


SACRAMENTO COUNTY
ELDER DEATH REVIEW TEAM
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SACRAMENTO, CALIFORNIA 95820



ANNUAL REPORT

COMMITTEE REPORT
2004



ACKNOWLEDGEMENTS

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We gratefully acknowledge the entire membership of the Sacramento Elder Death Review Team who contributed to the content of this report. A subcommittee of Team members provided direct oversight and approved the final report. The devotion and dedication of the subcommittee members that spent many hours compiling and qualifying the material in this report is monumental. The subcommittee members are as follows:

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Special thanks go to Deidre Kolodney who provided overall supervision of the staff and the production of this report. Jeff Rose with his legal expertise and penchant for quality and content spent countless hours on this report. We would also like to extend a special thank you to Margaret Ong with Sacramento City Fire Department for loaning us the services of her grant writer, Jackie Gora.

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OFFICE OF THE
DISTRICT ATTORNEY
SACRAMENTO COUNTY

JAN SCULLY
District Attorney

CYNTHIA G. BESEMER
Chief Deputy

MESSAGE FROM SACRAMENTO COUNTY
DISTRICT ATTORNEY JAN SCULLY

Many people over the age of 65 are abused in this country every day. Elderly adults can fall victim to neglect and financial, physical and psychological abuse. Sadly, many of these cases never come to the attention of the many agencies and community-based organizations whose goals are to assist the elderly. Far too often, the victim depends upon his or her abuser for basic necessities and care, thus the abuse goes unreported. Many victims fail to seek assistance because of fear, shame or embarrassment.

I, along with others in county government believe that through a multi-agency approach with the ability to tap the expertise within law enforcement, the social service agencies, the medical community and community organizations, we can enhance the protections and services so desperately needed by the elder and dependent adult population.

In August 1999, the Sacramento County District Attorney's Office and the Department of Health and Human Services partnered with law enforcement, local senior service agencies and advocates to create the "Focus on Elder and Dependent Adult Abuse Campaign." Multi-disciplinary working groups were formed and held regular meetings. The concept of a multi-disciplinary elder death review team was the outcome of this collaboration.

Recognizing the need to form working partnerships, identify causes and potential gaps in services, and to prevent elder abuse and neglect, the Sacramento County Elder Death Review Team (EDRT) was officially formed. I am proud to have played a part in the establishment of the first-in-the-nation Elder Death Review Team.

Elder death review team members strive to ensure that suspicious deaths of elders do not go unexamined. Sacramento County is fortunate to have many agencies, community advocates and individuals who are committed to the well-being of our elderly population. I am grateful to the EDRT members, to the agencies that support the team's efforts and for the partnerships we have forged on this difficult and important issue.

Sincerely,


JAN SCULLY
DISTRICT ATTORNEY

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SACRAMENTO COUNTY ELDER DEATH REVIEW TEAM
COMMITTEE ANNUAL REPORT – 2004



SACRAMENTO COUNTY
DEPARTMENT OF

Jim Hunt,
Director

Health & Human Services

Telephone: (916) 875-2002
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Department of Health & Human Services Director's Foreword

Sacramento County can feel justifiably proud that it has taken the lead in establishing a formal elder death review process. Sacramento County's Elder Death Review Team (EDRT) is composed of County staff and volunteers who have tirelessly worked to investigate and analyze the deaths of elders in Sacramento County.

Sacramento County's EDRT, along with seven other counties nationwide, was invited to share their experiences before the American Bar Association's Commission on Law and Aging in Washington, D.C. It is gratifying to see Sacramento County receiving national recognition for its work and innovation in protecting its frail and elderly citizens.

This team hopes that the information contained in this report will assist in reducing the number of preventable elder deaths in Sacramento County and will increase the commitment from all sectors of our society to enhancing the safety, welfare and well being of our senior citizens.

A handwritten signature in black ink, appearing to read "J. Hunt".

Jim Hunt, Director
Department of Health & Human Services



SACRAMENTO COUNTY
DEPARTMENT OF

Health & Human Services

Senior & Adult Services
Bert Bettis
Division Manager

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Jim Hunt
Director

Sacramento County Elder Death Review Team
4875 Broadway
Sacramento, CA 95820

Dear Sacramento County Elder Review Team:

The death of an older person is such a natural occurrence that it is altogether too easy to overlook, discount or rationalize away abuse as its root cause. With inquiry into the causality of suspicious deaths of older persons, there can be accountability and opportunity to prevent other such deaths. As members of the Sacramento County Elder Death Review Team, you have been a dynamic force addressing this issue. You successfully obtained legislation to authorize California counties to establish Elder Death Review Teams to investigate, prosecute, and prevent elder abuse deaths. You took the lead Statewide in establishing the first Elder Death Review Team.

This is truly a milestone in the protection and safety of seniors. Your first annual report reflects your hard work, the strength of your coordinated efforts and your determination to develop an expertise in the area of forensic geriatrics. On behalf of Sacramento County seniors, I commend you for your innovation and dedication.

Sincerely,

A handwritten signature in cursive script that reads "Bert Bettis".

Bert Bettis



I. EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

This is the first report of the Sacramento county elder death review team (EDRT) committee, encompassing the period between December 2001 and December 2003. Future reports of the EDRT will be prepared annually, between September 1st and November 30th, for presentation to the Sacramento County Board of Supervisors.

In July 1999, Sacramento County District Attorney Jan Scully and Director of Health and Human Services Jim Hunt entered into a collaboration to address elder abuse and neglect. The concept of an EDRT was a product of that collaboration.

The primary role of the EDRT is to serve as a multidisciplinary case investigating committee providing in-depth analysis of the possible contribution of abuse and neglect to deaths of elders in Sacramento County.

The mission of the EDRT is to “carefully and critically examine deaths associated with suspected elder abuse and/or neglect, identify and work towards the implementation of prevention strategies to protect our elder population.”

The core members of the team consist of the Office of the District Attorney; the office of the County Coroner; representatives from city, state and county law enforcement; the Department of Health & Human Services (DHHS); health care professionals; representatives from state and county licensing; Ombudsman’s office; and, Sacramento City and Sacramento Metropolitan Fire Departments.

The Sacramento EDRT is the first elder fatality review team in the nation and, as such, has been confronted with new and challenging issues every time they have convened. First and foremost, how was confidentiality to be ensured, both to meetings and case materials; what are the ethical considerations of sharing information member-to-member and agency-to-agency; how and what data was to be collected, and what would be the mechanism for such collection, to name just a few. Given the inevitability of death in the aging population, case selection was a more complex issue than in the traditional death review teams. The traditional death review teams, domestic violence death review and child death review, deal with populations where a death is immediately suspicious and triggers an investigation. Such is not the case with the elder population. Factors such as the natural end-of-life process, the rights of the elderly to choose the manner in which they want to live (and die), the rapid physical and mental deterioration that can often occur with the elderly, and isolation factors that often confound ones’ ability to understand the progress of ones’ demise, are just some of the reasons that the case selection process can be extremely challenging. The EDRT Protocol, an evolving document, was drafted to guide committee members in these areas.

While the EDRT reviewed well over 100 cases between December 2001 and December 2003, only five (5) cases were included in this first report. These five were selected because they illustrate the range of cases reviewed, and the issues most frequently confronted by the EDRT. The team’s original purpose was to determine, where possible, whether criminally culpable abuse/neglect, violations of administrative procedures, or breakdowns between service-provider agencies contributed to or caused the death of elderly adults and, having made such determinations, to develop appropriate investigative, enforcement, prosecution and prevention strategies to help reduce future incidences. The reviews conducted thus far have thankfully disclosed very few previously unrecognized cases of patient abuse or neglect. It has been gratifying to observe that the law enforcement and social service agencies tasked with investigating suspicious deaths are by-and-large receiving mandatory reports of suspicious deaths and investigating them appropriately. On the other hand, our reviews have confirmed an emerging recognition in the geriatric field that classifying elder deaths as abusive or negligent is greatly hampered by the lack of forensic medical markers that are generally accepted as being evidence of abuse or neglect. However, despite the paucity of published medical articles in this area, with the wide degree of expertise on the team, certain markers have been accepted to represent possible abuse or neglect.

After two years of case reviews, the mission of the team has expanded to encompass the broader mission of learning how to evaluate whether and when elders can choose marginal care providers and living arrangements in the end-of-life phase, and how to support them in their decisions. To date, some common themes have emerged. The team has grappled with the wide diversity of subjective beliefs about self-determination, capacity to consent and when to intervene to ameliorate the consequences of lifelong patterns of poor choices. The reviews have disclosed that as one enters the winter of life, most of the health issues which are addressed are not black and white, but rather exist in shades of gray and require a more complicated evaluation and intervention strategy than in the cases of children and victims of domestic violence. In keeping with the county's long-standing commitment to preserving the health and welfare of our most vulnerable citizens, the following findings and recommendations are made.

MAJOR FINDINGS AND RECOMMENDATIONS:

A higher level of scrutiny should be utilized in evaluating cases involving people with disabilities who are unable to communicate or explain their medical condition or living situation.

Law enforcement and protective service agencies should have the means to immediately consult with geriatric physicians who can provide guidance on evaluating an individual's medical condition.

An outreach and educational campaign should be conducted to educate not only the elderly, but also their care providers about the risks associated with common medications and the need for a reassessment of dosages as one ages.

An outreach and educational campaign should be conducted to educate the community on commonly observed conditions within the elderly community that are indicative of serious health risks.

A checklist should be developed so agencies tasked with investigating elder abuse and neglect can uniformly evaluate under what circumstances an elder adult may choose to live in an environment that may result in exacerbating the elder's deteriorating health.



II. INTRODUCTION

BACKGROUND

JEFF ROSE
DEPUTY DISTRICT ATTORNEY
SACRAMENTO COUNTY

THE PROBLEM

Each year 2 million Americans over the age of 65 are abused in this country. The problem of elder abuse is a serious issue that touches us all. One in 20 elders will become a victim of financial abuse, neglect/physical abuse, or psychological mistreatment. Many more victims will go unnoticed because of fear, shame, embarrassment, and lack of recognition or isolation. Compounding the problem is the fact that many of these victims rely and depend on their abusers for care.

As a result, many cases of elder abuse and neglect are missed and/or go unreported; the victims are often not offered assistance and continue to remain at risk. Even when elder abuse is indicated, the numbers of referrals to Adult Protective Services, law enforcement and forensic experts are exceedingly low. The sad truth is that since the elderly are expected to die, elder deaths due to abuse may not be recognized. Consequently, an accurate count of deaths due to elder abuse is not available.

Due in part to medical advances, those individuals over age 75 now represent the fastest growing segment of our population. By the year 2020, the number of senior citizens in California is expected to double. Today, there are 3.6 million Californians age 65 and older, of whom 136,000 live in Sacramento County.

THE BEGINNING

In August 1999, the Sacramento County District Attorney's Office and the Department of Health and Human Services partnered with law enforcement, local senior service agencies and advocates to create the "Focus on Elder and Dependent Adult Abuse Campaign": a unique regional partnership to highlight the issue and find solutions to the problem. Nine multi-disciplinary working groups formed and met regularly with members from various public and private agencies and hospitals, community based organizations, the faith community and private citizens.

