FIFTH ANNUAL REPORT TO THE FLORIDA DEPARTMENT OF ELDER AFFAIRS

THE FOURTH JUDICIAL CIRCUIT ELDER AND VULNERABLE ADULT ABUSE FATALITY REVIEW TEAM

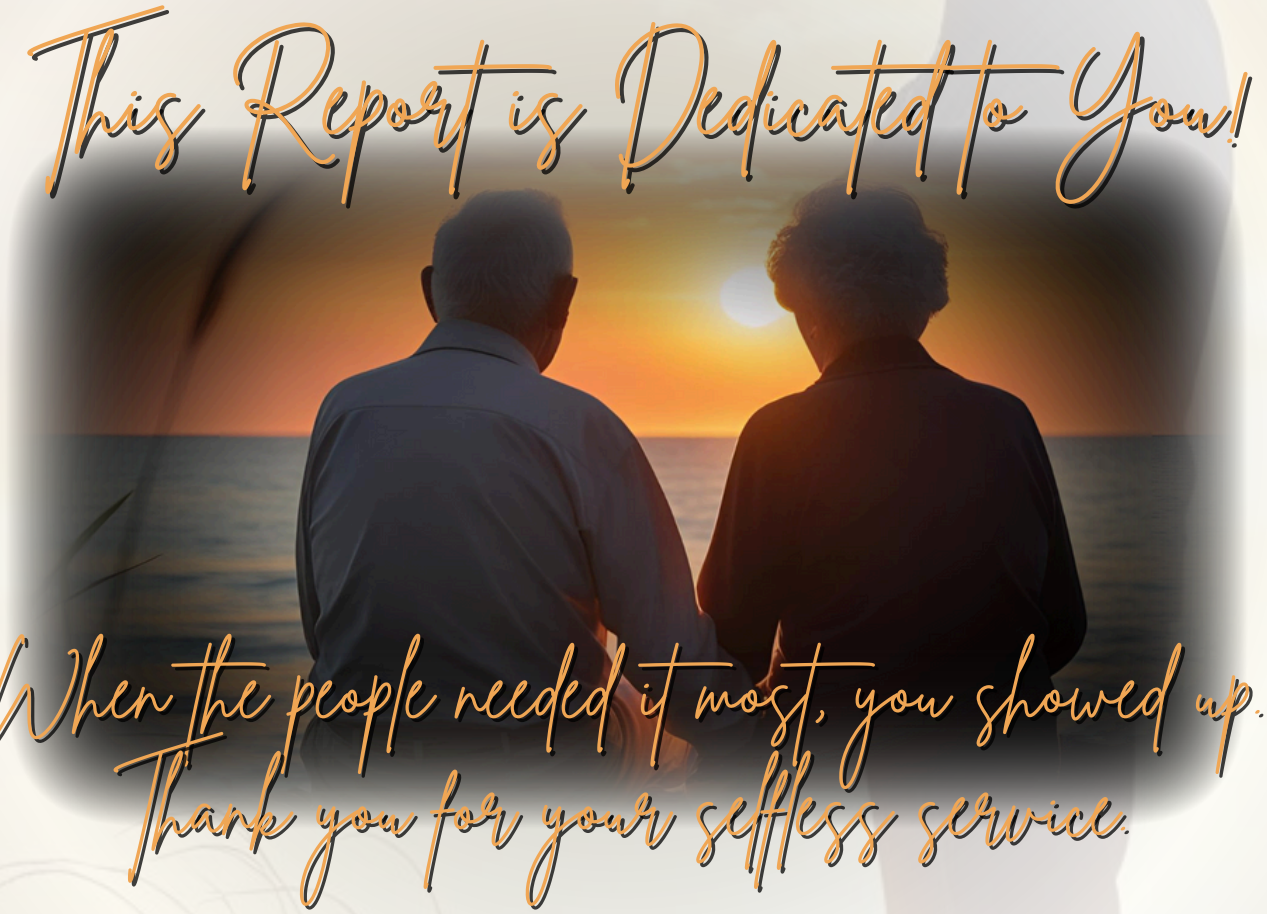
September 2025

The Executive Committee of the Fourth Judicial Circuit's Elder and Vulnerable Adult Abuse Fatality Review Team (hereafter simply referred to as the EV-FRT as a named entity) would like to thank each of the EV-FRT's members for their contributions over the past several years on this first of its kind Florida fatality review team.

Participation on the EV-FRT is voluntary, and the work of our members frequently extends beyond the normal professional responsibilities and working hour commitments of our members. For many of us, participating on this Team is a labor of love.

Being the first is never easy, but the perseverance and successes of this EV-FRT continue to pave the way for our colleagues across the state who remain committed to combatting elder and vulnerable adult abuse. None of which would be possible, of course, without the hard work and dedication of our amazing team members.

To our fellow team members (both past and present):



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-Chairs.

This report is respectfully submitted this August 29, 2025, 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.

2024 - 2025 ELDER AND VULNERABLE ADULT ABUSE FATALITY REVIEW TEAM

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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 elders and vulnerable adults by public and private agencies which may be related to incidents reviewed by the team.

(d) Whenever possible, develop communitywide 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) (2024).

2025 EXECUTIVE SUMMARY

"Our Society must make it right and possible for [older and vulnerable adults] not to fear the young or be deserted by them, for test of a civilization is the way that it cares for its helpless members" Pearl S. Buck [2]

The Co-Chairs of the EV-FRT would like to build on the foundational work outlined within this Fifth Annual Report which highlights the need for prevention, advocacy, and accountability in cases of elder and vulnerable adult abuse – particularly in those cases which ultimately end in the deaths of such vulnerable persons. Many of the findings and recommendations provided in this report reflect the ever-evolving challenges and legislative landscape which affect Florida's vulnerable adult population and the equity in services and protections they receive.

This year the Team was able to identify and review two relevant cases of abuse, exploitation, and neglect that are believed to have (at the very least) *contributed-to* the deaths of two "elderly persons" within Florida's Fourth Judicial Circuit. These case reviews are integral to the stated purpose and objectives of the Team to "learn how to prevent elder and vulnerable adult abuse and abuse-related deaths…", [3] as well as with developing "recommendations and potential changes in law, rules, and policies to [better] support the care of elders and vulnerable adults and to prevent abuse of such persons." [4]

It is worth noting that neither of the cases reviewed by the Team this year involved the immediate deaths of the victims, nor were either of the cases ever pursued as abuse-related homicides – nonetheless these cases fell within both the letter and spirit of the law which governs elder and vulnerable abuse fatality review teams in this state.[5] We draw special attention to these facts because, as one poignantly titled investigative report originally pointed out *(Gone Without a Case: Suspicious Elder Deaths Rarely Investigated)*, "[w]hen it comes to the elderly, the system errs by omission." [6] There can be no doubt that elder abuse and neglect increase mortality and hasten death in older adults,[7] and yet our traditional criminal justice investigation tools frequently fail to link an elderly person's premature death to prior abuse when the victim languishes for weeks, months, or even years following the initial reported abuse. "Because of gaps in government data, it's impossible to say how many suspicious cases have been written off as natural fatalities. However, the limited evidence available points to a significant problem." [8]

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[2] Quote from Pearl S. Buck, Buck, P.S. (2008). *The Good Earth.* Paw Prints..

