HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 253 Elder Abuse Fatality Review Teams
SPONSOR(S): Health & Human Services Committee, Children, Families & Seniors Subcommittee; Driskell and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 400

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	14 Y, 0 N, As CS	Morris	Brazzell
2) Oversight, Transparency & Public Management Subcommittee	13 Y, 0 N	Toliver	Smith
3) Health & Human Services Committee	17 Y, 0 N, As CS	Morris	Calamas

SUMMARY ANALYSIS

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

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

The bill creates s. 415.1103, F.S., authorizing the creation of a multidisciplinary, multiagency elder abuse fatality review team (EA-FRT) in each judicial circuit to review closed cases where the death of an elderly person was caused by, or related to, abuse or neglect. Participation in EA-FRT is voluntary and team members serve without compensation.

The bill includes procedures for organization and creation of an EA-FRT, appointment of EA-FRT members, and obtaining relevant records for an EA-FRT. In its review, an EA-FRT must consider the surrounding circumstances and events leading up to a fatal incident, identify any gaps in support and service delivery, and make recommendations for systemic improvements to prevent elder abuse and deaths. The bill grants EA-FRT members immunity from monetary liability and prohibits a cause of action relating to their participation in an EA-FRT in certain circumstances, with exceptions.

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

The bill has an indeterminate, insignificant, negative fiscal impact on DOEA. The bill has no fiscal impact to local governments.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

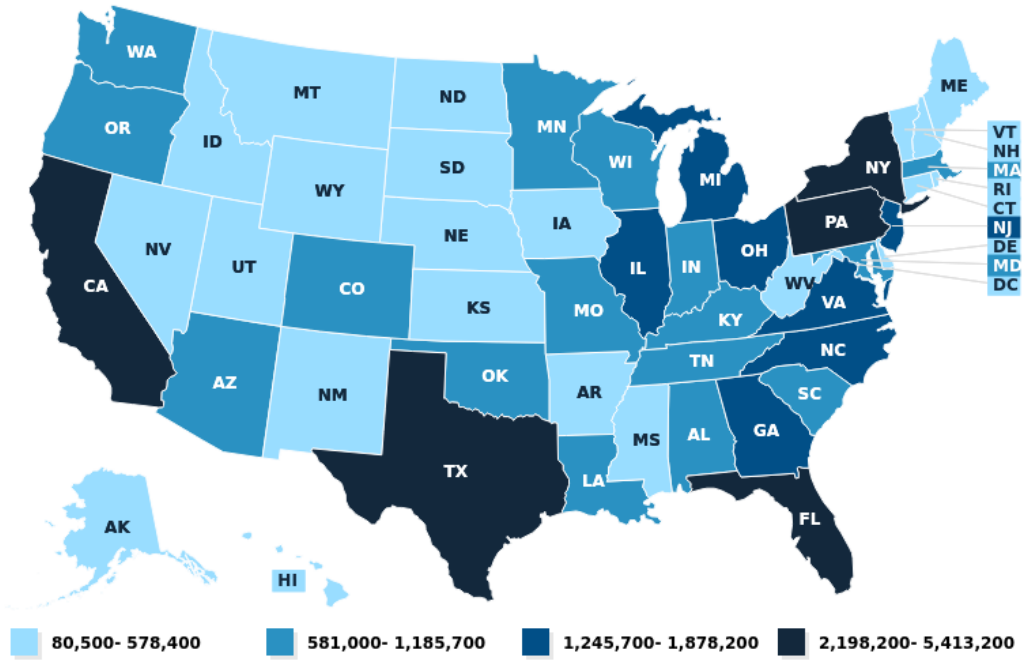
A. EFFECT OF PROPOSED CHANGES:

Background

Elder Population in Florida

As the country's "baby-boom" population reaches retirement age and life expectancy increases, the nation's elder population is projected to increase from 49.2 million in 2016[1] to 77 million by 2034.[2] Florida has long been a destination state for senior citizens and has the highest percentage of senior residents in the entire nation.[3] In 2018, Florida had an estimated 4.3 million people age 65 and older, approximately 20 percent of the state's population.[4] By 2030, this number is projected to increase to 5.9 million, meaning the elderly will make up approximately one quarter of the state's population and will account for most of the state's growth.[5]

National Distribution of Population Ages 65 and Older (2018)[6]



SOURCE: Kaiser Family Foundation's State Health Facts.