This interaction and teamwork laid the groundwork to develop a system of protection utilizing cross-agency and community collaboration. "The Focus on Elder and Dependent Adult Abuse", was the logical forum for community advocates to pose their questions and concerns regarding elder and dependent adult abuse. The concept of a multi-disciplinary elder death review team grew out of this process. Armed with the mission to review cases of suspicious elder deaths in skilled nursing and residential facilities, and/or the community, the elder death review team sought to develop protocols, policies and procedures that would facilitate an in-depth review of pre-death and death circumstances. The plan was to develop protocols that could be used as guidelines for investigative purposes as well as a retrospective review of the system of protection. Elder death review team members sought to ensure that suspicious deaths of elders would not go unexamined.

THE CHALLENGE

A mechanism whereby the County could establish a multi-disciplinary team to review the deaths for purposes of preventing and identifying abuse, and team members could exchange and divulge to one another information and records that were relevant to the prevention, identification and treatment of elderly and dependent persons. Without express statutory authority, a non-team member was not afforded the type of protection that is otherwise afforded to a third-party making a disclosure to domestic violence or child death review teams. Thus, exchange of vital information such as medical records and reports of abuse could not be allowed.

THE SOLUTION

The need to overcome the restriction of third-party disclosures inspired the sponsoring of legislation to establish elder death review teams in the State of California. Led by the District Attorney's Office, Sacramento County sponsored and wrote legislation (SB 333, Escutia) that authorized the establishment of elder death review teams in the State of California and allowed the third-party exchange of vital information, thus eliminating the confidentiality barriers.

During the legislative process leading up to the authorization of the bill, the Sacramento County Elder Death Review Team committee continued to meet regularly to draft comprehensive protocols and to share educational information with its members. On September 19, 2001, the Governor signed into law the Sacramento County sponsored legislation, authorizing the establishment of Elder Death Review Teams. The bill is codified in, Penal Code §'s 11174.4 thru 11174.9.

Armed with empowering legislation, the Sacramento County Elder Death Review Team (EDRT) was officially and jointly formed by the District Attorney's Office and the Department of Health and Human Services, with representatives from the Adult and Aging Commission, the Sheriff and Police Departments, the Coroner's Office, the State Department of Health Services, Licensing and Certification Division, the Long-Term Care Ombudsman, experts in the field of forensic pathology, medical personnel with expertise in elder abuse, and representatives of local and state agencies that are involved with elder abuse reporting. The first ten cases, referred by team members, were reviewed in December 2001.

THE RESULTS

Sacramento County is proud to have the first in the nation death review team, dedicated solely to investigating suspicious elder deaths.

III. ELDER DEATH REVIEW TEAM (EDRT) PROTOCOL

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Introduction

Establishment of an Elder Death Review Team

In July 1999, Sacramento County District Attorney Jan Scully and Director of Health and Human Services Jim Hunt entered into a collaboration to address elder neglect and abuse. The concept of an Elder Death Review Team (EDRT) is an outgrowth of that collaboration.

The primary role of the EDRT is to serve as a multidisciplinary case investigating committee providing in-depth analysis of the possible contribution of abuse and neglect to deaths of elders in Sacramento County. It also serves to strengthen system policies and procedures and to identify prevention measures to stop future incidents of elder abuse-related injuries and deaths.

There are Child Death Review Teams (CDRT's) and Domestic Violence Review Teams (DVDRT's) successfully operating throughout the state. Sacramento County is in the forefront in bringing the same type of critical analysis to elder deaths.

Elder Death Review Team Protocol

The Protocol states the Mission and Goals of the Sacramento County EDRT. It defines policies and procedures to follow in addressing issues that include: identifying team membership; deciding which cases to review; exchanging confidential information; and collecting and accessing data.

This protocol is intended to be used as a guide for the EDRT.

Purpose of the Elder Death Review Team

Mission Statement

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.

The Sacramento Elder Death Review Team (EDRT) will carefully and critically examine deaths associated with suspected elder abuse and/or neglect, identify, and work towards the implementation of prevention strategies to protect our elder population.

Goals

The goals of EDRT are:

- Prevent elder abuse fatalities
- Examine deaths of elders with suspected elder abuse and/or neglect
- Identify patterns that lead to fatal outcomes
- Determine whether reviewed deaths could have been preventable
- Develop prevention strategies
- Increase awareness of the responsibility of each Health Care Provider to consider abuse or neglect as a contributing factor to death
- Increase awareness of the responsibility of each Health Care Provider to refer cases arising from abuse or neglect to the appropriate agencies including but not limited to: Coroner, Adult Protective Services, State Licensing Department, Ombudsman, and Law Enforcement.
- Improve system responses by identifying gaps in delivery services
- Prosecution of offenders
- Develop intervention strategies to reduce fatalities and eliminate ongoing abuse and/or neglect

Team Membership

Core Members

The Sacramento County Elder Death Review team will consist of representatives of law enforcement, public health, social service agencies and health-care providers including, but not limited to, the following:

- Office of the District Attorney
- Office of the Coroner
- Law Enforcement
 - Sacramento County Sheriff's Department
 - Sacramento City Police Department
 - Citrus Heights Police Department
 - Elk Grove Police Department
- Department of Health & Human Services (DHHS)
 - Adult Protective Services
 - In-Home Support Services
 - Public Administrator/Public Guardian/Public Conservator
 - Public Health
 - Mental Health
 - Adult & Aging Oversight Committee
- Health Care Professionals
 - Hospital Emergency Rooms
 - UC Davis Medical Center
 - California Medical Training Center-UC Davis
 - Mercy Hospital

- Sutter Hospital Senior-Care
 - Kaiser Hospital
 - Kaiser Permanente Home Health, Hospice & Palliative Care
 - Sutter Health
 - Nurses and Pharmacists
- DSS/Community Care Licensing
 - State Department of Health Services Licensing and Certification
 - Ombudsman
 - Alta California Regional Services
 - Sacramento City Fire Department
 - Sacramento Metropolitan Fire Department
 - California Attorney General's Office-Bureau of Medi-Cal Fraud and Elder Abuse
 - County Counsel
 - California Attorney General's Office-Elder & Dependent Adult Abuse Unit

Other Members

This list is not inclusive, and other individuals may provide valuable insight for certain reviews. These representatives might include:

- Emergency Medical Technician (EMT)
- Gero-psychologist
- University of California Davis Medical Center-Psychiatry
- University California Davis Medical Center-Division of General Medicine

Team Leadership

The EDRT will be chaired by a representative of either the District Attorney's Office, the Sheriff's Department, or the DHHS Senior and Adult Services Division. The chair will serve for a minimum of one year. At the end of that time, the team may ask the current chair to continue in that position or select a new chair.

The co-chair will be a member from the community such as a representative from the Department of Health & Human Services, a geriatrician, skilled nursing facility representative, or others.

Staffing

The EDRT is staffed by one half-time EDRT Coordinator.

Meeting Schedule

The EDRT will meet once a month at the District Attorney's Office at 901 "G" Street on the fourth (4th) Thursday of the month at 1:30 p.m. Members shall designate an alternate in the event the member cannot attend a meeting. The alternate should be knowledgeable about the case placed on the agenda for review at that meeting.

Statutory Authority

California Penal Code Sections 11174.5-11174.9

11174.5

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.

11174.9. 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.

Case Review

Definitions

Penal Code 368. (a) The Legislature finds and declares that crimes against elders and dependent adults are deserving of special consideration and protection, not unlike the special protections provided for minor Children because elders and dependent adults may be confused, on various medications, mentally or physically impaired, or incompetent, and therefore less able to protect themselves, to understand or report criminal conduct, or to testify in court proceedings on their own behalf.

(b) (1) Any person who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult, with knowledge that he or she is an elder or a dependent adult, to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured, or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health is endangered, is punishable by imprisonment in a county jail not exceeding one year, or by a fine not to exceed six thousand dollars (\$6,000), or by both that fine and imprisonment, or by imprisonment in the state prison for two, three, or four years.

(c) Any person who, under circumstances or conditions other than those likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult, with knowledge that he or she is an elder or a dependent adult, to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health may be endangered, is guilty of a misdemeanor. A second or subsequent violation of this subdivision is punishable by a fine not to exceed two thousand dollars (\$2,000), or by imprisonment in a county jail not to exceed one year, or by both that fine and imprisonment.

(d) Any person who is not a caretaker who violates any provision of law proscribing theft, embezzlement, forgery, or fraud, or who violates Section 530.5 proscribing identity theft, with respect to the property or personal identifying information of an elder or a dependent adult, and who knows or reasonably should know that the victim is an elder or a dependent adult, is punishable by imprisonment in a county jail not exceeding one year, or in the state prison for two, three, or four years, when the money, labor, goods, services, or real or personal property taken or obtained is of a value exceeding four hundred dollars (\$400); and by a fine not exceeding one thousand dollars (\$1,000), by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, when the money, labor, goods, services, or real or personal property taken or obtained is of a value not exceeding four hundred dollars (\$400).

(e) Any caretaker of an elder or a dependent adult who violates any provision of law proscribing theft, embezzlement, forgery, or fraud, or who violates Section 530.5 proscribing identity theft, with respect to the property or personal identifying information of that elder or dependent adult, is punishable by imprisonment in a county jail not exceeding one year, or in the state prison for two, three, or four years when the money, labor, goods, services, or real or personal property taken or obtained is of a value exceeding four hundred dollars (\$400), and by a fine not exceeding one thousand dollars (\$1,000), by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, when the money, labor, goods, services, or real or personal property taken or obtained is of a value not exceeding four hundred dollars (\$400).al Code Section 368 defines elder abuse, neglect, and financial abuse.

Criteria

The Sacramento County EDRT will review the death of any individual 65 years and older, that meet any of the following criteria:

- Previous calls to the house for violence or abuse including, but not limited to: Adult Protective Services (APS); Ombudsman; Community Care Licensing (CCL); Department of Health Services (DHS) licensing; and Law Enforcement.
- Open or closed case involving abuse or neglects from agencies including, but not limited to: Adult Protective Services (APS), CCL, Law Enforcement, DHS Licensing and Certification, and Ombudsman
- Cases referred by health care providers, protective services agencies, and regulatory agencies
- Any case of blunt force trauma
- Any case wherein the attending physician requests review of the death
- Suspicious death in a long term care facility
- Accidental death from asphyxiation, toxicity or overdose
- Signs of abuse or neglect in the home
- Any death where there was disagreement between investigating agencies regarding the cause of death
- Any suspicious death of undetermined cause

Case Information

Once a case is identified for review, the EDRT Coordinator will send case information to EDRT members via a confidential e-mail, prior to scheduling the case for review at an EDRT meeting. The email will include the following information: name of the victim, date of birth, date of death and name of the facility that has been involved with the victim. If a member needs additional information he/she should contact the EDRT Coordinator.

The EDRT members should gather necessary information pertaining to the specific case and complete the EDRT Data Collection Form and send it to the Coordinator prior to the EDRT meeting.

At the EDRT meeting, members will review the facts and information gathered for each case. Policies and procedures will be identified that can prevent deaths from abuse or neglect.

Written materials generated from the meeting, such as case summaries or notes pertaining to the case will be collected by the Coordinator or the Chairperson. After material has been used to formulate

recommendations, all notes and written material will be shredded. All data collected for future reference will be encoded to ensure confidentiality.

