10,000-\$14,999 \$15,000-\$24,999 \$25,000-\$34,999
 \$35,000-\$49,999 \$50,000-\$100,000 \$100,000 on up

If a Suicide:

Had decedent previously attempted suicide? Yes No Unknown
Details

Did decedent express suicidal thoughts or tendencies? Yes No Unknown
Details

Was the decedent involved in self-destructive behaviors other than alcohol/drugs/suicide
attempts? Yes No Unknown
Details

Additional Information:

Appendix L

EXPLANATION OF CHART CATEGORIZING DATA COLLECTION FORMS

Teams from Houston, Orange County, Pulaski County, Sacramento, San Francisco, and San Diego submitted copies of their EA-FRT data collection forms. Project staff developed a chart (actually a collection of 13 smaller charts) to categorize the contents of those forms in order to make it easier for people using this replication manual to see the similarities and differences in the forms. No one form elicited every piece of information included in the six documents. Readers should use this chart to identify which form contains the item(s) of interest to them. If multiple forms request the same information, readers can easily find and then compare the pertinent provisions without having to search through six forms for the desired information.

Each form categorized the information it seeks in different ways and used different words and labels to do so. As a result, project staff members had to create their own method of categorizing the information and their own labels by analyzing and then clustering the similarities in the six forms. Staff developed the following 13 categories:

- Victim's personal information
- Perpetrator's personal information
- Victim's medical information
- Victim's legal/financial information
- Victim's contact with social services, health care, law enforcement, and other agencies

- Victim's and perpetrator's contact with the criminal justice system
- Risk factors – relationship between victim and perpetrator
- Risk factors – weapons, other violence, and history of abuse
- Risk factors – mental health and substance abuse
- Circumstances of death or incident related to death
- Process of investigation
- Team's review process
- Recommendations and preventive actions.

Staff made every attempt to be true to the teams' forms and consistent in approach, trying not to interpret or make judgments about the meaning of items. Staff sought guidance from team representatives when necessary. At times, staff was uncertain whether to classify a form as a data collection form or as a worksheet (see Appendix K). When that occurred, staff asked the teams to explain how the forms were used and categorized them as the team indicated. Nonetheless, some team members or other readers may question or disagree with some of the categorizations in the data collection chart developed by project staff.

The chart is not intended to serve as a guide to a model data collection form. It is simply a tool to enable readers to cross-reference the six team data collection forms if they wish to create an EA-FRT data collection form or change an existing form. To illustrate, the data collection chart indicates that the Houston, San Francisco, Sacramento, and San Diego forms request information about a victim's use of medications. Someone

interested in collecting data about that issue would know from the chart to look at those four forms in order to learn how those teams elicit and categorize that data.

Some of the forms requested the same information about the victim and perpetrator. To avoid redundancy and save space, project staff indicated those situations with an asterisk.

Appendix L
Team Data Collection Chart, Explanation of Chart, and Forms

TEAM DATA COLLECTION CHART

VICTIM'S PERSONAL INFORMATION

	Name	Race/ Ethnicity	Sex	Date of Birth	Age	Marital Status	County of Residence	Place of Residence (Facility, House, Apt. Etc.)	Zip Code	Social Situation (Relationships, Support Network)	Social Activities (Senior Center, Church, Clubs, Friends, Family)
Houston	X	X	X	X			X				
Orange County										X	
Pulaski County	X	X	X			X		X			X
Sacramento	X	X	X	X	X						
San Diego	X			X				X			
San Francisco	X	X	X	X	X		X	X	X		

PERPETRATOR'S PERSONAL INFORMATION

	Name	AKA (Aliases)	Race/Ethnicity	Sex	Age/Date of Birth	County of Residence	Residence (Describe)
Houston	X		X	X	X	X	
Orange County							
Pulaski County							
Sacramento	X	X	X	X	X		
San Diego	X				X		X
San Francisco	X	X	X	X	X		

* Information Requested About Victim and Perpetrator

VICTIM'S MEDICAL INFORMATION

	Past Medical History	Pre-Existing Life Threatening Disease or Condition	Diagnoses	Prescriptions	Lab Data (Blood, Radio, Etc.)	Physical Findings	Indicators of Health Risk Prior to Fatality	Contributing Factors (Lack of Mobility, Nutrition, Accident, Isolated, No Family, No Services)	Substance Use During the Incident
Houston									X
Orange County			X	X	X	X			
Pulaski County							X	X	
Sacramento			X						
San Diego	X	X							
San Francisco									

	Under Care of Primary Care Physician	Medications Taken	Medical Illnesses	Significant Medical Issues/Pre-Existing Disease	Functions in Weeks Before Death/As Completed	Description of Decline/Tempo of Illness	Cognitive Status Evaluation	Cognitive Status
Houston		X	X					
Orange County					X			
Pulaski County	X							
Sacramento	X	X		X	X	X	X	X
San Diego		X			X			
San Francisco		X		X	X	X	X	X

* Information Requested About Victim and Perpetrator

VICTIM'S LEGAL/FINANCIAL INFORMATION

	Estimated Net Worth (Income and Assets)	Own Home or Other Residence?	Did Victim Have a Guardian or Conservator?	Did Victim Have an Advance Directive or Durable Power of Attorney?	Describe Victim Contact With Legal/Financial Systems
Houston					
Orange County					
Pulaski County					
Sacramento	X	X	X	X	X
San Diego					
San Francisco	X	X	X	X	X

	Abuser Gain Financially From Death?	Financial Arrangements Between Perpetrator and Victim?	Describe Recent Changes to Will, Trust, Advance Directive	Financial Situation	Did Victim Control of Own Finances?
Houston					
Orange County		X		X	
Pulaski County					
Sacramento			X		
San Diego					X
San Francisco	X		X		

* Information Requested About Victim and Perpetrator

VICTIM'S CONTACT WITH SOCIAL SERVICES, HEALTH CARE, LAW ENFORCEMENT, AND OTHER AGENCIES

	APS	Ombudsman	EMS/911	Police	Protective Services (Shelters, Transitional Housing, Etc.)	Shelter	Legal	Peer Advocate	Counseling	Crime Victim's Compensation	Information and Referral
Houston	X	X	X	X	X	X	X	X	X	X	X
Orange County	X			X							
Pulaski County			X								
Sacramento	X			X							
San Diego	X			X	X						
San Francisco	X	X	X	X							

	Aging	Public Guardian	Laguna Beach Seniors	Contact With Health Professionals and Community Services 6 Months Prior to Death (MD, Day Center, Case Manager, Other)	Services in Place (Home Health, ElderChoices, Home Delivered Meals, Hospice, Visiting Nurses, VA)	List of Specific Organization/ Agencies Used by Victim Before the Incident	Allegation of Neglect	TEAM (Texas Elder Abuse Mistreatment Institute)
Houston	X					X		X
Orange County		X	X				X	
Pulaski County					X			
Sacramento		X		X	X			
San Diego								
San Francisco				X				

* Information Requested About Victim and Perpetrator

VICTIM'S AND PERPETRATOR'S CONTACT WITH THE CRIMINAL JUSTICE SYSTEM

	Injury in Prior Abusive Events	TRO Placed on Perpetrator by Victim	TRO Placed on Perpetrator by Other	TRO in Effect at Time of Homicide	Victim on Parole/Probation at Time of Homicide	Perpetrator has Prior Employment as Caregiver	Order of Protection Against Perpetrator at Time of Incident	Order of Protection Against Perpetrator in the Past Expired
Houston					X		X	X
Orange County								
Pulaski County								
Sacramento								
San Diego	X	X	X	X		X		
San Francisco								

	Order of Protection Against Perpetrator Pending	Order of Protection Against Perpetrator Applied For, Not Qualify	Order of Protection Against Perpetrator Applied For, But Dismissed	Order of Protection Against Perpetrator Applied For, But Not Filed	Order of Protection Against Victim at Incident Time	Order of Protection Against Victim in the Past Expired
Houston	X	X	X	X	X	X
Orange County						
Pulaski County						
Sacramento						
San Diego						
San Francisco						

* Information Requested About Victim and Perpetrator

RISK FACTORS-RELATIONSHIP BETWEEN VICTIM AND PERPETRATOR

	Victim's Relationship to Perpetrator (Primary Caregiver)	Perpetrator Involved in Other Suspicious Deaths	Description of Circumstances and Length of Relationship	Paid Relationship?	Same Sex Relationship?	Habitation Status	Controlling of Daily Activities?
Houston	X			X	X	X	
Orange County	X						
Pulaski County							
Sacramento	X		X		X		
San Diego	X	X					X*
San Francisco	X		X				