[3] *Supra* note 1 at (1)(d).

[4] *Supra* note 1 at (5)(e).

[5] *Supra* note 1.

[6] Chisun Lee, A.C. Thompson, and Carl Byker, *Gone Without a Case: Suspicious Elder Deaths Rarely Investigated*, Frontline PBS, https://www.pbs.org/wgbh/frontline/article/gone-without-a-case-suspicious-elder-deaths-rarely-investigated/ (last visited Aug. 14, 2025).

[7] Lachs, M.S., C.S. Williams, A. O'Brien, et al., Aug. 5 1998, "The Mortality of Elder Mistreatment," *Journal of American Medical Association*, Vol. 280, No. 54.

[8] *Supra* note 6.

When the American Bar Association (ABA) and Office for Victims of Crime first published a replication manual and made the case for creating elder abuse fatality review teams across the U.S., they described the ultimate goal of such teams to "foster examination of and improvement in the responses of [agencies and providers] to the growing numbers of victims of elder abuse."[9] And as the Florida Legislature wisely included in its own description of the purpose for elder and vulnerable adult abuse fatality review teams established in Florida, the goal is to improve "the system response to elder and vulnerable adult *abuse, exploitation and neglect*" – not just the deaths or fatalities that such forms of abuse may hasten or cause. [10]

Thanks to the open and honest discussion by the members of the EV-FRT of system flaws and suggestions for improvement identified in these two case reviews, we hope this report will serve solely to learn from the past to identify gaps in law, policies, and operating procedures with the hopes of making changes "to support the care of elders and vulnerable adults and to prevent the abuse of such persons."[11] We hope this Fifth Annual Report reflects Florida's ongoing commitment to safeguarding elders through a lens of reform, awareness and community resilience. By learning from the cases, we review and acting on new insights, the state takes another stride toward justice and improved elder care and victim outcomes.

We are proud that our Team continues to serve as a model for the state and strives to inspire stakeholders from other circuits in Florida to create more elder and vulnerable adult abuse fatality review teams across the state. More teams will prevent future tragedies in their respective circuits and communities – what could be better for our state's most vulnerable citizens?

[9] Lori A. Stiegel, J.D., *Elder Abuse Fatality Review Teams: A Replication Manual,* American Bar Association Commission on Law & Aging, https://www.americanbar.org/content/dam/aba/administrative/law_aging/fatalitymanual.authcheckdam.pdf (last visited Aug. 14, 2025).

[10] *Supra* note 1 at (1)(d).

[11] *Supra* note 1 at (5)(e).

METHODOLOGY FOR CASE SELECTION

Cases reviewed by the EV-FRT were identified and selected by the Chair of the Case Review Subcommittee, Special Prosecution Deputy Director Octavius Holliday of the Fourth Circuit State Attorney's Office (SAO). Cases reviewed by the EV-FRT were identified after a charging decision was made, and the case was disposed of by the SAO.

The EV-FRT reviewed two fatality cases during the 2024-2025 Team year. One of the cases reviewed by the Team (Case Review No. 2) occurred within the past calendar year (2024), while the other case reviewed by the Team (Case Review No. 1) stemmed from an offense that occurred in late 2017, in which the Victim languished under the Suspect's care until she passed away in early 2020. While the Suspect in Case Review No. 1 only pled guilty to the charge of Exploitation of an Elderly Person, the EV-FRT reasonably concluded that the Victim's steady physical and mental decline in the aftermath of the Suspect's neglect certainly "caused or contributed to"[12] her death.

As mentioned in last year's EV-FRT report,[13] while fatality review teams commonly focus on cases originating from the year prior to the date of the report, this EV-FRT continues to include older cases for fatality review that were not previously identified or screened by the Team. The two cases identified and reviewed by the 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 for review by the Team continue to fall short of the suspected scope of recent vulnerable adult abuse-related deaths in the Team's jurisdiction.

In last year's report, the EV-FRT described how securing adequate statutory protections for cases reviewed by this Team delayed the implementation and execution of clear case identification and review processes. Now, with the benefit of time and reflection, the EV-FRT has determined that it may be appropriate to revise these processes to allow more cases to be identified and screened by the Team going forward. Some areas for improvement to the EV-FRT's case identification, screening, and selection processes have been provided in this methodology section below.

Prior to drafting these suggested changes to the EV-FRT's methodology, members of the Report Drafting Subcommittee met with and interviewed several key members of the Duval County Domestic Violence Fatality Review Team (DVFRT) to obtain a better understanding of this long-standing team's processes. Members of the subcommittee then summarized and compared team processes in an effort to identify the best practices to implement in the future for the EV-FRT.

[12] Fla. Stat. § 415.1103 (1)(a)

[13] Fourth Annual Report to the Florida Department of Elder Affairs (2024).

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 a 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, 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.	• Recently, a new team member and representative of the SAO (Debbie Chastain) created a similar checklist for materials needed in EV-FRT case reviews.

Proposed Changes in EV-FRT Methodology

1. Identifying all cases of elder and vulnerable adult abuse, neglect, and exploitation, including those not immediately determined to be fatal.

2. Regularly reviewing arrest dockets in the 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. Working closely with Adult Protective Services (APS) team members to track cases of elder and vulnerable adult abuse referred to the SAO and/or local law enforcement (including non-fatal cases), as potential cases to be screened by the EV-FRT for further review.

4. Amending the name of the Case Review Subcommittee to the Case Screening Subcommittee, as well as changing the primary purpose of this subcommittee to the initial screening of elder and vulnerable adult abuse cases (including non-fatal cases), which may become appropriate for full fatality case review in the future.

5. Eliminating the use of the Case Review Subcommittee and revising the responsibilities of all EV-FRT members to participate in fatality case reviews.

Findings and Recommendations

Through the EV-FRT's review of the two fatality cases described in this report the Team was able to identify areas for potential policy changes and/or improvement to existing practices which are identified in Findings and Recommendations No. 1 - 7. However, the EV-FRT's findings and subsequent 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.