Confidentiality

In The Case Review Process

Confidentiality Issues

EDRT members recognize that confidentiality is essential to the EDRT process. Confidentiality must be approached on two levels: team confidentiality and member confidentiality. Team confidentiality includes all activities that occur during an EDRT meeting. Written information will be disseminated, reviewed, collected at the end of the meeting, and shredded.

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

Confidentiality as it relates to the EDRT process will be implemented according to the following guidelines:

- Dissemination of information beyond the purpose of the review team is prohibited
- Case information is limited to the actual review process to enlist interagency cooperation
- Use of any material for reasons other than which it was intended is prohibited
- EDRT members are prohibited from creating any files with specific case identifying information

Breaching Confidentiality

There will be no breaches of confidentiality. Should a breach of confidentiality be discovered, it will be investigated by the EDRT Chairs. If substantiated, the representative responsible will be asked to resign from the team and action shall be taken to prevent further breaches.

SACRAMENTO COUNTY ELDER DEATH REVIEW TEAM

Confidentiality Agreement

I, as a member of the Sacramento County Elder Death Review Team (EDRT) 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 a 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 as referenced in SB 333 (Escutia) the enabling legislation for Penal Code 11174.4 - 11174.9.

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

Date

Printed Name

Signature

Data Collection

Data will be collected and summarized by the EDRT to identify patterns or trends and to ensure consistent and uniform results. This data should include:

- Details of the incident (including where it occurred)
- Autopsy information, if performed
- Summary of the case
- Suspicious physical findings or indicators
- Alleged abuser information
- Elder medical information including prescriptions, cognitive status, dependency in assisted daily living needs
- Description of elder's contact with medical professionals
- Financial information regarding net worth, home ownership, trusts and wills
- Information on POA and Advanced Directives
- Agencies involved with the elder
- Relationships of parties involved and ages
- Any prior history of the perpetrator and the victim
- Alcohol or drug use
- Use of weapons
- Prior intervention contacts with the system
- Conclusions and recommendations
- Other pertinent information on a case-by-case basis.

The data will be used to formulate recommendations for changes in system policy and procedures and to identify elder abuse prevention strategies.



IV. MEDICAL CHALLENGES

MEDICAL CHALLENGES

DIANA KOIN, MD,
DIRECTOR
ELDER AND DEPENDENT ADULT ABUSE EDUCATION
UNIVERSITY OF CALIFORNIA MEDICAL CENTER

THE CHALLENGES

Elder abuse prevention and intervention is an evolving discipline. Although child abuse and domestic violence teams have led health professionals into a better understanding of family violence, the complexity of the crimes against elders and people with disabilities has made it more difficult to progress as rapidly. Attracting compassionate and creative workers to the field continues to be an issue.

Health professionals are not universally required to have elder abuse training although they are all mandated reporters under California law. Physicians have been noted to be particularly reluctant to participate in elder abuse cases. Specialists in Geriatric Medicine are the exception to this and are often actively involved in death review teams. However, less than twenty geriatricians complete their training in California each year.

The United States has had increasing recognition regarding elder abuse. Currently, the Elder Justice Act is gaining support in Congress. Once the Elder Justice Act becomes law, the differences among states' approaches to elder abuse will diminish.

ETHICAL CONSIDERATIONS

One of the frequently stated reasons health professionals are reluctant to become involved in an elder abuse case is their belief that it breaches their professional standards of confidentiality. Physician training about elder abuse is steadily increasing, but typically only psychiatrists receive training about legal priorities over-riding confidentiality guidelines when violence is the issue. Physicians also report being conflicted if both the victim and the perpetrator are their patients.

Because dementia is a frequent factor in elder abuse cases, it is an area where physicians are asked to establish whether or not a victim has any cognitive disability. Assessment of dementing illness is another area in which doctors have uneven training. Although physicians are often asked to assess a patient's capacity in hopes of establishing whether or not a victim had the ability to consent to a situation or transaction, doctors are generally only comfortable in determining whether or not a patient has the ability to consent to a medical procedure.

MEDICAL RECORDS

Medical records may provide a treasure of critical information for a death review team. Despite the importance of this source of data, death review teams may find medical records difficult for two reasons: access and organization.

Access to medical records is limited because of confidentiality and privacy laws. Nonetheless, because abuse is a public health issue, the information in the records is necessary for a review and potential prosecution. Often, members of a death review team are part of a medical organization in their clinical roles. It is important that their participation in a death review team (and their legal right to access and review records of victims to be discussed) be specifically designated to the medical records department in order to avoid any question of impropriety.

Death review teams may benefit from training in medical records organization. For example, when law enforcement is required to review a ten- inch thick chart for a neglect case, it is difficult and frustrating to locate something as basic as a reliable record of a patient's weight. Education in mastering the essentials of medical records can offer help to team members who do not have medical backgrounds



V. AN OVERVIEW OF ELDER DEATH IN SACRAMENTO COUNTY

THE CORONER'S EXPERIENCE

STEPHANY FIORE, MD
FORENSIC PATHOLOGIST
SACRAMENTO COUNTY CORONER'S OFFICE

INTRODUCTION

The Coroner's Experience is a summary of elder death investigations completed by the Sacramento County Coroner's Office in 2003. This report includes background information and an overview of manner of death in five specified areas: Natural, Homicide, Suicide, Accident, and Undetermined. Following the narrative is a series of graphs depicting trends in elder death in Sacramento County.

BACKGROUND

Deaths that fall within the jurisdiction of the Coroner's office include all non-natural deaths, all deaths related to contagious diseases, and individuals who have not been seen by a physician for more than 20 days prior to their death. Hospice and emergency room deaths are also reported to the Sacramento County Coroner's office as a matter of policy.

In 2003, 6348 deaths were reported to the Sacramento County Coroner's office. Of these deaths, 3759 concerned individuals 65 years of age and older. Autopsies were performed on 417 of these cases. The remaining 3342 were considered Non-Coroner's Investigations (NCIs). NCIs are natural deaths within jurisdiction of the Coroner's office; however, the decedent's physician is willing to sign the death certificate.

When a death is accepted as a Coroner's case, the assigned deputy coroner initiates an investigation. The extent of the investigation is assessed on a case-by-case basis. In all investigations, information is gathered regarding circumstances leading up to the death by speaking with family, friends, law enforcement, hospital personnel or anyone else who last had contact with the decedent. Medical history is obtained from the primary care physicians and medical records. If medications are found at the scene, the pills are counted to ascertain if they were being taken as prescribed. Evidence of tobacco, alcohol and drug abuse is also looked for at the scene.

Following the initial investigation, the body is autopsied by a forensic pathologist in order to determine the cause of death, or the medical reason why the individual died. Again, the circumstances of an individual case determine the extent of an autopsy. In all cases, an external examination is performed to look for signs of neglect or trauma. Some cases will require a more in depth look and an internal examination will also be performed. Additional testing, such as measuring drug levels or having the brain examined by a neuropathologist, is included if needed.

Manner of death is a classification assigned to address the circumstances under which a decedent met his/her demise. There are five manner of death classifications recognized by the State of California: Natural, Homicide, Suicide, Accident, and Undetermined. Therapeutic Complication is a new manner of death that is also being used in a few jurisdictions outside this state.

Following is a closer look at elder deaths investigated by the Sacramento County Coroner’s office in 2003, based on their classification of manner:

FIGURE 1

Manner of Death Classification	Description	Total Deaths Investigated (417)
Natural	Death attributed to progression of significant medical conditions, primarily related to heart disease or chronic illnesses.	271
Homicide (not the same as murder)	Traumatic death occurring at the hands of another. (Proof of intent to inflict harm on another is not required.)	3
Suicide	Self-inflicted traumatic death. (Proof of intent to inflict harm on oneself is required.)	14
Accident	Traumatic death where the investigation of the circumstances has shown that no foul play was involved (includes motor vehicle accidents, falls, drowning, etc.)	114
Undetermined	Death where, after a thorough investigation of the circumstances and a complete autopsy, there is insufficient information to render an opinion regarding the manner of death with a reasonable degree of certainty.	15

NATURAL DEATHS

Of the 271 natural deaths classified by the Sacramento County Coroner’s Office, approximately 80% were attributed to heart disease. The remaining 20% expired from chronic lung disease, various cancers, end-stage dementia, chronic alcoholism, community acquired pneumonia, and a few miscellaneous conditions (refer to Figure 2).

The public does not consider hypertension a lethal condition; however, autopsy results have shown otherwise. A closer look at the cardiac-related deaths (refer to Figure 3) reveals half the decedents had a known history of hypertension. Terminal manifestations of hypertension include rhythm disturbances and congestive heart failure secondary to significant enlargement of the heart, renal failure due to scarring of the kidneys, and strokes due to surges in blood pressure. An additional 17% percent of the cardiac deaths listed arteriosclerosis (hardening of the vessels) of either the coronary arteries or aorta as the attributing factor. In 13% both arteriosclerosis and hypertension were present. Other factors that contributed to cardiac deaths included chronic atrial fibrillation (11 cases) and diseases of the heart valves (4 cases). Arteriosclerosis was listed as a cause of death in 88 cases. This is a more general term that is used when a history of specific cardiac disease is not present, but the scene and circumstances suggest a sudden cardiac death. In a third of these individuals, a known risk factor for arteriosclerosis (such as diabetes or tobacco abuse) was present.

Malignancies that were listed as the primary cause of death included two cases of pancreatic cancer, two cases of lymphoma, and one each of the following: mesothelioma, breast, lung, kidney, bladder, rectal, brain, and metastatic cancer of unknown primary origin.

There is a location on the death certificate where other significant medical conditions are listed that were thought to have contributed to the death of the individual but were not related to the underlying cause of death. The most common listed conditions were chronic lung disease from tobacco abuse, diabetes, heart disease, dementia, cancer, obesity, and chronic alcoholism (refer to Figure 4). Less common conditions included recent history of minor trauma, tobacco abuse without associated lung disease, untreated hypothyroidism, hyperlipidemia, anemia, and inanition. Inanition is a wasting away of the body from lack of proper nutrition. This can be caused by chronic disease, but is also seen in elderly people who have lost their desire to eat for whatever reason, as well as in those who are neglected. The State of California requires listing a known history of cancer on the death certificate, even if the history was remote and not actively contributing to the current medical condition of the individual. The most common cancers listed were prostate (10 cases) and breast (6 cases). Other malignancies included rectal, endometrial, lung, laryngeal, kidney, skin, and chronic leukemia.

ACCIDENTAL DEATHS

FALLS

By far, the most common accidental deaths that occur in the elderly result from falls (40%). (Refer to figure 5.) Approximately two thirds of the falls reported to the Coroner's office occurred at the individual's home from a standing height on flat ground (30 cases). Eight of the falls reported took place in licensed care facilities, and five occurred outside the home while the individual was running errands. Four people fell from a height, such as standing on a ladder or step stool. (Refer to figure 6)

The number of accidental deaths related to falls in licensed care facilities appears low and may be a reflection of under reporting. Possible explanations for this will be discussed in more detail below. When looking at deaths resulting from falls, two main mechanisms are identified: head trauma and fractures. Subdural hematoma resulting from trauma to the head was listed as the cause of death in 28 cases (60%) and complications of fractures in 18 (38%). Positional asphyxia was listed as the cause of one death involving a fall.