	Obsessive-Possessive Beliefs?	Perpetrator Perceive Betrayal by Victim?	Victim Gave Perpetrator Ultimatum	Documented Prior Intimate Partner Violence Between Perpetrator and Victim	Prior Intimate Partner Violence Police Reports Between Victim and Perpetrator	Caregiver Relationship	Caregiver Prior Arrests
Houston				X	X		
Orange County						X	X
Pulaski County							
Sacramento							
San Diego	X*	X	X				
San Francisco							

* Information Requested About Victim and Perpetrator

RISK FACTORS-WEAPONS, OTHER VIOLENCE, AND HISTORY OF ABUSE

	Criminal History	On Parole/ Probation at Time of Homicide?	History of Committing Child Abuse	History of Other Types of Violence	History of Violence Towards Pets	History of Property Destruction	Ordered to Court Mandated Treatment Program	Stalking History?	Escalation of Abuse Before Homicide?	Graphic Threats to Kill	Homicidal Ideation
Houston	X	X									
Orange County											
Pulaski County											
Sacramento											
San Diego	X*		X*	X*	X*	X*	X	X	X*	X*	X*
San Francisco											

	Injury in Prior Abusive Incidents	TRO Violation	History of TROs Against Perpetrator	Police Involvement With Previous Elder Abuse Incident	TRO in Effect at Time of Homicide	APS Referrals	Contact With Protective Services	Involved in Other Suspicious Death	Access to Firearms/ Other Weapons	Threats With Weapons	Use of Weapons in Prior Incidents (Arson Included)
Houston											
Orange County											
Pulaski County											
Sacramento											
San Diego	X*	X	X	X*	X	X	X	X	X*	X*	X*
San Francisco											

* Information Requested About Victim and Perpetrator

RISK FACTORS-MENTAL HEALTH AND SUBSTANCE ABUSE

	Abuser Display Risk Behaviors (APS Reports, DV, Criminal History, Alcohol, Drugs, Mental Health Problems, Financial Problems)	Experienced Significant Life Stressors (Job Loss, Money Problems, Death of Family Member or Friend, Physical Health Problems)	Substance Use During Incident?	Other Substance Abuse by Caregiver or Other Person	During Events Leading to Death, Evidence of Illegal Substance or Alcohol Abuse? (Victim, Caregiver, Other Person)	Emotional/Mental/Physical Deterioration
Houston			X*			
Orange County						
Pulaski County						X
Sacramento				X	X	
San Diego		X*				
San Francisco	X					

	History of Substance Abuse	Drug Abuse	Alcohol Abuse	Gambling Abuse	History of Mental Illness	Mental Health Problems	Mental Health Diagnosis of Victim	History of Suicide Threat, Ideation	History of Suicide Attempt	History of Depression
Houston	X*				X*					
Orange County							X			
Pulaski County										
Sacramento		X	X		X	X		X	X	X
San Diego		X*	X*	X*		X*	X	X*	X*	
San Francisco										

* Information Requested About Victim and Perpetrator

CIRCUMSTANCES OF DEATH OR INCIDENT RELATED TO DEATH (Page 1 of 2)

	Place of Death	County of Death	Date/Time of Death	Date Pronounced Dead	Time Pronounced Dead	Cause of Death	Coroner's Findings	Cause of Death as Recorded in Death Certificate or Autopsy Report	Cause of Death as Recorded in Autopsy Report	Narrative Summary of Cause and Circumstances of Death
Houston			X	X	X				X	
Orange County							X			
Pulaski County						X				
Sacramento	X		X			X				
San Diego			X			X				
San Francisco	X	X	X					X		X

	Manner of Death	Other Significant Conditions Contributing to Death	Site/Location of Incident	Incident Date	Day of Week	Time of Incident	Incident/Type of Death	Murder-Suicide or Murder-Attempted Suicide	Concerning Physical Signs (Dehydration, Burns, Bruises, Malnourished)	Injuries to Victim	Acute Injuries/Fractures
Houston	X		X	X	X	X	X	X		X	
Orange County											
Pulaski County											
Sacramento									X		X
San Diego							X				
San Francisco		X							X		X

* Information Requested About Victim and Perpetrator

CIRCUMSTANCES OF DEATH OR INCIDENT RELATED TO DEATH (Page 2 of 2)

	Decubitus Ulcers at Death	Alcohol/ Drugs Involved	Type of Abuse Suspected	Narrative Summary of Type of Abuse Suspected	Were Others Injured?	Weapon/Method Used
Houston					X	X
Orange County						
Pulaski County						
Sacramento	X					
San Diego						
San Francisco	X	X	X	X		

* Information Requested About Victim and Perpetrator

PROCESS OF INVESTIGATION

	EMS Response	Police Response	Autopsy Performed? If so, Where and Were Pictures Reviewed?	Autopsy Performed?	Toxicology Report	Sexual Assault Analysis Conducted	Investigation by Coroner/ Police/APS/Attorney General/ OLTC, Other	Prosecution Warranted?	Source of Information (Coroner, APS, Law Enforcement)	Determination Whether There are Additional Suspects?
Houston	X	X				X				
Orange County										
Pulaski County		X					X	X	X	
Sacramento				X						X
San Diego					X					
San Francisco			X							X

* Information Requested About Victim and Perpetrator

TEAM'S REVIEW PROCESS

	Case No.	Death Certificate No.	Autopsy No.	ME No.	Assigned ID No.	Date of Review	Case Summary	Which Team Members Present for Review	Reporting County	Name of Reporter	Date of Report	Date/ Occurrence	Did Elder Abuse Occur?	Did Abuse Directly Contribute to Death?
Houston		X	X				X							
Orange County														
Pulaski County						X								
Sacramento					X					X	X		X	X
San Diego	X			X		X						X		
San Francisco					X			X	X	X	X		X	X

	Death Preventable	Lessons Learned From This Case (Provide Narrative)	Intervenable at Which Level (Individual, Family, Agency, Public Policy)?	Non-Intervenable	Undetermined if Intervention Possible	Indirect General Policy Recommendation Offered	Summary/ Questions	Reason Why Case Assigned to Death Review Team (Suspicious Death?)	Brief Summary of Case	Status of Review Complete or Incomplete?
Houston										
Orange County							X			
Pulaski County										
Sacramento	X	X					X	X	X	
San Diego			X	X	X	X				X
San Francisco	X	X						X	X	

* Information Requested About Victim and Perpetrator

RECOMMENDATIONS AND PREVENTIVE ACTIONS

	Did Team Recommend Additional Investigation?	List of Recommendations	Did Review Raise Policy/Practice Issues?	Did Review Raise System Issues?	Describe Team's Recommendations or Prevention Activities Proposed	What Changes, if Any, Have Been Made as a Result of Death?	What Agencies Were Involved?	What Agencies Should Have Been Involved?
Houston								
Orange County								
Pulaski County								
Sacramento	X		X	X	X	X	X	
San Diego		X					X	X
San Francisco	X		X	X	X	X		

* Information Requested About Victim and Perpetrator



Elder Abuse Fatality Review Team

CASE REPORT FORM

SECTION 1. PERSONAL IDENTIFIERS (VICTIM INFORMATION)

	<p>Incident:</p> <p>Homicide 1</p> <p>Suicide 2</p> <p>Accidental 3</p> <p>Death by omission 4</p>
1.) Victim's Name (last, first, middle):	
2.) Death Certificate #: _____	3.) Date of Death: ____/____/____
2a.) Autopsy Report #: _____	
4.) County of Residence	
<p>5.) Race/Ethnicity: 1 White 2 Black or African American 3 Hispanic/Latino</p> <p>4 Asian 5. American Indian or Alaska Native 6. Native Hawaiian or other Pacific Islander</p> <p>7. Other (specify) _____</p>	
6.) Sex: 1 Male 2 Female	7.) Date of Birth: ____/____/____
<p>8.) History of Substance Abuse: 1 Yes 2 No</p> <p style="padding-left: 40px;">Alcohol: 1 Yes 2 No</p> <p style="padding-left: 40px;">Illicit Drugs 1 Yes 2 No</p>	
<p>9.) Substance Use During Incident: 1 Yes 2 No 3 Unknown</p> <p style="padding-left: 40px;">1 Alcohol: 3 Prescription Drugs</p> <p style="padding-left: 40px;">2 Illicit Drugs: 4 Unknown Substance(s)</p>	

10.) History of Mental Illness:	1 Yes 2 No	What if known _____
1 Diagnosis or treatment for mental health:		1 Yes 2 No 3 Unknown
2 Victim of child abuse/ neglect-Physical:		1 Yes 2 No 3 Unknown
3 Victim of child abuse-sexual:		1 Yes 2 No 3 Unknown
11.) Reported to APS:	1 Yes 2 No	
If yes, please document APS findings: _____		
12.) Was the victim on probation at the time of the homicide?	1 Yes 2 No	
13.) Was the victim on parole at the time of the homicide?	1 Yes 2 No	

SECTION 2. PERSONAL IDENTIFIERS (PERPETRATOR INFORMATION)

