Sixth Annual Report to the

Florida Department of Elder Affairs

The Fourth Judicial Circuit Elder and Vulnerable Adult Abuse Fatality Review Team

September 2026

Dedicated to the Elder and Vulnerable Adult Community We Serve

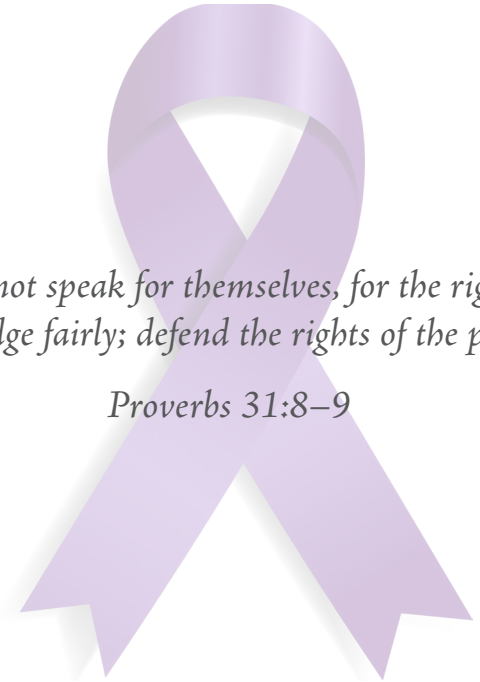
You are not forgotten. Your stories matter, and we carry them forward so that others may be spared what you endured.

The Executive Committee of the Fourth Judicial Circuit's Elder and Vulnerable Adult Abuse Fatality Review Team (hereafter simply referred to as EV-FRT) dedicates this Sixth Annual Report to the elders and vulnerable adults of our community — those we have served, those we continue to serve, and those we were, in some cases, unable to reach in time.

We also recognize that this work is only possible because of the members — past and present — who answer this call voluntarily, often well beyond the bounds of their normal professional duties. For many of us, this Team is a labor of love, and being the first of its kind in Florida has never been easy. But our members' perseverance exists in service of something larger than the Team itself — a community that provides our elders and vulnerable adults with the dignity, support, and protection they deserve, and a system capable of identifying and responding to early signs of abuse and neglect before a fatality occurs.

This report is respectfully submitted this September 1, 2026, by the Fourth Judicial Circuit Elder and Vulnerable Adult Abuse Fatality Review Team.

For more information regarding this EV-FRT, please visit the official website of the Office of the State Attorney for the 4th Judicial Circuit at sao4th.com.



"Speak up for those who cannot speak for themselves, for the rights of all who are destitute. Speak up and judge fairly; defend the rights of the poor and needy."

Proverbs 31:8–9

2025-2026 Elder and Vulnerable Adult Abuse Fatality Review Team

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Table of Contents

Appendix:

Disclaimer: *The findings and recommendations made in this report are based on the case information reviewed. As a result, the findings, opinions, and recommendations in the EV-FRT report do not necessarily reflect the views or positions of any individual member and entities they represent. No single person or team member is responsible for the drafting and/or submission of this report. The final version of this report is submitted by the Co-chair.*

Mission Statement

"(5) A review team must do all of the following:

(a) Review incidents of abuse, exploitation, or neglect of elders and vulnerable adults in the review team's geographic service area which are believed to have caused or contributed to the deaths of such persons.

(b) Take into consideration the events leading up to a fatal incident, available community resources, current law and policies, and the actions taken by systems or individuals related to the fatal incident, and any information considered relevant by the Team, including, but not limited to, a review of public records and records for which a public records exemption is granted

(c) Identify potential gaps, deficiencies, or problems in the delivery of services to elderly and vulnerable adults by public and private agencies which may be related to incidents reviewed by the Team.

(d) Whenever possible, develop community-wide approaches to address the causes of, and contributing factors to, incidents reviewed by the Team.

(e) Develop recommendations and potential changes in law, rules, and policies to support the care of elders and vulnerable adults and to prevent abuse of such persons." [1]

1 Florida Statute § 415.1103(5) (2026)

Executive Summary

"The moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the aged; and those who are in the shadows of life, the sick, the needy and the handicapped." — Hubert H. Humphrey[2]

This Sixth Annual Report reflects both how far the Fourth Judicial Circuit Elder and Vulnerable Adult Abuse Fatality Review Team (EV-FRT) has come and how much work remains ahead. Since its creation, this Team has sought to turn the lessons found in individual tragedies into meaningful opportunities to better protect elders and vulnerable adults throughout our community. That mission remains at the heart of this report.

Florida law asks fatality review teams to do more than simply examine what happened. We are charged with looking beyond the circumstances of an individual death to consider the events leading to the fatal incident, the resources and protections that were available, and the actions of the systems and individuals involved. We must identify gaps in the delivery of services, develop community-wide approaches to address contributing factors, and recommend changes in law, rules, and policies that may prevent similar harm in the future.3 This year's work reinforced just how important—and difficult—that responsibility can be.

During the 2025–2026 Team year, the EV-FRT reviewed two referrals involving deaths that occurred in 2025. Unlike prior years, these matters came to the Team through referrals from the Florida Department of Children and Families' Adult Protective Services (DCF/APS) and did not result in arrests or prosecutions. Although these two referrals provided significant opportunities for review, they also highlighted a continuing concern: the cases that reach this Team likely represent only a portion of the elder and vulnerable adult abuse-related deaths occurring within our jurisdiction. [4]

Elder and vulnerable adult fatalities present unique challenges for identification and review. Abuse, neglect, or exploitation may occur over months or years; victims may suffer from serious underlying illnesses, disabilities, or age-related conditions; and the consequences of maltreatment may not result in an immediate death. In some cases, abuse or neglect may therefore never be recognized as a contributing factor in a vulnerable adult's death. Many such deaths are never presented to a Medical Examiner because the cause of death is presumed to be natural, and co-occurring medical conditions may make it difficult to identify abuse or neglect as a contributing factor.[5]

These challenges are compounded by differences between the statutory authority granted to elder and vulnerable adult fatality review teams and that granted to domestic violence fatality review teams

[2] Hubert H. Humphrey, remarks at the dedication of the Hubert H. Humphrey Building, Washington, D.C., Nov. 1, 1977, Congressional Record, Nov. 4, 1977, vol. 123, p. 37287.

[3] *Fla. Stat. § 415.1103(5) (2026)*.

[4] See infra p.6.

[5] Id. The Team notes that many elder and vulnerable adult abuse cases do not immediately result in death and that co-occurring conditions may make identifying abuse as a cause or contributing factor difficult.

(DVFRT). Unlike Florida's DVFRTs, the EV-FRT presently lacks authority to review near-fatal incidents and other related cases in which a victim has not died. The Team believes expanding that authority would permit earlier identification of patterns and provide a more complete understanding of how abuse, neglect, exploitation, and isolation contribute to preventable deaths.[6]

For these reasons, one of the Team's most important lessons this year concerns not only *what* cases we review, but *how we find them*. The EV-FRT is examining ways to broaden and improve its case-identification and screening process, including identifying abuse, neglect, and exploitation cases that are not initially determined to be fatal; regularly reviewing Fourth Judicial Circuit arrest dockets for potential cases; and continuing to work closely with DCF/APS to track cases referred to law enforcement and the State Attorney's Office (SAO).[7]

The two cases reviewed this year also revealed opportunities for improvement at both the individual and systemic levels. At the case level, the Team identified concerns involving caregiver capacity and burnout, inadequate supervision of high-risk patients, medication diversion and narcotic monitoring, and the availability of respite or alternative placement when a caregiver can no longer safely provide care. These cases demonstrate that identifying a vulnerable adult's needs is only part of the equation; the system must also continually evaluate whether the person entrusted with meeting those needs remains physically and emotionally capable of doing so. [8]

Other findings extend beyond any single caregiver or provider. One of the cases reviewed this year involved nine DCF/APS reports concerning the same vulnerable adult and overlapping family members over approximately ten years. The Team found that these reports appeared to have been considered as individual incidents rather than collectively as evidence of a potentially escalating pattern. The Team therefore recommends that DCF/APS intake and investigation protocols require consideration of a vulnerable adult's full report history and provide for heightened review when recurring reports involve the same person or household.[9]

The Team also identified a significant need for greater coordination among DCF/APS, hospice and other medical providers, as well as MEs. In one case, APS substantiated multiple forms of maltreatment shortly before the vulnerable adult's death, while the death was medically certified as accidental. The presence of serious underlying illness can make it particularly difficult to determine whether abuse or neglect contributed to a death. Formal coordination among the agencies and professionals possessing different pieces of this information could help ensure that substantiated or pending findings of maltreatment are appropriately considered during a death investigation. [10]

[6] See Fla. Stat. §§ 415.1103 , 741.316 (2026). The Team recommends amending § 415.1103 to permit review of near-fatal incidents, related incidents of abuse, and suicides where abuse, isolation, or exploitation may be contributing factors.
[7] See infra p.8. Proposed Changes in EV-FRT Methodology.
[8] Id., pp. 9-19, Findings and Recommendations Nos. 1–4.
[9] Id., pp. 9-19, Finding and Recommendation No. 5; see also Fla. Stat. § 415.104 (2026).
[10] Id., pp. 9-19, Finding and Recommendation No. 6; see Fla. Stat. § 406.11 (2026).

