



Maine Elder Death Analysis Review Team





In the United States, an estimated 5 million seniors are victims of physical abuse, neglect, or financial exploitation each year.

12,000 of those victims live in Maine.

84 % of all elder abuse cases are never reported.



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INTRODUCTION BY THE PANEL CHAIR RICKER HAMILTON

In March 2003, the American Bar Association, Commission on Law and Aging, notified Maine that we had been selected as one of four project demonstration sites for “Promising Practices in the Development of Elder Abuse Fatality Review Teams.” The ABA stated goal for the project was to expand the fatality review team concept to deaths resulting from elder abuse in order to foster examination of and improvement in the response of adult protective services, law enforcement officers, prosecutors, victim services, health care providers and others to the growing number of victims of abuse.

The success of MEDART is due to the diverse makeup of the panel and their expertise. Team members include representatives from the Office of the Chief Medical Examiner, the Office of the Attorney General’s Healthcare Crimes Unit, Victim Witness Advocate Program, and Investigations Division; Adult Protective Services, Licensing and Certification, and Assisted Living Licensing Services of the Department of Human Services; the Maine State Police; the Long Term Care Ombudsman Program; the Maine Sheriff’s Association; the Maine Chiefs of Police Association; and the Department of Behavioral and Developmental Services, have made a significant difference. Communication and cooperation among the agencies has been enhanced and a clearer focus on older victims has been developed.

The Maine Elder Death Analysis Review Team (MEDART) has made tremendous strides in just one year. Under the leadership of Attorney General G. Steven Rowe and the Office of the Attorney General, MEDART received enabling legislation that includes confidentiality and access to records. For the first time, cases of death and serious bodily injury of older victims and vulnerable adults in Maine are being reviewed. It is through this process that MEDART will foster changes that will result in an improved systemic response to the needs of older victims.

The future is bright for the Team’s continued efforts and the need is clear. The United States Senate, Special Committee on Aging reports that 4% to 6% of our citizens over age 60 are abused each year and that approximately 84% of elder abuse cases are never reported. As the number of Maine’s citizens age 60 and older doubles over the next 25 years, we will need to develop and improve community systems that will meet our need. MEDART is an example of Maine’s leadership role in protecting those that are unable to protect themselves. MEDART is helping to develop a future that is safer for all of our citizens.

MISSION STATEMENT

The Maine Elder Death Analysis Review Team (MEDART) will examine deaths, and cases of serious bodily injury, associated with suspected abuse or neglect of the elderly and vulnerable adults. The purpose of MEDART is to review deaths related to abuse and neglect, and to identify whether systems that have the purpose or responsibility to assist or protect victims were sufficient for the particular circumstances or whether such systems require adjustment or improvement. MEDART will foster systems change that will improve the response to victims and prevent similar outcomes in the future.

MEDART recognizes that the responsibility for responding to and preventing fatalities related to abuse or neglect of the elderly and vulnerable adults lies within the community and not with any single agency or entity. It is further recognized that a careful examination of the fatalities provides the opportunity to develop education, prevention, and strategies that will lead to improved coordination of services for families and our elder population.

ABOUT THE MAINE ELDER DEATH ANALYSIS REVIEW TEAM

The Maine Elder Death Analysis Review Team, (MEDART) was formed in 2003 under the auspices of the Office of the Attorney General, and is charged with examining deaths and cases of serious bodily injury associated with suspected abuse or neglect of elderly and vulnerable adults. The team, whose membership includes representation from state, local and county law enforcement, prosecutors, victim advocates, licensing and certification, adult protective services, and mental health, meets monthly to review selected cases, the purpose of which is to identify whether systems that have the purpose or responsibility to assist or protect victims were sufficient for the particular circumstances or whether such systems require adjustment or improvement. MEDART seeks to foster system change that will improve the response to victims and prevent similar outcomes in the future.

MEDART was recognized by the Maine Legislature in 2003 with enabling legislation that provides for among other things, access to information and records, and confidentiality.¹ This was possible through the leadership of Attorney General G. Steven Rowe, and the testimony and support of Chief Medical Examiner Margaret Greenwald. Such leadership and timeliness was recognized nationally by other fatality review teams and will likely be incorporated into the ABA guide as a crucial step in forming future teams around the nation. For the complete language of the team's enabling legislation, see Appendix A.

