FOURTH ANNUAL REPORT TO THE FLORIDA DEPARTMENT OF ELDER AFFAIRS

THE FOURTH JUDICIAL CIRCUIT ELDER ABUSE FATALITY REVIEW TEAM

SEPTEMBER 2024

Remembering Jody Brandenburg

This year we lost our dear colleague, Joseph (Jody) A. Brandenburg, whose commitment to the Elder Abuse Fatality Review Team was among his many acts of service to the community, especially to elders. Jody's long experience and expertise in the funeral industry was invaluable to the Team, and his understanding and encouragement as a colleague and friend enriched us all immeasurably.

In mourning his death, we will honor his life and work by rededicating ourselves to the vital mission of this Team, which he so generously supported with his time and talents.

Respectfully submitted this August 30, 2024, by the Fourth Judicial Circuit Elder Abuse Fatality Review Team (EAFRT).

For more information regarding the Fourth Judicial Circuit EAFRT, please visit the official website of the Office of the State Attorney for the Fourth Judicial Circuit at sao4th.com.

2023 - 2024 ELDER ABUSE FATALITY REVIEW TEAM

Executive Committee

Team Co-Chair
Hon. Gary P. Flower
Administrative County Court Judge,
Duval County, Florida
Co-Chair of Administrative &
Management Subcommittee

Team Co-Chair
A.J. Mack
Records Servicing Manager,
VyStar Credit Union
Administrative & Management
Subcommittee

Diane Clark,
Lead Education Specialist,
Hubbard House
Co-Chair of Administrative &
Management Subcommittee, Co-Chair
Report Drafting Subcommittee

Linda Levin, M.S.G.,
Chief Executive Officer,
ElderSource, Inc.
Administrative & Management
Subcommittee, Case Review
Subcommittee

Karen Murillo,
Associate State Director of Advocacy,
AARP Florida
Co-Chair of Report Drafting
Subcommittee

Octavius Holliday,
Special Prosecution Director,
Human Rights Section, Fourth Circuit
State Attorney's Office
Chair of Case Review Subcommittee

Cindy Chambers,
Program Administrator,
Victim Services,
Office of the Florida Attorney General
Case Review Subcommittee

Team Members

Sgt. Branden Senters, Special Victims Unit, Clay County Sheriff's Office

Carl Harms, CA, Program Specialist, Victim Services, Office of the Florida Attorney General, Report Drafting Subcommittee

Sgt. Gary Porter, Special Assault Unit, Jacksonville Sheriff's Office, Case Review Subcommittee

Gregory Patient, Fourth Circuit Program Administrator, Adult Protective Services, Florida Department of Children & Families, Case Review Subcommittee

Jody Brandenburg, President, Hardage-Giddens Funeral Homes and Cemeteries

Kristin Gonzales, D.N.P., A.P.R.N., Baptist AgeWell Center for Senior Health

Mike Jorgensen, Managing Partner & Senior Counsel, Attorneys at Law, P.A.

Nicholas Milliron, Victim Services Director, Fourth Circuit State Attorney's Office

Det. Patrick Vitellaro, Robbery-Homicide Unit, Clay County Sheriff's Office

Paul Kellam, C.P.M., Northeast Region Director, Adult Protective Services, Florida Department of Children & Families

Randy Wyse, President, Jacksonville Association of Firefighters

Renae Lewin, Victim Specialist, Fourth Circuit State Attorney's Office, Case Review Subcommittee

Dr. Robert Buschbaum, M.D., Forensic Pathology Specialist, Fourth Circuit Medical Examiner's Office

Teresa Miles, Executive Director, Women's Center of Jacksonville, Case Review Subcommittee

Tracie Rayfield, District Ombudsman Manager, First Coast District, Long-Term Care Ombudsman Program

Travis Alessi, Fourth Circuit Operations Program Administrator, Adult Protective Services, Florida Department of Children & Families

CONTENTS

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 death of such person.*

(b) Take into consideration the events leading up to a fatal incident, available community resources, current law and policies, and the actions taken by the 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).

Executive Summary

"What have I done today to lighten the burden upon those who suffer?"
– Senator Claude Pepper

This report reflects the end of the EAFRT's fourth year in operation.

Of course, many of the members of this team have been working for much longer than the past four years to protect the safety and wellbeing of older adults in Florida – in some cases for several decades.