Several concerns identified in prior years also remain unresolved. Agencies serving vulnerable adults continue to operate through separate and often incompatible case-management systems and processes. These technological and procedural silos make it difficult for agencies to follow the status of shared cases, evaluate whether required communication is occurring, or identify opportunities for earlier intervention. The Team therefore continues to advocate for greater transparency, accountability, and statewide coordination in the exchange of information among the agencies responsible for protecting vulnerable adults.[11]

This year's reviews further highlighted the risks associated with high need caregiving and financial access. Individuals may assume substantial control over a vulnerable adult's care, residence, or finances without the background screening required in more formal arrangements such as court-appointed guardianship. The Team recommends exploring mechanisms that would allow families, institutions, and others to better assess, train, and support individuals before they are entrusted with significant health care responsibilities or financial authority. [12]

Financial institutions likewise occupy an important position in identifying exploitation because their employees may be among the first professionals to observe suspicious transactions, unusual withdrawals, or repeated third-party involvement with a vulnerable customer. Florida law already identifies certain financial institution employees as mandatory reporters and provides financial institutions with authority to take protective action when exploitation is suspected. The Team recommends increased training so that employees recognize both the warning signs of exploitation and the tools available to protect vulnerable customers. [13]

Perhaps the broadest lesson of this year's work is also the simplest: protecting vulnerable adults requires information to reach the right person before it is too late. Florida's mandatory reporting laws are an essential part of that protection, but laws cannot accomplish their purpose if the public and professionals who encounter vulnerable adults in need do not recognize the warning signs of abuse, neglect, and exploitation or understand their responsibility to report them. The Team therefore recommends a statewide public-awareness effort to increase understanding of vulnerable adult abuse and Florida's reporting requirements.[14] Education, training, communication, and collaboration remain central to nearly every recommendation contained in this report.

The cases reviewed by the EV-FRT are necessarily retrospective. We cannot change the circumstances experienced by the individuals whose lives we review. We can, however, ensure that those circumstances become lessons learned—lessons capable of improving the response of government agencies, law enforcement, medical providers, financial institutions, nonprofit organizations, caregivers, and our community as a whole.

[11] See infra pp. 9-19, Finding and Recommendation No. 9; see also Fla. Stat. § 415.104 (2026).
[12] Id., pp. 9-19, Finding and Recommendation No. 10; see Fla. Stat. § 744.3135 (2026).
[13] Id., pp. 9-19, Finding and Recommendation No. 11; see Fla. Stat. §§ 415.1034(1)(a), 415.10341.
[14] See infra pp. 9-19, Finding and Recommendation No. 7.

As the EV-FRT enters its next year, we remain committed to improving our own case-selection and review processes, strengthening collaboration with our local and state partners, sharing lessons learned with other Florida circuits interested in developing similar teams, and advocating for statutory authority that will allow elder and vulnerable adult fatality review teams to examine near-fatal incidents, suicides, and other cases that may reveal opportunities for earlier intervention.[15]

Six years into this effort, our purpose remains unchanged: **to learn from those we could not reach in time so that the next vulnerable adult may be reached sooner.** Every case reviewed gives us another opportunity to ask what could have been done differently, where the system could have responded better, and how we can turn that knowledge into action.

The elders and vulnerable adults of our community deserve nothing less.

"He that plants trees, loves others besides himself." — Thomas Fuller, Gnomologia (1732)

Submitted by The Honorable Gary P. Flower, Co-chair

[15] Id., p. 28, Looking Forward; see Fla. Stat. §§ 415.1103, 741.316 (2026).

Methodology for Case Selection

Cases reviewed by the EV-FRT for 2025-2026 were identified and selected by Special Prosecution Director Octavius Holliday. The SAO provided the EV-FRT two cases for review, and both deaths occurred in 2025. The two cases identified and reviewed by EV-FRT in this report offered valuable insights which are outlined in the Findings & Recommendations section of this report. However, the number of cases identified and shared with the Team for review continue to fall short of the suspected scope of recent vulnerable adult abuse-related deaths in the Team's jurisdiction.

In the 2024-2025 EV-FRT year, the Team identified and selected its cases for fatality review from a list of vulnerable adult abuse case referrals made to the SAO and local law enforcement by DCF/APS. Unfortunately, these case referrals did not meet the criteria for arrest by local law enforcement or prosecution by the SAO at the time, which meant the team was further limited by the lack of investigation information available for purposes of conducting the fatality reviews. This process did, however, help the EV-FRT to identify an ongoing problem with case tracking and information sharing among the three disciplines (DCF/APS, SAO, and local law enforcement) when it comes to elder and vulnerable adult abuse cases. Evidence of this problem continued to be seen this year (2025-2026), which is further described within the Findings and Recommendations section of this report. (See Finding/Recommendation No. 9).

As outlined in previous EV-FRT reports, the EV-FRT has encountered numerous challenges to case identification, selection, and review processes. While some of these challenges have since been addressed statutorily – such as by securing adequate public records protections for cases reviewed by the EV-FRT in 2023 – many on the team continue to push for updates to the existing case identification and selection processes to allow for more fatality case reviews. After implementing a case screening checklist modeled after the Fourth Circuit's DVFRT, the EV-FRT discovered an inadvertent gap in the selection criteria which likely screened out otherwise qualifying cases for the EV-FRT's review. The EV-FRT checklist mistakenly required cases to be first identified and referred by DCF/APS to qualify for EV-FRT review, thereby excluding elder and vulnerable adult abuse-related deaths where DCF/APS was not the reporting/referring agency. This error and the resulting gap are fundamentally tied to the problems with interagency case tracking and information sharing identified by the Team.

Additional considerations for improvement to the EV-FRT's case identification, screening, and selection processes have been provided in a comparison with the DVFRTs processes below.

Comparison of DVFRT & EV-FRT Case Identification & Screening Practices

Duval County DVFRT	Fourth Circuit EV-FRT
- Cases typically identified immediately for the SAO as homicides by law enforcement and tracked by way of an internal list maintained by domestic violence-trained staff of the SAO. - Law enforcement frequently determines whether the case is a homicide following an investigation and determination by the medical examiner (ME).	- Many elder/vulnerable abuse cases do not immediately result in death – in other words, the Victim languishes; these cases are therefore often not identified as homicides. - Due to comorbidities frequently present in older and vulnerable adults at time of death (e.g., frailty associated advanced age) identifying abuse as clear cause or contributing factor to a vulnerable person's death may be difficult or impossible to determine. - Most cases involving elder/vulnerable adult abuse are never presented to an ME because the cause of death is presumed to be natural [i.e., caused by one of the Victim's other apparent co-occurring conditions (e.g., advanced age, chronic illness, etc.)].
- Initial case information is provided to DVFRT members on a rotating basis for initial screening on appropriateness for full case review.	- To date, all cases have been identified and screened by the SAO prior to coming before other EV-FRT members for full case review.
- While the DVFRT has the statutory ability to review non-fatal cases of domestic violence[16], the DVFRT focuses on fatal cases only. - However, the DVFRT frequently flags and monitors serious cases of domestic violence in which the Victim may not die immediately as a result of the offense but rather languishes for some time thereafter.	- The EV-FRT currently lacks the statutory ability to review cases of elder/vulnerable adult abuse in which the Victim has not yet passed away. - Current EV-FRT case identification processes do not account for monitoring a Victim's deterioration following the prosecution of the initial offense.
- The DVFRT utilizes a checklist for records and information that must be researched and provided in each case review.	- A Team member and representative of the SAO created a similar checklist for materials needed in EV-FRT case reviews.

[16] Fla. Stat. § 741.316; see also note 7.

Proposed Changes in EV-FRT Methodology

1. Identifying all incidents of elder and vulnerable adult abuse, neglect, and exploitation, including fatal and *near*-fatal incidents; monitoring near-fatal incidents for VA deterioration and death until a statutory correction has been made to allow EV-FRT review of such cases.

2. Regularly reviewing arrest dockets in Fourth Judicial Circuit for elder and vulnerable adult abuse, neglect, and exploitation cases, particularly those listed in Chapter 825, Florida Statutes, as potential cases to be screened by the EV-FRT for further review.

3. Continuing to work closely with DCF/APS team members to track cases of elder and vulnerable adult abuse referred to the SAO and/or local law enforcement (including near-fatal cases), as potential cases for EV-FRT review and to continue improving the interagency case tracking and information-sharing with these cases.

Findings and Recommendations

Through the EV-FRT's review of the two fatality cases/referrals described in this report the Team was able to identify opportunities for professional education and training, proposed changes to existing policy, and improvement to existing agency and industry practices which are outlined in this section. However, as noted in the Methodology section of this report, the EV-FRT's findings and recommendations documented in this report were also influenced by the cases we did not have the opportunity to review this past year – the scope of which is impossible to measure.