Elder populations are vulnerable to abuse and exploitation due to risk factors associated with aging, such as physical and mental infirmities and social isolation.[7] In Florida, almost 1.3 million senior citizens

[1] Press Release, U.S. Census Bureau, *The Nation's Older Population is Still Growing, Census Bureau Reports* (June 22, 2017), Release Number: CB17-100, *available at*: https://www.census.gov/newsroom/press-releases/2017/cb17-100.html (last visited Feb. 13, 2020).
[2] Press Release, U.S. Census Bureau, *Older People Projected to Outnumber Children for First Time in U.S. History* (revised Oct. 8, 2019), available at: https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html (last visited Feb. 13, 2020).
[3] *Where Do the Oldest Americans Live?*, Pew Research Center, July 9, 2015, available at: https://www.pewresearch.org/fact-tank/2015/07/09/where-do-the-oldest-americans-live/ (last visited Feb. 13, 2020).
[4] U.S. Census Bureau, *Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States*, available at: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk (last visited Feb. 13, 2020).
[5] Florida Office of Economic & Demographic Research, *Population Data: 2016, 2020, 2025, 2030, 2035, 2040, & 2045, County by Age, Race, Sex, and Hispanic Origin*, pp. 89-90 and 269-70, available at: http://edr.state.fl.us/Content/population-demographics/data/Medium_Projections_ARSH.pdf (last visited Feb. 13, 2020); Florida Office of Economic & Demographic Research, *Econographic News: Economic and Demographic News for Decision Makers, 2019, Vol. 1*, available at: http://edr.state.fl.us/content/population-demographics/reports/econographicnews-2019v1.pdf (last visited Feb. 13, 2020).
[6] Kaiser Family Foundation, *State Health Facts, Population Distribution by Age,* https://www.kff.org/other/state-indicator/distribution-by-age/ (last visited Feb. 13, 2020).
[7] National Center on Elder Abuse, *What are the Risk Factors?,* https://ncea.acl.gov/About-Us/What-We-Do/Research/Statistics-and-Data.aspx#risk (last visited Feb. 13, 2020); U.S. Department of Justice, *Elder Justice Initiative, Older Adults, Families, and Caregivers,*

live in medically underserved areas and 1.4 million suffer from one or more disabilities.[8] According to the Department of Justice, approximately 1 in 10 seniors is abused each year in the United States, and incidents of elder abuse are reported to local authorities in 1 out of every 23 cases.[9] Elder abuse can have significant physical and emotional effects on an older adult, and can lead to premature death.[10] Abused seniors are twice as likely to be hospitalized and three times more likely to die than non-abused seniors.[11]

Elder abuse occurs in community settings, such as private homes, as well as in institutional settings like nursing homes and other long-term care facilities. Prevalent forms of abuse are financial exploitation, neglect, emotional or psychological abuse, and physical abuse; however, an elder abuse victim will often experience multiple forms of abuse at the same time.[12] The most common perpetrators of elder abuse are relatives, such as adult children or a spouse, followed by friends and neighbors, and then home care aides.[13] Research shows that elder abuse is underreported, often because the victims fear retribution or care for or trust their perpetrators.[14] Elder abuse deaths are more likely to go undetected because an elder death is expected to occur, given age or infirmity, more so than other deaths due to abuse such as a child death or a death involving domestic violence.[15] Experts believe this may be one of the reasons elder abuse lags behind child abuse and domestic violence in research, awareness, and systemic change.[16]

Florida's Adult Protective Services System

Chapter 415, F.S., creates Florida's Adult Protective Services (APS) under the Department of Children and Families (DCF). DCF protects vulnerable adults,[17] including elders, from abuse, neglect, and exploitation through mandatory reporting and investigation of suspected abuse.[18] This includes deaths allegedly due to abuse, neglect, and exploitation.[19] In FY 2018-19, DCF received 37,145 reports of abuse, neglect, or exploitation of persons aged 60 years or older and investigated 252 deaths in which the death was allegedly due to abuse or neglect.[20] During that same fiscal year, DCF verified 6,277 allegations of abuse or neglect, 34 of which involved a fatality.[21] Eighty-one (81) percent of these reports were from in-home settings, which is consistent with the research findings that relatives, friends, or caregivers are the main perpetrators of elder abuse.

DCF Adult Investigations Involving Victims Age 60+

https://www.justice.gov/elderjustice/victims-families-caregivers (last visited Feb. 13, 2020). *See also*, Xing Qi Dong et al., *Elder Abuse as a Risk Factor for Hospitalization in Older Persons*, JAMA Intern Med. 173:10 at 911-917 (2013).

[8] Department of Elder Affairs, *2018 Profile of Older Floridians,* http://elderaffairs.state.fl.us/doea/pubs/stats/County_2018/Counties/Florida.pdf (last visited Feb. 13, 2020).

[9] U.S. Department of Justice, *Elder Justice Initiative*, https://www.justice.gov/elderjustice (last visited Feb. 13, 2020). *See also*, Ron Acierno et al., *Prevalence and Correlates of Emotional, Physical, Sexual, and Financial Abuse and Potential Neglect in the United States: The National Elder Mistreatment Study*, 100:2 Am. J. Pub. Health, at 292-297 (Feb. 2010), available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2804623/ (last visited Feb. 13, 2020).

