The Florida Senate BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared	By: The Profe	essional St	aff of the Approp	oriations Subcommit	tee on Health and Human Services
BILL:	SB 422				
INTRODUCER:	Senator Gibson				
SUBJECT:	Elder Abuse Fatality Review Teams				
DATE:	January 9, 2018 REVISED:				
ANALYST		STAFF DIRECTOR		REFERENCE	ACTION
l. Hendon		Hendon		CF	Favorable
2. Loe		Williams		AHS	Pre-meeting
3.				AP	

I. Summary:

SB 422 authorizes the establishment of elder abuse fatality review teams in each judicial circuit to review fatal incidents of elder abuse, and make policy and other recommendations to help prevent future incidents of elder abuse-related fatalities. The bill exempts certain information and records acquired by a review team from discovery or introduction into evidence in specified actions or proceedings. The review teams are assigned to the Department of Elder Affairs for administrative purposes only.

The bill will increase state expenditures by an indeterminate amount. Depending upon the increase in workload for the Department of Elder Affairs, such costs may be absorbed within existing resources.

The bill takes effect on July 1, 2018.

II. Present

There are currently no designated Elder Abuse Fatality Review Teams in Florida. The Adult Protective Services Program, under the Department of Children and Families (DCF), is responsible for preventing further harm to vulnerable adults who are victims of abuse, neglect, exploitation, or self-neglect. The mandatory reporting requirement of persons who are required to investigate reports of abuse, neglect, or exploitation also extends to alleged deaths due to abuse or neglect.

The Florida Abuse Hotline, administered by the DCF, screens allegations of adult abuse and neglect to determine whether the information meets the criteria of an abuse report. If the criteria are met, a protective investigation is initiated to confirm whether there is evidence that abuse has

occurred; whether that is an immediate or long-term risk to the victim; and whether the victim needs additional services to safeguard his or her well-being.¹

Section 415.1034, F.S., enumerates persons that have an immediate, mandatory requirement to report to the central abuse hotline if they know, have suspicion, or have reasonable cause to suspect that a vulnerable adult has been or is being abused, neglected, or exploited. Additionally, any person required to investigate reports of abuse, neglect, or exploitation and who has reasonable cause to suspect that a vulnerable adult died as a result of abuse, neglect, or exploitation shall immediately report the suspicion to the appropriate medical examiner, the appropriate criminal justice agency and to the DCF, notwithstanding the existence of a death certificate signed by a practicing physician.²

The DCF is required, upon receipt of a report alleging abuse, neglect, or exploitation of a vulnerable adult, to begin within 24 hours a protective investigation of the matter.³ For each report it receives, the DCF shall perform an onsite investigation to determine, among other things, if the person meets the definition of a vulnerable adult and, if so, if the person is in need of services; whether there is an indication that the vulnerable adult was abused, neglected, or exploited; and if protective, treatment, and ameliorative services are necessary to safeguard and ensure the vulnerable adult's well-being.⁴

Section 415.1102, F.S., authorizes the DCF to develop, maintain, and coordinate the services of one or more multidisciplinary adult protection teams in each of its regions. A "multidisciplinary adult protection team" is defined as a team of two or more persons trained in the prevention, identification, and treatment of abuse of elderly persons.⁵ The multidisciplinary teams may be composed of, but are not limited to, psychiatrists, psychologists, or other trained counseling personnel; law enforcement officers; medical personal with experience or training to provide health services; social workers who have experience or training in the prevention of abuse of the elderly or dependent persons; and public and professional guardians.⁶ The multidisciplinary team is convened to supplement the protective services activities of the Adult Protective Services program of the DCF.⁷

III. Effect of Proposed Changes:

Section 1 creates s. 415.1103, F.S., to authorize the creation of an elder abuse fatality review team in each judicial circuit⁸ to review fatal or near-fatal incidents of abuse, neglect, or violence against the elderly. Each review team is composed of volunteers from numerous state and local

¹Florida Department of Children and Families; Protecting Vulnerable Adults, *available at:* http://www.myflfamilies.com/service-programs/adult-protective-services/protecting-vulnerable-adults (last visited Nov. 7, 2017).

² Section 415.1034(2), F.S.

³ Section 415.104(1), F.S.

⁴ Section 415.104(2), F.S.