1.) Alleged perpetrator's Name (last, first, middle):		
2.) County of Residence:		
3.) Race/Ethnicity: 1 White 2 Black or African American 3 Hispanic/Latino 4 Asian 5. American Indian or Alaska Native 6. Native Hawaiian or other Pacific Islander 7. Other (specify)_____		
4.) Sex: 1 Male 2 Female	5.) Date of Birth: ____/____/____	
6.) History of Substance Abuse:	1 Yes 2 No 3 Unknown	
1 Alcohol:	3 Prescription Drugs	
2 Illicit Drugs:	4 Unknown Substance(s)	
7.) Substance Use During Incident:	1 Yes 2 No 3 Unknown	
1 Alcohol:	3 Prescription Drugs	
2 Illicit Drugs:	4 Unknown Substance(s)	
8.) History of Mental Illness:	1 Yes 2 No	What if known _____
1 Diagnosis or treatment for mental health:		1 Yes 2 No 3 Unknown
2 Victim of child abuse/neglect – Physical:		1 Yes 2 No 3 Unknown
3 Victim of child abuse – Sexual:		1 Yes 2 No 3 Unknown
4 Compliance with medication:		1 Yes 2 No 3 Unknown

9.) Criminal History:		1 Yes 2 No	
If yes, please provide the following information for each offense:			
Case	Offense Type	What (if any) Charges Filed	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
10.) Was the perpetrator on probation at the time of the homicide?		1 Yes 2 No	
11.) Was the perpetrator on parole at the time of the homicide?		1 Yes 2 No	

SECTION 3. NATURE OF RELATIONSHIP

1.) Victim's Relationship to Perpetrator (at time of the homicide):			
1 Spouse or Common Law	2 Ex-Spouse or Ex-Common Law		
3 Boyfriend or Girlfriend	4 Ex-Boyfriend or Ex-Girlfriend		
5 Son or Daughter	6 Grandchild		
7 Sibling	8 Niece or Nephew		
9 Provider/Caregiver	Paid: 1 Y or 2 N		
2.) Same Sex Relationship:		1 Yes 2 No	
3.) Habitation Status:			
1 Living Together at Time of Incident		1 Yes	2 No
2 Living separately		1 Yes	2 No
3 Separated and Divorce Pending		1 Yes	2 No
4 Separated and Divorce Final		1 Yes	2 No
5 Previously Lived Together, No Divorce Pending or Final		1 Yes	2 No

SECTION 4. MEDICAL INJURIES/AUTOPSY FINDINGS

1.) Location of incident: Key Map Designation_____
2.) Site of incident (Choose One Only):

1 Shared Residence	2 Victim's Residence	3 Perpetrator's Residence
4 Victim's Workplace	5 Parking Lot	6 Street
7 Assisted Care Facility		
8 Other (Please Specify) _____		
3.) Incident Date: ____ / ____ / ____		
4.) Day of Week:		
1 Monday	2 Tuesday	3 Wednesday
4 Thursday	5 Friday	
6 Saturday	7 Sunday	
5.) Time of Incident: ____:____		
5a.) Date Pronounced Dead: ____ / ____ / ____		
5b.) Time Pronounced Dead: ____:____		
6.) Weapon/Method Used:		
Handgun:	1	
Shotgun:	2	
Rifle:	3	
Other:	4	(Please Specify) _____
Knife Used:	5	(Please Specify) _____
Blunt Object:	6	(Please Specify) _____
Drowning:	7	
Hanging:	8	
Overdose:	9	(Please Specify) _____
6A). Neglect ___ Caregiver Neglect ___ Self-Neglect		
Physical ___1___		
Medical ___2___		
Both ___3___		
7.) Was a sexual assault analysis conducted? 1 Yes 2 No 3 Unknown		
If yes: 1 Positive 2 Negative		
8.) What injuries did the victim suffer? (circle all that apply):		
1 gunshot/s	2 stab/incised wounds	3 broken bones/cartilage
4 cuts/abrasions	5 strangulation	6 lacerations/slashes/gashes
7 burns	8 smoke inhalation	9 bruises/contusions/hematomas
10 decubitus ulcers	11 dehydration	12 lack of sustaining medication
13 malnutrition/starvation		
14 Other _____		
9.) Murder – Suicide: 1 Yes 2 No		

10.) Murder – Attempted Suicide: 1 Yes 2 No
11.) How Many Others Injured: 0 1 2 3 4 5
12.) Cause and manner of death recorded in autopsy report: _____
13.) Police Agency(s) that Responded: _____ _____
Offense Report Number: _____
Emergency services that responded: _____ _____

SECTION 5. INTIMATE PARTNER VIOLENCE

1.) Documented Prior Intimate Partner Violence (IPV) Between Victim and Perpetrator: 1 Yes 2 No
2.) Prior IPV Police Reports Between Victim and Perpetrator: How Many IPV Police Reports: _____ Dates: ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___

SECTION 6: RESOURCE UTILIZATION BY VICTIM

1.) Social Services Sought by Victim or others on victim’s behalf (circle all that apply):
Shelter: 1
Legal: 2
Peer Advocate: 6
Counseling: 7
Crime Victims’ Compensation: 8
Information & Referral: 9
APS 10
Aging 11
Ombudsmen 12
TEAM Services 13

Other:	14	(Please Specify) _____
2.) Please List the Specific Agencies/Organizations Utilized by the Victim before the incident:		

SECTION 7: PROTECTIVE ORDER

1.) Order of Protection Against Perpetrator (at time of incident):		
1 Yes	2 No	Date Issued: ____/____/____
2.) Order of Protection Against Perpetrator (pending):		
1. Yes	2 No	
3.) Order of Protection Against Perpetrator (applied for, but did not qualify):		
1 Yes	2 No	
4.) Order of Protection Against Perpetrator (applied for, but dismissed):		
1 Yes	2 No	
5.) Order of Protection Against Perpetrator (applied for, but not filed):		
1 Yes	2 No	
6.) Order of Protection Against Perpetrator: (in the past):		
1 Yes	2 No	Date Issued: ____/____/____
7.) Order of Protection Against Victim: (at time of incident):		
1 Yes	2 No	Date Issued: ____/____/____
8.) Order of Protection Against Victim: (in the past):		
1 Yes	2 No	Date Issued: ____/____/____

SECTION 8: MEDICAL ISSUES

1. Medical Illness (Circle all that apply)

- | | |
|------------------------|---|
| CHF | 1 |
| AD or other (dementia) | 2 |
| Depression | 3 |
| Diabetes | 4 |
| GERD | 5 |
| Hypertension | 6 |
| Other | 7 |

2. Number of Medications (List all below) _____

_____	_____	_____
_____	_____	_____
_____	_____	_____

CASE SUMMARY

Orange County, California Elder Death Review Team
Case Review Chart

Victim		
Timeline: Agency Contact	Date	Result of Contact
APS		
Laguna Beach Seniors		
Laguna Beach PD		
Public Guardian		
Allegations of Neglect		
Prior Medical Information		
Diagnoses		
Prescriptions		
Functional Status		
Lab Data (blood, radio, etc.)		
Physical Findings		
Mental Health		
Social Situation		
Relationships		
Support Network		
Caregiver		
Relationship		
Prior Arrests		
Financial Situation		
Coroner's Findings		
Suspected Perpetrator		
Relationship		
Prior Arrests		
Financial Arrangement		
Summary		
Summary		
Questions		

Pulaski County Fatality Review Team

Date of Review: _____

Name of Victim: _____

Facility: _____

Sex:

- _____ Male
- _____ Female

Race:

- _____ Asian
- _____ Black
- _____ Hispanic
- _____ Other
- _____ White
- _____ Unknown

Marital Status:

- _____ Never Married
- _____ Married
- _____ Separated
- _____ Divorced
- _____ Widowed
- _____ Unknown

Primary Care Physician: _____

Cause of death:

Police response to residence/facility:

- _____ Yes
- _____ No

Contributing factors:

- _____ Lack of mobility
- _____ Nutrition
- _____ Accident
- _____ Isolated
- _____ No family
- _____ No family involvement
- _____ No services

Source of information:

- _____ Coroner
- _____ APS
- _____ Law enforcement
- _____ Prosecuting attorney
- _____ Victim advocate

Services in place:

- _____ Home Health
- _____ ElderChoices
- _____ Home Delivered Meals
- _____ Hospice
- _____ Visiting Nurses
- _____ V.A.