[10] U.S. Department of Justice, *Elder Justice Initiative*, https://www.justice.gov/elderjustice (last visited Feb. 13, 2020). *See also*, Mark S. Lachs et al., *The Mortality of Elder Mistreatment*, 280:5 JAMA at 428-432 (1998), available at: https://jamanetwork.com/journals/jama/fullarticle/187817 (last visited Feb. 13, 2020).

[11] U.S. Department of Justice, *Elder Justice Initiative*, https://www.justice.gov/elderjustice (last visited Feb. 13, 2020). *See also*, Xing Qi Dong et al., *Elder Abuse as a Risk Factor for Hospitalization in Older Persons*, JAMA Intern Med. 173:10 at 911-917 (2013).

[12] National Center on Elder Abuse, *Challenges in Elder Abuse Research,* https://ncea.acl.gov/About-Us/What-We-Do/Research/Statistics-and-Data.aspx#challenges (last visited Feb. 13, 2020).

[13] National Center on Elder Abuse, *Who are the Perpetrators?*, https://ncea.acl.gov/About-Us/What-We-Do/Research/Statistics-and-Data.aspx#perpetrators (last visited Feb. 13, 2020).

[14] Center for Disease Control and Prevention, *Understanding Elder Abuse*, *Fact Sheet 2016*, https://www.cdc.gov/violenceprevention/pdf/em-factsheet-a.pdf (last visited Feb. 13, 2020).

[15] U.S. Department of Justice, National Institute of Justice, *Elder Justice Roundtable Report: Medical Forensic Issues Concerning Abuse and Neglect*, October 18, 2000, p. 8, available at: https://www.ncjrs.gov/pdffiles1/nij/242221.pdf (last visited Feb. 13, 2019).

[16] Id. at pp. 7-10.

[17] A vulnerable adult is a person 18 years of age or older whose ability to perform normal activities of daily living or to provide for his or her own care or protection is impaired due to mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging. S. 415.102(28), F.S.

[18] S. 415.101(2), F.S.

[19] Department of Children and Families, *CF Operating Procedure No. 140-2: Adult Protective Services* (Feb. 2019), pp. 4-9 - 4-10, http://www.dcf.state.fl.us/admin/publications/cfops/CFOP%20140-xx%20Adult%20Services/CFOP%20140-02,%20Adult%20Protective%20Services.pdf (last visited Feb. 13, 2020).

[20] Email from Lindsey Zander, Deputy Director of Legislative Affairs, Department of Children and Families, RE: APS Statistics (Oct. 30, 2019) (On file with House Health and Human Services Committee staff).

[21] Id.

FYs 2012-2017[22]							
FY	**Reports Received [1]**	**Unique Reports [2]**	**# Verified**	**Deaths Reported/ Investigated [3]**	**# Verified**	**In-Home**	**Institutional**
2018-2019	37,145	35,814	6,277	252	34	81.12%	18.88%
2017-2018	39,046	37,395	5,749	245	28	81.88%	18.12%
2016-2017	41,192	39,005	5,423	181	27	82.77%	17.23%
2015-2016	42,609	39,998	5,639	178	21	82.91%	17.09%
2014-2015	39,639	37,381	5,371	236	40	82.52%	17.48%
2013-2014	36,926	34,922	3,934	197	27	83.96%	16.04%
2012-2013	33,833	32,092	3,309	153	17	83.14%	16.86%
[1] *Reports received* ***counts Initial and Additional intakes accepted by the Hotline. There may be more than one call/reporter on the same incident.***							
[2] *Unique reports* ***represents a unique count of intakes received. Multiple intakes on the same incident are not counted.***							
[3] ***All reports accepted by the Hotline are investigated.***							

Central Abuse Hotline

DCF maintains a statewide 24/7 toll-free central abuse hotline where anyone can report known or suspected abuse, neglect, or exploitation.[23] This includes, but is not limited to, vulnerable adults. Any person that knows or has reasonable cause to suspect abuse, neglect, or exploitation of a vulnerable adult is required to immediately report this knowledge or suspicion to the central abuse hotline.[24] The hotline number must be provided to clients in nursing homes[25] and publicly displayed in every health facility licensed by the Agency for Health Care Administration (AHCA).[26] The number is also listed on the agency websites for DCF, AHCA, and the Department of Elder Affairs (DOEA).[27]

Additionally, any person who is required to investigate allegations of abuse, neglect, or exploitation, and who has reasonable cause to suspect that a vulnerable adult died as result of such harm must report that suspicion to DCF, the medical examiner, and appropriate criminal justice agency.[28] Medical examiners in turn are required to consider this information in their cause of death determinations and report their findings to DCF and the appropriate criminal justice agency and state attorney.[29]

