The Fourth Judicial Circuit
Elder Abuse Fatality Review Team

Second Annual Report to the Florida Department of Elder Affairs

September 2022

This report is dedicated to the incalculable number of vulnerable older adult Floridians who died as a result of some form of elder abuse, as well as to the loved ones of those fallen elders, and to those who work each and every day to prevent and investigate these abuses.

– Hon. Gary P. Flower, Duval County Court Judge, and Linda J. Levin, CEO, ElderSource, Inc. – Chairpersons for the Fourth Judicial Circuit Elder Abuse Fatality Review Team

Respectfully submitted this September 1, 2022 by the Fourth Judicial Circuit Elder Abuse Fatality Review Team (EAFRT).

For more information regarding the Fourth Judicial Circuit EAFRT, please visit our website at https://www.sao4th.com/resources/for-the-public/elder-abuse-fatality-review-team-eafrt/.

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Our Mission

"(3) An elder abuse fatality review team shall do all the following:

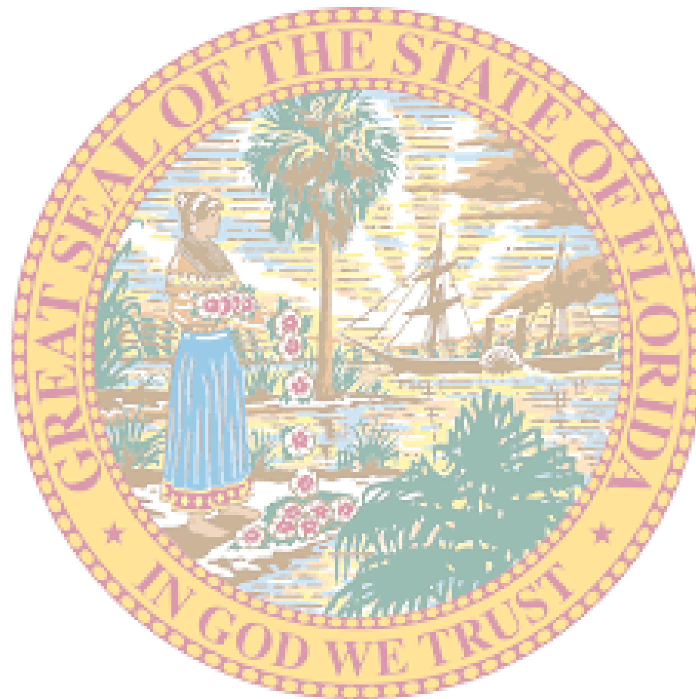
(a) Review deaths of elderly persons in its judicial circuit which are found to have been caused by, or related to, abuse or neglect.

(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.

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

(d) Whenever possible, develop communitywide approaches to address the causes of, and contributing factors to, deaths reviewed by the team.

(e) Develop recommendations and potential changes in law, rules, and policies to support the care of elderly persons and to prevent elder abuse deaths."[1]



[1] Purpose statement is provided directly from Florida Statute § 415.1103, which authorizes each judicial circuit to form its own elder abuse fatality review team.

Executive Summary

"Elder abuse is a silent problem that robs seniors of their dignity, security, and – in some cases – costs them their lives."[2]

The National Council on Aging estimates that up to 5 million older Americans suffer from some form of elder abuse every year.[3] Research by the World Health Organization suggests 1 in 6 older adults (60 years of age or older) suffer from elder abuse worldwide.[4] Recent studies in the U.S. indicate that the prevalence of elder abuse may have increased by as much as 84% since the beginning of the COVID-19 pandemic.[5]

Elder abuse increases the average senior's risk of death by as much as 300%.[6] Abuse in older adults is a global public health problem steadily increasing each year. As the global population of adults age 60 and older will more than double over the next 30 years, the number of elder abuse victims is anticipated to increase by *at least* 45%.[7] And yet, despite the overwhelming and steadily increasing rate of elder abuse, the availability of reliable research into the incident rates and intervention responses of elder abuse is considerably lacking at the state and national levels.[8]

There are many contributing factors to the deficit of reliable data on elder abuse (and consequently elder abuse fatalities), which include the lack of cohesive and standardized definitions of elder abuse, discrepancies

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[2] National Council on Aging. (2021, Feb. 23). *Get the Facts on Elder Abuse*. https://www.ncoa.org/article/get-the-facts-on-elder-abuse

[3] National Council on Aging. (2021, Feb. 23). *Get the Facts on Elder Abuse*. https://www.ncoa.org/article/get-the-facts-on-elder-abuse

[4] World Health Organization. (2022, June 13). *Abuse of older people*. https://www.who.int/news-room/fact-sheets/detail/abuse-of-older-people#:~:text=Around%201%20in%206%20people,abuse%20in%20the%20past%20year (2017 assessment which reviewed over 50 studies across 28 countries.).