Finding No. 1 - Caregiver Incapacity and Avoidance. (Case/Referral Review 2025-2)

The primary caregiver and alleged perpetrator (AP) in this case lacked the physical capability to safely and adequately manage a high-level of needs of the vulnerable adult (VA) due, in part, to her own recent medical procedure. This incapacity was compounded by active avoidance behaviors exhibited by the AP—specifically, sleeping on a separate floor because she could not cope with the VA's expressions of pain. This inadequate supervision likely led to a critical delay in responding to the VA's fall – the fatal incident in this case.

Recommendation No. 1 - Enhanced Caregiver Capacity Screenings.

Health care and hospice providers should implement policies for mandatory, recurring assessments of a primary caregiver's physical and psychological capacity prior to and following a patient's discharge to at-home care. It is the Team's recommendation that specific protocols should be established to periodically assess the caregiver's support needs and ability to continue providing care, particularly when a caregiver discloses or exhibits their own recent medical procedures, physical limitations, or significant emotional distress managing a VA's end-of-life symptoms.

Moreover, health care and hospice providers should offer initial and ongoing training and support to family caregivers on health and safety responsibilities including, but not limited to medication management and tracking, safe mobility/transfer assistance, food and nutrition, and available caregiver/patient supports and assistance.

For patients with a documented history of falls and compounding risk factors (such as the use of blood thinners and severe cognitive/physical decline), it is the Team's recommendation that care plans and training should explicitly address safety planning and VA supervision recommendations for family caregivers. If, as in this case, the VA cannot be left unsupervised, the provider's care plan should include additional respite care options and safety plan instructions for caregivers in cases of emergency, illness, injury, or other unexpected obstacles to providing the necessary care or supervision.

Ideally these policies and processes should include coordination and communication with social services and/or aging and disability network providers.

Finding No. 2 - Medication Diversion and Medical Neglect. (Case/Referral Review 2025-2)

The EV-FRT found significant discrepancies in the pill counts of highly regulated narcotics (i.e., Morphine, Ativan, Hydrocodone) occurring within a few days of the VA's prescriptions being filled. The AP's admission to administering medications off-schedule, her failure to contact the on-call health care provider as instructed, and her evident impairment as documented in a DCF/APS report (indicating slurred speech) strongly indicate medication diversion and the unauthorized, unsafe practice of administering medicine by a layperson without training. And even if there was no evidence that the AP was likely illegally the VA's prescription medication in this case, the pill count discrepancies noted by hospice staff still raise other serious concerns, such as the potential overmedication of the VA and/or the sale or illegal distribution of the narcotics by the AP.

Recommendation No. 2 - Strengthened Narcotic Monitoring and Reporting. (Case/Referral Review 2025-2)

It is the Team's recommendation that agencies providing or overseeing in-home care and/or end-of-life care should enforce narcotic control policies and provide training for family caregivers responsible for administering regulated medications. When significant discrepancies in controlled substances – particularly when coupled with signs of the caregiver likely impairment – staff should be required to execute immediate, concurrent reports to DCF/APS and local law enforcement for potential diversion and neglect.

The primary intent behind any policies developed from this recommendation should be focused on early identification and intervention in cases of medication mismanagement to protect vulnerable patients. However, such policies should also strive to avoid placing additional stressors or unnecessary responsibilities on family caregivers, who are frequently unpaid, overwhelmed, and lack the training and support needed to properly care for their loved ones.

Finding No. 3 - Unsafe Environmental Protocols. (Case/Referral Review 2025-2)

Solo caregivers providing care and support to a loved one without additional caregiver support or assistance can create untenable conditions for both the caregiver and vulnerable adult receiving care. Family caregivers operating without the assistance of friends or family members able to provide respite care – time for the caregiver to properly care for themselves (including undisturbed hours of sleep) – are set up to fail from the beginning.

In this case, the AP would leave the residence unlocked for expected hospice staff to enter the home while she slept in an upstairs room. The AP's bedroom was located far from the VA, which meant that the VA was frequently left in an unsupervised setting, creating unsafe conditions, particularly for a VA with a documented history of falls and a high-risk of internal bleeding due to prescribed blood thinners.

To be clear, this Finding is in no way intended to absolve the AP in this case from the arguably negligent care she provided to the VA; instead, the EV-FRT hopes this worst-case scenario can help to highlight a much larger, systemic, and often unseen problem faced by family caregivers of elder and vulnerable adult loved ones across the state – inadequate support.

Recommendation No. 3 - Respite Care, Caregiver Support, and Other Intervention Protocols.

Caregiver burnout is a major problem that cannot be ignored, particularly as more family caregivers step up to assist in the care of an aging adult relative. In a 2025 report on caregiving, AARP found that 64% of family caregivers experience high emotional stress, 45% experience significant physical strain, and nearly a quarter of family caregivers report feeling alone and without support.[17]

It is the Team's recommendation that medical, palliative, and social service providers should automatically and periodically assess family caregivers for the availability of caregiver support, both for programmatic support (e.g., respite care programs) and personal network support (i.e., friends and family members also involved in a vulnerable adult's at-home care). The Team also recommends that medical, palliative, and social service providers be required to provide a list of caregiver supports available to the VA or caregiver, as well as clear instructions for who the caregiver or VA should contact if the caregiver is no longer able to safely and adequately provide care.

Family caregivers should not be left to navigate complex care support systems by themselves, nor should a vulnerable adult patient be discharged into the care of a family caregiver without being offered some form(s) of ongoing support (e.g., respite care). Whether due to illness, injury, or some other emergency, family caregivers will need access to respite care-type support at some point. Services and providers that heavily rely on the care provided by family caregivers, such as hospice care, should be set up to offer training, support, and back-up care to family caregivers when it is needed.

[17] AARP, & National Alliance for Caregiving. (2025). Caregiving in the US 2025. AARP. https://doi.org/10.26419/ppi.00373.001 [aarp.org]

Finding No. 4 - Inadequate Safety Intervention by Professionals. (Case/Referral Review 2025-2)

Despite evidence that the AP actively demonstrated an inability to manage the VA's pain and her expression of emotional distress and overwhelm due to the VA's continuous crying, the Team found no evidence that hospice, medical, or social service professionals offered or required an alternative form/setting of care, such as inpatient care or emergency respite services, prior to the VA's fall and fatal injury. The fatal injury to the VA might have been prevented by one or more of the providers offering intervention when identifying signs of caregiver distress.

Recommendation No. 4 - Safety Planning for Caregivers and High-Need Patients.

As described in early Recommendations in this section, medical, palliative, and social service providers owe responsibility to monitor the health and safety of VAs discharged into at-home care, to ensure these patients continue to receive adequate care in a safe environment. When providers notice red flags that a family caregiver is becoming overwhelmed or is otherwise unable to provide the necessary level of care for a VA, these warning signs should automatically trigger safety intervention steps, including the provision of emergency respite care. While such safety intervention should attempt to support and rehabilitate the family caregiver where possible, the primary focus and objective should always be ensuring the health, safety, and dignity of the VA.

Finding No. 5 - DCF/APS apparently failed to connect a series of individual abuse-related reports involving the same VA and similar allegations, which delayed identification and intervention of the ongoing neglect and financial exploitation situation for approximately ten years. (Case/Referral Review 2025-1)

Between 2015 and 2025, DCF/APS investigated nine separate reports involving the same VA and several of the VA's family members; however, most of these reports were closed with findings of "No Indicator"[18] or "Not Substantiated." Each report appears to have been evaluated as a standalone incident, as opposed to viewing as a clear pattern of repeated allegations involving the same alleged perpetrators. Earlier steps taken by DCF/APS could have identified the broad pattern of financial control, which ultimately resulted in the loss of the VA's residence.

[18] See Florida Department of Children and Families (2020). Adult protective services [Florida Department of Children and Families Operating Procedure (CFOP) No. 140-2, Chapter 4]. Effective May 13, 2020, the department eliminated "No Indicator" as an investigative closure finding for adult protective services. All legacy findings or outcomes where evidence is insufficient to meet the preponderance standard are now consolidated under the single designation of "Not Substantiated."

Recommendation No. 5 - DCF/APS intake and investigation protocols should require a complete review of an alleged VA's full complaint and report history – not just prior substantiated findings – so that recurring reports involving the same household trigger additional review.

Where multiple reports are filed on the same VA within a defined period, regardless of individual findings, the case should be flagged for supervisory review and reassessment of risk.

This protocol change could be implemented as a revision to DCF/APS's internal investigative procedures under the general investigative authority of Fla. Stat. § 415.104, without requiring new legislation. It is the Team's recommendation that DCF/APS could be the agency responsible for developing and issuing this guidance.

Finding No. 6 - The ME's determination of manner of death failed to account for substantiated maltreatment findings by DCF/APS – illustrating a recurring disconnect between protective investigations and subsequent medical death determinations. (Case/Referral Review 2025-2)

The VA's death was medically certified as accidental, attributed to complications of blunt force head trauma, even though DCF/APS had substantiated Inadequate Supervision, Substance Misuse, and Physical Injury by her caregiver in the days preceding her death. Because the VA's underlying illness independently elevated her risk of injury and death, the caregiver's contribution to her decline was not reflected in the official cause and manner of death.