Social Activities:

- _____ Senior Center
- _____ Church/church group
- _____ Clubs
- _____ Friends
- _____ Family

Emotional/Mental/Physical Deterioration:

- _____ Suicidal
- _____ Loss of physical ability to function
- _____ Poor compliance re medications
- _____ Depression
- _____ Economic problems
- _____ Loss of family support

Indicators of health risk prior to fatality:

- _____ Yes
- _____ No
- _____ Unknown

Repeated 911 calls:

- _____ Yes
- _____ No

Investigation:

- _____ Coroner
- _____ Attorney General
- _____ Police
- _____ OLTC
- _____ APS
- _____ Other

Prosecution warranted:

- _____ Yes
- _____ No

Revised 1/20/04

Sacramento County Elder Death Review Team

ID # _____
(Assigned by Coordinator)

Name of Reporter: _____

Date of Report: _____

Agency of Reporter: _____

Decedent Name: _____ Race/Ethnicity: _____ Gender: _____

Age: _____ DOB: _____ DOD: _____

Reason Case Brought to Death Review Team (open APS case, suspected homicide or suicide, etc.).

What course of action do you wish to see from EDRT? _____

Agencies Involved with Elder and required for presentation

- | | |
|---|--|
| <input type="checkbox"/> Alta | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Adult Day Health | <input type="checkbox"/> IHSS |
| <input type="checkbox"/> APS | <input type="checkbox"/> Law Enforcement |
| <input type="checkbox"/> CCL | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Coroner | <input type="checkbox"/> PA/PG/PC |
| <input type="checkbox"/> DHS | <input type="checkbox"/> Other |
| <input type="checkbox"/> Fire | |
| <input type="checkbox"/> Home Health | |

Place of Death (residence, nursing home, etc.): _____

Cause of Death: _____

Autopsy Performed? Yes Full Yes Partial No

Summary of Case:

Additional information that may be helpful to the team in their review:

Questions/Concerns:

DATA ELEMENTS

1. Suspicious Physical Findings/Indicators

<p>1. Acute Injuries or Fractures? <input type="checkbox"/> Yes, explain: <input type="checkbox"/> No</p>	<p>2. Decubitus ulcers present at time of death? <input type="checkbox"/> Yes, describe number and stages: <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Dehydration <input type="checkbox"/> Burns <input type="checkbox"/> Bruises <input type="checkbox"/> Malnourished <input type="checkbox"/> Other</p>
---	--	--

2. Alleged Abuser Information

<p>1. Name of Alleged Abuser: (First, M. Last) / / AKA's</p>	<p>2. Age</p>	<p>3. Additional Suspects:</p>
<p>4. Gender of Alleged Abuser <input type="checkbox"/> Male <input type="checkbox"/> Female</p>	<p>5. Race/Ethnicity (check all that apply) <input type="checkbox"/> African Am <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Am <input type="checkbox"/> Pacific Is <input type="checkbox"/> Other:</p>	
<p>6. Relationship of alleged abuser with elder: <input type="checkbox"/> Son <input type="checkbox"/> Girlfriend <input type="checkbox"/> Nursing home staff <input type="checkbox"/> Daughter <input type="checkbox"/> Boyfriend <input type="checkbox"/> B&C staff <input type="checkbox"/> Wife <input type="checkbox"/> Sibling <input type="checkbox"/> Home health aid <input type="checkbox"/> Husband <input type="checkbox"/> Other Relative <input type="checkbox"/> Friend/Acquaintance <input type="checkbox"/> Grandchild <input type="checkbox"/> Same sex partner <input type="checkbox"/> Other</p>		<p>7. Describe circumstances and length of relationship:</p>

Additional Details	
--------------------	--

3. Elder's Medical Information

<p>1. Elder's cognitive status:</p> <input type="checkbox"/> No cognitive impairment <input type="checkbox"/> Mild cognitive impairment <input type="checkbox"/> Dementia Diagnosed by doctor: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<p>2. Cognitive status evaluation:</p> <input type="checkbox"/> None <input type="checkbox"/> MSSE score: _____, date (mm/yy) <input type="checkbox"/> Other evaluation: <input type="checkbox"/> Depression Scale
<p>3. Describe elder's function in weeks prior to death. How many weeks?</p> <p>Dependent (needs help) in:</p> <input type="checkbox"/> Bathing <input type="checkbox"/> Dressing <input type="checkbox"/> Toileting <input type="checkbox"/> Eating <input type="checkbox"/> Transferring from bed to chair <input type="checkbox"/> Walking	<p>4. Describe significant medical illnesses of elder:</p> <input type="checkbox"/> Heart Disease <input type="checkbox"/> Lung Disease <input type="checkbox"/> Cancer <input type="checkbox"/> History of stroke <input type="checkbox"/> History of hip fracture <input type="checkbox"/> Other
<p>5. Other life problems for elder</p> <input type="checkbox"/> Hx of Alcohol Abuse <input type="checkbox"/> Unknown <input type="checkbox"/> Hx of Drug Abuse <input type="checkbox"/> Hx of Mental Illness <input type="checkbox"/> Hx of Suicidal ideation/actions <input type="checkbox"/> Hx of Depression <input type="checkbox"/> Other: _____	<p>6. Describe decline/tempo of illness:</p>
<p>7. Describe elder's contact with health professionals and community services during the 6 month prior to death:</p> <input type="checkbox"/> MD: <input type="checkbox"/> E.R. <input type="checkbox"/> Day Center: <input type="checkbox"/> Acute Care <input type="checkbox"/> Case Manager: <input type="checkbox"/> HH Agency <input type="checkbox"/> Other: _____	<p>8. Medications taken by elder:</p>
<p>Does client have a primary care doctor?</p>	

4. Elder's Legal/Financial Information

<p>1. Elder's estimated net worth (income and assets):</p>	<p>2. Did elder own a home or other residence:</p> <input type="checkbox"/> Yes, describe: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown
<p>3. Did elder have a conservator?</p> <input type="checkbox"/> Yes, describe: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	<p>4. Did elder have Advanced Directives or DPOA?</p> <input type="checkbox"/> Yes, describe: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown
<p>5. Describe elder's contact with legal/financial systems:</p> <input type="checkbox"/> Lawyers <input type="checkbox"/> Banks <input type="checkbox"/> CPAs <input type="checkbox"/> Others	<p>6. Describe any recent changes to elder's will, trusts, or advanced directives:</p>

CONCLUSIONS AND RECOMMENDATIONS FROM TEAM REVIEW**Conclusions**

<p>1. Did elder abuse occur in this case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear</p> <p>Explain:</p>	<p>2. Did abuse directly contribute to elder's death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear</p> <p>Explain:</p>
<p>3. Was elder's death preventable? <input type="checkbox"/> Yes, definitely <input type="checkbox"/> Yes, probably <input type="checkbox"/> Probably not <input type="checkbox"/> Not at all <input type="checkbox"/> Unable to tell</p> <p>Explain:</p>	
<p>4. Lessons learned from this case (narrative).</p>	

Recommendations and Preventative Actions

<p>1. Did Team Review recommend additional investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>	<p>1a. If Yes, explain:</p>
<p>2. Were policy or practice issues raised? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>	<p>2a. If Yes, explain:</p>
<p>3. Were system issues raised? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>	<p>3a. If Yes, explain:</p>
<p>4. Describe recommendations or prevention activities proposed by the team:</p>	
<p>5. What changes, if any, have been made as a result of this elder's death? (Please update later if new information becomes available).</p>	

**County of San Diego Elder Death Review Team
CASE REVIEW- INVESTIGATIVE REPORT**

Review Date:

**Case Closed ()
Case Held Over () DATE:**

Victim's Name	DOB	Date/Time of Death	Type of Death	ME No.	Case No.
---------------	-----	--------------------	---------------	--------	----------

INVESTIGATIVE SUMMARY

I. Victim's Information:

II. Past Medical History:

III. Pre-existing Life Threatening Disease/ Condition:

IV. Toxicology Report:

V. Cause of Death:

VI. Suspect's Name:

VII. Suspect's DOB:

Risk Factors	< 12 mos. ago		> 12 mos. ago		Comments
1. Escalation of abuse prior to homicide	P	V	P	V	
2. Graphic threats to kill	P	V	P	V	
3. Homicidal Ideation	P	V	P	V	
4. Stalking history by perpetrator	Yes	No	Yes	No	
5. Injury in prior abusive incidents. (required medical treatment from hospital/emergency treatment)	P	V	P	V	
6. TRO placed on perpetrator by victim	Yes	No	Yes	No	
7. TRO placed on perpetrator by other person	Yes	No	Yes	No	
8. TRO violation by perpetrator	Yes	No	Yes	No	
9. History of TROs against perpetrator	Yes	No	Yes	No	
10. TRO in effect at time of homicide					
11. Police involved with previous elder abuse incident.	P	V	P	V	
12. Prior APS referral (s)	P	V	P	V	
13. Other:					

WEAPONS

14. Access to firearms or other weapons	P	V	P	V	
15. Use of weapons in prior incidents (arson included)	P	V	P	V	
16. Threats with weapons	P	V	P	V	

RELATIONSHIP OF VICTIM & PERPETRATOR

17. Relationship of Victim & Perpetrator:

- Family Member: (specify)
- Care Provider: (specify)
- Stranger:
- Other: (describe)
-