The age groups that were at the highest risk of dying from a subdural hematoma were those in their 70's (12 cases) and 80's (10 cases). Four of the individuals were in their 90's and two in their 60's. The number one risk factor in the elderly for developing a subdural hematoma is anticoagulation therapy with coumadin (8 cases). The second is atrophy (shrinking) of the brain related to dementia (4 cases). Chronic alcoholism is another risk factor for developing a subdural hematoma (3 cases). There is not only an increased risk of falling while inebriate, but alcoholism may also cause a bleeding tendency secondary to liver damage and/or produce brain shrinkage.

Bleeding into the subdural space is a result of tearing veins that stretch between the dura (a thick covering of the brain) and the surface of the brain. In young persons, the subdural space is not visible, as the dura and brain are in close proximity to one another. However, as a person ages and their brain begins to shrink, this space increases in size resulting in tension on the bridging veins making them more vulnerable to tears. Because of this, the amount of force required to produce a tear in one of these vessels is minimal in the elderly or alcoholic. Even an incomplete fall where a person is caught before hitting the

ground could produce enough force to jostle the brain inside the skull and create a small tear in a vein. These small tears can result in life threatening hemorrhages for individuals with an impaired ability to stop bleeding once it starts (i.e. alcoholics or persons taking coumadin).

It is not an uncommon scenario for an individual to have slipped earlier in the day, later retire to bed, and never wake up again, only to find a large subdural hemorrhage at autopsy. When these deaths occur at home, they are reported to the Coroner's office. When an individual is found dead in bed at a licensed care facility, the death may be attributed to their natural disease, overlooking the minor fall that occurred earlier in the day. If the doctor is willing to sign a death certificate, these cases go unreported. Interestingly, only two of the 28 deaths resulting from subdural hematoma were reported by licensed care facilities. Five of the falls occurred out in the community and the remaining 21 deaths were due to falls that occurred in the decedent's own home.

The risk of death from a fracture appeared higher in those over 80 years (14 cases) than those 70 years and younger (4 cases). Femur/hip was listed as the site of injury in 9 of the 18 deaths related to fractures from falls. The remaining sites were about equally distributed between the neck, rib cage, pelvis, and ankle. Most deaths associated with fractures from falls result from secondary complications. Bronchopneumonia was the most common complication listed as the immediate cause of death (8 cases). Other less common complications included embolization of blood clots from the legs or fat/bone marrow from the fractured bone, hemorrhage, and respiratory failure from quadriplegia.

The factors leading to the development of bronchopneumonia are multiple, with immobility associated with convalescence and intubation for mechanical ventilation being the most important. Poor nutritional status, peripheral vascular disease, and osteoporosis retard the healing process making the period of convalescence longer in the elderly and placing them at increased risk of developing complications. In addition, these patients often have other medical conditions, such as heart disease and diabetes, which also interfere with rapid recovery and contribute to the risk of developing complications.

There may be an under reporting of fracture-related deaths as well. In people with severe osteoporosis, a hip fracture may spontaneously occur as the person stands causing the person to fall (i.e. the fracture causes the fall rather than the fall causing the fracture). Many clinicians are willing to certify these deaths as naturally occurring fractures from osteoporosis; therefore, they may not be reported to the Coroner's office. Six of the 18 fracture-related falls reported to the Coroner's office occurred at a licensed care facility while the remaining 12 occurred at the decedent's home.

MOTOR VEHICLE ACCIDENTS

Motor vehicle accidents at 29% were the second leading cause of accidental deaths investigated by the Coroner's Office. In 2003, 33 deaths were due to motor vehicle accidents with 18 involving more than one vehicle and 3 a single vehicle. The remaining 12 victims were pedestrians who were struck by a motorized vehicle (refer to Figure 7). The ages of the three drivers involved in the solo accidents were 65, 74, and 87 years. All lost control of the vehicle they were operating and ran into stationary objects. One driver was on his way to have a blood test and had been fasting, which may have caused him to black out. Another driver lost control as she was exiting a freeway. The third driver failed to see a semi truck parked on the side of the road and rear-ended it. This accident occurred late at night. None of these drivers were intoxicated.

Of the 18 people involved in a multi-vehicle collision, 10 were drivers and 8 were passengers. The drivers' ages ranged from 65 to 87 years. Seven of these accidents occurred while the decedent was trying to cross or make a left turn at an intersection. Five of these drivers were found to be at fault: one for running a red light, two for turning left into oncoming traffic, and two for failing to yield to cross traffic. Three of these accidents occurred in the evening, between 6 and 8 pm, during the winter months when it is dark out. One driver was rear-ended by a semi truck when his vehicle stalled in traffic. The truck was unable to see the decedent's vehicle due to heavy fog and loss of taillights from the stall.

The complete circumstances of the remaining four driver fatalities are unknown. Drug testing was performed on five of these cases and was negative. Prolonged survival precluded evaluation of intoxication in the other five cases. Two of the drivers were wearing a seat belt at the time of the accident and three were known to be unrestrained. It is unknown if any safety equipment was being used in the other five cases.

Five of the eight traffic fatalities where the decedent was a passenger also took place at an intersection. The driver of the vehicle the decedent was in was at fault in all five accidents. Three ran red lights and two failed to yield to cross traffic. Four of these drivers were also elderly (70s and 80s). The age of the fifth driver is unknown. Of the remaining three passenger fatalities, one involved a golf cart mishap of unknown circumstances and another high-speed head on collision with a felon at large. The third was a motorcycle accident where the decedent was riding on the back. The driver of the motorcycle was speeding and lost control when he braked to avoid rear-ending a slowed vehicle in front of him and ejected the 68 year old female off the back of the bike.

The pedestrians ranged from 76 to 93 years of age. Seven of the twelve pedestrians were in the process of crossing the street at the time they were struck. Four of the accidents occurred at night and the driver was unable to see them until too late. Of the remaining three, one man ran out into the street after his dog, another attempted to cross the street after exiting a bus, and the third was an on duty crossing guard wearing a reflective vest. One lady was struck in a parking lot when she walked behind a car that was backing out of a stall. Out-of-control vehicles that left the road struck two unfortunate pedestrians. The other two cases involved a man with dementia who wandered into the roadway in front of a car and a 77-year-old homeless man who was lying in the roadway when he was struck. These latter two accidents also occurred at night making them difficult to see. In all cases, the driver stopped and rendered aid.

FIRE-RELATED FATALITIES

There were nine deaths caused by smoke inhalation and burns from accidental fires. The ages of these independent elders ranged from 66 to 85 years. All lived alone. Four victims fell asleep while smoking cigarettes catching the bed or chair they were lying in on fire. Two victims ignited inflammable liquid they had accidentally spilt on their clothing: one by changing a propane tank and the other by filling a cigarette lighter. A 76 year old woman caught her clothing on fire while cooking supper for herself. She didn't call 911 until her daughter discovered her injuries the next day because she was afraid to go back into a nursing home. An 84-year-old man was driving a tractor when a chain dragging in the back accidentally set the grass on fire. Another man died from an electrical fire in his home

MISCELLANEOUS ACCIDENTS

The remaining accidental deaths represent a hodge-podge of events (refer to figure 5). Five people aspirated on food. All had a history of prior stroke that impaired their ability to swallow. Four people drowned, two while swimming and two while bathing. These types of drowning typically occur when the individual has a sudden cardiac event in the water and submerges. There were four cases of asbestosis-related lung disease, which are classified as accidental due to industrial exposure. Four people died from medical misadventures while in the hospital. The heart was perforated in two cases, one during placement of a pacemaker and the other a central venous catheter. One man developed a lung abscess when a feeding tube was inadvertently placed down his airway instead of his esophagus. The fourth patient received an excessive dose of morphine when the nurse misread the orders. Two people died during the course and scope of their employment. One developed heat stroke while roofing a house and the other run over by a forklift. There were two deaths related to drug intoxication, one from cocaine and the other from multiple prescription drugs admixed with alcohol. The man abusing cocaine was 66 years of age.

The final four accidental deaths were all unique. A diabetic woman died from an infected cat bite. A man suffered severe injuries when the car he was working on fell on top of him. A man died from a shotgun wound when the weapon he was carrying accidentally discharged after he tripped and fell. Finally one man hemorrhaged to death from his dialysis shunt after minor trauma activated bleeding from the needle puncture site.

SUICIDES

Unlike natural and accidental deaths, suicides only make up about three percent of the deaths that occur in people 65 years or older. In 2003, there were 14 suicides that took place in this age group in Sacramento County. The ages ranged from 66 to 87 years. Males commit suicide four times more often than females. Approximately 70% of the deaths were from gunshot wounds to the head with the other 30% split between hanging, drug overdose, and suffocation by placing a plastic bag over the head (refer to Figure 8).

Two of the women ended their life by taking an overdose of their prescription medication. Antidepressants, especially tricyclics and the serotonin reuptake inhibitors (e.g. Prozac), in combination with pain medication and/or muscle relaxants is the most common cocktail used. The third woman, also the oldest individual in this group, used a firearm. Only one individual left a suicide note. Another had their final Will and Testament in clear view along with a copy of Final Exit, a book put out by the Hemlock Society that instructs those with terminal illnesses how to die with dignity.

Four people had previously voiced their desire to end their life to either family members or their physicians. One took his life impulsively after his daughter confronted him about the dishonest intentions of his exceptionally young girlfriend. Failing health was cited as the reason for ending life in all but two of the cases. Social isolation was a contributing factor in half the cases. Three individuals had a long history of psychiatric illness. Two suffered from years of depression and the third had paranoid delusions. Two people also had recent traumatic events in their life. One was a victim of a violent robbery and the other was upset about his grandchildren being removed from the home for unknown reasons by Child Protective Services

HOMICIDES

Homicides are not the same as murder, which is a legal term where intent is implied. Proof of intent is not required in ruling a death a homicide. Actual homicidal deaths are rare in the elderly. There is increasing concern in the community about elder abuse and neglect; however, these deaths can be difficult to separate out for a number of reasons that have been addressed elsewhere in this report.

The three cases presented in this section were all intentional homicides that are in various stages of prosecution by the District Attorney's Office. Two of the victims were in their 60's and one in her 70's. Two were female and one male. One of the victims was brutally murdered by her grandson. Unfortunately, this is not uncommon. These grandchildren are typically troubled youths involved with drugs and the grandmothers take them into their homes after all the other family members have washed their hands of them. An argument develops over money-related matters and the grandmother becomes a victim of a violent death. The other woman was beaten to death by a man she hired to help her around the house. Robbery is thought to be the motive in this case. The third homicide was a man who was the victim of a hold up at an automated teller machine outside of a bank. He was shot through his car window as he tried to escape the assailants.

UNDETERMINED

Approximately 3.5% of the cases were finalized with an undetermined manner of death. This percentage falls well within the nationally accepted standard. Six of the 15 deaths were classified as "Undetermined, no autopsy pursuant to California Government Code Section 27491.43". This government code allows for a certain group of people, namely Christian Scientists, to legally refuse medical treatment and autopsy based on their religious beliefs. Because an autopsy cannot be performed, both the cause and manner of death are certified as Undetermined; however, they are essentially natural deaths. All six individuals were residents at Olive Glen Skilled Nursing Facility, a care home for Christian Scientists. Our experience has been that the residents in this facility are given excellent care. An external examination is performed on all cases and there have never been any signs of neglect or abuse. The quality of care rendered at Christian Science Sanatoriums has wide spread recognition and has been the subject of publication in the medical literature [Am J Forensic Med Pathol 1993 Mar; 14 (1): 10-1].