Many elder and vulnerable adult investigations fall into the following Catch-22 scenario: In the absence of a clear case of homicide (e.g., an apparent gunshot wound or untimely and unexpected death in a young and health adult), law enforcement and the SAO wait for the ME to determine the VA's death was caused (even partially) by abuse or neglect before formally opening a criminal case. Meanwhile, the ME, who is unaware of the allegations of prior abuse or neglect and likewise not alerted by the existence of open, pending homicide investigation, fails to distinguish the victim's condition from the comorbidities

of aging and/or pre-existing illnesses and conditions. Finally, even with enough evidence to substantiate the claim that the VA was subjected to abuse, neglect, or exploitation prior to their death, DCF/APS is required to rely on the likely uninformed determination from the ME listed on the VA's death certificate before they can substantiate the death of the VA due to maltreatment. – Consequently, a review of the records for all three agencies (DCF/APS, law enforcement, SAO) would suggest no elder or vulnerable adult abuse-related fatality ever occurred.

Recommendation No. 6 - Formal coordination protocols should be established between DCF/APS, hospice/medical providers, law enforcement, and MEs so that a substantiated finding of abuse or neglect is documented and reviewed as part of a VA's death investigation.

This is particularly important where the VA's underlying medical conditions could otherwise mask the contribution of abuse or neglect to the cause or manner of death.

This coordination could be grounded in the ME's existing statutory duty to investigate deaths that are unexpected, unusual, or not readily explainable under Fla. Stat. § 406.11,[19] which would support a mandatory consultation with DCF/APS whenever a VA's death under investigation has a pending or substantiated finding for maltreatment.

Finding No. 7 - There is an overall lack of awareness and understanding of Florida's mandatory reporting laws and obligations in situations of suspected vulnerable adult abuse.

The EV-FRT has observed these apparent gaps in awareness and understanding among laypeople and professionals alike.

Recommendation No. 7 - The State of Florida should launch a statewide public awareness campaign, led by DCF/APS to educate Floridians on identifying VA abuse, neglect, and exploitation, as well as the requirements and steps for reporting VA abuse to the Abuse Hotline.

Mandatory training targeting the professions most likely to interact with a VA or to witness signs of VA abuse would be an important and worthwhile first step towards addressing this problem, however it should not stop there. A public awareness campaign for all Floridians would empower friends, neighbors, and community members to come forward and speak up when they see warning signs of abuse, which should facilitate earlier intervention in such cases – hopefully, before permanent harm occurs.

The EV-FRT recommends using a variety of media platforms to facilitate broad public awareness and to connect with the diverse populations and demographics of our state. We also recommend using real case scenarios which demonstrate the signs of abuse and highlight the potential consequences to the VA when others fail to report.

Finding No. 8 - The EV-FRT continues to face challenges with case identification and selection due to the continued gap in statutory authority to review *near*-fatal and related cases of VA abuse.

The EV-FRT has noted in every annual report to date that the disparities between EV-FRT's and DVFRT's statutory capabilities – most notably, the ability of DVFRT's, but not EV-FRT's, to "review fatal and *near*-fatal incidents of DV, *related DV matters and suicides*"[20] – significantly impair the Team's ability to identify and learn from a broader sample of VA cases that could yield meaningful findings and

[19] Fla. Stat. § 406.11 (2026) (Medical Examiner's duty to investigate deaths that are unexpected, unusual, or not readily explainable).
[20] Fla. Stat. § 741.316 (2026).

recommendations. As this EV-FRT continues to operate as the only known fatality review team of its kind in the state, this significant gap in capabilities hampers the State of Florida's overall efforts to combat elder and vulnerable adult abuse.

Recommendation No. 8 - This Team implores the Florida Legislature to amend EV-FRT's statutory authority to be commensurate with that of DVFRT's, including the ability to review *near*-fatal incidents and related incidents of abuse and suicides.

Currently the EV-FRT is limited to reviewing incidents of abuse, exploitation, or neglect which are believed to have caused or contributed to the death of an elder or vulnerable adult. Amendments should be made to Fla. Stat. § 415.1103, modeled after Fla. Stat. § 741.316, to explicitly authorize the EV-FRT to review near-fatal incidents of elder or vulnerable adult abuse (e.g., attempted homicide, severe neglect, critical medical events), including suicides, particularly where elder or vulnerable adult abuse, isolation, or exploitation are believed to be contributing factors.

This amendment would enable the team to identify cases where the elder or vulnerable adult's death was ultimately expedited by or tied to the preceding abuse but still did not trigger a fatality review. We see this happen with countless elder abuse cases; a fatality review is not triggered either because the victim languished for an extended period of time following the abuse or because the victim's death was never flagged for a suspicious death review in the first place – both perfect examples of the very "gaps, deficiencies, [and] problems" EV-FRT's were tasked by the Florida Legislature to uncover and report on in the first place.

A statutory amendment broadening the scope of cases capable for review by EV-FRTs is consistent with the legislative intent of Fla. Stat. § 415.1103 (1)(d), to learn how to prevent elder and vulnerable adult abuse and abuse-related deaths by intervening early and improving the system response to elder and vulnerable adult abuse, exploitation, and neglect. And the failure to amend the statute continues to deny elder and vulnerable adults across Florida the same dignity and protection afforded to other victims of crime and their families.

Finding No. 9 - Interagency communication and coordination are hampered by the use of different, siloed, and incompatible case management systems, slow migration processes to new case management systems, and the lack of sufficient internal policies and procedures to promote or compel inter-agency collaboration and communication.

As the Team discovered and documented in last year's report, the EV-FRT reviewed the existing digital case management systems of several stakeholder agencies involved in the investigation and/or prosecution of vulnerable adult abuse cases, particularly between DCF/APS, law enforcement, and SAO. These three professions are mandated by Fla. Stat. § 415.104 to communicate and collaborate with one another in such cases. The Team found that each agency utilized its own unique case management tracking software, along with their own internal policies and procedures when it came to managing, tracking, and reporting on cases of elder and vulnerable adult abuse.

Most of the agencies' case management systems are not compatible with one another, and these agencies are unable to access or easily share across systems for purposes of communicating or coordinating on a case/referral. Additionally, where several agencies had recently migrated to new case management systems, the Team found that the agencies lacked full capabilities to manage and track case reporting within these systems, either due to a lack of training and familiarity with the new software or because aspects of functionality had not yet been built or resolved. Indistinguishable between the newest and longest standing case management systems, however, was the EV-FRT's inability to determine how existing interagency reporting is occurring under Fla. Stat. § 415.104, let alone whether it is effective or could be improved upon.

From a practical perspective, none of these agencies view or treat elder or vulnerable adult cases/referrals as "shared" inter-agency cases. DCF/APS often refers the case to law enforcement and the SAO shortly before closing a protective services investigation – and, in situations involving fatalities, the case is likely to be closed sooner due to the absence of an ongoing threat or safety concern – because, for all intents and purposes, the VA is not at risk of future harm (the basis for protective investigations). Even though both law enforcement and the SAO are statutorily required to provide criminal case updates to DCF/APS following a VA case referral, DCF/APS rarely receives any response, let alone status updates, from either office. And sadly, as referenced in Finding and Recommendation No. 6 of this report, in most cases involving a fatality, a criminal case will never be opened from which either law enforcement or the SAO could report.

The consistently changing technology and lack of incentive to address compatibility between case management systems is likely to continue perpetually until some action is taken at the state level to address these gaps. However, for any technology-focused solution to be effective, the State of Florida must first provide the necessary training, accountability, and transparency for all three disciplines (DCF/APS, law enforcement, SAO) to understand and execute their respective roles in shared VA abuse cases.

Recommendation No. 9 - Interagency communication and collaboration should be tracked and transparently reported statewide to allow for true evaluation of both the challenges and successes of such collaboration.

It remains the recommendation of the Team that one or more agencies (government and/or receiving government funds) collect reports and data when services were denied to the victim and ensure the appropriate agencies are aware of services being denied. The warehousing and monitoring of the services denied could assist with removing the caregiver or moving the victim to another residence, which the services would be accepted.

Finding No. 10 - Individuals are not consistently screened for criminal history before assuming informal caregiving or financial authority over a vulnerable adult.

In Case Review 2025-1, the AP had an extensive criminal history, including armed robbery, possession of a firearm by a convicted felon, and multiple DUI's, that was never considered in assessing his access to the VA's finances and residence. No existing statutory or agency mechanism requires such screening for informal, unlicensed caregivers or individuals granted financial access by a VA or their family.

By contrast, Fla. Stat. § 744.3135[21] requires even court-appointed nonprofessional (family) guardians, along with professional guardians and their employees, to undergo level 1 or level 2 background screening before appointment. No comparable requirement exists for informal caregivers or individuals granted financial access, such as through a POA, outside the guardianship process — leaving a gap for exactly the kind of unsupervised access seen in this case.

Recommendation No. 10 - The State should explore mechanisms — such as a public-facing background screening tool or clearer guidance for families and financial institutions — to allow screening of individuals before they are granted formal or informal caregiving or financial authority over a VA.