Protective Investigations

Once DCF believes there is reasonable cause to suspect abuse or neglect of a vulnerable adult, they begin an investigation within 24 hours, to be conducted in cooperation with law enforcement and the state attorney.[30] DCF investigators determine, among other things, whether the vulnerable adult is in need of services, whether there is evidence of abuse, neglect or exploitation, the nature and extent of any harm, and what is necessary to ensure the victim's safety and well-being.[31] DCF investigators must complete their investigations and submit their recommendations within 60 days of the initial report.[32] If DCF determines that a victim is in need of protective services or supervision, it will provide or facilitate the provision of those services to the victim.[33] If a victim dies during an open investigation, DCF

[22] Id.
[23] S. 415.103(1), F.S.
[24] S. 415.1034(1), F.S.
[25] S. 408.810(5)(a)2., F.S.
[26] S. 400.141(1)(m), F.S.; AHCA poster can be found here: https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Long_Term_Care/docs/Nursing_Homes/Posters/NURSING_HOME_POSTER_ENGLISH_LETTER.pdf (last visited Feb. 13, 2020).
[27] Department of Children and Families, *Report Abuse Neglect or Exploitation*, http://www.myflfamilies.com/service-programs/abuse-hotline/report-online (last visited Feb. 13, 2020); Agency for Health Care Administration, *Complaint Administration Unit*, http://ahca.myflorida.com/MCHQ/Field_Ops/CAU.shtml (last visited Feb. 13, 2020). Department of Elder Affairs, *Elder Abuse Prevention Program*, http://elderaffairs.state.fl.us/doea/abuse_prevention.php (last visited Feb. 13, 2020).
[28] S. 415.1034(2), F.S.
[29] S. 415.1034(2), F.S.
[30] S. 415.104(1), F.S. Note, DCF does not investigate reports of elder abuse when the adult victim is determined *not* to be vulnerable under s. 415.102(28), F.S. Those elder abuse cases are the sole jurisdiction of law enforcement agencies.
[31] S. 415.104(3), F.S.
[32] S. 415.104(4), F.S.
[33] S. 415.105(1), F.S.

investigators must verify the cause of death before closing the case to determine if the death was related to abuse or neglect.[34]

If there is a report that a death occurred due to elder abuse, neglect, or exploitation, the DCF investigator notifies the department's registered nurse specialist (RNS)[35] staffing his or her region within 24 hours. If the alleged victim resided with other vulnerable adults, DCF conducts an on-site investigation to ensure the safety of these individuals as well.[36]

The DCF investigator and RNS work together to gather all relevant medical investigative information, including but not limited to medical records, the death certificate, the autopsy report, and specific questions to be included in the investigative process.[37] The DCF investigators also gather other relevant information such as copies of any related law enforcement investigations, criminal history and abuse reports relating to the alleged perpetrator, and prior adult protective services records relating to the victim or perpetrator, including the facilities where the death occurred.[38]

The DCF investigators review all of this information before making their determinations as to the cause of death and will summarize their findings in a report.[39] In these cases involving an elder abuse death, DCF designates a second party to review the DCF investigators' findings before closing the case.[40] The second party reviews the investigation process to ensure that it was thorough and that all issues were properly addressed; reviews the reports for completeness and accuracy; and documents its review for DCF's records.[41]

Adult Protection Teams

Current law authorizes DCF to create multidisciplinary Adult Protection Teams in each district[42] to support activities of the protective services program and provide services the team finds necessary for victims of elder abuse.[43] The teams can only provide these services with the consent of the vulnerable adult, the person's guardian, or court order, and should not duplicate services provided by other units or offices of DCF.[44]

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

- Psychiatrists, psychologists, other trained counseling personnel;
- Police officers or other law enforcement officers;
- Medical personnel who have sufficient training to provide health services;
- Social workers who have experience or training in preventing the abuse of elderly or dependent persons; or
- Public and professional guardians under part II of chapter 744, F.S.[45]

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[34] Department of Children and Families, *CF Operating Procedure No. 140-2: Adult Protective Services* (Feb. 2019), p. 15-2, available at: http://www.dcf.state.fl.us/admin/publications/cfops/CFOP%20140-xx%20Adult%20Services/CFOP%20140-02,%20Adult%20Protective%20Services.pdf (last visited Feb. 13, 2020).
[35] An RNS is a Florida-licensed registered nurse who assists the DCF in its APS investigations by providing medical expertise to help inform the DCF's findings, Department of Children and Families, *CF Operating Procedure No. 140-11: Adult Protective Services Registered Nurse Specialist* (Oct. 21, 2011), p. 1, available at: https://www.dcf.state.fl.us/admin/publications/cfops/CFOP%20140-xx%20Adult%20Services/CFOP%20140-11,%20Adult%20Protective%20Services%20Registered%20Nurse%20Specialist.pdf (last visited Feb. 13, 2020).
[36] *Supra* note 34, at 21-1.
[37] *Supra* note 34, at 21-2.
[38] Id.
[39] *Supra* note 34, at 21-2 - 21-3
[40] *Supra* note 34, at 21-3.
[41] Id.
[42] DCF has now adopted a regional structure rather than a district-based structure.
[43] Ss. 415.1102(1), 415.1102(4), F.S. DCF has established 15 Adult Protection Teams statewide, varying in how often and under what circumstances they convene, Email from Lindsey Perkins Zander, Deputy Director of Legislative Affairs, Department of Children and Families, RE: Adult Protective Services Statistics (Jan. 5, 2018) (On file with House Health and Human Services Committee staff).
[44] Ss. 415.1102(4), 415.1102(5), F.S.
[45] Ss. 415.1102(1), 415.1102(2), F.S.