MEDART was chosen early on as one of four "*elder fatality review teams*" in the United States to serve as a pilot program for a Department of Justice funded initiative managed by the American Bar Association's Commission on Law and Aging. The goal of the pilot program is to expand the fatality review team concept, and to develop and disseminate a replication and best practices guide. For its role in the program, the team received \$5000 in "*seed money*" to help defray set up costs.

¹ M.R.S.A. Title 5 §200-H

MEDART successfully completed two case reviews in 2003, both of which were followed by detailed reports of findings, and recommendations. Each report was delivered to Attorney General Rowe for his review and consideration. While it is too early to track changes affected by the work of MEDART, it is the belief of the membership that such changes will effect legislation, policy, education and best practices. Most important, the Maine Elder Death Analysis Review Team believes its work will affect the quality of life for seniors throughout the State of Maine.

CASE SUMMARY INFORMATION

The Maine Elder Death Analysis Review Team aims to review 8-10 cases per year. In 2003, the Team chose to wait until legislative protections were in place before reviewing cases, and as such, was only able to review 2 cases. In 2004, the team is on track to review 9 cases. Of the 2 cases reviewed in 2003, the following characteristics were noted:

Ages and Relationships of the Parties:

- In the first of the two cases reviewed in 2003, the decedent was an 87 year old male. The person suspected of abuse or neglect was a healthcare worker, not related to the decedent.
- In the second of the two cases, the decedent was a 78 year old female. The person suspected of abuse or neglect was the decedent's brother.

Status of Perpetrators:

- Neither of the two suspected perpetrators was criminally prosecuted.

Cause of Death:

- In the first case, death occurred as a result of a lack of hydration or nutrition per order of the decedent's primary care physician and per request of family members. This order followed a debilitating stroke, suffered by the decedent several weeks earlier.
- In the second case, death occurred in 1997, as a result of malnutrition stemming from severe mental retardation.

PANEL RECOMENDATIONS AND PROGRESS TO DATE

The concept for the Maine Elder Death Analysis Review Team was developed in the late fall of 2002. For the twelve months following, the team worked to establish guidelines and protocols which would ensure confidentiality, scope and authority. Start up funding was secured for the team, and membership was defined. After enabling legislation was enacted in the summer of 2003, and protections were in place, the team initiated the case review process. Two cases were selected for review in the early winter of 2003. The following recommendations were made by the membership:

1. Hospitals should have a policy, if not already in place, to review a family's legal right to make medical decisions absent any known legal authority.
2. If not already in place, a procedure for enforcement of hospital ethics committees' recommendations ought to be adopted.
3. Consideration ought to be given to enhancing the penalties under 17-A M.R.S.A. § 555, Endangering the Welfare of a Dependent Person. Currently, a violation of this statute is a Class D crime. Additional language, which could provide a method of enhancing the penalty to a Class C crime, might include language similar to that included in 17-A M.R.S.A. § 554, Endangering the Welfare of a Child. The following paragraphs correspond to the language currently included in 17-A M.R.S.A. § 555. Proposed changes are represented in paragraphs 1(b)(c)(e).

1. A person is guilty of endangering the welfare of a dependent person if that person:

- a. Intentionally, knowingly or recklessly endangers the health, safety or mental welfare of a person who is unable to perform self-care because of advanced age, physical or mental disease, disorder or defect; or

- b. Intentionally, knowingly or recklessly endangers the health, safety or mental welfare of a person who is unable to perform self-care because of

advanced age, physical or mental disease, disorder or defect and which in fact causes death, or;

c. Intentionally, knowingly or recklessly endangers the health, safety or mental welfare of a person who is unable to perform self-care because of advanced age, physical or mental disease, disorder or defect and which in fact causes serious bodily injury.

d. As used in this section “endangers” includes a failure to act only when the defendant had a legal duty to protect the health, safety or mental welfare of the dependent person. For purposes of this section, a legal duty may be inferred if the defendant has assumed responsibility for the care of the dependent person.

e. Endangering the welfare of a dependent person is a Class D Crime except that a violation of subsection 1, paragraph B, is a Class B Crime, and violation of subsection 1, paragraph C, is a Class C crime.

4. Continue to provide elder abuse awareness training for police cadets attending the Maine Criminal Justice Academy and increase the number of in-service trainings for those already employed in the field of criminal justice.

5. Dehydration and malnutrition in older individuals is often an unrecognized cause of hospitalizations, morbidity, and mortality. Effective treatment in acute cases requires expertise not generally available in rural healthcare settings. Accordingly, state and local training should be mandated for all healthcare professionals and healthcare facilities to assist in the diagnosis, treatment and prevention of dehydration and malnutrition in elderly and dependant adults. Specialized training should be mandated for hospital emergency room staff to ensure the proper treatment of acute cases.