**County of San Diego Elder Death Review Team
CASE REVIEW- INVESTIGATIVE REPORT**

Victim's Name	DOB	Date/Time of Death	Type of Death	ME No.	Case No.
RELATIONSHIP DYNAMICS/CONTROL					
18. Controlling of daily activities		P V	P V		
19. Obsessive-possessive beliefs		P V	P V		
20. Perpetrator perceives he/she has been betrayed by victim		Yes No	Yes No		
21. Victim gives perpetrator an ultimatum		Yes No	Yes No		
MENTAL HEALTH & SUBSTANCE ABUSE					
Risk Factors		< 12 mos. ago	> 12 mos. ago	Comments	
22. Victim drug abuse (circle all that apply)		Cocaine Crack Crystal Meth. Heroin Marijuana Other:	Cocaine Crack Crystal Meth. Heroin Marijuana Other:		
23. Perpetrator drug abuse (circle all that apply)		Cocaine Crack Crystal Meth. Heroin Marijuana Other:	Cocaine Crack Crystal Meth. Heroin Marijuana Other:		
24. Alcohol abuse		P V	P V		
25. Gambling abuse		P V	P V		
26. Mental health problems (i.e. depression in perpetrator or victim)		P V	P V		
27. Mental health diagnosis of victim: (describe)					
28. History of suicide threat(s), ideation(s)		P V	P V		
29. History of suicide attempt(s)		P V	P V		
OTHER VIOLENCE/ABUSE					
30. History of committing child abuse		P V	P V		
31. History of committing other types of violence		P V	P V		
32. History/threats of violence towards pet(s)		P V	P V		
33. Destruction of property		P V	P V		
OTHER ISSUES					
34. Prior criminal history		P V	P V		
35. Previous contact with protective services (e.g. shelters, transitional housing, mental health counseling, substance abuse treatment etc.)		P V	P V		
36. Perpetrator ordered to a court mandated treatment program		Yes No	Yes No		
37. Perpetrator experienced significant life stressors (e.g. loss of job, financial problems, death of a family member/close friend, physical health problems)		Yes No	Yes No		
38. Victim experienced significant life stressors (e.g. loss of job, financial problems, death of a family member/close friend, physical health		Yes No	Yes No		

**County of San Diego Elder Death Review Team
CASE REVIEW- INVESTIGATIVE REPORT**

Victim's Name	DOB	Date/Time of Death	Type of Death	ME No.	Case No.
problems)					
39. Perpetrator involved in other suspicious death		Yes No	Yes No		
40. Perpetrator has prior employment as caregiver		Yes No	Yes No		
41. Ability of victim to complete ADLs		1 3 5		1= totally dependent on others 3= some assistance needed 5= totally independent	
42. Victim's prescription medications: (describe)					
43. Victim resided in: <ul style="list-style-type: none"> • Own residence alone • Own residence w/ others (specify) • Residential Care Facility • Hospice • Other (describe) 					
44. Perpetrator's residence: (describe)					
45. Control of victim's finances: <ul style="list-style-type: none"> • Victim • Family member • Other (describe) 					

INTERVENABLE/NOT INTERVENABLE/UNDETERMINED STATUS

1. **Intervenable at the:** Individual/Family () Agency Level () Public Policy ()
2. **Not Intervenable** _____
(Given similar circumstances, no opportunity existed to intervene).
3. **Undetermined** _____
(Unable to determine if intervention was possible based on the limited information available to the team).
4. **General Policy** _____
(While not directly related to the findings of the case, policy recommendations were determined).

RECOMMENDATIONS

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

**County of San Diego Elder Death Review Team
CASE REVIEW- INVESTIGATIVE REPORT**

REVIEW STATUS

Case Closed () Case Held Over ()

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

WHO WAS INVOLVED	WHO SHOULD HAVE BEEN INVOLVED

Date/	ccurance

Confidential San Francisco Elder Death Review Data Collection Form (Penal Code 1117.4 et seq)

IDENTIFYING INFORMATION

I. Reporting Team

1. Reporting County	2. Name of Reporter	3. Date of Report
---------------------	---------------------	-------------------

II. Elder Identification

1. Elder's name: (First, M. Last) / /		2. Date of Birth (mm/dd/yyyy)	3. Date of Death (mm/dd/yyyy)
4. County of Death	5. Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	6. Age, years:	7. Place of residence <input type="checkbox"/> House/Apt. <input type="checkbox"/> Nursing Home <input type="checkbox"/> B&C <input type="checkbox"/> Other:
8. Residence County	9. Zip code	10. Race/Ethnicity (check all that apply) <input type="checkbox"/> African Am <input type="checkbox"/> Asian: <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Am <input type="checkbox"/> Pacific Is <input type="checkbox"/> Other:	

III. Assigned Identification Number: - -

NOTE: First 2 digits for County Number [1-58]; second 2 digits for year; third 4 digits for unique number assigned by the EDRT (e.g. Alameda's first reported case would be 01-00-0001).

IV. Reasons Why Case Was Assigned to Death Review Team

Why is this a SUSPICIOUS death?

CAUSE AND CIRCUMSTANCES OF DEATH

V. General Information

1. Cause of death from death certificate or autopsy report	2. Autopsy Performed? Autopsy Number: <input type="checkbox"/> Yes full <input type="checkbox"/> Yes partial: <input type="checkbox"/> No <input type="checkbox"/> Pictures Reviewed Where was Autopsy Performed?
3. Other significant contributing conditions to death:	
4. Place of Death: <input type="checkbox"/> Elder's home <input type="checkbox"/> Relative's home <input type="checkbox"/> Friend's home <input type="checkbox"/> Nursing home: _____ <input type="checkbox"/> Licensed B&C <input type="checkbox"/> Unlicensed B&C <input type="checkbox"/> Hospital: _____ <input type="checkbox"/> Other:	
5. Acute injuries or fractures? <input type="checkbox"/> Yes, explain: <input type="checkbox"/> No	6. Decubitus ulcers present at time of death? <input type="checkbox"/> Yes, describe number and stages: <input type="checkbox"/> No
7. Alcohol or drugs involved? <input type="checkbox"/> Yes, explain: <input type="checkbox"/> No	8. Concerning Physical Signs? <input type="checkbox"/> Dehydration <input type="checkbox"/> Burns <input type="checkbox"/> Bruises <input type="checkbox"/> Malnourished <input type="checkbox"/> Other:

VI. Narrative summary of cause and circumstances of death

--

DEATH INVESTIGATION INFORMATION**VII. Alleged Abuser Information**

1. Name of Alleged Abuser: (First, M. Last) / / AKA's:		2. Age	3. Additional Suspects:
4. Gender of Alleged Abuser <input type="checkbox"/> Male <input type="checkbox"/> Female		5. Race/Ethnicity (check all that apply) <input type="checkbox"/> African Am <input type="checkbox"/> Asian: <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Am <input type="checkbox"/> Pacific Is <input type="checkbox"/> Other:	
6. Relationship of alleged abuser with elder: <input type="checkbox"/> Son <input type="checkbox"/> Girlfriend <input type="checkbox"/> Nursing home staff <input type="checkbox"/> Daughter <input type="checkbox"/> Boyfriend <input type="checkbox"/> B&C staff <input type="checkbox"/> Wife <input type="checkbox"/> Sibling <input type="checkbox"/> Home health aid <input type="checkbox"/> Husband <input type="checkbox"/> Other Relative <input type="checkbox"/> Friend/Acquaintance <input type="checkbox"/> Grandchild <input type="checkbox"/> Same sex partner <input type="checkbox"/> Other: Additional Details:		7. Describe circumstances and length of relationship:	
8. Did Alleged Abuser Display Risk Behaviors? <input type="checkbox"/> Hx of APS reports/prior elder abuse <input type="checkbox"/> Hx of DV/Intimate Partner Violence <input type="checkbox"/> Criminal history <input type="checkbox"/> Alcohol problem/abuse <input type="checkbox"/> Drug problem/abuse <input type="checkbox"/> Mental health problems <input type="checkbox"/> Financial problems <input type="checkbox"/> Other:		9. Did alleged abuser gain financially from elder's death? <input type="checkbox"/> Yes, describe <input type="checkbox"/> No	
10. Type of abuse suspected: <input type="checkbox"/> Neglect <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Financial Abuse <input type="checkbox"/> Abandonment <input type="checkbox"/> Isolation <input type="checkbox"/> Other			
11. Narrative summary of type of abuse suspected:			