Because Fla. Stat. § 744.3135 already establishes a background-screening framework for guardianship, extending or adapting a similar screening option for informal caregiving and financial-access arrangements would build on an existing system rather than requiring an entirely new one.

Finding No. 11 - Financial institutions are best positioned to detect early indicators of financial exploitation, however financial institution personnel are not consistently trained to recognize or report red flags (e.g., repeated third party-accompanied withdrawals). (Case/Referral Review 2025-1)

In Case Review 2025-1, bank personnel observed family members bringing the VA to the bank to withdraw funds on a monthly basis over an extended period. However, none of the employees at the bank ever attempted to investigate or report the suspicious activity as it was occurring. In fact, the intervention in this case only occurred as a result of the VA experiencing a medical emergency inside the bank; if this had not occurred, it is unlikely that the exploitation would have ever been identified or reported.

Recommendation No. 11 - Financial institutions should be required to provide regular staff training about identifying and reporting signs of financial exploitation, mandatory reporting obligations under Ch. 415 of Florida Statutes, and legal report-and-hold authority available to financial institutions in cases of suspected exploitation. Additionally, financial institutions should be required to establish written, internal escalation protocols for suspicious account activity involving vulnerable account holders.

Bank, savings and loan, and credit union officers and employees are already among the mandatory reporters identified in Fla. Stat. § 415.1034(1)(a).[22] Fla. Stat. § 415.1041[23] separately authorizes financial institutions to report suspected exploitation and place a temporary hold on a customer's disbursement or transaction. All financial institutions should provide regular training to ensure staff recognize their mandatory reporting obligations, as well as the report-and-hold authority available to them.

[21] Fla. Stat. § 744.3135(1) (2026) (requiring all guardians seeking court appointment, other than certain corporate guardians, and all employees of a professional guardian with fiduciary responsibility to a ward — including nonprofessional/family guardians — to submit to a credit history investigation and level 2 background screening under s. 435.04).
[22] Fla. Stat. § 415.1034(1)(a) (2026) (listing bank, savings and loan, and credit union officers, trustees, and employees among the persons required to report known or suspected abuse, neglect, or exploitation of a vulnerable adult).
[23] Fla. Stat. § 415.10341 (2026) (authorizing a financial institution to report suspected financial exploitation of a specified adult and to place a hold on a disbursement or transaction).

Finding No. 12 - The aging-services provider allowed a community-based service referral to lapse and failed to ensure the continued care for a VA with high-needs who was no longer capable of caring for herself, had no identifiable care provider, and was not receiving any other services or support. (Case/Referral Review 2025-1)

At the time of the incident, the VA had no identified caregiver despite being assessed as needing assistance with ADL's, including bathing, dressing, meal preparation, transportation, financial management, and medical care. Her only documented service, Meals on Wheels, ended in July 2025, and the in-home eligibility assessment conducted in August 2024 was terminated before a referral to Community Care for the Elderly (CCE) occurred.[24] This left VA without any form of assistance or protective supervision for an extended period, during which the documented financial exploitation in this case was allowed to continue unchecked.

Recommendation No. 12 - Agencies conducting in-home eligibility assessments should not be permitted to terminate a referral without a documented and completed hand-off to a comparable continuing service provider, especially for VAs with no identified caregiver.

It is the Team's recommendation that when an initial service such as Meals on Wheels is ending or an if client is later determined ineligible for continued services, the referring agency should be required to confirm the VA's connection with an alternative service, such as CCE, before the case can be closed. Likewise, when a VA is receiving community-based services determined from an initial assessment set to expire, the referring agency should continue to provide for the existing services until a new assessment can be performed and alternative service, if needed, offered.

The health, safety, and dignity of a known VA with high needs, like the individual in this case, should never be left to an administrative process that lacks adequate checks and balances, as were evidently missing in this case.

Finding No. 13 - DCF/APS erred in failing to investigate the visible, physical injury sustained by a VA during a financial exploitation incident, as evidence of a second form of maltreatment. (Case/Referral Review 2025-1)

The VA sustained a skin tear and bruising to both arms when she was forcibly pulled upright in her wheelchair during a visit to withdraw funds from her account. While the exploitation itself was substantiated, the maltreatment recorded and investigated by DCF/APS in this case reflect only Exploitation, Neglect & Self-Neglect (No Indicator) and Inadequate Supervision (No Indicator) — the documented physical injury was not screened or investigated as a separate form of maltreatment,[25] evidently because it occurred in the course of the same incident as the exploitation.

[24] Fla. Stat. §§ 430.201-430.207 (2026) (the "Community Care for the Elderly Act," establishing community-based services intended to assist functionally impaired elderly persons in living independently).
[25] Fla. Stat. § 415.102 (2026) (defining "abuse," "neglect," and "exploitation" for purposes of Adult Protective Services investigations); see also Fla. Stat. § 415.104 (2026) (general investigative authority of the Department).

Recommendation No. 13 - When a VA sustains a physical injury in the course of a suspected exploitation incident, investigators should screen for and document "Physical Injury" as an independent form of maltreatment, alongside a co-occurring maltreatment like "Exploitation."

It is the Team's recommendation that DCF/APS intake and investigation protocols should be updated to require this dual documentation whenever injury and financial exploitation co-occur, so that physical harm sustained during an exploitation incident is not treated as merely incidental evidence to a financial exploitation allegation.

Case Review 2025-1

Date of Death: November 22, 2025

Vulnerable Adult: Female, 95, White Non-Latino/Caucasian

Vulnerabilities and Special Classification(s):

- Neurological and Cognitive Impairments (e.g., Dementia, TBI)
- Other Sensory and Communication Disabilities (Visual, Speech)
- Physical and Mobility Disabilities
- Mental Health and Psychiatric Conditions
- Limited English Proficiency (LEP)
- Deaf/Hard of Hearing (ASL or Assistive Tech Needs)

Alleged Perpetrator: Male, 49, White Non-Latino/Caucasian

Maltreatment(s):	**Finding(s):**
Exploitation (Financial/Material)	Substantiated
Neglect & Self-Neglect	No Indicator
Inadequate Supervision	No Indicator

I. NARRATIVE OF ALLEGATION(S)

A. Relationship — Family - Grandchild, (co-habitating)

B. Case Summary

Due to an unknown neurocognitive-type disorder and physical limitations, VA was classified as a vulnerable adult as of September 25, 2025. VA was experiencing an undiagnosed mental decline and neurological problems that impaired her ability to move her legs, which was compounded by a significant spinal curvature. Consequently, the VA became dependent on her wheelchair for mobility. The VA also suffered from visual impairment and required assistance with her ADLs and IADLs, which include bathing, dressing, performing strenuous household tasks, housekeeping, meal preparation, grocery shopping, laundry, transportation, and managing her finances and medical matters. However, the VA had no identifiable caregiver as her health and abilities declined.

During this period of physical and mental decline, the VA began coming to her local bank several individuals claiming to be her "family." The alleged family members came to the bank with the VA monthly. They would present their IDs to the teller, and proceed to withdraw money from VA's account in her presence. The alleged family members would force the VA to sit up in her wheelchair for the transaction, causing a tear on one arm and bruising on the other on at least one occasion.

On this same occasion that injuries were seen on the VA's arms, the VA began to exhibit strange behaviors and was apparently unable to answer questions from staff. The VA's concerning behavior prompted bank employees to call for emergency medical assistance. When the VA's alleged family members learned that emergency services had been called, they fled the scene; with leaping over obstacles (e.g., furniture) to escape the bank before first responders arrived.

Emergency services responded to the scene and assessed the VA as having an altered mental state; she was able to state her name but showed alternating signs of aggression and extreme listlessness. Emergency services transported the VA to a local hospital where it was determined she was suffering from sepsis. The VA was admitted to the hospital, and her medical needs were addressed.

DCF/APS was contacted and an investigation was conducted. When the Adult Protective Investigator (API) met with the VA, she was only able to provide her name; she apparently did not know her date of birth, the current date, or the name of the current President of the United States. The VA repeatedly requested "warm tea — not hot, not cold, but warm tea" from the API.

After the VA's condition was stabilized, she was discharged into the care of a local nursing care facility on October 27, 2025, but was readmitted to the hospital on November 16, 2025. The VA passed away during this second hospitalization on November 22, 2025.

Documented evidence obtained by API during the course of the protective investigation indicated that the VA's grandson, the AP, had presented financial instruments (checks) from the VA's checking account for deposit into his own account. API compared the signatures on the deposited checks to documents signed by the VA and found clear discrepancies. Collateral statements from the VA's financial institution confirmed that the AP was neither an account holder nor in possession of a valid POA to conduct financial transactions for the VA's account. The VA had no known home care services and reportedly no local relatives. The full sum of money withdrawn by the alleged family members could not be determined.

Based on the evidence obtained from the bank, the protective services investigation was concluded with substantiated findings of exploitation. The VA died on November 22, 2025, during the course of the protective services investigation. Due to VA's passing, the API reported there were no further implications for the safety of the VA and closed the DCF/APS investigation. DCF/APS noted that the evidence gathered sufficiently supports the allegation, with a preponderance of proof. The findings were substantiated by documented evidence and statements from financial institutions.