The EV-FRT identified several obstacles in relevant state statutes and the practical application of these statutes which the EV-FRT believes have hampered our ability to properly detect and identify cases for review. Consequently, Findings and Recommendations No. 8 - 9 of this section are not tied to specific fatality cases reviewed but are nevertheless relevant to "support[ing] the care of elders and vulnerable adults and to prevent[ing] abuse of such persons." [14]

Case-Specific Findings & Recommendations

Finding No. 1 – The involvement of multiple agencies and providers can dilute responsibilities and lead to a failure to provide timely intervention and assistance to victims of elder/vulnerable adult abuse. (Case Review No. 1)

In Case Review No. 1, we outlined how various agencies and stakeholders were engaged with investigating or aiding a vulnerable adult victim over the course of at least four months, however the victim continued to remain in an unsafe environment with the perpetrator until the time of his arrest several months later.

When multiple agencies and organizations are involved in a case of vulnerable adult abuse, it is easy for each to focus exclusively on their own limited purpose or role – like investigating alleged abuse, building a criminal case, or providing a specific service to the vulnerable adult. The danger of this approach is that each professional assumes that the other professionals involved will address important problems when they arise because they perceive it as being "somebody else's job." This is not to suggest the professionals don't care about the vulnerable adult, but rather that they become uncertain or unsure as to what they can or should do within their professional roles.

Working in professional silos falls short of the multidisciplinary approach we hope to encourage in the future through the work of the EV-FRT because it impedes what should be the ultimate goal of all parties involved – protecting the vulnerable person.

[14] Fla. Stat. § 415.1103 (5)(e) (2025).

Recommendation No. 1 – Vulnerable adult investigations and intervention should have multidisciplinary teams that coordinate services amongst various agencies and providers to ensure the vulnerable adult's wellbeing and protection is prioritized, similar to Child Protection Teams in Fla. Stat. § 39.303.

Cases like those reviewed by the EV-FRT this year underscore the need for better collaboration and coordination between agencies and providers when it comes to vulnerable adult cases.

The use of Child Protection Teams to coordinate the services, care, and protection of children believed to be abused or neglected is well-established under Florida law. In fact, Florida law requires that one or more Child Protection Teams be established in each of DCF's services areas across the state.

Chapter 39, Florida Statutes – the child protective equivalent of Ch. 415 for vulnerable adult protection – emphasizes the need to provide a "protection system that reflects a partnership between the department, other agencies, the courts, law enforcement agencies, service providers, and local communities."[15] Recognizing the multidisciplinary needs of children in need of social services and protection by the State calls for a system that always prioritizes the health and safety of the person above all else.

If the professionals involved in Case Review No. 1 had access to a Vulnerable Adult Protection Team at the time, it is likely that victim intervention would have occurred earlier – providing the Victim with adequate care and supervision, as well as preventing the Suspect from continuing his exploitation of the Victim's finances. A Vulnerable Adult Protection Team would have ensured that the Victim's issue of financial needs (i.e., guardianship) was addressed sooner, which *may have* prevented the extent of financial hardship suffered in the case.

Additionally, if a Vulnerable Adult Protection Team had been available and used in Case Review No. 1, it is likely that the Suspect's continued exploitation of the Victim following his arrest would have been detected and addressed sooner. Such a team approach would have likely led to the Suspect's arrest on new charges of exploitation and an immediate revocation of his bond.

Finding No. 2 – The interference with agencies and providers in assisting a vulnerable adult victim leaves professionals in a stalemate and the victim without critical services. (Case Review No. 1)

In Case Review No. 1, we described how the Suspect prevented the Victim from receiving essential in-home care from providers after it had been ordered by APS. Unfortunately, this is not the first case in which the EV-FRT found a Suspect impeding efforts to assist a vulnerable adult victim, and the various members of this Team recognize this to be a recurring issue in the field. However, our Team members

[15] Fla. Stat. 39.001 (1)(c) (2025).

also acknowledge that preventing a vulnerable adult from receiving services through otherwise non-criminal conduct (e.g., refusing to answer the door for providers or telling providers the services are no longer wanted), creates a challenging situation for all involved.

Recommendation No. 2 – Stakeholders should be trained on how to respond to the intentional interference with essential services for a vulnerable adult in connection to a vulnerable adult protection investigation or action, which may necessitate the arrest and prosecution of the party responsible for such interference.

While interfering with vulnerable adult community services is not explicitly a violation of Florida criminal law, the consequences of such conduct (e.g., the continued neglect of a vulnerable adult) effectively make such conduct criminal. Therefore, all stakeholders should be trained to report the intentional interference with services in connection with a vulnerable adult protective investigation to law enforcement.

Moreover, given the regularity of such occurrence, there should be an automatic case alert or trigger response for APS and law enforcement when service providers report that services have been intentionally obstructed. This should automatically reopen the case for APS, if it has already been closed, as further investigation is now warranted.

Finding No. 3 – Criminal justice professionals in Florida are not trained in addressing the complex, multidisciplinary needs and issues of vulnerable adult abuse cases. (Case Review No. 1)

In Case Review No. 1, we found that the Victim's safety and protection was not adequately addressed in the criminal case (i.e., following arrest and during the criminal prosecution of the Suspect). For example, we found that following the Suspect's arrest, while the criminal court issued an order of No Contact with the Victim, the court did not address the Suspect's authority under a durable power of attorney (DPOA) for the Victim. While it is unclear whether the criminal court was aware of this DPOA at the time of addressing the Suspect's conditions of pretrial release, this case highlights a gap in traditional training and education for criminal justice professionals.

Even if the court had been aware of the Suspect's abuse of a DPOA in this case, a *criminal* judge might not know that a provision of *civil* statute [Fla. Stat. § 709.2116 (1)] grants them the authority to take appropriate action as to the DPOA *sua sponte* and within the context of the criminal case.

While criminal investigators, prosecutors, and judges in Florida typically receive education and training on best practices and legal resources unique to other specialized categories of crimes (e.g., domestic violence), they do not commonly receive such training or guidance when it comes to criminal vulnerable adult abuse cases. This constitutes a major gap in existing procedures and practices.

Recommendation No. 3 – Standard criminal justice training and education should include specific guidance on protecting the safety of victims and the community in cases of vulnerable adult abuse.

Criminal justice training for vulnerable adult abuse cases should provide guidance to criminal courts and prosecutors on pretrial release conditions that are unique to the nature of the abuse – for example, in a case of exploitation, the court should be trained to suspend positions of power and authority that a perpetrator may utilize to continue the exploitation of the victim following his/her arrest.