VIII. Elder's Medical Information

1. Elder's cognitive status: <input type="checkbox"/> No cognitive impairment <input type="checkbox"/> Mild cognitive impairment <input type="checkbox"/> Dementia <input type="checkbox"/> Unknown		2. Cognitive status evaluation: <input type="checkbox"/> None <input type="checkbox"/> MSSE score: _____, date (mm/yy) <input type="checkbox"/> Other evaluation:	
3. Describe elder's function in weeks prior to death: Dependent (needs help) in: <input type="checkbox"/> Bathing <input type="checkbox"/> Dressing <input type="checkbox"/> Toileting <input type="checkbox"/> Eating <input type="checkbox"/> Transferring from bed to chair <input type="checkbox"/> Walking		4. Describe significant medical illnesses of elder: <input type="checkbox"/> Heart Disease <input type="checkbox"/> Lung Disease <input type="checkbox"/> Cancer <input type="checkbox"/> History of stroke <input type="checkbox"/> History of hip fracture <input type="checkbox"/> Other	
5. Other life problems for elder <input type="checkbox"/> Hx of Alcohol Abuse <input type="checkbox"/> Unknown <input type="checkbox"/> Hx of Drug Abuse <input type="checkbox"/> Hx of Mental Illness <input type="checkbox"/> Hx of Suicidal ideation/actions <input type="checkbox"/> Hx of Depression <input type="checkbox"/> Other:		6. Describe decline/tempo of illness:	
7. Describe elder's contact with health professionals and community services during the 6 months prior to death: <input type="checkbox"/> MD: <input type="checkbox"/> Day Center: <input type="checkbox"/> Case Manager: <input type="checkbox"/> Other:		8. Medications taken by elder	

IX. Elder’s Legal/Financial Information

1. Elder’s estimated net worth (income and assets):	2. Did elder own a home or other residence? <input type="checkbox"/> Yes, describe: <input type="checkbox"/> No <input type="checkbox"/> Unknown
3. Did elder have a conservator? <input type="checkbox"/> Yes, describe: <input type="checkbox"/> No <input type="checkbox"/> Unknown	4. Did elder have Advanced Directives or DPOA? <input type="checkbox"/> Yes, describe <input type="checkbox"/> No <input type="checkbox"/> Unknown
5. Describe elder’s contact with legal/financial systems: <input type="checkbox"/> Lawyers <input type="checkbox"/> Banks <input type="checkbox"/> CPAs <input type="checkbox"/> Others	6. Describe any recent changes to elder’s will, trusts, or advanced directives?

X. Elder’s Contact with Adult Protective Services (APS)

1. Number of APS referrals regarding elder:	2. Date of first APS referral (mm/yy): Reporter:
3. Additional APS referral dates/reporter:	
4. Describe what led to APS referral(s):	
5. Describe actions taken by APS:	

XI. Elder’s Contact with Ombudsman

1. Number of Ombudsman referrals regarding elder:	2. Date of first Ombudsman referral (mm/yy): Additional referral dates:
3. Describe what led to Ombudsman referral(s):	
4. Describe actions taken by Ombudsman:	

XII. Elder’s Contact with Emergency Medical Services (EMS)

1. Number of EMS contacts regarding elder:	2. Date of first EMS contact (mm/yy): Additional contact dates:
3. Describe what led to EMS contact(s):	
4. Describe actions taken by EMS:	

XIII. Elder’s Contact with Police

1. Number of police contacts regarding elder:	2. Date of first police contact (mm/yy): Report #:
3. Additional Police contacts/report #:	
3. Describe what led to police contact(s):	
4. Describe actions taken by police:	

XIV. Brief Summary of Case

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CONCLUSIONS AND RECOMMENDATIONS FROM TEAM REVIEW

XV. Conclusions

1. Team members present for case: <input type="checkbox"/> DA <input type="checkbox"/> City Attorney <input type="checkbox"/> Geriatrician <input type="checkbox"/> Internist <input type="checkbox"/> Medical Examiner <input type="checkbox"/> EMS <input type="checkbox"/> APS <input type="checkbox"/> Police <input type="checkbox"/> Social Worker <input type="checkbox"/> Ombudsman <input type="checkbox"/> Others:	
2. Did elder abuse occur in this case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear Explain:	3. Did abuse directly contribute to elder's death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear Explain:
4. Was elder's death preventable? <input type="checkbox"/> Yes, definitely <input type="checkbox"/> Yes, probably <input type="checkbox"/> Probably not <input type="checkbox"/> Not at all <input type="checkbox"/> Unable to tell Explain:	
5. Lessons learned from this case (narrative)	

XVI. Recommendations and Preventive Actions

1. Did Team Review recommend additional investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	1a. If Yes, explain:
2. Were policy or practice issues raised? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	2a. If Yes, explain:
3. Were system issues raised? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	3a. If Yes, explain:
4. Describe recommendations or prevention activities proposed by the team?	
5. What changes, if any, have been made as a result of this elder's death? (Please update later if new information becomes available)	

Elder Abuse, a Silent Epidemic

- **There are an estimated 5 million cases of elder abuse each year in the United States.**
- **84 % of those cases are not reported to authorities.**
 - **Each year, approximately 12,000 Maine Seniors are victims of physical abuse, neglect, or financial exploitation.**
- **Over 40% of all elder abuse involves financial exploitation.**

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MAINE ELDER DEATH ANALYSIS REVIEW TEAM 2003 MEMBERSHIP

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(Maria Robinson, Assistant Attorney General, Health Care Crimes Unit, Office of the Attorney General)
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(Peter Mauro Jr., Community Resource Development, Bureau of Elder and Adult Services)
Lou Dorogi, Director, Licensing and Certification *
(Diane Jones, Licensing and Certification)
Timothy Doyle, Lieutenant, Maine State Police Criminal Investigation Division
(James Urquhart, Sergeant, Maine State Police Criminal Investigation Division)
Mary Farrar, Victim Witness Advocate, Office of the Attorney General
(Denise Giles, Victim Services Coordinator, Department of Corrections)
Margaret Greenwald, Chief Medical Examiner *
(James Ferland, Administrator, Office of the Chief Medical Examiner)
Brenda Gallant, Director, Long Term Care Ombudsman Program
(Catherine Valcourt, Legal Counsel, Long Term Care Ombudsman Program)
Ricker Hamilton, Protective Program Administrator, Bureau of Elder and Adult Services *
(Rick Mooers, Protective Program Administrator, Bureau of Elder and Adult Services)
Lloyd Herrick, Sheriff, Oxford County, Maine Sheriff's Association
(James P. Madore, Sheriff, Aroostook County, Maine Sheriff's Association)
Brian MacMaster, Director of Investigations, Office of the Attorney General *
(Michael Webber, Detective, Office of the Attorney General)
Donald O'Halloran, Chief of Police, Old Town Police Department, Maine Chiefs of Police Association
(Joseph Rogers, Chief of Police, Hamden Police Department, Maine Chiefs of Police Association)
Norm Croteau, District Attorney, Androscoggin County, Maine District Attorneys Association *
Theresa Turgeon, Director, Office of Geriatric Services, Bureau of Developmental Services *

**ex officio members*

INTRODUCTION BY THE PANEL CHAIR RICKER HAMILTON

In March 2003, the American Bar Association, Commission on Law and Aging, notified Maine that we had been selected as one of four project demonstration sites for “Promising Practices in the Development of Elder Abuse Fatality Review Teams.” The ABA stated goal for the project was to expand the fatality review team concept to deaths resulting from elder abuse in order to foster examination of and improvement in the response of adult protective services, law enforcement officers, prosecutors, victim services, health care providers and others to the growing number of victims of abuse.

The success of MEDART is due to the diverse makeup of the panel and their expertise. Team members include representatives from the Office of the Chief Medical Examiner, the Office of the Attorney General’s Healthcare Crimes Unit, Victim Witness Advocate Program, and Investigations Division; Adult Protective Services, Licensing and Certification, and Assisted Living Licensing Services of the Department of Human Services; the Maine State Police; the Long Term Care Ombudsman Program; the Maine Sheriff’s Association; the Maine Chiefs of Police Association; and the Department of Behavioral and Developmental Services, have made a significant difference. Communication and cooperation among the agencies has been enhanced and a clearer focus on older victims has been developed.

The Maine Elder Death Analysis Review Team (MEDART) has made tremendous strides in just one year. Under the leadership of Attorney General G. Steven Rowe and the Office of the Attorney General, MEDART received enabling legislation that includes confidentiality and access to records. For the first time, cases of death and serious bodily injury of older victims and vulnerable adults in Maine are being reviewed. It is through this process that MEDART will foster changes that will result in an improved systemic response to the needs of older victims.

The future is bright for the Team’s continued efforts and the need is clear. The United States Senate, Special Committee on Aging reports that 4% to 6% of our citizens over age 60 are abused each year and that approximately 84% of elder abuse cases are never reported. As the number of Maine’s citizens age 60 and older doubles over the next 25 years, we will need to develop and improve community systems that will meet our need. MEDART is an example of Maine’s leadership role in protecting those that are unable to protect themselves. MEDART is helping to develop a future that is safer for all of our citizens.