6. Develop and implement a system that would require a referral to Adult Protective Services for those people who are age 18 or older, are Mainecare (Medicaid) recipients, and three years have passed since a claim has been filed by a provider.

APPENDIX A:

ENABLING LEGISLATION

§200-H. Maine Elder Death Analysis Review Team

There is created, within the Office of the Attorney General, the Maine Elder Death Analysis Review Team, referred to in this section as "the team." [2003, c. 433, §1 (new).]

1. Composition. The team is composed of 13 members as follows:

A. The Chief Medical Examiner, ex officio; [2003, c. 433, §1 (new).]

B. The Director of Investigations for the Office of the Attorney General, ex officio; [2003, c. 433, §1 (new).]

C. The Director of the Division of Licensing and Certification within the Department of Human Services, Bureau of Medical Services, ex officio; [2003, c. 433, §1 (new).]

D. The Director of the Health Care Crimes Unit within the Office of the Attorney General, ex officio; [2003, c. 433, §1 (new).]

E. The Director of Community Resource Development within the Department of Human Services, Bureau of Elder and Adult Services, ex officio; [2003, c. 433, §1 (new).]

F. The Director of the Adult Protective Services program within the Department of Human Services, Bureau of Elder and Adult Services, ex officio; [2003, c. 433, §1 (new).]

G. The Director of Adult Mental Health Services within the Department of Behavioral and Developmental Services, ex officio; [2003, c. 433, §1 (new).]

H. The executive director of the long-term care ombudsman program, as established in Title 22, section 5106, subsection 11-C, ex officio; [2003, c. 433, §1 (new).]

I. A representative of victim services, appointed by the Attorney General; [2003, c. 433, §1 (new).]

J. A commanding officer of the Criminal Investigation Division within the Department of Public Safety, Bureau of the State Police, appointed by the

Attorney General; [2003, c. 433, §1 (new).]

K. A prosecutor, nominated by a statewide association of prosecutors and appointed by the Attorney General; [2003, c. 433, §1 (new).]

L. A police chief, nominated by a statewide association of chiefs of police and appointed by the Attorney General; and [2003, c. 433, §1 (new).]

M. A sheriff, nominated by a statewide association of sheriffs and appointed by the Attorney General. [2003, c. 433, §1 (new).]
[2003, c. 433, §1 (new).]

2. Designees; terms of office. An ex officio member may appoint a designee to represent the ex officio member on the team. A designee, once appointed, qualifies as a full voting member of the team who may hold office and enjoy all the other rights and privileges of full membership on the team. All of the appointed members of the team serve for a term of 3 years. Any vacancy on the team must be filled in the same manner as the original appointment, but for the unexpired term. [2003, c. 433, §1 (new).]

3. Meetings; officers. The team shall meet at such time or times as may be reasonably necessary to carry out its duties, but it shall meet at least once in each calendar quarter at such place and time as the team determines, and it shall meet at the call of the chair. The Attorney General shall call the first meeting before January 1, 2004. The team shall organize initially and thereafter annually by electing a chair and a vice-chair from among its members. The vice-chair shall also serve as secretary. [2003, c. 433, §1 (new).]

4. Powers and duties. The team shall examine deaths and serious injuries associated with suspected abuse or neglect of elderly adults and vulnerable adults. The purpose of such examinations is to identify whether systems that have the responsibility to assist or protect victims were sufficient for the particular circumstances or whether such systems require adjustment or improvement. The team shall recommend methods of improving the system for protecting persons from abuse and neglect, including modifications of statutes, rules, training and policies and procedures. [2003, c. 433, §1 (new).]

5. Access to information and records. In any case subject to review by the team, upon oral or written request of the team, notwithstanding any other provision of law, any person that possesses information or records that are necessary and relevant to a team review shall as soon as practicable provide the team with the information and records. Persons disclosing or providing information or records upon request of the team are not criminally or civilly liable for disclosing or providing information or records in compliance with this subsection. [2003, c. 433, §1 (new).]

6. Confidentiality. The proceedings and records of the team are confidential and are

not subject to subpoena, discovery or introduction into evidence in a civil or criminal action. The Office of the Attorney General shall disclose conclusions of the review team upon request, but may not disclose information, records or data that are otherwise classified as confidential. [2003, c. 433, §1 (new).]