The Economic Crimes Division of a local law enforcement agency was notified and initiated an investigation into financial exploitation, identifying VA as the victim and the AP as the probable suspect. During this inquiry, it was revealed that the suspect received a property deed from VA in 2017 and subsequently sold it in 2026, three months after VA's death. Law enforcement closed the criminal investigation into this matter on June 5, 2026. Based on the evidence examined, law enforcement determined there was insufficient probable cause to file charges against the AP for criminal of exploitation.

C. Children Present — No Children

D. Location — (Duval County), Jacksonville

II. CRIMINAL HISTORY

A. Vulnerable Adult: — No Record

B. Alleged Perpetrator: — History

09/04/2025 – Simple Battery (Not VA) – Arrest Warrant Denied

11/27/2006 – Armed robbery with a firearm (two counts/ Not VA); Possession of a firearm by a convicted felon (two counts); Driving while license permanently revoked (Habitual felony offender); Aggravated fleeing/attempting to elude a LEO - Pled guilty/Adjudicated guilty Sentenced to serve twenty years Florida State Prison

12/06/2005 – DUI; DUI refuse to provide breath/blood/ urine – Pled no contest/Adjudicated guilty; Sentenced to serve nine months in county jail (with sixty-six days' time served)

08/05/2005 – DUI – Pled no contest/Adjudicated guilty; Sentenced to serve nine months in county jail

05/22/2004 – Fugitive (out of state warrant) case dropped

05/20/2004 – Petit theft; Carrying a concealed weapon – Pled no contest/Adjudicated guilty; Sentenced to serve two days in county jail

11/01/2003 – Petit theft – Pled no contest/adjudication withheld

III. CIVIL RECORDS AND REPORTS:

A. Vulnerable Adult: No Record

B. Alleged Perpetrator: No Record

IV. SERVICES

A. Vulnerable Adult: History

10/20/2021 – Community referral to a local service agency where she received Meals on Wheels services from 08/16/2024 – 07/01/2025

08/20/2024 – In home assessment to determine eligibility for Meals on Wheels services, Services terminated before a referral could be made for Community Care for the Elderly

B. Alleged Perpetrator: No Record

V. OTHER CONCERNS

Multiple reports identified several family members who appear to have financially exploited the VA by taking her to financial institutions for the purpose of having the VA withdraw money for the AP's use. Although her mental capacity at the time of many of these transactions was unknown, the VA is believed to have suffered from a diminished capacity during the most recent of these transactions, at the least.

The exploitation allegations date back as far as 2015 and continued through the time of the VA's death in 2025. All allegations were investigated by DCF/APS and findings documented in every case listed by intake date below, however no protective service interventions are documented in this ten-year timeframe. The pattern documented by the DCF/APS reports is very concerning, particularly as simultaneous changes were being made to the VA's property records. Multiple properties belonging to VA and her deceased husband reflect changes noting the husband's passing April 28, 2007, through death certification. The husband's name remained on the properties per the death certificate, confirming VA was continuously married to him from before the properties' acquisition through the date of his death.

On June 23, 2017, the VA, with the assistance of legal representation, transferred multiple properties into a named revocable living trust.

On September 22, 2017, three months following the transfer to VA's trust, a quitclaim deed for the VA's primary residence (now part of the named trust), was filed which purportedly transferred the property over to the AP.

It is well-documented in DCF/APS investigations dating as far back as 2015 that VA experienced a pattern of financial exploitation, which was often accompanied by verbal threats to the VA. A summary listing all DCF/APS reports is provided below:

- 08/21/2015 – Exploitation – Substantiated (Grandson – Co-habitating – Not AP); DCF/APS Investigation Closed on 10/15/2015

- 06/23/2016 – Exploitation – No Indicator (Grandson – Co-habitating – Not AP); DCF/APS Investigation Closed on 08/18/2016

- 06/01/2017 – 06/01/2017 – Exploitation – Not Substantiated (Grandson – Co-habitating – Not AP); DCF/APS Investigation Closed on 06/07/2017

- 11/27/2017 – Exploitation – Not Substantiated (Tenant – Not Co-habitating); DCF/APS Investigation Closed on 12/01/2017

- 07/17/2018 – 07/17/2018 – Self-Neglect – No Indicator; DCF/APS Investigation Closed on 07/23/2018

- 07/26/2018 – Mental Injury – No Indicator (Daughter – Co-habitating); DCF/APS Investigation Closed on 09/07/2018

- 09/24/2018 – 09/24/2018 – Exploitation – No Indicator (Caregiver – Not Co-habitating); DCF/APS Investigation Closed on 10/10/2018

- 08/02/2019 – Exploitation – No Indicator (AP – Unknown Co-habitating); DCF/APS Investigation Closed on 09/11/2019

- 01/04/2024 – Self-Neglect – No Indicator; DCF/APS Investigation Closed on 02/22/2024

- 04/02/2025 – Exploitation – No Indicator (AP – Co-habitating); DCF/APS Investigation Closed 06/01/2025

Case Review 2025-2

Date of Death: August 24, 2025

Vulnerable Adult: Female, 79, White Non-Latino/Caucasian

Vulnerabilities and Special Classification(s):
- Neurological and Cognitive Impairments (e.g., Dementia, TBI)
- Physical and Mobility Disabilities

Alleged Perpetrator: Female, 62, White Non-Latino/Caucasian

Maltreatment(s):	Finding(s):
Neglect & Self-Neglect (VAINS)	Substantiated
Inadequate Supervision	Substantiated
Substance Misuse	Substantiated
Physical Injury	Substantiated
Internal Injuries	Not Substantiated
Death	Not Substantiated

II. NARRATIVE OF ALLEGATION(S)

A. Relationship — Family - Adult Child, (co-habitating)

B. Case Summary

The VA was a 79-year-old female suffering from cancer and a neurodegenerative disease that caused her severe pain and weakness. She was bed bound and in need of total care, and she lacked the capacity to consent to services. Due to her physical and neurological limitations, the VA was classified as a vulnerable adult and, separately, as a "fall risk" by numerous medical staff. The VA was receiving services from home hospice for comfort care. The AP, the VA's daughter, was her primary caregiver. The VA had come to live with the AP at a time when the AP herself was recuperating from a medical procedure that limited her capacity to provide care.

On August 13, 2025, the VA was taken to the hospital following a fall at home. The emergency room physician noted a small hematoma on the left posterior side of the VA's head, with several punctate areas (dotted areas) of bleeding but no lacerations (tears). The VA was on a blood-thinning medication due to a history of blood clots in her lungs, which placed her at heightened risk for bleeding.

On August 16, 2025, hospice staff attempted to reach the AP after the VA was reported to be uncomfortable and restless; the AP was not present in the home and did not answer

repeated phone calls. Upon arrival, hospice nursing staff found the VA on the floor, screaming in pain. The AP, who had been asleep upstairs, reported that the VA may have been on the floor for approximately an hour. The VA was assessed with bruising to her right eye and both upper extremities; no bleeding was noted at that time.

During the same visit, hospice nursing staff conducted a narcotic count and identified substantial discrepancies between the medication on hand and what had been dispensed days earlier: a bottle of Morphine contained approximately 12 ml when 30 ml had been dispensed on August 14, 2025; an Ativan prescription had 20 tablets remaining when 60 had been dispensed on August 14, 2025; and a Hydrocodone prescription had 3 tablets remaining when 42 had been dispensed on August 12, 2025. When the AP was reached, her speech was slurred, and she admitted to administering medication to the VA more frequently than prescribed, stating the prescribed dosing "wasn't working" for the VA's pain. The AP attributed the pill-count discrepancy to a partial pharmacy fill; however, the reviewing investigator found no markings on the manufacturer's bottle indicating a partial fill. In a subsequent interview, the AP stated that she had not taken any of the VA's medications, noting that she had prescriptions of her own.

Hospice staff reported that the AP was frequently unavailable when contacted or requested at the VA's bedside, often remaining upstairs and, by her own account, asleep — stating that she could not bear to listen to the VA's cries of pain. The AP stated she left the front door unlocked so that hospice staff could come and go without her needing to answer the door.

On August 17, 2025, the VA was taken to the hospital for unmanageable pain. Imaging of her bilateral wrists revealed soft tissue swelling, consistent with the fall witnessed by hospice staff the day before. The VA was then hospitalized and no longer under the AP's supervision and care.

The VA died on August 24, 2025, at 9:19 p.m., while under hospice care. The ME certified the manner of death as "accidental," with the cause of death listed as "chronic complications of blunt force head trauma with subdural hematoma;" chronic cerebrovascular disease was also noted as a "significant contributing condition."

C. Children Present — No Children

D. Location — (Duval County), Jacksonville, FL

II. CRIMINAL HISTORY

A. Vulnerable Adult: — No Record

B. Alleged Perpetrator: — No Record

III. CIVIL RECORDS AND REPORTS

A. Vulnerable Adult: No Record

B. Alleged Perpetrator: No Record

IV. SERVICES

A. Vulnerable Adult: History

Home Hospice Care Services – Active at time of VA's death (See Case Narrative and Other Concerns for Relatable Details)

B. Alleged Perpetrator: No Record

V. OTHER CONCERNS

Documentation of the administration of medications was not performed by the AP, despite multiple instructions from staff to call the on-call provider regarding pain management issues.

