E20 Investigating Elder Deaths

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After attending this presentation, attendees will better understand the signs and symptoms of elder maltreatment and the need to perform complete and thorough medicolegal death investigations in these cases, including scene investigations, ancillary studies such as toxicology screening, review of medical records, autopsy, and imaging when warranted in order to properly determine the cause and manner of death. Elder Death Review Teams (EDRT) provide interdisciplinary review of elder deaths in an attempt to develop prevention strategies to decrease the incidence of elder abuse.

This presentation will impact the forensic science community by emphasizing the need for comprehensive medicolegal death investigations in order to differentiate elder maltreatment from deaths due to natural disease of elders aged 60 years and older in suspicious deaths and to conduct interdisciplinary EDRT in an attempt to improve outcomes for this population.

The population of elders aged 60 years and over is projected to double in size and comprise 20% of the total United States population by 2050.[1] As this population grows, the maltreatment of elders is an increasing and disturbing problem worldwide. Research suggests that at least one in ten elders experiences some type of abuse but only one in 23 cases will be reported, according to the National Center on Elder Abuse.[2,3]

Elders are a vulnerable population due to their pathophysiology and lack of overall healthcare understanding. Conditions other than natural disease processes, such as hip fractures, subdural hematomas, sepsis, untreated decubitus ulcers, and malnourishment, may hasten their death. The medicolegal community must ensure that thorough investigations are completed to separate normal and expected findings from abuse and neglect.

Only two states, Arkansas and Missouri, have laws that mandate reporting of elder deaths that occur in a residential care facility, assisted living facility, intermediate care facility, or skilled nursing facility to the medical examiner/coroner regardless of whether or not the death was due to natural causes.[4,5] Furthermore, only 33 states or United States territories require the medical examiner/coroner or persons who perform the duties of the medical examiner/coroner to report cases of suspected abuse, leaving 31 states or territories without mandatory reporting requirements.[6] In order to address epidemiological studies, consistent reporting is necessary.

It is paramount for individuals who investigate and document elder deaths to be properly trained in order to recognize possible signs of maltreatment. A systematic approach, beginning with the death and scene investigation, followed by a complete autopsy, concluding with an interdisciplinary elder death review ensures proper classification of cause and manner of death. This methodical approach also allows for the development of prevention measures to decrease the incidence of future cases.

Deaths of elders should not automatically be assumed to result from natural disease. Accidents, suicides, and homicides can and do occur in the elder population. The development of a comprehensive standardized reporting form to collect appropriate information will assist in differentiating these cases and will be discussed.

The Georgia Department of Human Services Division of Aging and the Fulton County Medical Examiner's Office collaborated to develop a database documenting demographic and risk factors for elder abuse, neglect, and exploitation cases.[7] The team reviews cases weekly, notifying the medical examiner/coroner of any suspected maltreatment, initiating further investigation which may not have been pursued otherwise. The project will be discussed in detail.

Premature deaths of elders should be investigated as seriously as those of children and younger adults. This outlook will decrease the incidence of maltreatment occurring in a population that continues to grow as individuals live longer.

References:

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Elder Maltreatment, Geriatric, Scene Investigation