Likewise, criminal justice training and processes should be tailored to prevent a perpetrator from leveraging or accessing exploited funds or property to secure his or her release on bond. There are insufficient safeguards currently to flag or stop this from occurring automatically – if this cannot be remedied, criminal justice professionals must be trained to research sources of funds and property used to secure bail.

Finding No. 4 – An agent's authority under a DPOA is not affected by the agent's arrest in connection with an abuse of this position. (Case Review No. 1)

While Chapter 709, Florida Statutes, articulates that exploitation or abuse of or by the agent of his or her authority provided by a DPOA constitutes grounds to revoke or terminate an agent's authority, it does not provide any automatic safeguards upon the agent's arrest in connection with abusing his/her authority. This appears to be a gap in existing law that can be easily remedied.

Recommendation No. 4 – An agent's authority provided by a DPOA should be automatically suspended upon the arrest of that agent when the underlying offense involves charges of theft, fraud, or exploitation – particularly when those charges are linked with the beneficiary of the DPOA.

While a court may be required to revoke a DPOA outright, the agent's arrest based upon probable cause that he has committed some type of fraud or theft, should automatically suspend his authority until such time as the appropriate court is able to review and rule on the issue.

Finding No. 5 – The lack of coordinated communication between state agencies hampers the ability of professional and regulatory agencies from acting quickly in cases of criminal vulnerable adult abuse. (Case Review No. 1)

In Case Review No. 1, we discovered that the Suspect's occupation and licensing may have allowed him to access sensitive investigative information, as well as permitted him continued access to other vulnerable persons. Unfortunately, the record was bare when it comes to the notification of relevant state agencies of his arrest and the nature of his pending charges, however based on the experience of members of the

Team, there is no automation or transparent process when it comes to notifying state agencies of such a criminal arrest. This is a gap which we should be capable of addressing in this new technological age.

Recommendation No. 5 – Criminal arrests for offenses under Chapter 825, Florida Statutes, and for other crimes related to vulnerable adult abuse should be mandatorily provided to relevant state licensing and regulatory agencies that may have supervision or authority over the suspect's license or profession.

Whether this is a requirement under statute for the courts or the SAO to provide such notification, or achieved through an automated system by use of an interagency arrest notification – this process needs to be streamlined, and one or more stakeholders clearly tasked with ensuring it is carried out.

Finding No. 6 – Existing practices (or the absence of such practices) prevents the detection of elder abuse-related fatalities in cases where death does not immediately follow the abuse. (Case Review No. 2)

Oftentimes in cases of vulnerable adult abuse, particularly with cases involving neglect, the victim will not die close in time to the discovery of such abuse. In fact, in many cases of elder and vulnerable adult abuse we see victims placed promptly into emergency-, and subsequently institutionalized-, care in the wake of such abuse. In nearly every case, once hospitalized/institutionalized, the victim's physical and mental conditions continuously decline until the time of his or her death. There can be no doubt in such cases that the victim's abuse hastened his/her death and reduced his/her remaining quality of life. However, these cases are seldom investigated as homicides or linked as abuse-related fatalities. This is because of two primary issues we've identified: a lack of long-term monitoring by state agencies and systems, coupled with a lack of thorough medical examination or autopsy.

The system set up for vulnerable adult protection in Florida is predicated on prompt intervention and fast closures of cases. The focus of APS in such cases is quite simply to remove the imminent threat of harm to the vulnerable adult, thereby resolving the case. In other words, once a victim is hospitalized or removed from a dangerous setting and determined to be safe, the objectives of social services have been met, and there is no further monitoring of the victim's health or condition by APS.

Likewise, the criminal justice system is not designed to follow a victim's condition long-term based on the possibility the victim's ultimate death may at some indeterminate point in the future be linked to his/her abuse.

The only other traditional mechanism for monitoring long-term medical conditions and subsequently identifying homicides would be through medical practitioners and examinations. Unfortunately, as we've discussed throughout this report, the cause of death is presumed to be natural or the result of a co-occurring condition

(e.g., advanced age, chronic health conditions, etc.) in most cases of death for older and vulnerable adults. The easy assumption of natural causes for an older or vulnerable adult's death in most cases means autopsies are rarely conducted in such cases. And, even if an autopsy were to occur, unless the ME is aware of the prior abuse to the victim and its potential link to the victim's death, they are unlikely to flag such a death as suspicious or a suspected homicide.

Recommendation No. 6 – The deaths of older and vulnerable adults with previously documented abuse should be automatically flagged for further investigation by a medical examiner.

While it is unlikely that every case of vulnerable adult abuse is linked to that vulnerable adult's subsequent death, our understanding that such abuse has been directly linked to the mortality of vulnerable adults warrants closer examination and review of available medical records and evidence. For deaths occurring closer in time to the abuse (within 12 months), an autopsy should be mandated to determine its connection with the abuse.

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. (Case Review No. 2)

Recommendation No. 7 – The State of Florida should launch a statewide public awareness campaign, led by DCF to educate Floridians on what constitutes abuse, neglect, and exploitation, as well as the requirements to report such abuse and how to make a report.

The EV-FRT recommends using a variety of media platforms to achieve necessary awareness and connection with the diverse populations and demographics in our state. We'd also suggest using real case scenarios which demonstrate the signs of abuse and highlight the potential consequences to the vulnerable adult when others fail to report.

Systemic Findings & Recommendations

Finding No. 8 – The EV-FRT continues to face challenges due to the continued 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 domestic violence, *related domestic violence matters and suicides.*" [16]

The limited authority or purview of the EV-FRT by statute which prevents the Team from reviewing near-fatal cases, suicides, and other related cases of abuse impair the EV-FRT's ability to perform its essential functions – namely identifying cases appropriate for review.

Recommendation No. 8 – The EV-FRT's statutory authority should be amended to be commensurate with those provided to DVFRT's, including the ability to review *near-fatal incidents, 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 abuse (e.g., attempted homicide, severe neglect, critical medical events), including suicides, particularly where elder abuse, isolation, or exploitation are believed to be contributing factors.

This amendment would enable a more holistic understanding of elder and vulnerable adult fatalities – 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.

Finding No. 9 – Interagency communication and coordination are hampered by the use of different, siloed, and incompatible case management systems, as well as the slow process of migration to new systems, which impairs each agency's capabilities.

The EV-FRT looked into the available systems of several stakeholder agencies involved in vulnerable adult abuse cases, particularly between APS, law enforcement, and the SAO – which are all mandated by Fla. Stat. § 415.104 to communicate and collaborate with one another on such cases. The Team found that each agency utilized its own unique case management tracking software and processes when it comes to cases of abuse. For the most part these systems are not compatible with one another, and these agencies are unable to access one another's systems to check on the status or progress of a shared case.