The AP attempted to account for the missing pills by claiming they were a partial fill. However, investigators noted the Morphine was in a manufacturer's bottle not adjusted by the pharmacy, and there were no markings on the pill bottles to indicate a partial fill. The AP denied taking the VA's medication, stating she had her own. No further inquiry was documented by hospice staff and available for review by this Team.

The VA had a documented history of falls dating back to December 2024, corresponding with a decline in her neurocognitive status. Additionally, the VA was prescribed a blood-thinning medication due to a history of blood clots in the lungs, which placed her at a high risk for internal bleeding.

This case illustrates the same detection challenge described elsewhere in this report – a VA already receiving hospice/comfort care for a terminal or degenerative condition who experienced documented, substantiated abuse and neglect by her caregiver, and yet her subsequent death was medically certified as "accidental," without an explicit finding linking it to the abuse. Because the VA's underlying conditions (cancer, neurodegenerative disease, prior falls, and anticoagulant therapy) independently elevated her risk of injury and death, distinguishing the caregiver's contribution to her decline from the natural progression of her illness required careful information-sharing between hospice, DCF/APS, and the ME.

Although DCF/APS substantiated four separate categories of maltreatment — Inadequate Supervision, Substance Misuse, Medical Neglect, and Physical Injury — the ME's finding of an accidental manner of death, occurring days after the documented fall and pill-count discrepancies, underscores the Team's recurring concern that abuse-related fatalities involving VAs in hospice or end-of-life care are unlikely to be identified as such through traditional death investigation methods.

Looking Forward

We started out by reflecting on the work of the EV-FRT from the past five years and appreciating how much the Team has accomplished as a pioneer in Florida's elder and vulnerable adult justice landscape. We now turn our focus to what's ahead for the EV-FRT for the 2026-2027 team year and beyond.

On a micro-level, as a functioning and evolving Team, several goals for the upcoming year have been identified that will improve the Team's functionality and efficacy. Here are just a few of the Team objectives for the year ahead:

- To ensure the Team is adequately representing the community it serves, the EV-FRT is currently reviewing its case selection methodology. This review includes exploring various approaches to identify elder and vulnerable adult abuse fatality cases in our area that have either not yet been prosecuted or do not qualify for criminal prosecution, such as instances where the perpetrator has died by suicide.
- The EV-FRT is looking forward to updating the Team's new member orientation materials and process. These updates will incorporate recent positive changes in state law and reflect key insights gained from the EV-FRT's work over the last five years.
- The EV-FRT is continuously updating its case review template to include all necessary details identified by the team as relevant to the specific victimizations encountered.
- Following this year's case reviews, the EV-FRT intends to pursue a formal coordination protocol between DCF/APS, hospice/medical providers, and Medical Examiners (see Recommendation No. 7), so that a substantiated DCF/APS finding of abuse or neglect is documented and considered as part of a VA's death investigation.
- The EV-FRT also plans to raise, as a discussion topic, the caregiver and financial-access screening gap identified in Recommendation No. 11 — namely, that Fla. Stat. § 744.3135 already screens court-appointed family guardians, but no comparable mechanism exists for informal caregivers or individuals granted financial access outside a guardianship proceeding.

At a slightly higher level, we hope to resume our work with other circuits across the state that may be interested in initiating elder and vulnerable adult abuse fatality review teams of their own. As a first-of-its-kind, the Team has garnered a lot of interest and questions from other jurisdictions over the past five years, and we hope to share some of this EV-FRT's lessons learned and best practices with our peers. We also hope that by fostering relationships with other circuits across Florida our EV-FRT will benefit from learning different perspectives and methods already being utilized by other multidisciplinary teams across the state.

Finally, at a state level, this EV-FRT hopes to have the opportunity to work closely with our allies in agencies like the DoEA, DCF, DOH, and AHCA, to gain a better understanding of the existing processes and policies already in place for interagency and public-private collaboration across elder and vulnerable adult care. We hope to likewise have the opportunity to highlight and showcase systems that are working effectively as intended, so that we, as a state, can adopt the most effective methods of identifying and intervening in situations where individuals are at the greatest risk of experiencing elder or vulnerable adult abuse and abuse-related deaths.

Chief among the EV-FRT's state-level priorities for the year ahead is pursuing the legislative amendment described in Recommendation No. 9 — expanding the Team's statutory authority under Fla. Stat. § 415.1103 to permit review of near-fatal incidents and suicides where abuse, isolation, or exploitation are believed to be contributing factors, consistent with the authority already granted to the DVFRT under Fla. Stat. § 741.316.

A. Cross-Sector Training Recommendations

The Team recommends training and education be provided, if not required, for specific professionals, industries, and disciplines.

1. Semiannual training on topics related to elder and vulnerable adult abuse, neglect, and exploitation to professionals within industries that provide care, services, or receive DCF/APS referrals per statute, to elder or vulnerable adults, including, but not limited to: law enforcement, prosecution, medical and long-term care staff, financial services staff, social services, and aging and disability network providers. Training professionals engaged in financial services and banking should emphasize warning signs of exploitation red flags, as well as the report-and-hold authority provided in Florida Statutes §§ 415.10341 and § 517.34.

2. DCF/APS professionals should receive training in trauma-informed care to help with identifying the appropriate level of services for the elder and vulnerable adults. This should be paired with the report-history cross-referencing protocol described in Recommendation No. 5, since training alone will not resolve a system that evaluates each report in isolation.

3. Mandatory training and policies must be created to teach case coordination, tracking, and appropriate information-sharing between law enforcement, prosecutors, and DCF/APS for all vulnerable adult abuse-related referrals from DCF/APS. Such training should be offered to all three disciplines to ensure a uniform approach to case reporting and tracking.

4. Prior to discharging a patient or hospice recipient from an inpatient or hospital setting into the care of a family caregiver for in-home care, the medical or hospice provider should assess the health, mobility, and care needs of the vulnerable adult patient or care recipient, and offer suitable, free training to the caregiver on proper health and safety practices, including the safe management and administration of medications prescribed to the patient.

B. Relevant Legal Authority

Florida Statute § 415.104 – Protective investigations of cases of abuse, neglect, or exploitation of vulnerable adults; transmittal of records to state attorney.

(1) The department shall, upon receipt of a report alleging abuse, neglect, or exploitation of a vulnerable adult, begin within 24 hours a protective investigation of the facts alleged therein.

Children & Families Operating Procedures[26] 140-2 § 1-7(e) – INTRODUCTION TO ADULT PROTECTIVE SERVICES – Roles & Responsibilities.

e. State Attorney. The state attorney determines whether his/her office will conduct a criminal investigation based on the information provided by the department and from information gathered by his office, and whether prosecution of any individual in the investigation will occur. The state attorney's office will report their findings to the department within 15 days following the completion of their investigation and include a determination of whether or not prosecution is justified and warranted.

Children & Families Operating Procedures 140-2 § 1-7(f) – INTRODUCTION TO ADULT PROTECTIVE SERVICES – Roles & Responsibilities.

f. Law Enforcement.

(1) The department should, per section 415.105(5), F.S., immediately notify law enforcement, when the department has reasonable cause to suspect that abuse, neglect, or exploitation has occurred and was perpetrated by a second party. Law enforcement will determine whether to conduct a criminal investigation and if they conduct it concurrently or independently of the department's investigation.

(2) The department, per section 415.103(4), F.S. is mandated to immediately notify local law enforcement in writing upon determining reasonable cause to suspect that a victim died as a result of abuse, neglect, or exploitation.

Florida Statute § 415.104(5) – Protective investigations of cases of abuse, neglect, or exploitation of vulnerable adults; transmittal of records to state attorney.

(5) Whenever the law enforcement agency and the department have conducted independent investigations, the law enforcement agency shall, within 5 working days after concluding its investigation, report its findings to the state attorney and to the department.

Florida Statute § 415.104(8) – Protective investigations of cases of abuse, neglect, or exploitation of vulnerable adults; transmittal of records to state attorney.

(8) Within 15 days after completion of the state attorney's investigation of a case reported

[26] Children & Families Operating Procedures (CFOP) (2025).

to him or her pursuant to this section, the state attorney shall report his or her findings to the department and shall include a determination of whether or not prosecution is justified and appropriate in view of the circumstances of the specific case.

Children & Families Operating Procedures 140-2 § 19-4. – CLOSURE OF CASE RECORD, Report Closure.

a. No later than 60 days following the receipt of a report, the supervisor must review the investigation for completeness and accuracy. The supervisor must then close the investigation in the electronic case management system. Once an investigation is closed no further investigative activity occurs.

Children & Families Operating Procedures 140-2 § E-25. – DEATH ALLEGATIONS, DEATH DUE TO ABUSE/NEGLECT.

Sources of Verification. Any or all of the following may be necessary [to determine a vulnerable adult died as a result of abuse or neglect] depending on the circumstances. (Documentation from medical professional, medical examiner/coroner required.)