- The community-based care lead agency;
- State, county, or local law enforcement agencies;
- The school district;
- A mental health treatment provider;
- A certified domestic violence center;
- A substance abuse treatment provider; and
- Any other members that are determined by guidelines developed by the State Child Abuse Death Review Committee (CADR).[46]

Child Abuse Death Review Committee

Child Abuse Death Review (CADR) Committees are granted access to all information and records from any state agency or political subdivision so long as the information may assist in reviewing a child's death.[47] Local CADR committees review individual facts and circumstances of a child's death and provide the state CADR committee with demographic data, any gaps or deficiencies identified in the system, and recommendations for improvement.[48] The state CADR committee provides direction for the review system and analyzes the data and recommendations received from local CADR committees.[49] The state CADR committee then submits a comprehensive annual report to the Governor and Legislature by December 1 each year.[50]

In the last fiscal year, all 22 local CADR committees used collected data to develop prevention action plans, including 194 activities designed to prevent child abuse.[51] Because drowning and asphyxia were the top causes of death in the previous year's data review, action plans included media campaigns, education, and training for safe sleep and water safety.[52] Similarly, because there is significant overlap between child maltreatment and domestic violence, substance abuse, and mental health, some action plans also addressed improvements in and increased access to parenting education, domestic violence advocates, and mental health treatment.[53]

Florida's Domestic Violence Fatality Review Teams

The state's Domestic Violence Fatality Review Teams (DV-FRT) are multidisciplinary teams that review fatal and near-fatal incidents of domestic violence, related domestic violence matters, and suicides.[54] DV-FRTs can be established at the local, regional, or state level.[55] Currently, there are 25 local DV-FRTs and one statewide team.[56] The DV-FRTs are assigned to the Florida Coalition against Domestic Violence for administrative purposes only, so the structure and activities of a team are determined at the local level.[57]

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

- Law enforcement agencies;
- The state attorney's office;
- The medical examiner's office;
- Certified domestic violence centers;
- Child protection service providers;

[46] S. 383.402(3)(a), F.S.
[47] S. 383.402(5), F.S.
[48] S. 383.402(3)(b), F.S.
[49] S. 383.402(2)(b), F.S.
[50] S. 383.402(4), F.S.
[51] Department of Health, *State Child Abuse Death Review Committee Annual Report December 2017*, p. 51, available at: http://www.flcadr.com/reports/_documents/Final_CADR_2017.pdf (last visited Feb. 13, 2020).
[52] Id.
[53] Id.
[54] S. 741.316(1), F.S.
[55] S. 741.316(2), F.S.
[56] Report of the Attorney General's Statewide Domestic Violence Fatality Review Team, *Faces of Fatality Vol. IX,* (June, 2019) https://www.fcadv.org/sites/default/files/FACES%20OF%20FATALITY%20IXweb.pdf (last visited Feb. 13, 2020).
[57] Ss. 741.316(5), 741.316(2), F.S.

- The office of the court administration;
- The clerk of the court;
- Victim services programs;
- Child death review teams;
- Members of the business community;
- County probation or corrections agencies; and
- Any other persons who have knowledge regarding domestic violence fatalities, nonlethal incidents of domestic violence or suicide, including research, policy, law or other related matters.[58]

The DV-FRTs review events leading up to the domestic violence incident, available community resources, current laws and policies, actions taken by systems and individuals related to the incident and parties, and any information or action deemed relevant by the team.[59] The teams' purpose is to learn how to prevent domestic violence by intervening early and improving the response of an individual and the system to domestic violence.[60] Each team determines the number and type of incidents it will review and makes policy and other recommendations as to how incidents of domestic violence may be prevented.[61]

The Office of the Attorney General and the Florida Coalition against Domestic Violence co-chair the statewide DV-FRT, which meets quarterly to review data collected by the local teams, identify systemic gaps, and summarize its findings and recommendations for changes to the service delivery system in an annual report.[62]

Various initiatives were developed based on these reviews. For example, the reviews revealed that perpetrators had a prior history of domestic violence, substance abuse, or violent crimes in 50 percent of cases reviewed. In response, the statewide team developed a pilot project to train and increase coordination between local law enforcement agencies, prosecutors, judges, probation officers, and domestic violence advocates.[63] The purpose of this cooperation was to identify risk factors sooner, protect the victims, and prevent fatalities.[64] Similarly, the reviews showed that 70 percent of victims had surviving children--some of whom even witnessed the fatal incident. The statewide team identified the need for and promoted collaboration with community partners to protect and provide services to the surviving children.[65]