⁵ Section 415.1102(1), F.S.

⁶ Section 415.1102(2), F.S.

⁷ Section 415.1102(3), F.S.

⁸ There are currently 20 judicial circuits in Florida.

agencies as well as community partners. Each volunteer serves without compensation for a twoyear term. Each team will determine the number of cases it will review and must limit its review to closed cases in order to avoid interference with an ongoing criminal investigation or prosecution.

The elder abuse fatality team's review may include a review of events leading up to the incident, available community resources, actions taken by systems and individuals related to the incident, and any other information deemed relevant to the team. The review team is directed to make policy and other recommendations as to how incidents of elder abuse deaths may be prevented. Each team is required to submit its recommendations to the Executive Office of the Governor, the President of the Senate, the Speaker of the House of Representatives, the Department of Children and Families, and the Department of Elder Affairs.

The bill exempts a member of a review team in the performance of his or her duties as a review team member from monetary liability. Additionally, all information and records acquired by an elder abuse fatality review team are not subject to discovery or introduction into evidence in any civil or criminal action. The elder abuse fatality review teams are assigned to the Department of Elder Affairs for administrative purposes only.

Section 2 provides an effective date of July 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Any public records or open meetings issues are addressed in SB 424.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

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⁹ The bill provides for membership to include, but not be limited to, the following or their representatives: law enforcement agencies; the state attorney; the medical examiner; a county court judge; adult protective services; an 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 court administration; 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 other persons with knowledge regarding fatal incidents of elder abuse, domestic violence, or sexual violence.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The Department of Elder Affairs may incur additional costs associated with providing administrative support to the various elder abuse fatality review teams. Other public agencies whose staff serve on the review teams may incur some costs.

VI. Technical Deficiencies:

The bill does not specify the appointing authority for the members of the review team. As a result, anyone that falls within the particular membership categories may "volunteer" to participate on the review team. This may raise concerns because the review team has access to information that is otherwise confidential and exempt from public disclosure.

The bill appears somewhat contradictory when determining the scope of a review team's review, and the number of cases each review team will review. For example, the bill specifies that a review team shall limit its review to closed cases, but restricts the determination by a review team of the number of cases it will review to only cases in which an elderly person's death is verified to have been caused by abuse or neglect. This apparent contradiction is further complicated by another provision of the bill that mandates a review team be provided access to any information or records contained in a closed file that pertains to an elder, including information or records from a law enforcement agency, which are deemed necessary for the team to carry out its duties. The distinction of whether a closed case involving an elderly person's death is determined to have been caused by abuse or neglect is important because in this circumstance, most relevant information is publicly available pursuant to s. 415.107(3)(l), F.S. If the scope of a review team's review is not limited to cases in which an elderly person's death is verified to have been caused by abuse or neglect, this could potentially permit the team to review cases of individuals whose deaths were caused by events other than abuse or neglect, which does not currently afford a similar public records protection.

VII. Related Issues:

Review teams will most likely need access to confidential information in order to complete its reviews. Section 415.107, F.S., makes reports and investigations of elder abuse and/or neglect confidential but the team will most likely need this information to complete its reviews.

The bill mandates the establishment of elder abuse fatality review teams in each judicial circuit to review fatal incidents of elder abuse. Removing the mandate would allow local communities to establish these teams only if there is substantial local support and buy-in to effectively carry out the intent of the legislation.

The bill requires each elder abuse fatality review team to submit its recommendations to the Executive Office of the Governor, the President of the Senate, the Speaker of the House of Representatives, the Department of Children and Families, and the Department of Elder Affairs. This would lead to a maximum of 20 separate reports being sent to these entities. A state-level

elder abuse fatality team could be established to serve as a central repository to receive the local teams' recommendations. This state-level team would review and synthesize the local recommendations into a single statewide report to be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives. This structure would mirror the State Child Abuse Death Review Committee in the Department of Health. ¹⁰

The bill does not define the term "elder," specifically the age at which a person is deemed to be an elder, which may lead to inconsistency in the cases a team chooses to review. Providing a definition of "elder" which establishes, at a minimum, the age of a person eligible for a team review will allow for more standardized comparability amongst the separate reports required to be submitted by each team.

VIII. Statutes Affected:

This bill creates section 415.1103 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

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¹⁰ Section 383.402, F.S.