MISSION STATEMENT

The Maine Elder Death Analysis Review Team (MEDART) will examine deaths, and cases of serious bodily injury, associated with suspected abuse or neglect of the elderly and vulnerable adults. The purpose of MEDART is to review deaths related to abuse and neglect, and to identify whether systems that have the purpose or responsibility to assist or protect victims were sufficient for the particular circumstances or whether such systems require adjustment or improvement. MEDART will foster system change that will improve the response to victims and prevent similar outcomes in the future.

MEDART recognizes that the responsibility for responding to and preventing fatalities related to abuse or neglect of the elderly and vulnerable adults lies within the community and not with any single agency or entity. It is further recognized that a careful examination of the fatalities provides the opportunity to develop education, prevention, and strategies that will lead to improved coordination of services for families and our elder population.

ABOUT THE MAINE ELDER DEATH ANALYSIS REVIEW TEAM

The Maine Elder Death Analysis Review Team, (MEDART) was formed in 2003 under the auspices of the Office of the Attorney General, and is charged with examining deaths and cases of serious bodily injury associated with suspected abuse or neglect of elderly and vulnerable adults. The team, whose membership includes representation from state, local and county law enforcement, prosecutors, victim advocates, licensing and certification, adult protective services, and mental health, meets monthly to review selected cases, the purpose of which is to identify whether systems that have the purpose or responsibility to assist or protect victims were sufficient for the particular circumstances or whether such systems require adjustment or improvement. MEDART seeks to foster system change that will improve the response to victims and prevent similar outcomes in the future.

MEDART was recognized by the Maine Legislature in 2003 with enabling legislation that provides for among other things, access to information and records, and confidentiality.¹ This was possible through the leadership of Attorney General G. Steven Rowe, and the testimony and support of Chief Medical Examiner Margaret Greenwald. Such leadership and timeliness was recognized nationally by other fatality review teams and will likely be incorporated into the ABA guide as a crucial step in forming future teams around the nation. For the complete language of the team's enabling legislation, see Appendix A.

MEDART was chosen early on as one of four “*elder fatality review teams*” in the United States to serve as a pilot program for a Department of Justice funded initiative managed by the American Bar Association’s Commission on Law and Aging. The goal of the pilot program is to expand the fatality review team concept, and to develop and

¹ M.R.S.A. Title 5 §200-H

disseminate a replication and best practices guide. For its role in the program, the team received \$5000 in “*seed money*” to help defray set up costs.

MEDART successfully completed two case reviews in 2003, both of which were followed by detailed reports of findings, and recommendations. Each report was delivered to Attorney General Rowe for his review and consideration. While it is too early to track changes affected by the work of MEDART, it is the belief of the membership that such changes will effect legislation, policy, education and best practices. Most important, the Maine Elder Death Analysis Review Team believes its work will affect the quality of life for seniors throughout the State of Maine.

CASE SUMMARY INFORMATION

The Maine Elder Death Analysis Review Team aims to review 8-10 cases per year. In 2003, the Team chose to wait until legislative protections were in place before reviewing cases, and as such, was only able to review 2 cases. In 2004, the team is on track to review 9 cases. Of the 2 cases reviewed in 2003, the following characteristics were noted:

Summary of Facts:

- Case #2003-01 focused on the incidents surrounding the July 2, 2002 death of an 87-year-old female who died as a result of a lack of hydration or nutrition per order of the decedent's primary care physician and per request of family members. This order followed a debilitating stroke, suffered by the decedent several weeks earlier.
- Case # 2003-02 focused on the incidents surrounding the August 30, 1997, death of a 78-year-old female who died as a result of malnutrition stemming from a condition of mental retardation. Prior to her death, the decedent lived at home with her brother and was reportedly kept locked in a bedroom for a period of 20 years or more.

Ages and Relationships of the Parties:

- In the first of the two cases reviewed in 2003, the decedent was an 87-year-old male. The person suspected of abuse or neglect was a healthcare worker, not related to the decedent.
- In the second of the two cases, the decedent was a 78-year-old female. The person suspected of abuse or neglect was the decedent's brother.

Status of Perpetrators:

- Neither of the two suspected perpetrators was criminally prosecuted.

Cause of Death:

- In the first case, death occurred as a result of a lack of hydration or nutrition per order of the decedent's primary care physician and per request of family

members. This order followed a debilitating stroke, suffered by the decedent several weeks earlier.

- In the second case, death occurred in 1997, as a result of malnutrition stemming from severe mental retardation.

Community Interventions and Use of Services:

In both cases, the decedent had little to no contact with community services.

PANEL RECCOMENDATIONS AND PROGRESS TO DATE

The concept for the Maine Elder Death Analysis Review Team was developed in the late fall of 2002. For the twelve months following, the team worked to establish guidelines and protocols which would ensure confidentiality, scope and authority. Start up funding was secured for the team, and membership was defined. After enabling legislation was enacted in the summer of 2003, and protections were in place, the team initiated the case review process. Two cases were selected for review in the early winter of 2003. The following recommendations were made by the membership:

1. Hospitals should have a policy, if not already in place, to review a family's legal right to make medical decisions absent any known legal authority.
2. If not already in place, a procedure for enforcement of hospital ethics committees' recommendations ought to be adopted.
3. Consideration ought to be given to enhancing the penalties under 17-A M.R.S.A. § 555, Endangering the Welfare of a Dependent Person. Currently, a violation of this statute is a Class D crime. Additional language, which could provide a method of enhancing the penalty to a Class C crime, might include language similar to that included in 17-A M.R.S.A. § 554, Endangering the Welfare of a Child.
4. The following paragraphs correspond to the language currently included in 17-A M.R.S.A. § 555, Endangering the Welfare of a Dependent Person. Proposed changes are represented in paragraphs 1(b)(c)(e).

1. A person is guilty of endangering the welfare of a dependent person if that person:
 - a. Intentionally, knowingly or recklessly endangers the health, safety or mental welfare of a person who is unable to perform self-care because of

advanced age, physical or mental disease, disorder or defect; or

b. Intentionally, knowingly or recklessly endangers the health, safety or mental welfare of a person who is unable to perform self-care because of advanced age, physical or mental disease, disorder or defect and which in fact causes death, or;

c. Intentionally, knowingly or recklessly endangers the health, safety or mental welfare of a person who is unable to perform self-care because of advanced age, physical or mental disease, disorder or defect and which in fact causes serious bodily injury.

d. As used in this section “endangers” includes a failure to act only when the defendant had a legal duty to protect the health, safety or mental welfare of the dependent person. For purposes of this section, a legal duty may be inferred if the defendant has assumed responsibility for the care of the dependent person.

e. Endangering the welfare of a dependent person is a Class D Crime except that a violation of subsection 1, paragraph B, is a Class B Crime, and violation of subsection 1, paragraph C, is a Class C crime.

5. Continue to provide elder abuse awareness training for police cadets attending the Maine Criminal Justice Academy and increase the number of in-service trainings for those already employed in the field of criminal justice.

6. Dehydration and malnutrition in older individuals is often an unrecognized cause of hospitalizations, morbidity, and mortality. Effective treatment in acute cases requires expertise not generally available in rural healthcare settings. Accordingly, state and local training should be mandated for all healthcare professionals and healthcare facilities to assist in the diagnosis, treatment and prevention of dehydration and malnutrition in elderly and dependant adults. Specialized training should be mandated for hospital emergency room staff to ensure the proper treatment of acute cases.

7. Develop and implement a system that would require a referral to Adult Protective Services for those people who are age 18 or older, are Mainecare (Medicaid) recipients, and three years have passed since a claim has been filed by a provider.

APPENDIX A:

ENABLING LEGISLATION

(Note: The MEDART enabling legislation has been deleted from this appendix because it was already provided in Appendix G)

Vicarious Trauma

Amidst the past decade's burgeoning literature on trauma and its direct impact on victims, there has evolved a much-deserved interest concerning the impact on professionals of working with these traumatized victims. More and more, we are beginning to note that work with trauma victims exacts a psychological cost from emergency/crisis services personnel, victim service providers and other professionals who have immediate or extended interaction with these victims. These costs may range from short-term reactions stemming from work with a particular victim to long-range alterations of the helper's own cognitive schemas, beliefs, expectations, and assumptions about self and others.

Vicarious trauma, or what some professionals refer to as compassion fatigue or secondary traumatic stress, is a term coined to describe a process whereby trauma counselors and other helpers experience disruptive and painful psycho-social effects which may persist and intensify over time. Accepting others' "reality" and being empathetic is generally accepted as a vital necessity in the healing process. If a victim's reality has at the center certain assumptions that have been shattered due to their victimization experience, then there is likely to be an inevitable erosion of the same assumptions within those who work with these victims, for either a short intensive period or over a more extended period of time.