[16] Fla. Stat. § 741.316

Additionally, several agencies have either recently migrated to a new case management system or are preparing to do so at this time. With agencies that had recently migrated to a new system, we found that the agencies lacked full capabilities with these systems either due to a lack of training and familiarity with the new software, or aspects of functionality were not yet been built or resolved. As for agencies preparing to migrate to new systems, they were reluctant to invest time and resources into improving the capabilities of a dated system.

In both scenarios, the result was a lack of ability to evaluate and improve collaboration between agencies. In fact, the EV-FRT was unable to determine how existing interagency reporting is occurring under Fla. Stat. § 415.104, let alone whether it is effective or could be improved upon.

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.

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.

EV-FRT recommends one or more agencies (government and/or receiving government funds) to collect reports/data which services was denied to the victim and ensure the appropriate agencies are aware of services being denied. The warehousing and monitoring of the denied services could assist with removing the caregiver or moving the victim to another residence which the services would be accepted.

The cases presented to EV-FRT for review are closed/historical. Thus, the findings and recommendations are after the event and cannot be corrected for the victim. The findings and recommendations on this report may be accepted as “Lessons Learned” going forward to engage all local, state, and federal agencies, not-for-profit organizations, and private organizations to make the effort which would aid the victim. In Florida, we’re all mandatory reporters. “See something, say something “applies and should be reported internally and to the appropriate external agencies. Those who depend on others for care should have access and protection to ensure their health and safety are not being compromised.

Case Review No. 1

Date of Death: 03/01/2020

Victim: Female, Age 85

Suspect: Male, Age 53

Offense: Count 1: Neglect of Elderly Person or Disabled Adult

Count 2: Exploitation of an Aged Adult (Less Than $10,000)

Disposition: Count 1: Nolle Pros

Count 2: 12/18/2018 - Pled Guilty/Withhold Adjudication; four days in County Jail w/credit for time served; 18 months' probation with special conditions to not interfere with services for Victim's care and have no access as Power of Attorney. The suspect was further ordered to pay court costs.

I. CRIME(s)

A. RELATIONSHIP Mother/Son (cohabitating)

B. CASE SUMMARY

The Victim lived with her son, the Suspect, who was her caregiver and agent with a Durable Power of Attorney (DPOA). September 2017, she was discharged from a nursing home, and it was determined that she could not be left home alone and needed in-home services due to her significant vulnerabilities.

Following the Victim's release from nursing facility care she was enrolled in a case management program through a local in-home senior care agency responsible for providing care for the Victim. The in-home senior care agency scheduled their case management team to meet with both the Victim and the Suspect to determine what services would need to be in place for the Victim. Suspect failed to show up for 3 consecutive scheduled home visits that were to take place beginning November 2017. Due to the Suspect's interference and refusal of services the Victim was terminated from the program mid-December 2017, but the Victim continued to contact the agency several times to report that she had been left home alone and needed help.

The agency made a report to the Florida Department of Children and Families (DCF) and Adult Protective Services (APS) investigated the complaint and made a verified finding of neglect. The APS investigation indicated that the Victim's personal hygiene had been allowed to deteriorate and that the conditions in the home were very unhealthy. It was also determined that the electricity bill had not

been paid by the Suspect and that conditions in the home had worsened as a result. As part of the investigation by APS, the Victim was removed from the care of her son and placed with another relative.

APS made a report to the law enforcement who undertook an investigation which resulted in an arrest warrant being issued on January 31, 2018. As a result of a search warrant, the Suspect was arrested on February 5, 2018, and initially charged with abuse, aggravated abuse, neglect of an elderly person or disabled adult. He was held on a bond of $50,000 and further ordered not to have contact with the Victim.

The criminal case was filed by the SAO on February 15, 2018, with upgraded two count charges of neglect of elderly person or disabled adult and a second charge of exploitation of an aged adult.

As to the exploitation charge, it was determined that the Victim's bank account was overdrawn and that mortgage and utility payments were missed, despite her having a healthy pension income. Mortgage payments ceased in May 2018 and foreclosure was filed in October 2018. Official records reflect that the Suspect still had DPOA over the Victim's finances during this time-period.

The Suspect entered a plea agreement, and the case was disposed of on December 19, 2018. Suspect pled guilty/withhold adjudication; four days in county jail w/credit for time served; comply with all standard conditions of ordered 18 months' probation in addition to; 25 community service hours; cost of supervision waived; submit to random urinalysis; court cost in the total amount $766.00; not interfere with services for Victim's care and retain no access as power of attorney for the Victim.

The Victim died two years later in March of 2020.[17]

C. CHILDREN PRESENT N/A

D. LOCATION Jacksonville, Florida

II. CRIMINAL HISTORY

A. Victim: No Record

B. Suspect: History

1. 11/14/2014 Making Threats (Harm to Person or Property) (Not Victim) – Not Filed

2. 06/22/2012 Trespass or Trespass Warning Issued (Not Victim) – Not Filed

[17] This case was reviewed by the EV-FRT due to the victim experiencing a consistent decline in her health and wellbeing following the events described herein. While this case was not charged as a homicide, the team reasonably suspects that the Victim's death was hastened by the neglect and exploitation by the Suspect

3. 10/23/2011 Simple Assault/Battery (Not Victim) – Not Filed

4. 09/12/1996 Simple Assault/Battery (Not Victim) – Not Filed

5. 07/04/1996 Violation of an Injunction for Protection Against Domestic Violence (Victim) – Nolle Pros

III. CIVIL RECORDS AND REPORTS

A. Victim: See Other Concerns for Relatable Details

B. Suspect: See Other Concerns for Relatable Details

IV. SERVICES

A. Victim: History

1. 09/2017 In-Home Senior Care Agency Case Management Program – Referral Terminated 12/2017 due to the Suspect's interference. (See Other Concerns for Relatable Details)

2. 06/2018 Registered Professional Guardianship Program – Successful placement and ordered (See Other Concerns for Relatable Details)

B. Suspect: None Found

V. OTHER CONCERNS

September 29, 2017 – DCF reported to police that the Victim's son was exploiting her due to having her DPOA. Suspect was supposed to help the Victim with her bills because she suffers with mental limitations. The Suspect took all the Victim's money out of the bank and her electricity was disconnected. Police responded and the Victim's home was registering at 103 degrees. The victim was upset about her son's actions.