Members and allies of this team fought for years simply for the authority to conduct elder abuse-related fatality case reviews in the first place, which have been standard practice with domestic violence-related fatalities in Florida for over twenty years. These same members and allies then continued the fight – this time to obtain sufficient privacy protections for the victims and families at the center of the cases we reviewed (again modeling a standard practice that has been in place for over twenty years in domestic violence fatality case reviews).

Even those who are newer to this mission have enthusiastically embraced the challenges associated with being on a first-of-its-kind elder justice team in our state. And how could they not, when our work "to care for those who once cared for us is one of the highest honors"? [2]

Our team has worked tirelessly over the past four-plus years to create, assemble, grow, and enhance the EAFRT for the people of Nassau, Duval, and Clay Counties. Everything – from the composition of the EAFRT membership to the development of the team's policies, procedures, and processes – reflect the time, dedication, and perseverance of this team.

We are very proud of the work this EAFRT has accomplished thus far, and we're excited to see what we accomplish in the year(s) ahead.

We hope that Governor DeSantis, Secretary Branham, and Secretary Harris, as well as the leadership of the Florida Legislature, see the value of this team's work, as briefly outlined within the pages of this report.

We hope too that our allies within Florida's Department of Elder Affairs (DoEA), Department of Children & Families (DCF), Department of Health (DOH), and Agency for Health Care Administration (AHCA), remain committed to the mission shared by this EAFRT (and others, as they're established across the state) to identify new ways to "support the care of elders and vulnerable adults and to prevent abuse of such persons [in Florida]." [3]

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[2] Quote by Tia Walker. Speers, P., & Walker, T. (2013) *The Inspired Caregiver: Finding Joy While Caring for Those You Love. CreateSpace Independent Publishing Platform.*

[3] Florida Statute § 415.1103(5)(e) (2024).

Methodology for Case Selection

Cases reviewed by the EAFRT were identified and selected by the Chair of the Case Review Subcommittee, Octavius Holliday. Mr. Holliday also serves as the official team designee of the Fourth Circuit State Attorney's Office (SAO).

Both cases reviewed by the EAFRT were identified after a charging decision had been made, and the case disposed of, by the SAO. Both cases pertained to fatalities occurring in 2022.

While domestic violence fatality review teams typically review cases originating from the year prior to date of the report (e.g., Jan.-Dec. 2023 for report published in 2024), the EAFRT had to go further back to identify cases appropriate for fatality review.

One of the reasons that the 2023-2024 EAFRT reviewed two fatalities occurring over a year prior the date of review is because attempts at case reviews in previous years had to be postponed due to problems with the then-existing state statute (Fla. Stat. § 415.1103). The necessary Sunshine Law and public records law exemptions needed to protect confidential case-related information were added to the elder abuse fatality review team statute[4] in 2023 by Senate Bills 1540 and 1542. The EAFRT was only able to fully conduct each case review after the law finally went into effect on July 1, 2023.

With the expanded options provided by Senate Bills 1540 and 1542 for identifying and selecting elder abuse-related cases appropriate for fatality review the EAFRT may consider revising its methodology for fatality case selections in the future.

[4] Florida Statute § 415.1103 (2024).

Findings and Recommendations

Both cases reviewed by the EAFRT involved elder abuse and/or neglect spanning over a period of time, in one case at least a week and in the other over a few months. In each case the team identified missed opportunities for earlier intervention and, perhaps, prevention of the elderly person's death.

Finding No. 1:

A primary takeaway by this EAFRT is that communication between all providers and professionals within an older adult's system of care is critical to preventing elder abuse and abuse-related deaths. This means that we must remove silos between care providers, case managers, and social services, including those caused by differences in terminology, policies, and case/care tracking processes (i.e., databases).