Burnout (due to job-related stress) and caregiver stress have long been recognized as potential problem areas when working with victims of crime and the criminal justice system. We are now more fully aware, however, that the potential effects of working with trauma survivors can be even more impacting and lasting because of the continuous bombardment of emotionally shocking images of horror and suffering, which is characteristic of serious trauma — especially when the helper is working with such victims day after day, one after the other. Assumptions about one's vulnerability and one's belief in a meaningful, reasonable, or fair world are regularly shaken.

It is clear, therefore, that we must learn to be sensitive to the experience of vicarious trauma and proactively protect ourselves against its effects — to be passionate in our self care. By doing this, we are facilitating the continuation of quality care and ensuring our own health growth and lifestyle.

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Vicarious Traumatization

Challenge: Fatality review work can be very difficult psychologically. Focusing on deaths, many of which are truly terrible, and the flaws in the systems that might have prevented those deaths can have an effect on team members. Looking at awful pictures of bedsores, horrible living conditions, and dead bodies in various states may be a daily but uncomfortable occurrence to some team members; To others, it is a new and especially difficult experience. The difficulty of the work may cause EA-FRT members to experience grief and rage, become numb emotionally, lose focus and energy, and burn out. As a result of these feelings, members may face health and social problems that result in them leaving the team or their job. These reactions are called “vicarious traumatization,” also known as “compassion fatigue” or “secondary traumatic stress.”

Vicarious traumatization is a term used to describe “a process whereby trauma counselors and other helpers experience disruptive and painful psycho-social effects (that) may persist and intensify over time.” The effects of vicarious traumatization may be comparable to post-traumatic stress disorder. How can team members protect themselves from or deal with vicarious traumatization? Is the use of “black humor” by team members appropriate?

Suggestions/Solutions: The materials provided at Appendix N, Part 5 provide information on the warning signs of vicarious traumatization and suggest ways in which *individuals* may prevent or respond to the problem. These excellent materials also contain resource books and Web sites, and should be shared with team members.

But the materials do not suggest ways by which *teams*, as an entity, can deal with the circumstances that may lead members to experience vicarious traumatization. EA-FRT members, however, have shared some ideas:

- Some amount of humor, including “black humor,” can be a good release and an important coping skill for teams. Its use can also indicate a strong level of comfort and trust among team members. But the use of humor may seem inappropriate or insensitive to some team members, particularly those who may join a team after it has existed for awhile, or guests.
- Emotional reactions to case presentations, such as grimaces or groans, may be useful to other team members who use the reaction of other team members to judge how bad a case is. But such reactions may also be viewed as inappropriate. Even worse, they may be misinterpreted as being about an agency’s response to the victim, rather than about what happened to the victim. Team members suggested that, in keeping with the “no blame, no shame” mentality of the EA-FRT, it is important for members to keep their emotional reactions about the victim and not about the role of the service provider. Alternatively, other times and means of reacting to cases that do not jeopardize the cohesiveness of the team should be provided.

- An alternative process for enabling emotional reactions to cases may be a debriefing process at a designated time. For example, a team could decide that emotional reactions during case presentations and discussions are inappropriate, but set aside a time period at the end of the discussion or each meeting to allow to allow members to share and examine their emotional reactions to the victim's situation.
- It is critical for team members to discuss the affect of vicarious traumatization in general and the use of humor and emotional reactions to case presentations in particular. To build a strong EA-FRT, members must have the opportunity to share their views about sensitive and appropriate reactions to the cases under discussion and to reach consensus about these practices.
- As new members join the team, whether they are new representatives from an agency that has been on the team or representatives from an agency new to the team, they need to be advised about the results of earlier discussions about these issues. Additionally, earlier decisions may need to be revisited, so that new members are provided with an opportunity to share their views about the use of humor and emotional reactions to case presentations.

VICARIOUS TRAUMATIZATION: *Intervention Strategies for Each Realm of the Service Provider's Life*

Professional

- ⇒ Supervision/consultation
- ⇒ Scheduling: client load and distribution
- ⇒ Balance and variety of tasks
- ⇒ Education: giving and receiving
- ⇒ Work space

Organizational

- ⇒ Collegial support
- ⇒ Forums to address vicarious traumatization
- ⇒ Supervision availability
- ⇒ Respect for service providers and clients
- ⇒ Resources: mental health benefits, space, time

Personal

- ⇒ Making personal life a priority
- ⇒ Personal psychotherapy
- ⇒ Leisure activities: physical, creative, spontaneous, relaxation
- ⇒ Spiritual well-being
- ⇒ Nurture all aspects of yourself: emotional, physical, spiritual, interpersonal, creative
- ⇒ Attention to health

In All Realms

- ⇒ Mindfulness and self-awareness
- ⇒ Self-nurturance
- ⇒ Balance: work, play, rest
- ⇒ Meaning and connection

Adapted from: Saakvitne, K.W., Pearlman, L.A. & The Staff of the Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy. (1996). *Transforming the pain: A workbook on Vicarious Traumatization*. New York, NY: W.W. Norton & Company, 85.

RESOURCES

Figley, Charles R., Ph.D. (Ed.). (1995). *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. New York: Brunner/Mazel Publishers.

McCann, I.L. and Pearlman, L.A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3(1), 131 - 149.

Saakvitne, Karen W., Ph.D. and Laurie Anne Pearlman, Ph.D. (1996). *Transforming the Pain: A Workbook on Vicarious Traumatization for Helping Professional Who Work with Traumatized Clients*. New York: W.W. Norton & Company.

Stamm, Beth Hudnall, Ph.D. (Ed.). (1995). *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, & Educators*. Lutherville, MD: Sidran Press.

Frankl, Victor. (1959). *Man's Search for Meaning: An Introduction to Logotherapy*. New York: Washington Square Press.

O'Hara, Valerie, Ph.D. (1995). *Wellness at Work: Building Resilience to Job Stress*. Oakland, CA: New Harbinger.

National Center for Posttraumatic Stress Disorder
<http://www.ncptsd.org/>

International Society for Traumatic Stress Studies
<http://www.istss.org>

National Association of Social Workers, New York City
<http://www.naswnyc.org/>

How Are We Affected?

- This work forces us to see the human potential for cruelty.
- We then experience *strong* reactions of grief, rage, and outrage.
- Reactions grow as we *repeatedly* hear about & see the consequences of people's pain.
- Begin to *alternately* experience over-whelming feelings & numb ourselves to get thru the day.

Vicarious Trauma: Basic Elements

- Not traumatized *directly*
- Suffer *gradual* increase of exposure
- Second-hand exposure (multiplied crime after crime, client after client) can traumatize caregivers
- Parallels experience of PTSD
- Can reduce effectiveness & shorten tenure

Combination of Factors

- Nature of work
- Nature of people worked with
- Cumulative exposure to trauma
- Organizational context of work
- Social & cultural context of work

Personal Contributing Factors

- Unrealistic professional expectations
- Personal history of trauma
- Unfounded belief about stoicism
- Current stressful personal life
- Coping strategies that do not help & carry heavy costs

Warning Signs

- No time or energy for self (chronic fatigue)
- Disconnection from loved ones & social withdrawal (feeling isolated)

- Feeling distrustful of others, both inside and outside our jobs
- Increased pessimism/cynicism

Warning Signs

- Loss of compassion
- Feeling overly responsible for everything
- Denying our own needs in the face of “all the work that must be done to protect others”
- Overusing our own coping skills
- Relationship problems

Warning Signs

- Generalized anxiety & depression
- Sleep disruptions / nightmares
- Intrusive imagery / thoughts
- Dissociation / depersonalization

ABCs of Addressing VT: *Awareness*

- Be self-aware; know your own trauma map and limitations.
- Take care of yourself.
- Create a self-care list and post it prominently in your home or office.
- Inventory your current lifestyle choices & make necessary changes.

ABCs of Addressing VT: *Balance*

- Give self permission to fully experience emotional reactions.
- Maintain clear work boundaries.
- Set realistic goals for self.
- Change job tasks, when possible.
- Seek out new leisure activity (non-job related).

ABCs of Addressing VT: Connection

- Listen to feedback from colleagues, friends, & family members.
- Avoid professional isolation.
- Remember your spiritual side.
- Develop support systems.
- Avoid *psychosclerosis*.

Journaling

- Improves emotional & physical health
- Recent research (SMU & Ohio State):
 - ✓ Increased T-cell production
 - ✓ Drop in number of doctor visits
 - ✓ Fewer absentee days
 - ✓ Generally improved physical health
- JAMA recommends 20 min/day writing:
 - ✓ “Writing about stressful events seems to help people change how they view them.”

Some Journaling Basics:

- Choose something to write in or on.
- Choose something to write with.
- Record context: time/ date/ any details.
- Don't put restrictions on your writing.
- Don't worry about spelling or grammar.
- Take a break when you finish.
- Can be private or for sharing.