Elder Fatality Review Teams in other States

Currently, at least 15 jurisdictions have elder fatality review teams at the state or local level.[66] For example, California, another state with a disproportionate senior population, statutorily authorized local elder fatality review teams in 2003 and now has an elder fatality review team in over 30 of its 58 counties.[67]

One of the first multidisciplinary elder fatality review teams was created in 1999, in Sacramento County, California. After years of reviewing cases, the review team noted that a common pattern of abuse involved a relative caregiver's inability to cope with the responsibility of caring for an elder whose health

[58] S. 741.316(1), F.S.
[59] S. 741.316(2), F.S.
[60] S. 741.316(2), F.S.
[61] S. 741.316(2), F.S.
[62] *Supra* note 56.
[63] Report of the Attorney General's Statewide Domestic Violence Fatality Review Team, *Faces of Fatality, Vol. VII,* (June 2017), p. 21, http://fcadv.org/sites/default/files/face_fatality_vii.pdf (last visited Feb. 13, 2020).; Report of the Attorney General's Statewide Domestic Violence Fatality Review Team, *Faces of Fatality, Vol. VI,* (June 2016), pp. 6-8, http://fcadv.org/sites/default/files/FACES%20OF%20FATALITY%20VI.pdf (last visited Feb. 13, 2020).
[64] Id.
[65] *Supra* note 63.
[66] National Adult Protective Services Association, *The State of Elder Fatality Reviews in the U.S.* (Webinar), http://www.napsa-now.org/wp-content/uploads/2017/03/03142017-EFRT-Webinar.pdf (last visited on Feb. 13, 2020).
[67] The National Long-Term Care Ombudsman Resource Center, *Long-Term Care Ombudsman Activities Regarding Abuse, Neglect and Exploitation*, May 10, 2011, http://ltcombudsman.org/uploads/files/issues/Chart-Summary-SLTCO-FINAL-May-10.pdf (last visited Feb. 13, 2020).

and mobility were rapidly deteriorating. In response, the review team created a resource guide for elder caregivers and independent elders alike, including contact information for agencies that can help with financial issues, transportation, conservatorship, home repair, medical issues, mental health issues, and other important needs.[68] Pharmacies, senior centers, medical clinics, religious centers, and other senior organizations distributed the brochure.[69]

The team also facilitated cooperation between disciplines to provide comprehensive vital services to elders in one location.[70] Acting on the review team's recommendations, the local coroner's office and adult protective services launched a project to improve communication between both agencies, the local district attorney's office implemented training and education on elder issues, and the local sheriff's department launched a volunteer program in its elder abuse unit to better detect and investigate financial fraud cases. The review team also established an interdisciplinary team of adult protective services staff and medical staff to provide intensive case management services, which has resulted in a 49 to 69 percent reduction in emergency room visits for participating elders.[71]

Soon after its inception, an elder fatality review team in Ingham County, Michigan, including police, prosecutors, adult protective services, the medical examiner, and emergency personnel, identified elder abuse in a death that law enforcement had deemed ordinary: through this multidisciplinary approach, the team determined that the elder's state caregiver had administered a lethal dose of morphine. These findings facilitated the prosecution and conviction of the perpetrator.[72]

Florida law does not authorize the EA-FRTs.

American Bar Association Elder Abuse Fatality Review Team Manual

In 2001, the federal Department of Justice commissioned the American Bar Association Commission on Law and Aging (ABA-COLA) to identify promising practices in the development of elder abuse fatality review teams. The ABA-COLA studied pilot programs from 8 local and state jurisdictions.[73] The ABA-COLA then created a replication manual based on these 8 programs.[74]

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

Recommendations for pilot programs were to:

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

The manual recommends that review teams include representatives from agencies or organizations that can provide insight into the systems and issues affecting elders, elder abuse, and elder fatalities,