> For example, contracted providers with the DoEA (e.g., local area agencies on aging and lead agencies for Community Care for the Elderly), have some degree of access for reporting case updates and concerns through the APS Referral Tracking Tool (ARTT). This tool is utilized by the DCF's Adult Protective Service (APS) unit to track referrals for services and care. However, Florida's Statewide Medicaid Managed Care (SMMC) program does not appear to interface with ARTT – even though one of the necessary services that a client of APS may require is SMMC. This gap between case management systems appears to limit the communication, oversight, and follow up that could take place when it comes to SMMC referrals.
>
> This example is particularly relevant because, as we see in Case Review No. 2, while SMMC was contacted regarding services for an elderly person (which could have revealed signs of serious neglect before the elderly victim required hospitalization), they were also blocked from providing services to the elderly person by a second-party perpetrator (i.e., the criminally responsible adult child and caregiver of the victim). Had SMMC relayed this information to APS, additional steps could have potentially been taken for follow up, which may have identified the neglect sooner. Unfortunately, these separate agencies and organizations lacked a shared system or process for tracking and sharing information regarding individual clients, so this elderly person's declining health was not caught in time to prevent her subsequent hospitalization or death.

Recommendation No. 1: All agencies, programs, and providers involved in the care of older adults should have access to a shared, uniform system or database for tracking the care provided to each elderly client.

Finding No. 2:

Due to the use of separate and frequently inaccessible databases, processes, and procedures for monitoring the care and wellbeing of older adult clients by providers, the EAFRT is unable to identify or recommend specific procedures to address "gaps, deficiencies, or problems in the delivery of services to elders and vulnerable adults by public and private agencies..."[5]

Based on the information available to the EAFRT, it does not appear that we have created the necessary checks and balances within the elder care system (at large) to identify and respond to warning signs of potential abuse or neglect.

> For example, the EAFRT is unaware of any standard or requirement that a provider like SMMC must notify APS or any other agency if they are prevented from providing care to a vulnerable adult. This does not mean that such a policy does not exist within SMMC, but it does mean that despite the collaboration and research of the multiple disciplines on this EAFRT (see membership list on pages ii and iii), the team could not identify any such policy. This in and of itself is a problem or gap that should be addressed.

Recommendation No. 2: In addition to sharing information through uniform reporting systems (see EAFRT Recommendation No. 1), there should be clear and transparent procedures for reporting and responding to warning signs of elder abuse (e.g., being denied access to provide medical assessment and care). These procedures should be applied to all agencies and providers within the elder system of care, to create checks and balances to prevent a failure by any one individual (e.g., not reporting the denial of access to a client) from preventing follow up by the system as a whole.

Finding No. 3:

Prior incidents of elder abuse, neglect, or exploitation (regardless of case disposition) are relevant to a risk assessment with the caregiver responsible for providing care to a vulnerable adult.

> Within the professional caregiving industry, there is a greater chance that an individual's history of injunctions, arrests, and convictions pertaining to elder abuse would disqualify such a person from being hired as a caregiver. However, when it comes to individuals caring for a friend or family member in a personal capacity, the background of that caregiver is unlikely to be questioned until they are suspected of

[5] Florida Statute § 415.1103(5)(c) (2024).

committing a new case of abuse - far too late to help a vulnerable, elderly person in their care.

When the elder care system becomes involved in providing services, supports, or care to an elderly person, or when an investigation into potential vulnerable adult abuse arises, the background of the caregiver should be researched and factored into decisions made regarding that elderly person's safety and care. This does not mean that a family member serving as a caregiver would be disqualified from continuing to provide care, but it should be flagged as a warning sign or indicator for potential future elder abuse.

Recommendation No. 3: When the elder care system is contacted to provide services, care, or investigations pertaining to a vulnerable adult who is reliant on assistance from a caregiver, the system should carefully consider the caregiver's history in how it provides services, care, and necessary follow up.

Case Review No. 1

Date of Death: 3-15-2022

Victim: Male, Age 77
Defendant: Male, Age 44

Charge: Aggravated Neglect of Elderly and/or Disabled Adult
Disposition: The State Attorney's Office offered a plea deal for six months for a charge of Neglect of an Elderly Person which the defendant refused. After the Defendant had served nine months in jail awaiting trial, the State Attorney's Office dropped the case with the filing of a Nolle Pros.

I. CRIME

A. RELATIONSHIP Parent/Child

B. CASE SUMMARY

The Victim was under the care of his adult son (Defendant). The Victim's condition had been deteriorating over several months. Evidence indicated that the Victim was very difficult with the Defendant, and the Defendant reported that his father would refuse outside help. The Victim and the Defendant didn't live at the same residence. The Defendant reported that he would check on his father every day at least twice a day, but the Victim was left alone when his son was absent. According to the Defendant, after an argument, for several days prior to November 15, 2021, the Defendant did not visit the Victim, leaving him alone and without help during this period.