In nine cases (2%), a single manner of death could not be decided upon with a reasonable degree of certainty. Two cases involved drug intoxications where the levels detected were exceptionally high but the intent to intentionally harm oneself could not be shown. Two deaths were due to traumatic subdural hematomas that developed in institutionalized patients. There was no history of fall or any other explanation as to why they developed, so the manner was left undetermined. A man with dementia fell off the roof of his home while on leave from an Alzheimer's facility. The manner was left undetermined because it was uncertain whether the fall was accidental or suicidal.

Another man was found in the river and appeared to have intentionally taken his life; however, there were some suspicions of foul play, which could not be ruled out. Another case where foul play could not be ruled out involved a man who suffered burns from his wall heater. He appeared to have accidentally fallen between the couch and heater; however, there were accusations that one of his children may have

been responsible. One death was due to complications of a seizure disorder. It was unclear if the seizure was related to old brain injuries or alcohol withdrawal, two equally likely explanations in this individual. The final case was one that appeared to be related to natural disease; however, caregiver neglect could not be ruled out.

SUMMARY

Approximately 60% of all the cases referred to the Sacramento County Coroner's Office in 2003, involved people 65 years of age and older. The vast majority of these cases (89%) were released from the jurisdiction of the Coroner's Office because they were apparent natural deaths without any history of trauma or suspicions of foul play and the regular treating physicians of these individuals were willing to sign the death certificates. The remaining 11% (417 deaths) were retained for additional investigation.

When analyzed by manner of death, or the circumstances under which the death took place, 65% were certified as natural, 27% as accidental, 3.5% suicidal, and less than one percent as homicidal. The manner of death could not be determined in 3.5% of cases.

Heart disease was implicated in 80% of the deaths that were determined to have been from natural causes. There was a documented history of long standing hypertension in 50% of these cases and a history of coronary artery disease in 17%. An additional 13% had known risk factors for developing heart disease, such as diabetes, obesity, tobacco abuse, and high cholesterol. Other medical conditions that significantly impact the health of the elderly include chronic lung disease from many years of smoking, diabetes, dementia, obesity, and chronic alcoholism.

Falls and motor vehicle accidents were responsible for approximately 70% of all the accidental deaths reported in 2003. When looking at deaths related to falls, people died from a subdural hematoma complicating head trauma 1.5 times more often as they did from complications of fractures. Coumadin anticoagulation, dementia, and chronic alcoholism are the three most important risk factors for developing a subdural hematoma in the elderly. Even what may appear to be a minor accident can result in life threatening consequences in people with these risk factors. Furthermore, the effects of the head trauma may not be immediately apparent, but may develop many hours after the incident, which caused the injury. Only 7% of people dying from a subdural hematoma following a fall were reported by a licensed care facility. It is believed that this figure reflects an under-reporting of these deaths because the accidents are often thought of as insignificant and the patient later dies in his/her sleep from what is presumed to be natural causes.

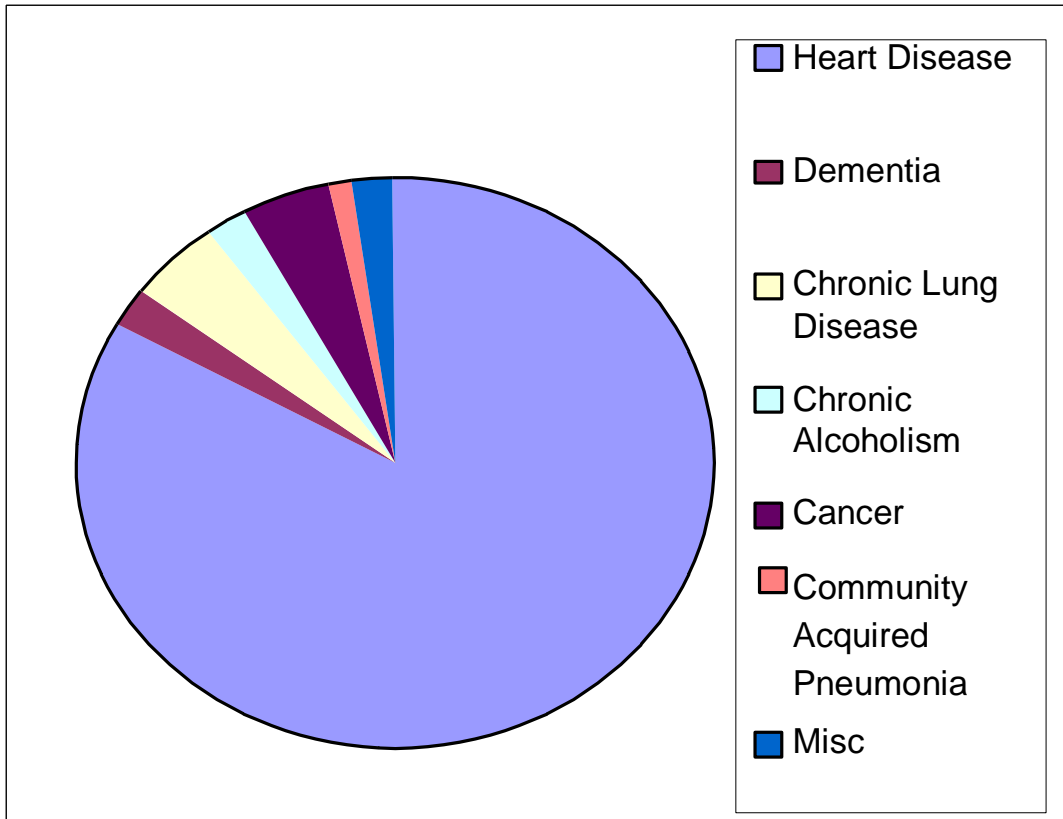
Of the 33 traffic fatalities investigated, two-thirds involved people inside a vehicle and one-third pedestrians struck by a moving vehicle. An elderly driver was found to be at fault in half the accidents involving one or more vehicles. Running a red light and failing to yield the right of way when crossing or making a left turn at an intersection were the cited violations. Impaired vision from driving at night appeared to play a role in some of the cases. Intoxication by drugs or alcohol did not appear to be a factor. In two-thirds of the pedestrian related accidents, there were factors that impaired the visibility of the driver in seeing his victim. Half the accidents occurred at night on dimly lit roadways. In two cases, a solid object blocked the driver's sight of the victim.

Suicide is an uncommon, but real occurrence in the elderly. Failing health and social isolation are the two main factors that drive an elderly individual to take his/her own life. Males over the age of 85 remain the highest risk group for suicides. Homicidal violence in the elderly population is fortunately rare. Victims tend to be frail and easily overpowered by the assailant. Robbery/money played a roll in all three homicides that occurred in 2003.

Attached is a series of graphs to illustrate the findings of the Sacramento County Coroner's Office in this report.

Natural Deaths

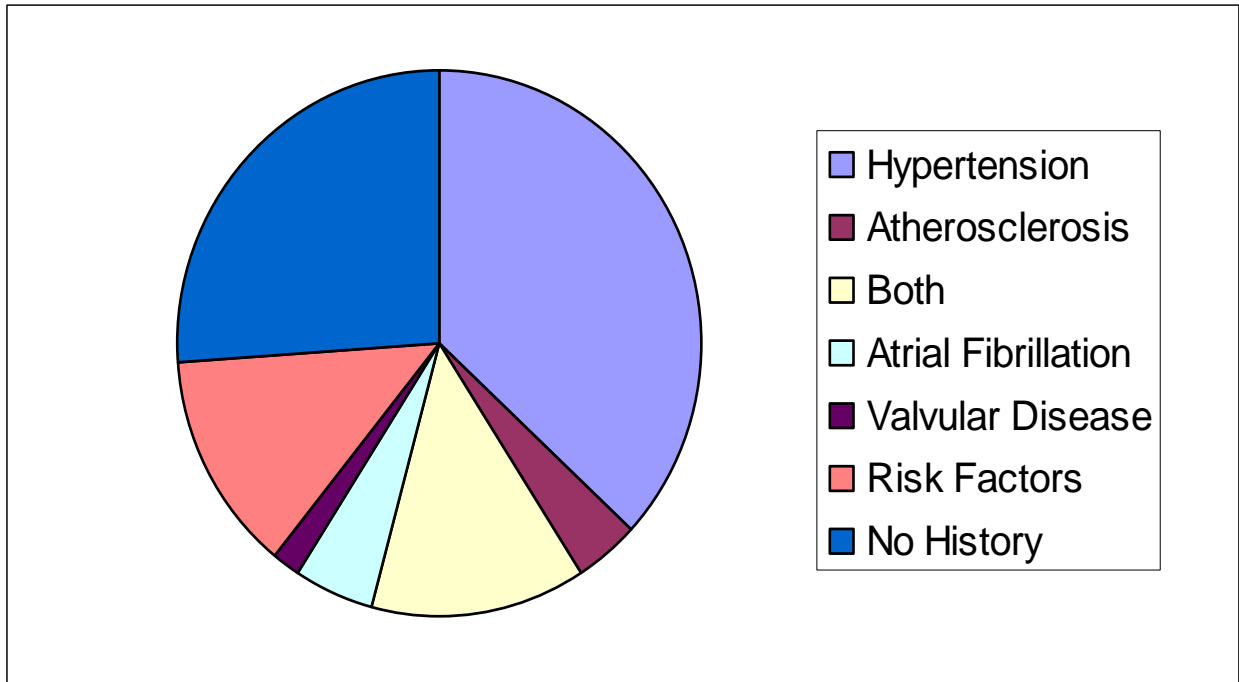
Figure 2



Heart Disease	225
Cancer	12
Chronic Lung Disease	13
Dementia	6
Chronic Alcoholism	6
Community Acquired Pneumonia	3
Miscellaneous	6
Total	271

