G48 Elder Abuse and Neglect Death Review: Use of an Interagency Team

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After attending this presentation, attendees will understand the organization and implementation of an elder death review team, using the San Diego experience as an example.

This presentation will impact the forensic community and/or humanity by providing general awareness of efforts of local governments to address the issue of elder abuse and neglect deaths. The experience of San Diego County's elder death review team may be helpful to other jurisdictions in developing teams.

There is a growing national concern about abuse and neglect of the elderly. San Diego was one of the first counties in California to develop an Elder Death Review Team in response to legislation enacted in 2001. The California law provides for the development of an interagency review 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." The law lists suggested team membership, including experts in the field of forensic pathology, experts in geriatrics, coroners and medical examiners, district and city attorneys, law enforcement, public administrators, ombudsmen and representatives from adult protective services.

San Diego County chose to set up the committee through a Memorandum of Agreement (MOA) between the District Attorney's Office, the Sheriff's Office, the Medical Examiner's Office, and the Health and Human Services Agency (which includes Aging and Independence Services). Representatives of these agencies are permanent members of the committee and rotate the chairmanship. The MOA provides guidelines for membership of the committee, objectives, recommendations, and confidentiality. The objectives include identification of risk factors and the facilitation of communication between agencies in order to reduce the number of elder deaths due to abuse and neglect.

The Elder Death Review Team borrowed ideas from existing Domestic Violence and Child Fatality review teams. All information is considered confidential, and all members must sign a confidentiality agreement. Paperwork is kept to a minimum. The committee has opted to discuss only one case per meeting. Discussion goals include determination of the nature of the abuse or neglect, if any, whether it played a role in the death, and an assessment of its preventability. A case review-investigative report form was developed to summarize each case. The committee discussions conclude with recommendations, which can range from changing individual departmental policies to public education to proposing legislation.

The committee has had its share of growing pains, and some issues have yet to be resolved. However, the authors believe the development of a County Elder Death Review Team is one step in raising awareness of elder abuse and neglect and reducing its prevalence.

Elder Abuse, Elder Neglect, Elder Death Review

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