October 11, 2017 – Police and Rescue personnel were called to the Victim's home. The Victim had fallen and was unable to move. They forced entry into her home and transported her to a local hospital. The Victim was home alone. The Suspect was called and notified of the incident.

November 2017 – As stated in the Case Summary the Victim was enrolled in services with an in-home senior care agency. Several attempts were made by the in-home senior care agency to meet with the Victim and the Suspect to assess her needs. The Suspect repeatedly missed these appointments.

December 2017 – The Victim was terminated from the in-home senior care agency, despite calls a couple of times a week for three weeks from the Victim asking for assistance as she was left home alone. The report indicates that the Victim did not know what to do in the event of an emergency.

December 12, 2017 – Police responded to the Suspect's place of employment in reference to an auto theft. The Suspect told police that when he got ready to leave to go home, the car was gone. The registered owner of the vehicle was the Victim, however Suspect stated she was in a nursing home and no longer drove the vehicle. On December 27, 2017, Police saw the vehicle at a residence and inquired with the resident of the home. She called for the Suspect, and he came to the door and told Police that he learned Victim's vehicle was repossessed and he just got it back.

February 5, 2018 – Pursuant to the search warrant, Suspect was arrested, the Victim was placed in the care of another family member. When police spoke to a different family member, he stated that he believed that the Suspect had been using the Victim's money to buy drugs. This family member also stated that Suspect would not allow him to visit the Victim because he had raised issues about the Victim's care with the Suspect. This family member stated that the Victim has trouble getting around and recalling events that made her vulnerable to abuse. The family member also indicated that he believed his options were limited because the Suspect was the listed Agent under a DPOA for the Victim.

Further analysis of the criminal and civil case records, as well financial records provided by the Victim's bank suggest that the Suspect retained his authority under the DPOA for the Victim for several months following the date of his arrest for neglect and exploitation in this case. Bank records reflect that the Suspect was removed from the Victim's bank account prior to the filing of criminal charges (as early as September of 2017), but there is no indication the Suspect's authority as a DPOA was addressed in 2017. The criminal court record for this case is devoid of any mention of the Suspect's authority under the DPOA until the time of the Suspect entering a plea – 10 months following the date charges were filed by the SAO.

While the APS report for this matter reflects the Victim's placement with another relative for her safety and wellbeing, it does not appear that social services addressed the issue of the Suspect's continued authority under the DPOA, nor do we have any records to suggest the Victim's relative took any steps to obtain guardianship or control as the Victim's fiduciary.

May 10, 2018 – APS reported that other relatives were taking the Victim out of the initial facility she was placed in. The relatives and non-relatives were taking the Victim to the bank to further exploit her financially. It is alleged in this report that the Suspect was using others by proxy to obtain access to the Victim's funds. As a result, the Victim was placed in a local locked and secured adult living facility to ensure all her needs were being addressed and to ensure no one would be able to take her out without prior authorization.

APS referred Victim to a Registered Professional Guardianship Program to establish emergency guardianship to ensure she received proper and needed care. Civil court records reflect that the program guardian filed a petition for guardianship over the Victim was filed in May 2018 and that a probate court appointed a professional guardian to oversee the financial needs of the Victim in June 2018. At the time of

appointing the professional guardian, the probate court also finally orders to suspend the Victim's DPOA naming the Suspect as her agent. This is approximately 4 months following the date of charges being filed against the Suspect by the SAO.

May 11, 2018 – The APS findings from May 10, 2018, were reported to the SAO; this resulted in a motion to revoke defendant's bond filing with the court. The motion to revoke defendants bond indicates that the State would show the defendant was charged with neglect of an elderly person, that no victim contact was a condition of the defendant's bond, and that the defendant continued to have indirect contact with the Victim through various relatives. The court calendared a hearing on the motion to revoke bond for May 16, 2018, which was rescheduled for June 13, 2018. Court's ruling on motion is not available for case review, but it is known the Suspect remained out on bond.

May 2018 – Part of the exploitation investigation in this case involves the unpaid mortgage payments for the Victim's home during the time she was in the care of the Suspect and while the Suspect was still clearly exercising and abusing his authority under the DPOA. Unfortunately, following the Suspect's arrest and during the pendency of the criminal case, it appears the Victim's home mortgage payments continued to go unpaid. The Victim's mortgagee filed a Notice of Default on the Victim's mortgage in May of 2018, and the Victim's home was subsequently foreclosed upon in December 2018. Given the confusion described above, as to who (if anyone) was acting as fiduciary for the Victim immediately following the Suspect's arrest, the review team is unable to determine who was responsible for managing payments for the Victim's mortgage for at least a 4-month period. This appears to have been an oversight that went unnoticed and unaddressed in both the criminal and social services cases. Despite her having a healthy pension income it is unclear whether the Victim's regular income to her account following the arrest of the Suspect would have been enough to cover her unpaid mortgage payments and other needs collectively, but it is concerning that the Victim's financial affairs were not apparently managed for this 4-month period.

Case Review No. 2

Date of Death: 09/11/2024

Victim: Female, Age 88

Suspect: Male, Age 63

Offense: Count 1: Abuse/ Neglect of an Elderly Person

Disposition: Count 1: 10/25/2024 – Arrest Warrant Denied; No Prosecution

I. CRIME(s)

A. RELATIONSHIP Mother/Son (cohabitating)

B. CASE SUMMARY

On September 11, 2024, law enforcement responded to a call concerning domestic disturbance. The disturbance involved a dispute between the relatives of an elderly woman (Victim) who had passed away that day while in hospice care. The relatives were trying to remove the Victim's son (Suspect) from the Victim's house.

One of the relatives told the officer that they had a video that showed the Suspect physically abusing the Victim in August of 2024. When asked why they did not report the abuse in August, they stated that they had talked to a lawyer from another state who told them that they could not use the videos recorded in the house as evidence. They also stated that the Suspect had threatened to harm her in the past, but that they had not reported these threats to law enforcement at the time they were made. The relatives further stated that they were taking care of the Victim as a family and that the Suspect had not been appointed the sole caregiver.

The officer advised the relatives and the Suspect that the Suspect could not be removed from the house until an eviction or unlawful detainer was ordered by a court. He also provided the relatives with the means to share the video with law enforcement.

The video dated July 26, 2024, shows the Suspect degrading the Victim verbally and arguing with her about how he takes care of her. At two points during the video, the Suspect physically grabs and redirects the Victim's head back to maintain eye contact with him.

One of the relatives told police in a subsequent conversation stated that she believed the Suspect's treatment of the Victim had contributed to her death; however, her doctors did not indicate this as a contributing cause.