[68] Sacramento County District Attorney's Office, *County of Sacramento Elder Death Review Team 2012 Report*, p. 5, http://www.sacda.org/files/7414/2671/1371/2012_EDRT_Annual_Report.pdf (last visited Feb. 13, 2020).
[69] Sacramento County District Attorney's Office, *County of Sacramento Elder Death Review Team 2008 Report*, p. 5, http://www.sacda.org/files/5514/2671/1055/2008_EDRT_Report_Final.pdf (last visited Feb. 13, 2020).
[70] Sacramento County District Attorney's Office, *County of Sacramento Elder Death Review Team 2015 Report*, p. 2-3, http://www.sacda.org/files/9914/2671/1266/EDRT_2015_Report_FINAL.pdf (last visited Feb. 13, 2020).
[71] *Supra* note 69.
[72] Chisun Lee, A.C. Thompson, and Carl Byker, *Gone Without a Case: Suspicious Elder Deaths Rarely Investigated*, Frontline PBS, https://www.pbs.org/wgbh/frontline/article/gone-without-a-case-suspicious-elder-deaths-rarely-investigated/ (last visited Feb. 13, 2020).
[73] Houston, Texas; Maine; Orange County, California; Pima County, Arizona; Pulaski County, Arkansas; Sacramento, California' San Diego, California; and San Francisco, California. Lori A. Stiegel, J.D., *Elder Abuse Fatality Review Teams: A Replication Manual*, American Bar Association Commission on Law & Aging, https://www.americanbar.org/content/dam/aba/administrative/law_aging/fatalitymanual.authcheckdam.pdf (last visited Feb. 13, 2020).
[74] Id.

such as Adult Protective Services, the Attorney General's Office, elder lawyers, forensic pathologists, medical examiners, geriatricians, health providers, or victim assistance programs.

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

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

On October 20, 2017, the Department of Justice announced more than $3.42 million in funding to respond to elder abuse and victims of financial crimes, which included funding to the ABA-COLA to enhance and evaluate elder abuse fatality review teams.[75]

Florida's Public Records and Open Meetings Requirements

The Florida Constitution provides that the public has the right to access government records and meetings.[76] The public may inspect or copy any public record made or received in connection with the official business of any public body, officer, or employee of the state, or of persons acting on their behalf.[77] The public also has a right to notice and access to meetings of any collegial public body of the executive branch of state government or of any local government.[78]

In addition to the Florida Constitution, the Florida Statutes specify conditions under which public access must be provided to government records and meetings. The Public Records Act guarantees every person's right to inspect and copy any state or local government public record.[79] The Sunshine Law requires all meetings of any board or commission of any state or local agency or authority at which official acts are to be taken be noticed and open to the public.[80]

The Legislature may create an exemption to public records or open meetings requirements if there is a specifically stated public necessity justifying the exemption and it is narrowly tailored to accomplish the stated purpose of the law.[81]

Active criminal intelligence information and active criminal investigative information are exempt from public record requirements, including such information held by a state attorney.[82] Current public records law distinguishes active information relating to criminal intelligence and criminal investigative information from other forms of such information.[83] "Active" means information related to intelligence gathering conducted with a reasonable, good faith belief that it will lead to detection of ongoing or reasonably anticipated criminal events, as such information relates to criminal intelligence

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[75] Press Release, Department of Justice, *Justice Department Invests $3.42 Million in Fight Against Elder Abuse and Financial Exploitation* (Oct. 20, 2017), available at: https://www.justice.gov/opa/pr/justice-department-invests-342-million-fight-against-elder-abuse-and-financial-exploitation (last visited Feb. 13, 2020).
[76] Fla. Const., art. I, s. 24.
[77] Fla. Const., art. I, s. 24(a).
[78] Fla. Const., art. I, s. 24(b).
[79] Section 119.011(12), F.S., defines "public record" as all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency. Section 119.011(2), F.S. defines "agency" as any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency. The Public Records Act does not apply to legislative or judicial records, *Locke v. Hawkes*, 595 So. 2d 32 (Fla. 1992). The Legislature's records are public under s. 11.0431, F.S.
[80] S. 286.011(1)-(2), F.S.
[81] Fla. Const., art. I, s. 24(c).
[82] S. 119.071(2), F.S.
[83] S. 119.011(3), F.S.

information.[84] For criminal investigative information, such information is considered "active" as long as it is related to an ongoing investigation which is continuing with a reasonable, good faith anticipation of securing an arrest or prosecution in the foreseeable future.[85] Further, criminal intelligence and criminal investigative information shall be considered "active" while such information is directly related to pending prosecutions or appeals.[86] The word "active" does not apply to information in cases which are barred from prosecution under the provisions of s. 775.15, F.S., or other statute of limitation.[87]

Confidentiality of Reports and Records Concerning Vulnerable Adults

Current law protects all records concerning reports of abuse, neglect, or exploitation of a vulnerable adult,[88] including reports made to the central abuse hotline,[89] and all records generated as a result of those reports are confidential and exempt[90] from public record requirements.[91] Access[92] to these records is granted only to the following entities in specified circumstances:

- DCF, AHCA, DOEA, and Agency for Persons with Disabilities employees or agents with certain relevant responsibilities, or the employees or agents of an agency of another state with jurisdiction similar to those agencies;
- A criminal justice agency investigating a report of known of suspect abuse, neglect, or exploitation of a vulnerable adult;
- The state attorney of the judicial circuit in which the vulnerable adult resides or in which the alleged abuse, neglect, or exploitation occurred;
- Any victim, the victim's guardian, caregiver, or legal counsel, and any person who DCF has determined might be abusing, neglecting, or exploiting the victim;
- A court;
- A grand jury, by subpoena upon its determination that access to such records is necessary;
- An official of the Florida advocacy council, State Long-Term Care Ombudsman program, or long-term care ombudsman council;
- Any person engaged in bona fide research or auditing, so long as the identifying information is not made available;
- The Public Employees Relations Commission for the sole purpose of obtaining evidence for appeals; and
- Any person in the event of the death of a vulnerable adult determined to be a result of abuse, neglect, or exploitation.[93]