Heart Disease

Figure 3



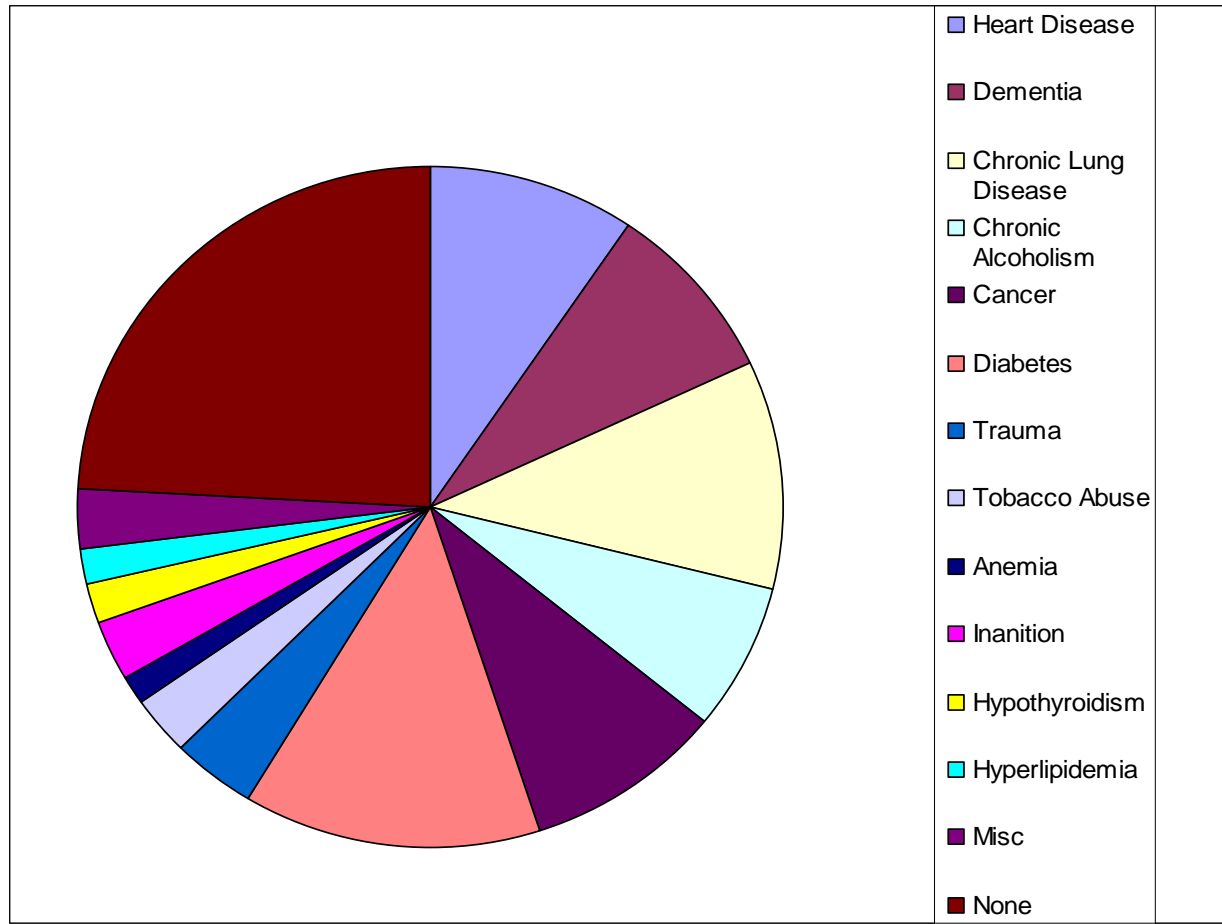
Hypertension	83
Arteriosclerosis	9
Both Hypertension & Arteriosclerosis	30
Atrial Fibrillation	11
Valvular Disease	4
Arteriosclerosis w/ known risk factors	29
Arteriosclerosis w/ no history	59

Total **225**

Sacramento County Coroner's Office, 2003

Contributing Conditions

Figure 4

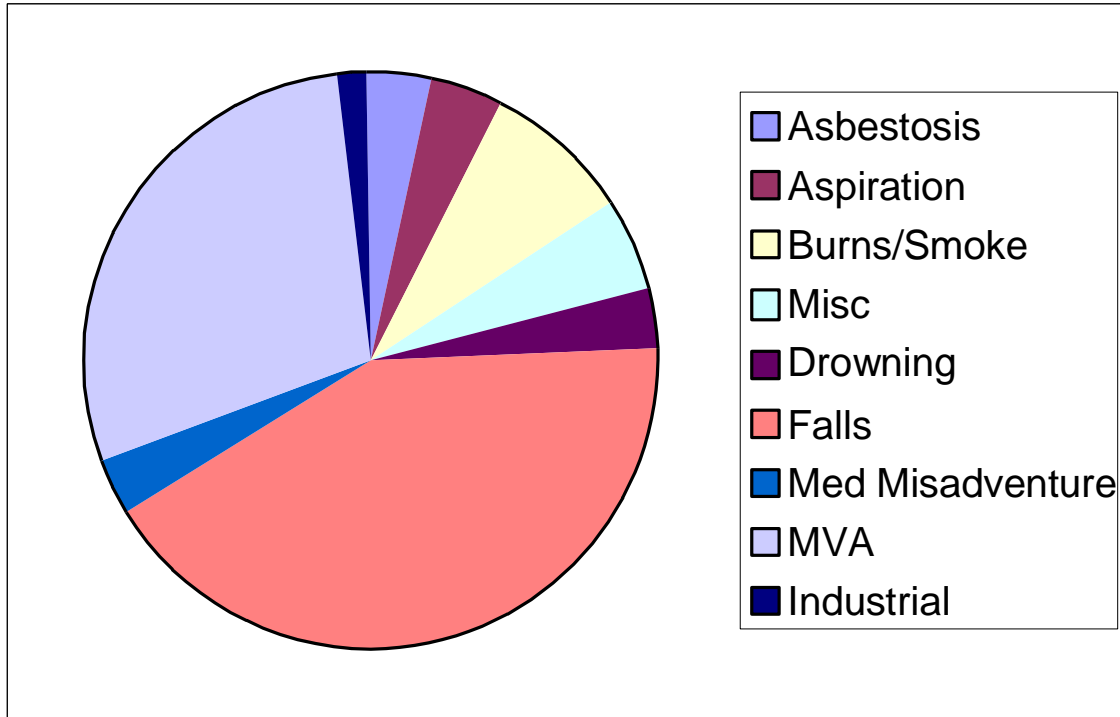


Chronic Lung Disease	30
Diabetes	37
Heart Disease	26
Dementia	24
Chronic Alcoholism	19
Cancer	26
Tobacco Abuse	8
Obesity	21
Hypothyroidism	6
Trauma	11
Hyperlipidemia	4
Anemia	4
Inanition	7
None	67
Miscellaneous	8

Sacramento County Coroner's Office, 2003

Accidents

Figure 5



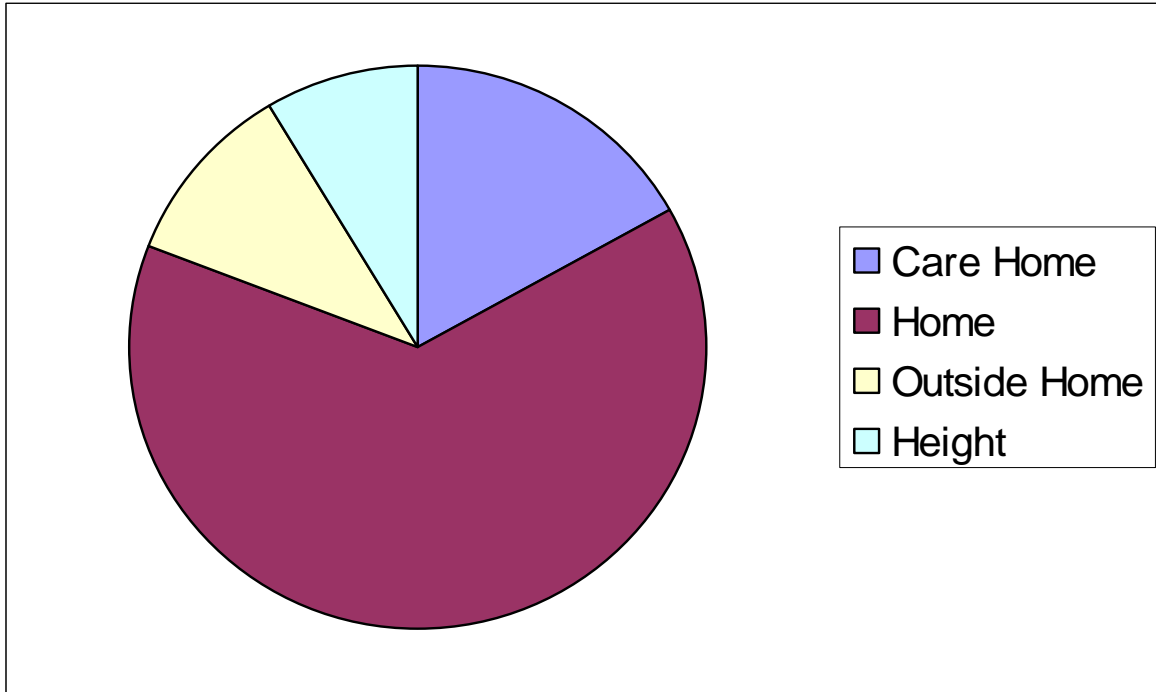
Falls	47
Drowning	4
Motor Vehicle Acc.	33
Aspiration	5
Burns/smoke	9
Industrial	2
Miscellaneous	6
Asbestosis	4
Medical Misadventure	4

Total **114**

Sacramento County Coroner's Office. 2003

Falls Locations

Figure 6



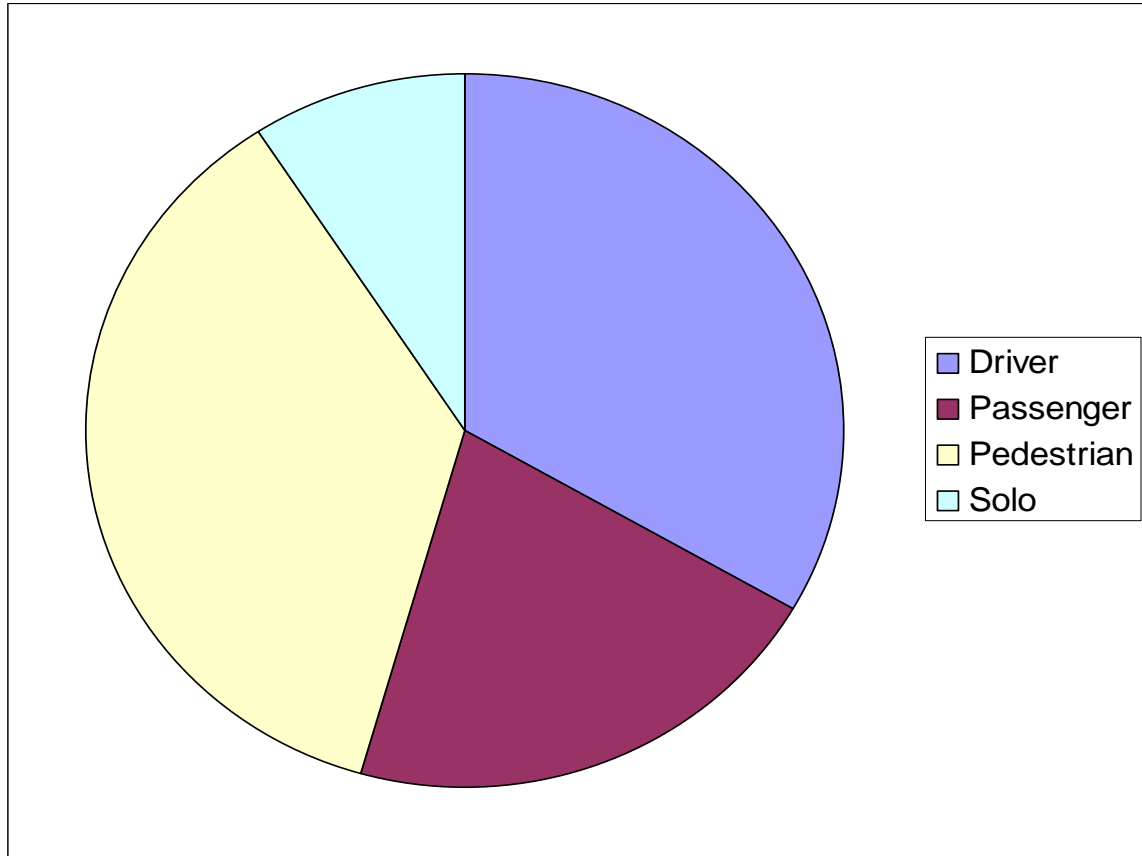
Home	30
Care home	8
Height	4
Outside home	5