The officer made a referral to the SAO with a request for an arrest warrant. Upon review by the SAO, a determination was made that the actions of the Suspect did not rise to the level of a probable cause that a crime had been committed, and no further criminal action was warranted.

C. CHILDREN PRESENT N/A

D. LOCATION Jacksonville, Florida

II. CRIMINAL HISTORY

A. Victim: No Record

B. Suspect: No Record

III. CIVIL RECORDS AND REPORTS

A. Victim: None Found

B. Suspect: None Found

IV. SERVICES

A. Victim: None Found

B. Suspect: None Found

V. OTHER CONCERNS

One of the biggest challenges in cases of elder abuse where the Victim languishes for days, weeks, or even months after the offensive conduct is proving that the abuse was a direct cause of or contributing factor to the Victim's death. In this case the Victim's doctors did not indicate any traumatic injury caused by the Suspect or that the Victim's death was in any way hastened by the Suspect's abuse. In the absence of an autopsy the review team is unable to determine definitively that the Victim's death was caused or contributed to by the abuse. And, even if an autopsy had been performed, the Victim's other existing medical conditions and frailty associated with her advanced age would have made it difficult for a medical examiner to testify as to the exact harm caused directly by the Suspect.

If the Victim's abuse had been reported to DCF and investigated earlier, it is possible that such intervention might have prevented or delayed the Victim's death; however, this remains unclear from the records available in this case.

A. Member Spotlights

Judge Gary P. Flower

The EV-FRT is proud to celebrate one of its own: Duval County Judge Gary P. Flower, the 2025 recipient of the Florida Chief Justice Award for Judicial Excellence.

Each year, this prestigious award honors one county court judge and one circuit judge who exemplifies the very best of the judiciary. Judge Flower's recognition is a testament to his unwavering commitment to justice, integrity, and public service.

In presenting the award, Chief Justice Carlos Muñiz of the Florida Supreme Court remarked that the nominating materials for Judge Flower showed how he exemplifies the professional responsibilities of a judge, and the standards expected of the legal profession.

"Judges have a duty to live up to the highest ideals of public service. We all are trying to achieve excellence, to be supportive colleagues, and to always put service to the people first," Chief Justice Muñiz said. "Judge Flower clearly demonstrates these qualities. He has shown himself to be a judge all of us can look to as a model of professionalism and commitment to our highest standards."

Colleagues who nominated Judge Flower spoke passionately of his impact. One wrote, "Over the course of his 25 years of service as a Duval County Court judge, Judge Flower has shown a genuine dedication and commitment to improving the judicial branch, and its jurists, with a special emphasis on judicial education." Another noted, "To say Judge Flower has had an immeasurable impact through his teachings and mentorship on a vast portion of the state judiciary would be an immense understatement. It is my opinion that such teachings and mentorship will be Judge Flower's legacy for years to come."

Judge Flower has served on the county court bench since 2000, including four terms as administrative judge. He has held leadership roles as president and chair of education for the Conference of County Court Judges, co-department head for the Advanced College of Judicial Studies, and faculty member at the Florida Judicial College. He also serves as Vice Chair of Florida's Judicial Qualifications Commission (JQC).

A founding member and current co-chair of the EV-FRT, Judge Flower has been a driving force behind the group's mission even before its creation in 2020. He helped establish the EV-FRT's precursor, the Duval County Coordinated Community Response to Elder Abuse (CCR), led by the Women's Center of Jacksonville. For this important work, he was honored in 2019 with the Delores Barr Weaver Elder Advocacy Award from CCR partner ElderSource.

Before his appointment to the bench, Judge Flower served as an assistant state attorney, magistrate, child support hearing officer, and private attorney. He earned his law degree from Stetson University College of Law in Gulfport, Florida.

Judge Flower often says, “People are not my burden to bear but my privilege to serve.” Those words speak volumes about the heart he brings to his work—and the deep respect he inspires in all who serve alongside him.

RECIPIENT OF THE
2025 CHIEF JUSTICE AWARD
FOR JUDICIAL EXCELLENCE

Karen C. Murillo

The EV-FRT is both honored and proud to celebrate one of our own, Karen C. Murillo, as she dedicates more time to her powerful advocacy work for Florida's elder and vulnerable adult community in her role as Associate State Director of Advocacy for AARP Florida.

From her inception with the EV-FRT, Karen has demonstrated an impressive depth of knowledge and a genuine passion for the well-being of our state's elderly population. Her enthusiastic approach to legislative drafting and review processes has been characterized by determination and meticulous attention to detail. Karen's steadfast commitment to justice is commendable.

We would like to honor Karen as an Elder Justice Champion, recognizing the profound value she brings to her collaborations. Her professional trajectory, which began with her undergraduate studies at the University of Central Florida and advanced through her law degree at the University of Miami School of Law, is truly inspirational. Her experience with the Palm Beach County State Attorney's Office and the Florida Office of the Attorney General exemplifies her unwavering dedication continuing to serve citizens with AARP Florida. Karen's career seamlessly blends the rigor of legal expertise with heartfelt compassion—qualities that are invaluable in today's legal landscape.

The concept of a "Great Cloud of Witnesses" [18] is often discussed, and in Karen's case, this Cloud consists of a multitude of elder advocates whom she has mentored and inspired. Her keen sense of ethics, paired with an openness to diverse perspectives, has significantly uplifted our state's most vulnerable citizens. Every group she has joined and every team she has supported has seen the benefits of her involvement; those she has influenced emerge more empowered and capable, continuing the legacy of her impactful guidance.

True assistance is often characterized by selflessness. It is crucial that we actively support victims and their families both physically and emotionally. Instead of merely discussing challenges, we must engage in volunteering, connect with those affected, and seek practical ways to uplift their spirits and enhance their well-being. Additionally, advocating for the rights of victims and survivors facing vulnerabilities is essential. We must ensure they receive the support they need, allowing their voices to be heard and their needs addressed. Karen's career trajectory and ongoing endeavors epitomize this commitment and fervor.

As former President Ronald Reagan wisely noted, "We have problems in our country, and many people are praying and waiting for God to do something. I just wonder if maybe God isn't waiting for us to do something. And while no one else is capable of doing everything, everyone is capable of doing something." [19]

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[18] Hebrews 12:1-2.

[19] Quote from President Ronald Reagan (April 13, 1982), The Ronald Reagan Presidential Foundation & Institute, *Remarks on Private Sector Initiative at a White House Luncheon for National Religious Leaders*, https://www.reaganfoundation.org/ronald-reagan/quotes/we-have-problems-in-our-country-and-many-people-are (last visited Aug. 20, 2025).