On November 15, 2021, Jacksonville Fire and Rescue was dispatched to the residence of the Victim, and he was transported to a local hospital where he was admitted with multiple serious medical conditions and injuries. He was discharged to a skilled nursing facility on January 5, 2022, where he remained until his death on March 15, 2022. The Medical Examiner listed Manner of

Death as an "Accident," and noted a reported history of falls. The Medical Examiner listed Cause of Death as "Complications of blunt force chest trauma, with bilateral rib fractures and chronic respiratory failure, status post-cardiac arrest(s)."

After the Victim's hospitalization on November 15, 2022, investigations were conducted by the Department of Children and Families, the Jacksonville Sheriff's Office, and the State Attorney's Office. The Defendant was arrested on February 15, 2022, and charged with Neglect of an Elderly Person or Disabled Adult. The State Attorney's Office's amended that charge to Aggravated Neglect of an Elderly Person or Disabled Adult on March 15, 2022, the date of the Victim's death.

C. CHILDREN PRESENT N/A
D. LOCATION Jacksonville, Florida

II. CRIMINAL HISTORY-None

III. CIVIL RECORDS AND REPORTS

A. Victim: None
B. Defendant: None

IV. SERVICES

A. Victim: None
B. Defendant: None

V. OTHER CONCERNS

There is no record of involvement of any outside agencies in the months leading up to the Victim's hospitalization in November of 2021.

Case Review No. 2

Date of Death: 1-27-2022

Victim: Female, Age 89
Defendant 1: Male, Age 49
Defendant 2: Female, Age 56

Charge: Aggravated Neglect of Elderly and/or Disabled Adult
Disposition: Both Defendants entered a plea of guilty to the court on a lesser included charge of Neglect. Both Defendants were Adjudicated Guilty and sentenced to twenty-nine days incarceration, with credit for twenty-nine days time served.

I. CRIME

A. RELATIONSHIP 1 Parent/Child
RELATIONSHIP 2 Girlfriend/Partner of Defendant 1

B. CASE SUMMARY

The Victim was under the care of her adult son (Defendant 1) and the girlfriend of the adult son (Defendant 2). Evidence indicated that the Victim lacked capacity and was bedbound, needing a high level of care. The Victim and Defendants lived in the same residence. Evidence indicated that the Victim was not provided reasonable care and lived in environmental hazards.

On January 25, 2022, Defendant 1 failed to admit a home health aide to the home. Defendant 1 didn't answer the door. On January 26, 2022, the Victim's primary care physician sent an ARNP to the Victim's residence, and no one answered the door.

On January 27, 2022, the Victim was transported to a local hospital's emergency room via ambulance. Hospital staff reported that she was unresponsive, covered in feces and urine, with severe weight loss, skin breakdown, and sores. The Victim died on January 27, 2022.

Investigations were conducted by the Department of Children and Families, the Jacksonville Sheriff's Office, and the State Attorney's Office. Both Defendants were charged with Aggravated Neglect of an Elderly or Disabled Adult.

C. CHILDREN PRESENT N/A
D. LOCATION Jacksonville, Florida

II. CRIMINAL HISTORY

Defendant 1 had several alcohol related charges and one battery charge (not against the Victim).

Defendant 2 had three prior arrests (in 2016, 2017, and 2019) for Battery on a Person 65 Years of Age or Older against the Victim in this case. Defendant was also previously arrested for contacting the Victim in violation of probation for the 2017 offense.

III. CIVIL RECORDS AND REPORTS

A. Victim: None
B. Defendant: None

IV. SERVICES

A. Victim: The record indicates that services by a home health aide and the Victim's physician's office were ordered, but it does not appear these services were received due to being denied access to the Victim.
B. Defendant: None

V. OTHER CONCERNS

There are questions about the extent of communication between the service provider(s). There are also concerns about one of the caregivers for the Victim (Defendant 2) having three previous arrests for battery against the Victim.

Looking Forward

We started out by reflecting on the work of the EAFRT from the past four-plus years and appreciating how much this group has accomplished as a pioneer in Florida's elder justice landscape. We now turn our focus to what's ahead for the EAFRT for the 2024-2025 team year and beyond.