Additionally, the identity of any person reporting abuse, neglect, or exploitation of a vulnerable adult may not be released, without that person's consent, to any person other than the employees of DCF responsible for protective services, the central abuse hotline, or the appropriate state attorney or law enforcement agency.[94]

Effect of the Bill

Elder Abuse Fatality Review Teams in Florida

[84] Id.
[85] Id.
[86] Id.
[87] Id.
[88] *Supra* note 17.
[89] *Supra* note 23.
[90] There is a difference between records the Legislature designates exempt from public record requirements and those the Legislature deems confidential and exempt. A record classified as exempt from public disclosure may be disclosed under certain circumstances. *See WFTV, Inc. v. Sch. Bd. of Seminole*, 874 So.2d 48, 53 (Fla. 5th DCA 2004), *review denied* 892 So.2d 1015 (Fla. 2004); *City of Riviera Beach v. Barfield*, 642 So.2d 1135 (Fla. 4th DCA 1994); *Williams v. City of Minneola*, 575 So.2d 683, 687 (Fla. 5th DCA 1991). If the Legislature designates a record as confidential and exempt from public disclosure, such record may not be released, by the custodian of public records, to anyone other than the persons or entities specifically designated in statute. *See* Op. Att'y Gen. Fla. 85-62 (1985).
[91] S. 415.07, F.S.
[92] The term "access" is defined to mean a visual inspection or copy of the hard-copy record maintained in the district. S. 415.07(7), F.S.
[93] S. 415.07(3), F.S.
[94] S. 415.07(6), F.S.

HB 253 creates s. 415.1103, F.S., authorizing the creation of a multidisciplinary, multiagency elder abuse fatality review team (EA-FRT) in each judicial circuit to review elderly persons' deaths alleged or found to have been caused by, or related to, abuse or neglect.

Membership and Organization

An EA-FRT may include, but is not limited to, representatives from public and private entities that study, treat, investigate, or prevent elder abuse, including but not limited to law enforcement agencies, health and social services agencies, healthcare practitioners, and nonprofit organizations.[95] Participation in an EA-FRT is voluntary and members serve without compensation or reimbursement for per diem or travel expenses. Members or the entities they represent bear the administrative costs of operating the EA-FRT.

The state attorney or his or her designee may initiate establishment of an EA-FRT in his or her judicial circuit and may call the first organizational meeting of the team. At an initial EA-FRT meeting, members choose two members to serve as co-chairs and may reelect them by a majority vote for up to two consecutive terms. Members serve for two-year terms, to be staggered as determined by the chairs.

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

The bill allows EA-FRTs already operating before July 1, 2020, to continue operating as long as they comply with the requirements established under the bill.

Review Process

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

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

Records

The bill requires the state attorney to assign closed cases to an EA-FRT and he or she must redact identifying information from such cases before assignment. A case is considered closed when it no longer contains active[96] information related to ongoing intelligence gathering, an ongoing investigation, or pending prosecutions or appeals. This means that the only cases that will be turned over by a state attorney to an EA-FRT for review will be those cases which are no longer active, and are open for public inspection.

Additionally, an EA-FRT may access information that is voluntarily provided by a victim's family or any other person. The bill requires an EA-FRT to inform any person who voluntarily provides information or

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

[96] *See* s. 119.011(3), F.S.

records that such information or records are subject to public disclosure unless a public records exemption applies. The bill also authorizes an EA-FRT to share information with other EA-FRTs.

Annual Reports

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

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

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

Immunity

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

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Creates s. 415.1103, F.S., relating to elder abuse fatality review teams.
Section 2: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill creates an indeterminate, insignificant, negative fiscal impact on DOEA. To the extent that any EA-FRTs are established, DOEA is required to submit an annual report to the Governor, Legislature, and DCF summarizing the reports from all of the teams. DOEA can absorb this impact within existing resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

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

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill does not require rulemaking to implement.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On November 7, 2019, the Children, Families and Seniors Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment allowed Elder Abuse Fatality Review Teams in existence on July 1, 2020, to continue to exist.

On February 18, 2020, the Health and Human Services Committee adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Requires the state attorney to initiate fatality review teams, assign cases for review, and redact identifying information from assigned cases.
- States that a case is considered closed when it no longer involves active information.
- Removes the requirement that review teams be administratively housed within the Department of Elder Affairs.

The analysis is drafted to the committee substitute as passed by the Health and Human Services Committee.