This is an opportune moment for us to make a meaningful difference. We are the advocates for those who have been silenced, and together, it is imperative that we remain united in our support for one another.

We extend our sincere gratitude for her tireless dedication, which reflects the highest form of support for those we may never meet.

Karen, we extend our sincere gratitude for your exemplary and selfless contributions through tireless dedication, which reflects the highest form of support for those we may never meet. Though you will always be just a phone call or email away, your presence will be deeply missed.

It has been, and will continue to be, a privilege to witness your ongoing progress in advocacy, where you will relentlessly champion the rights of others with unwavering dedication and a selfless spirit.

GRATITUDE.

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[20] 140-2 § 1-7(e) – 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.

Children & Families Operating Procedures 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.

[20] Children & Families Operating Procedures (CFOP).

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 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. Description of Team Committees and Subcommittees

The EAFRT was established on July 1, 2020, by the Florida Legislature (Florida Statute 415.1103) further amended on July 1, 2023, by the Florida Legislature changing the name of the review teams to Elder and Vulnerable Adult Abuse Fatality Review Teams (EV-FRT) to reflect an added change in scope.

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.

- **Administrative and Management Subcommittee**: The Administrative and Management Subcommittee is responsible for determining the eligibility for membership and training.

- **Case Review Subcommittee**: The Case Review Subcommittee is led by a representative from SAO. The SAO representative determines which cases are available to be reviewed by the members of the team. The Case Review Subcommittee will provide case summaries to the full membership prior to inclusion in the annual report.

- **Report Drafting Subcommittee**: The Report Drafting Subcommittee is responsible for drafting the annual report each year before September 1. The EV-FRT Co-Chair's will submit the final report to the Florida Department of Elder Affairs.

- **Parliamentarian**: The Parliamentarian is responsible for ensuring the rules of order and proper procedures are conducted during the meetings.

D. 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. 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 dysfunctioning, 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).

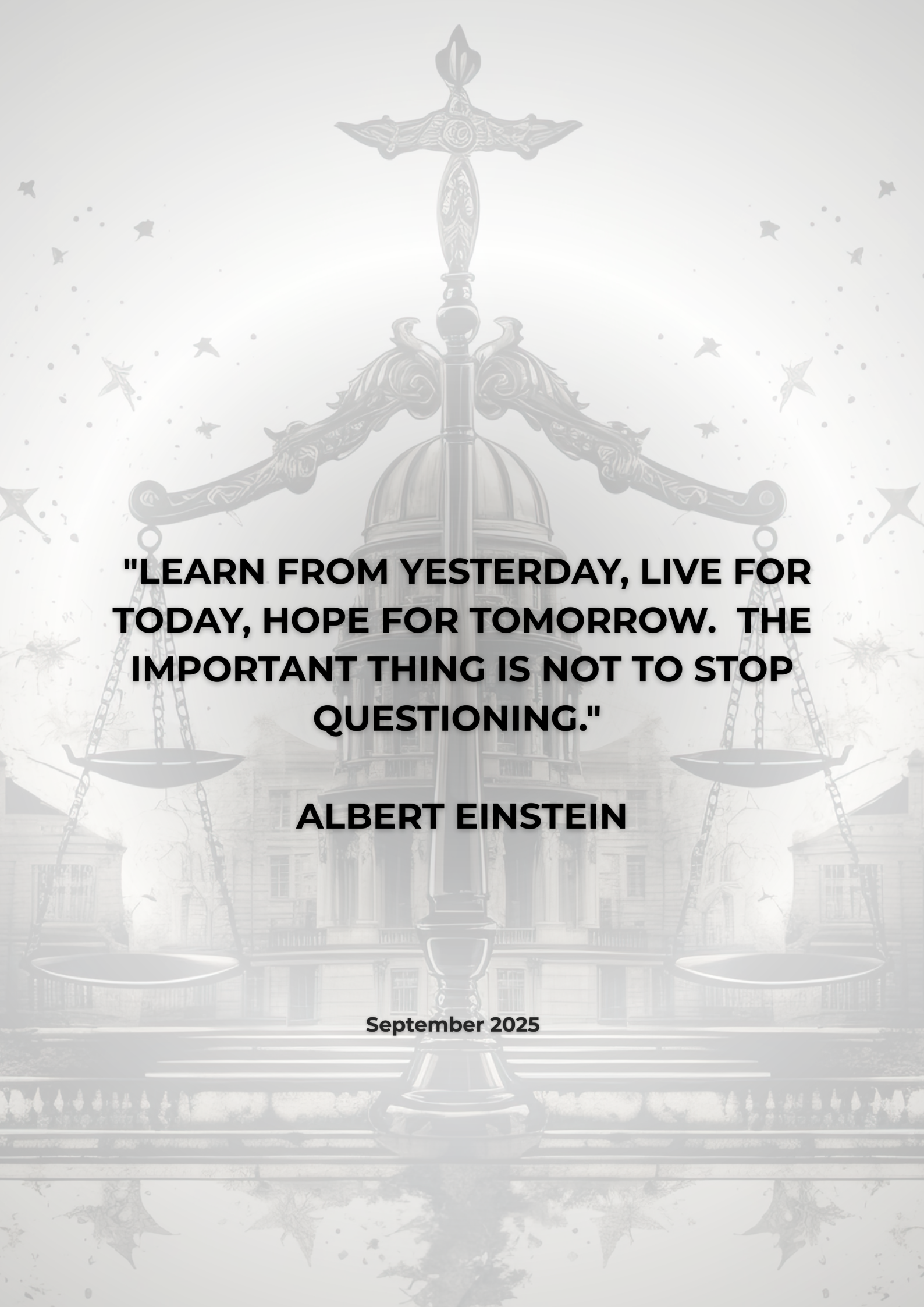
- Vulnerable Adult. A person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or 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).

E. Abbreviations and Acronyms

*Note: Acronyms used for the below-listed departments and agencies refer specifically to Florida departments and agencies unless otherwise stated.

ABA	American Bar Association
APS	Adult Protective Services
AARP	American Association of Retired Persons
CCR	Coordinated Community Response
CFOP	Children & Families Operating Procedures
DCF	Department of Children & Families
DOH	Department of Health
DPOA	Durable Power of Attorney
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)
N/A	Not Applicable
ME	Medical Examiner
OAG	Office of the Attorney General (Florida)
SAO	Office of the State Attorney for the 4th Judicial Circuit



"LEARN FROM YESTERDAY, LIVE FOR TODAY, HOPE FOR TOMORROW. THE IMPORTANT THING IS NOT TO STOP QUESTIONING."

ALBERT EINSTEIN

September 2025