Total **47**

Sacramento County Coroner's Office, 2003

Motor Vehicle Accidents

Figure 7



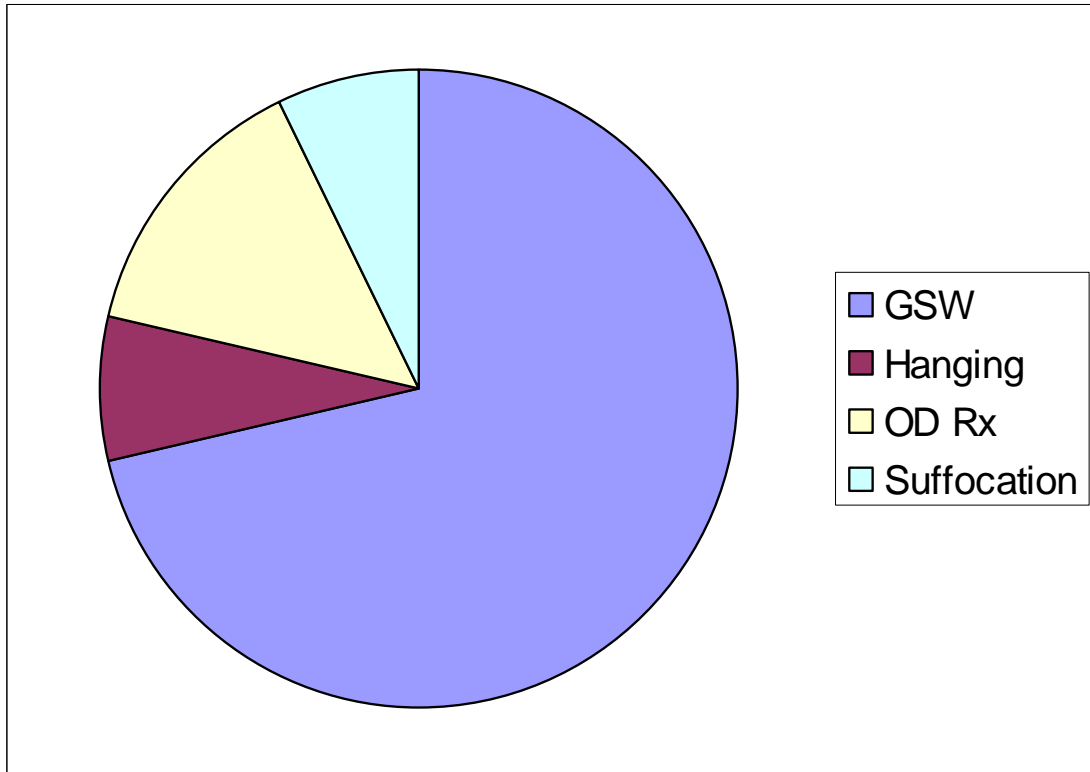
Pedestrian	12
Driver	11
Passenger	7
Solo	3

Total **33**

Sacramento County Coroner's Office, 2003

Suicides

Figure 8



Gun Shot Wound Head	10
Hanging	1
Over Dose of Medication	2
Suffocation	1
Total	14



VI. CASES

SUMMARY OF ADULT PROTECTIVE SERVICES CASES REVIEWED BY EDRT

(SUMMARY OF CASES, FINDINGS AND CASE SPECIFIC RECOMMENDATIONS)

NOTE: The following five cases were selected to illustrate the range of cases reviewed by the EDRT Committee. Additionally, these cases were selected due to the fact that many of the issues presented therein were seen repeatedly in other cases reviewed by the EDRT Committee.

CLIENT NO. 1

Summary:

S.R. was a 67 year old, developmentally delayed female with cerebral palsy and limited communication ability. Since 1985, S.R. had been living in a private residence where a family friend cared for her. Also living in the residence were two other adults who participated in the care of S.R. In 2002, S.R. was referred to APS by a hospital social worker that reported that S.R. was hospitalized for dehydration and a urinary tract infection earlier in the month. After discharge from the hospital, S.R. came to a follow-up visit and was noted to have dried feces on her person. A week later she was seen for a contusion above her left eyebrow. One of the care providers told hospital staff that her young daughter was pushing S.R. in her wheelchair and she fell out. Upon exam at the hospital, medical personnel harbored suspicions of sexual assault and abuse, however, there were inconclusive findings to substantiate it. S.R. was hospitalized and later discharged to a skilled nursing facility. S.R. died a few months later from conditions unrelated to any suspected neglect or abuse.

Findings

The S.R. case was one of the first cases reviewed by the Elder Death Review Team. The case was reviewed as a “test case”. That is, although the client did not die as a direct result of the abuse or neglect, the team wanted to examine the death of an elder where the elder had interaction with a number of different agencies leading up to their death. The team’s review of the S.R. case included participation and follow-up by multiple agencies. Law enforcement conducted additional investigation, medical members of the team conducted evidence review and the case was evaluated by the District Attorney’s Office. There was insufficient evidence to support the filing of any criminal charges, however, there were issues identified and addressed as a result of the team’s review. Service gaps and system problems were identified by members of the Elder Death Review Team as well as agency reviews independent of the team. Though multiple systems were involved with the care, protection and treatment of S.R., several of those systems failed to adequately recognize and/or address risk factors and implement appropriate preventative measures. Recommendations include:

Recommendations

- 1) A higher level of scrutiny in cases involving people with disabilities who may have communication problems and therefore are less able to protect themselves. This includes medical providers and others who may need to seek additional, clarifying information to challenge assumptions and gain a more accurate assessment of what is observed. As noted in one of the independent reviews, “In order to understand a situation as fully as possible it is necessary, whenever possible, to consider the opposite and to explore that possibility. For instance, if a caretaker’s explanation for an injury appears plausible (i.e. when APS was told that S.R. was bruised when her legs gave out), it will give greater information and understanding in the assessment to consider the possibility of abuse”.
- 2) Protective services agencies should have a means to regularly consult physicians familiar with geriatrics and dependent adults.
- 3) Possible liaison positions in agencies. If not liaison positions than a higher level of communication between service providers including as needed multi-agency, multidisciplinary case staffing’s.
- 4) Training for all medical providers to increase compliance with mandatory reporting requirements.

CLIENT NO. 2

Summary

V.H. was a 73 year-old female. She was referred to APS by a hospital social worker. The hospital social worker became concerned for the client when the client's son, who was also the client's care provider, showed up at the hospital with papers for the client to sign which would transfer title of the client's home from the client to her son. At the time the client was admitted to the hospital she was in serious condition due to what was initially believed to be an overdose of Vicodin. The client died 6 days after being admitted to the hospital. The cause of death was determined to be liver failure and was ruled by the Coroner's Office to be accidental. The case was reviewed by EDRT due to concerns of potential abuse and over self-medication.

Findings

The client was prescribed Vicodin for severe low back pain, but it appeared that she was taking more than the recommended dosage. Vicodin is composed of hydrocodone and acetaminophen (Tylenol.) The client did not die from the hydrocodone component of the drug, rather she developed liver failure from an over concentration of the acetaminophen component. It was unclear from the available documentation whether the client suffered from impaired metabolism of acetaminophen from either another medication she was taking or some underlying liver disease. Another possibility is that she may have been taking over-the-counter Tylenol in addition to the Vicodin without realizing that Vicodin contains acetaminophen, or that large quantities of acetaminophen can cause liver failure, especially in the elderly who have greater susceptibility due to the bodies reduced ability to rid the system of toxins. The ability to determine precisely the circumstances of the client's death were hampered due to the fact that the client self-medicated and was reported to be extremely secretive about her medications. The review revealed no reason to believe the care provider was in any way responsible for the client's condition or death.

Recommendations

- 1) It is recommended that the county engage in an educational out-reach program to educate not only the elderly, but additionally their care providers, family and other potential gate keepers, the risks of common, everyday medications.
- 2) Additionally, this outreach program should include the providing of information on commonly observed conditions within the elderly community that are indicative of serious health risks, or can lead to more serious conditions if not treated appropriately.

CLIENT NO. 3

Summary

R.L. was a 96 year-old man with no family, who was referred to APS by his bank due to a suspicion of financial abuse by his part-time care provider(s)/landlord(s). The part-time care providers, who were also the client's landlords, were taking large sums of money from the client's checking account, allegedly for groceries (approx. \$2,000.00 per month). The client lived in a small house behind the residence occupied by the part-time care providers. APS responded and interviewed R.L., who told the APS social worker that his care providers "took care of everything for him", including his finances because he "couldn't see and couldn't sign his name". He seemed confused about his finances, but was very clear that he wanted the care providers to continue to provide care for him. Due to what appeared to be an excessive amount of money being taken from the client's account for "groceries", the APS social worker asked the bank to "red flag" the client's account, thus allowing the care providers \$100.00 per week for the client's groceries, until a thorough investigation into the client's finances could be completed. The care providers were advised of the limit on spending. During the initial unannounced home visit on 10/29/02 the APS social worker noted that the client appeared to be receiving adequate care. Subsequent visits were made by the APS social worker on 11/19/02 and 12/17/02. Although the client's condition appeared to be unchanged, the issue of the care providers' use/misuse of the client's funds was still a concern. The APS social worker, along with a conservator, made a subsequent visit to the client on 1/16/03 for the purpose of safeguarding the client's estate. During that visit, the client was observed to be disoriented and reported that he had fallen and was unable to move from a sitting position. The APS social worker called an ambulance and the client was admitted to a hospital. The client was diagnosed as being malnourished, anemic, and suffering from dehydration and acute renal failure. In addition, he had bedsores on his upper back, buttocks, shoulder, heel and ear. These initial problems resolved with treatment. While in the hospital the client was tested for dementia and was noted to be at risk for aspirating his food. The client died in the hospital 10 days after being admitted. An autopsy determined that the client died from aspiration pneumonia. Long-standing heart and lung disease were also believed to have played a significant role in his death.

Findings

While the care provider(s)/landlord(s) were receiving monies to assist the client, it was impossible to establish them as having sufficient "care and custody" so as to make them legally responsible for the client's care or lack thereof. Additionally, an autopsy concluded that the client died from factors that are a part of the natural aging process and not from neglect from his "care provider(s)/landlord(s)". The health of an elderly person (96 years) can deteriorate very rapidly as evidenced by the fact that it was slightly less than one month between the visit by the APS social worker on 12/17/02, where his condition appeared to be stable and unchanged, and the visit on 1/16/03, when he needed to be hospitalized.

Regarding the possible financial abuse, it was impossible to establish that the client lacked capacity, at the time the checks were written, to dispose of his assets as he wished, or that any monies were passed contrary to his wishes.

On a positive note, the bank did an excellent job of notifying the appropriate agency when they first came to suspect the possibility of financial impropriety.

Additionally, the APS social worker responded quickly to address the concerns of the bank and was thus able to stop the flow of money from the client's account.

Recommendations

1) While the APS social worker met the state mandates for the number and frequency of visits, the frail elderly (85 years +) may often benefit from increased frequency of visits during the course of an investigation. This is

especially true of those who are isolated, have no family or friends, or are not living with a care provider who can monitor them on an on-going basis.

It is recommended that the Adult Protective Services Program create an on-going case management unit whose mandate was the increased monitoring of those seniors (85 years +) who are determined to be in a marginal state due to either their mental or physical condition, or their living arrangements.