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

- The EAFRT is currently reviewing our case selection methodology and exploring different methods for identifying qualifying elder abuse fatality cases in our area that have not yet been prosecuted and/or do not qualify for criminal prosecution (e.g., perpetrator committing suicide).
- The EAFRT plans to update our new member orientation materials and process to account for recent changes to state law and key takeaways identified by the EAFRT in our work over the past four years.
- The EAFRT has already begun revising and updating our template case review form to incorporate additional details deemed relevant by the team.

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

Finally, at a state level, this EAFRT 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 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 at identifying and intervening in situations where individuals are at the greatest risk of experiencing elder abuse and abuse-related deaths.

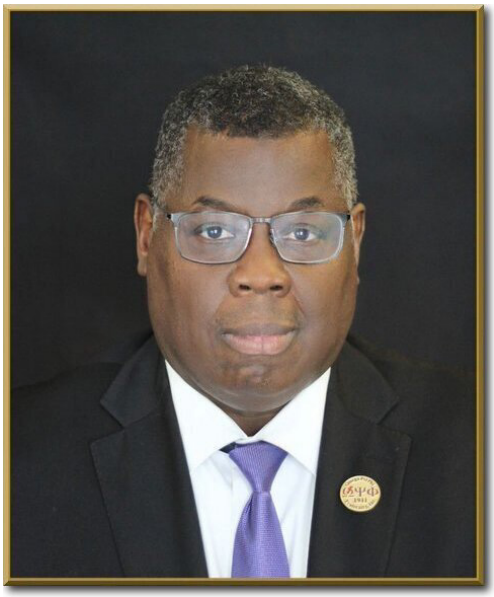
A. Team Member Spotlight

The EAFRT is pleased to recognize the accomplishments of one of its own members, Assistant State Attorney Octavius Holliday.

Octavius Holliday, a director in the Fourth Circuit State Attorney's Office Special Prosecution Unit and head of the Human Rights Division, was named the 2024 Claude Pepper Outstanding Government Lawyer. This statewide honor is given to an outstanding Florida attorney who has made "an extraordinary and exemplary contribution as a practicing government lawyer" with at least 10 years of government practice. The award is named in honor of Claude Pepper, a Florida attorney, U.S. Senator, and U.S. Representative with a long legacy of fighting for the dignity of older Americans.

Mr. Holliday has more than 16 years of public service experience and serves the greater Jacksonville community outside of work through robust volunteerism. He is the Vice President of the Jacksonville Graduate Chapter of Omega Psi Phi Fraternity, Inc. and oversees all chapter committees, including its award-winning in-school mentoring committee and the Lamplighter Male Mentoring Program. Mr. Holliday has been a member of 100 Black Men of America's Jacksonville Chapter since 2009.

State Attorney Melissa Nelson describes Mr. Holliday as an excellent prosecutor in the courtroom, a leader in the State Attorney's Office, and community-focused ambassador outside of work. State Attorney Nelson also called him a dedicated public servant who is "extremely worthy of this prestigious recognition." [6]



[6] Office of the State Attorney for the Fourth Judicial Circuit of Florida. (2024, June 21). SAO4'S PROSECUTORS SWEEP OUTSTANDING GOVERNMENT LAWYER AWARDS [Press Release]. https://sao4th.com/media/l2vnhpjg/sao4-release-octavius-holliday-marcus-isom-win-outstanding-government-lawyer-awards.pdf

B. Relevant Legal Authority

Florida Statute § 15.104 – 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 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.

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).

The following EAFRT 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 an Assistant State Attorney (ASA) from the Office of the State Attorney. The ASA will determine which cases are available to be reviewed by the members of the team. The team will prepare case review reports for the full membership to review to review and vote for inclusion on the annual report.

- **Report Drafting Subcommittee:** The Report Drafting Subcommittee is responsible for drafting the annual report each year before September 1. The full membership is to review and adopt the report prior to submission 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 abuse or neglect of the vulnerable adult. – CFOP[7] 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).

- 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).

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

- 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).

- 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 *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).

"THE DISTRESSING CRIME OF ELDER ABUSE OFTEN OCCURS IN QUIET, PRIVATE SETTINGS, MAKING A VOCAL, PUBLIC RESPONSE THAT MUCH MORE IMPORTANT."

UNITED NATIONS SECRETARY-GENERAL BAN KI-MOON

SEPTEMBER 2024