1. Documentation from medical professional; and

2. Statement of witness; or

3. Direct admission from possible responsible person; or

4. Documentation from law enforcement officer.

C. Mandatory Reporting

415.1034 Mandatory reporting of abuse, neglect, or exploitation of vulnerable adults; mandatory reports of death.—

(1) MANDATORY REPORTING.—

(a) Any person, including, but not limited to, any:

1. Physician, osteopathic physician, medical examiner, chiropractic physician, nurse, paramedic, emergency medical technician, or hospital personnel engaged in the admission, examination, care, or treatment of vulnerable adults;
2. Health professional or mental health professional other than one listed in subparagraph 1;
3. Practitioner who relies solely on spiritual means for healing;
4. Nursing home staff; assisted living facility staff; adult day care center staff; adult family-care home staff; social worker; or other professional adult care, residential, or institutional staff;
5. State, county, or municipal criminal justice employee or law enforcement officer;
6. Employee of the Department of Business and Professional Regulation conducting inspections of public lodging establishments under s. 509.032;
7. Florida advocacy council or Disability Rights Florida member or a representative of the State Long-Term Care Ombudsman Program;
8. Bank, savings and loan, or credit union officer, trustee, or employee; or
9. Dealer, investment adviser, or associated person under chapter 517,who knows, or has reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited must immediately report such knowledge or suspicion to the central abuse hotline.

(b) To the extent possible, a report made pursuant to paragraph (a) must contain, but need not be limited to, the following information:

1. Name, age, race, sex, physical description, and location of each victim alleged to have been abused, neglected, or exploited.
2. Names, addresses, and telephone numbers of the victim's family members.
3. Name, address, and telephone number of each alleged perpetrator.
4. Name, address, and telephone number of the caregiver of the victim, if different from the alleged perpetrator.
5. Name, address, and telephone number of the person reporting the alleged abuse, neglect, or exploitation.
6. Description of the physical or psychological injuries sustained.

7. Actions taken by the reporter, if any, such as notification of the criminal justice agency.

8. Any other information available to the reporting person which may establish the cause of abuse, neglect, or exploitation that occurred or is occurring.

(2) MANDATORY REPORTS OF DEATH.—Any person who is required to investigate reports of abuse, neglect, or exploitation and who has reasonable cause to suspect that a vulnerable adult died as a result of abuse, neglect, or exploitation shall immediately report the suspicion to the appropriate medical examiner, to the appropriate criminal justice agency, and to the department, notwithstanding the existence of a death certificate signed by a practicing physician. The medical examiner shall accept the report for investigation pursuant to s. 406.11 and shall report the findings of the investigation, in writing, to the appropriate local criminal justice agency, the appropriate state attorney, and the department. Autopsy reports maintained by the medical examiner are not subject to the confidentiality requirements provided for in s. 415.107.

D. Description of Team Committees and Subcommittees

The authority to conduct elder abuse fatality reviews was established by the Florida Legislature on July 1, 2020, by Florida Statute 415.1103. This statute was later amended on July 1, 2023, changing the name of these review teams to elder and vulnerable adult abuse fatality review teams – reflecting a broader scope for team review.

The following EV-FRT Committees and Subcommittees are established:

- **Executive Committee:** The Executive Committee is the governing body and responsible for guiding the team by prioritizing issues and making sure the decisions and actions are in accordance with the mission of the team.
- **Report Drafting Committee:** The Report Drafting Committee is responsible for drafting the annual report each year before September 1. The EV-FRT Co-chairs are responsible for submitting the finalized report to the Florida Department of Elder Affairs.

E. Glossary

Fla. Stat. § 415.1103 – Elder and Vulnerable Adult Abuse Fatality Review Teams.

(2) For purposes of this section and s. 415.1104, the term "elder and vulnerable adult" refers to a person who meets the criteria for any of the following terms:

(a) Vulnerable adult as defined in s. 415.102.

(b) Disabled adult as defined in s. 825.101.

(c) Elderly person as defined in s. 835.101.

- **Caregiver.** A person who has been entrusted with or has assumed the responsibility for frequent and regular care of or services to a vulnerable adult on a temporary or permanent basis and who has a commitment, agreement, or understanding with that person or that person's guardian that a caregiver role exists. "Caregiver" includes, but is not limited to, relatives, household members, guardians, neighbors, and employees and volunteers of facilities as defined in subsection (9). For the purpose of departmental investigative jurisdiction, the term "caregiver" does not include law enforcement officers or employees of municipal or county detention facilities or the Department of Corrections while acting in an official capacity. – Fla. Stat. § 415.102(5).
- **Death Due to Abuse/Neglect Finding.** Permanent and irreversible cessation of all vital functions as determined by a physician or medical examiner. The action or lack of action by the possible responsible person must be directly attributable to the abuse or neglect of the vulnerable adult. – CFOP 140-2, E-25.
- **Disabled Adult.** A person 18 years of age or older who suffers from a condition of physical or mental incapacitation due to a developmental disability, organic brain damage, or mental illness, or who has one or more physical or mental limitations that restrict the person's ability to perform the normal activities of daily living. – Fla. Stat. § 825.101(3).
- **Durable Power of Attorney.** A power of attorney terminates if the principal becomes incapacitated, unless it is a special kind of power of attorney known as a "durable power of attorney." A durable power of attorney must contain specific wording that provides the power survives the incapacity of the principal. Most powers of attorney granted today are durable. The Florida Bar. (2025) Consumer Pamphlet: Florida Power of Attorney.
- **Elderly Person.** A person 60 years of age or older who is suffering from the infirmities of aging as manifested by advanced age or organic brain damage, or other physical, mental, or emotional dysfunction, to the extent that the ability of the person to provide adequately for the person's own care or protection is impaired. – Fla. Stat. § 825.101(4).

- **Not Substantiated Finding.** A possible summarized finding of maltreatment for an Adult Protective Service investigation used when there is an absence of credible evidence, or when what evidence exists falls short of a preponderance to support that the specific injury or harm was the result of abuse, neglect, exploitation, or self-neglect. May also be referred to as an *unsubstantiated finding*. – CFOP 140-2,19-3.a.(1).
- **Power of Attorney.** A legal document delegating authority from one person to another. In the document, the maker of the power of attorney (the "principal") grants the right to act on the maker's behalf as that person's agent. What authority is granted depends on the specific language of the power of attorney. A person giving power may make it very broad or may limit to certain specified acts. The Florida Bar. (2025) Consumer Pamphlet: Florida Power of Attorney.
- **Substantiated Finding.** A possible summarized finding of maltreatment for an Adult Protective Service investigation used when there is a preponderance (greater than 50% of evidence supports that the alleged incident(s) of abuse, neglect, self-neglect, or exploitation occurred) of credible evidence that supports the maltreatments. May also be referred to as a *substantiated* or *verified finding*. – CFOP 140-2, 19-3.a.(2).
- **Victim.** Any vulnerable adult named in a report of abuse, neglect, or exploitation. – Fla. Stat. § 415.102(27).
- **Vulnerable Adult.** A person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging. – Fla. Stat. § 415.102(28).
- **Vulnerable Adult in Need of Services.** A vulnerable adult who has been determined by a protective investigator to be suffering from the ill effects of neglect not caused by a second party perpetrator and is in need of protective services or other services to prevent further harm. – Fla. Stat. § 415.102(29).

F. Abbreviations and Acronyms

ABA American Bar Association

ADLs Activities of Daily Living

AHCA Agency for Health Care

AP Alleged Perpetrator

API Adult Protective Investigator

APS Adult Protective Services

ASL American Sign Language

AARP American Association of Retired Persons

CCR Coordinated Community

CFOP Children & Families Operating Procedures

DCF Department of Children & Families

DoEA Department of Elder Affairs

DOH Department of Health

DPOA Durable Power of Attorney

DUI Driving Under the Influence

DV Domestic Violence

DVFRT Domestic Violence Fatality Review Team

EAFRT Elder Abuse Fatality Review Team

EV-FRT Elder and Vulnerable Adult Abuse Fatality Review Team

JQC Judicial Qualifications Commission (Florida)

IADLs Instrumental Activities of Daily Living

LEO Law Enforcement Officer

LEP Limited English Proficiency

ME Medical Examiner

OAG Office of the Attorney General (Florida)

POA Power of Attorney

SAO State Attorney's Office for the Fourth Judicial Circuit of Florida

TBI Traumatic Brain Injury

VA Vulnerable Adult

VAINS Vulnerable Adult in Need of Services

***Note: These acronyms are only intended for use in this report. For approved terminology and acronyms of specific agencies, departments, or entities referenced in this report, please refer directly to reference materials provided by those agencies, departments, and entities.**

Closing Thoughts

This report is, at its core, a record of what this Team discovered by looking closely at what transpired before the tragic deaths of two vulnerable adults. We must ask ourselves, case by case, what could have interrupted that outcome? The findings and recommendations in this report are offered in that same spirit – not as criticism of any one agency or individual, but as an honest accounting of the gaps this Team is positioned to identify, and our good-faith efforts to resolve them.

"The opposite of love is not hate, it's indifference." — Elie Wiesel