2) It is further recommended that the county assist in identifying and applying for potential grants that could address this issue.

CLIENT NO. 4

Summary

B.O. was a 76 year-old female with end stage advanced lung and brain cancer who was referred to Adult Protective Services by a hospital social worker. The hospital social worker reported that B.O.'s adult daughter threatened her (the reporting party) during discussions about her mother's care. The hospital social worker/reporting party felt that the adult daughter of B.O. had psychiatric issues that impacted her ability to make good decisions regarding her mother's medical care. B.O. remained an in-patient at the hospital at the time of the referral to APS because a comprehensive discharge plan hadn't yet been developed due to the adult daughter's unwillingness or inability to comprehend the serious aspects of her mother's new diagnosis. The APS social worker attempted to work with B.O.'s daughter, but she refused to discuss her mother's care with the social worker. Conservatorship was applied for but was denied. B.O. requested she be allowed to return home, where she had resided with her daughter previous to her hospital admission. Despite APS and hospital misgivings, B.O. was eventually released home to her daughter's care with home health follow-up. B.O. died of cardiac arrest four days after discharge from the hospital.

Because medications prescribed for B.O. upon discharge were not given to her by her daughter and the daughter appeared uninterested in other discharge instructions, the Elder Death Review Team examined the B.O. case to determine whether there was enough evidence for the daughter to be prosecuted for lack of medical care and/or would any of the measures prescribed for the mother's care have prolonged B.O.'s life

Findings

Although the home situation with victim's daughter was not "ideal", EDRT was unable to confirm abuse or neglect. B.O. desired to return home and her daughter did not want her placed in a skilled nursing facility. B.O. had a terminal illness that was inoperable. Although her daughter did not follow discharge instructions for comfort care and refused home health, no determinations could be made that the daughter's inability or unwillingness to administer care to her mother in her final days caused or accelerated her death. This was a case that EDRT team members struggled with, because it challenged member's concepts of a "good death" vs. a "bad death." The "quality" of B.O.'s death became the question and the discussion once members concluded that neither abuse nor neglect could be confirmed.

Recommendations

1) Utilization, when possible, the MDT (multi-disciplinary team) meetings or "staffings" to obtain comprehensive input on cases involving elders with terminal conditions and less than satisfactory family support or service options. "Staffings" may need to be impromptu and conducted outside regularly scheduled MDT meetings if the urgency of the situation does not coincide with the regularly scheduled meetings. The services of the MDT are available to the EDRT without charge. This recommendation is made not only for consideration of every possible service option for the client, but also recognizes the difficulty services providers may find themselves in dealing with individuals and families that are resistant to care, and or individuals or families that have what appears to be an unacceptable paradigm for dying.

CLIENT NO. 5

Summary

A.L. was an 86 year old, frail, non-ambulatory male referred to APS by the In-Home Support Services social worker because of a filthy home reeking of urine, with care providers who seemed to be scarce in their presence and care. Client had a long history of alcohol abuse and appeared to select his care provider's based on their ability to provide him with alcohol, including a recent care provider who would pick him up at home and transport him to a bar where the two of them would sit around and drink for hours. The client had been acutely hospitalized many times, including just prior to the APS referral. The APS worker recommended placement, however the client refused and reluctantly selected a new care provider. The new provider apparently never provided services. The client was found to be in very poor health by the APS public health nurse who visited the client approximately one month later. The client was hospitalized and died soon after.

Findings

A.L. was clearly making poor decisions that negatively impacted his health. Many times adults knowingly choose to live in conditions that may be considered substandard or less than desirable by health care providers or the community at large. Factors that may contribute to these choices include the adult's values, socioeconomic standards and cultural/familial background and experience. In addition, adults who have lived in less than desirable or seemingly dysfunctional situations most of their lives do not necessarily make more desirable choices as they age or become ill. This was a case that underscores the debate about an adult client's right to autonomy, including the right to make poor decisions, vs. the authority of public agencies and their duty to intervene when a client is so negatively impacted that they have become a danger to themselves.

Recommendations

- 1) Increased funding for APS units that deal with cases involving clients with high-risk behavior or acute medical conditions that require more frequent follow-up visits.
- 2) The County needs to provide leadership to press for legislation to provide IHSS with the ability to cut off funding to providers that are not providing agreed upon care for IHSS clients amounting to abuse or neglect of that client.



VII. ADDITIONAL RECOMMENDATIONS

GENERAL RECOMMENDATIONS

The County should commit to an outreach program to attract and train retired professional members from the community to educate the elder community in the following areas:

1. To provide education and information regarding financial abuse and scams that target the elderly. In addition to the financial abuse issues, the volunteers will be trained to recognize, address and report all other types of elder abuse and to take that information into the community.
2. Establish a volunteer telephone contact program within APS. This program will provide APS clients with additional contacts with the potential to alert APS should the client need assistance.
3. Establish a management development team with the medical community at the executive level. The goal of this team would be to educate the health care system of the serious need for their cooperation and participation in EDRT. The result of this collaboration would be a level of trust, which would enable us to share vital information in a more expedient manner.



VIII. DATA COLLECTION

METHOD OF DATA COLLECTION

Compiling meaningful data on the elder deaths reviewed by the EDRT Committee during its first couple of years in existence was challenging due to the complexity of the issues encountered, and the difficulties of consistent data collection. Elder deaths can be diversely presented, as opposed to, for instance, domestic violence related deaths, where every case is presumed a homicide and therefore, governmental intervention is necessary on at least some level. Elder deaths are complicated by a variety of factors that are not encountered by other death review teams; the fact that one is dealing with natural end-of-life issues, the right of the elderly to choose the manner in which they want to live (and die), incomplete data due to isolation that affects many elderly, dementia that may affect the choices an elderly person makes but, usually, not their right to make them, just to name a few. In an attempt to cast a wide net, so as not to overlook a case that could provide some insight to the issues, the team settled on a model that examined elder deaths that were suspicious for a wide variety of reasons. These included those deaths that would normally be identified as public health concerns, defined as any death involving an elderly person with multiple serious health conditions and without the ability to access support systems. For the goal was often not determining culpability, but rather prevention. As a result, elder death review team data for the first yearly report is broad based in its description, rather than a report reflective of specific data elements.

For the reasons cited above the team struggled with defining its scope of review and the critical data elements involved. However, with each meeting, and with each new case reviewed, the team further defined its focus. As a result, the team has written and adopted the four-page Sacramento County Elder Death Review Team Critical Data Collection Form. The essential information collected via the use of this form will provide specific data, across a wide variety of categories, which can hopefully be used to identify service gaps and formulate prevention strategies.

EDRT CASE PRESENTATION CASES PRIORITY ORDER

The following criteria has been established for Case Presentation Order:

1. There is potential for on-going harm to a specific elderly individual, or to other elderly individuals similarly situated.
2. Case deals with potential community service gaps.
3. Case involves potential criminal conduct.
4. Case deals with issues of significant community concern (high profile.)
5. The case presenter, or other necessary party, is unavailable at a later date.

Questions/Concerns
 DATA ELEMENTS

1. Suspicious Physical Findings/Indicators

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

3. 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"/> Unknown <input type="checkbox"/> Hx of Alcohol Abuse <input type="checkbox"/> Hx of Mental Illness <input type="checkbox"/> Hx of Drug Abuse <input type="checkbox"/> Hx of Depression <input type="checkbox"/> Hx of Suicidal ideation/actions <input type="checkbox"/> Other: _____	6. Describe decline/tempo of illness:
7. Describe elder's contact with health professionals and community services during the 6 month 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:

4. 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:

5. Agencies Involved with Elder

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

ID # _____

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>	



IX. RESOURCE REFERENCES

ELDER INTERNET RESOURCES

Organizations:

Action on Elder Abuse

<http://www.elderabuse.org.uk>

Administration on Aging

<http://www.aoa.gov>

American Association of Retired People

<http://www.AARP.org>

American Geriatrics Society

<http://www.americangeriatrics.org>

American Medical Directors Association

<http://www.amda.com>

American Psychological Association Office on Aging

<http://www.apa.org/pi/aging/homepage.html>

American Society of Adult Abuse Survivors and Professionals

<http://www.ASAAPS.org>

American Society on Aging

<http://www.asaging.org>

Andrus Center, University of Southern California

<http://www.usc.edu/dept/gero>

Clearinghouse on Abuse of the Elderly-National Center on Elder Abuse

(302) 831-3525

<http://www.elderabusecenter.org/default.cfm?p=cane.cfm>

<http://db.rdms.udel.edu:8080/CANE/index.jsp>

Elder abuse Resources at Questia-The Online Library of Books and Journals

http://www.questia.com/index.jsp?CRID=aubse_of_the_elderly&OFFID=SEL

Elder Web

<http://www.elderweb.com>

Gerontological Society of America

<http://www.geron.org>

National Center on Elder Abuse

<http://www.elderabusecenter.org>

National Committee for the Prevention of Elder Abuse
<http://www.preventelderabuse.org>

National Council on the Aging
<http://www.ncoa.org>

Pepper Institute on Aging and Public Policy
<http://www.pepperinstitute.org>

Resources for Elderly Crime Victims
<http://www.ojp.usdoj.gov/ovc/help/evresources.htm>

US Senate Special Committee on Aging
<http://www.aging.senate.gov>

Word Bridges
<http://www.wordbridges.net>

TRAINING:

Training Resource Inventory at NCEA:
http://www.elderabusecenter.org/pdf/publication/ncea_training_res_inventory.pdf



X. APPENDICES

APPENDIX I

ELDER ABUSE INDICATORS

	Increased index of suspicion	Not necessarily suspicious
ABRASIONS & LACERATIONS	Multiple skin tears, skin tears longer than 1”, skin tears which leave scarring, skin tears in sites other than arms and legs	1-2 small (less than 1 inch) skin tears, especially on the arms and legs
BRUISING	Bruises to face and neck, chest wall, abdomen and buttocks, and particularly to palms and soles of feet, defensive injuries to backs of arms and hands	Bruising than can reasonably be attributed to falls, which are common in the elderly
FRACTURES	Fractured, subluxed, or avulsed teeth or fractures of the zygomatic arch or the mandible and maxilla (jaw bones). Fractures of the head, spine and trunk. Spiral fracture of a large bone w/no hx of gross injury, fractures w/rotational component	Fractures of the hip and distal wrist and vertebral fractures, limb fractures, sprains or strains or musculoskeletal injuries
DECUBITI	Foul smelling or necrotic ulcer which is not brought to the attention of the physician and not appropriately cared for	Ulcers over sacrum, hip and heels
MALNUTRITION	More than 40% loss of body weight can lead to death	Old age results in a decline of both smell and taste, which decreases appetite. Diseases, poor dentition, depression, dementia and malabsorption syndromes may contribute to weight loss and under nutrition, as can strokes, Parkinson’s, ALS, cancer and disorders of the esophagus
DEHYDRATION	In moderate climates, loss of water results in death within 10 days. This time frame is much shorter for older people	Elderly are much more prone to dehydration and can experience very rapid changes in fluid status asymptotically
MEDICATION USE	Prescription for an older person of a standard dose of medication may be an indicator of abuse	Older persons should receive medications in doses smaller than those received by younger adults b/c of their decreased hepatic metabolism and decreased plasma protein binding