[5] World Health Organization. (2022, June 13). *Abuse of older people*. https://www.who.int/news-room/fact-sheets/detail/abuse-of-older-people#:~:text=Around%201%20in%206%20people,abuse%20in%20the%20past%20year

[6] National Council on Aging. (2021, Feb. 23). *Get the Facts on Elder Abuse*. https://www.ncoa.org/article/get-the-facts-on-elder-abuse

[7] World Health Organization. (2022, June 13). *Abuse of older people*. https://www.who.int/news-room/fact-sheets/detail/abuse-of-older-people#:~:text=Around%201%20in%206%20people,abuse%20in%20the%20past%20year

[8] Burnes, D., MacNeil, A., Nowaczynski, A., Sheppard, C., Trevors, L., Lenton, E., Lachs, M. S., & Pillemer, K. (2021). *A scoping review of outcomes in elder abuse intervention research: The current landscape and where to go next. Vol. 57* (101476), 1-8. https://www.sciencedirect.com/science/article/pii/S1359178920301804?via%3Dihub=

between anticipated intervention outcomes in cases of elder abuse,[9] and perhaps most significantly, the critical underreporting and under-investigation of elder abuse cases nationally. It is estimated that for every case of elder abuse reported to authorities, 24 additional cases go unreported and undetected.[10] It's important to note that this disquieting statistic on reporting provides no information regarding probability of a successful investigation for the 1 in 24 cases of elder abuse actually reported.

Unfortunately, Florida follows this national trend of an overall scarcity of information available regarding the scope and impact of elder abuse across the state. Historically, no single agency, organization, or workgroup has been tasked with collecting statistics on the many different forms of elder abuse occurring within the Sunshine State. Unlike domestic violence statistics, which are uniformly identified, tracked, and reported by the Florida Department of Law Enforcement each year, the annual scope of elder abuse is not consistently identified or tracked by law enforcement or social services in Florida. Thankfully in 2020, the State of Florida took a monumental first step towards remedying this data deficit by authorizing the creation of elder abuse fatality review teams across the state through Florida Statute § 415.1103.

Fatality review teams are unique because they offer a *wide angle, multidisciplinary case stud[y] conducted in a climate that promotes open discovery of information. Review teams obtain information on deaths from multiple sources for their discussions on the often extremely complex death events. Teams are comprised of individuals with expertise relevant to the deaths and from agencies and services representing death investigation, public health, medicine, law enforcement, social services, mental health, education and many others.*[11] As we've identified previously in our statewide efforts to combat domestic violence and child abuse, and related deaths, the only way to effectively identify, assess, and respond to these insidious and often hidden forms of abuse is through a multidisciplinary response.[12]

Thanks to the tireless work of lawmakers and elder justice advocates, Florida now has the *potential* to begin identifying cases of elder abuse (in all its forms), regardless of how a case may have originally been reported or identified. The codification of Florida Statute § 415.1103 was an important *first step* towards responding to elder abuse fatalities, but additional steps are required for Florida's elder abuse fatality review teams to identify and

[9] Burnes, D., MacNeil, A., Nowaczynski, A., Sheppard, C., Trevors, L., Lenton, E., Lachs, M. S., & Pillemer, K. (2021). *A scoping review of outcomes in elder abuse intervention research: The current landscape and where to go next. Vol. 57* (101476), 1-8. https://www.sciencedirect.com/science/article/pii/S1359178920301804?via%3Dihub=

[10] National Center on Elder Abuse. (n.d.). *Research, Statistics, and Data – Prevalence of Mistreatment*. Retrieved August 30, 2022, from https://ncea.acl.gov/What-We-Do/Research/Statistics-and-Data.aspx#prevalence

[11] The National Center for the Review and Prevention of Child Deaths. (2011). *The Coordination & Integration of Fatality Reviews*. Michigan Public Health Institute. https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/CoordinatedReviews.pdf

[12] *See* Fla. Stat. § 741.316 and Fla. Stat. § 383.402. (Florida authorized the creation of child abuse death review committees in 1999 and codified the creation of domestic violence fatality review teams one year later – both of which rely upon a multidisciplinary response and review of qualifying abuse cases.)

review qualifying cases, assemble meaningful statewide data on elder abuse, and make recommendations which effectively combat elder abuse in Florida. The following action items have been identified by this team as essential to the future efforts of all elder abuse fatality review teams in Florida:

- Expanding the potential sources of case referrals by permitting all members of the team to identify and refer cases for review;
- Increasing the scope of records available to the review teams by permitting all members of the team an opportunity to provide and request relevant records;
- Protecting all confidential victim and case-related information reviewed by the teams through the addition of a public records exemption;
- Facilitating the frank and open dialogue regarding each case by the team by removing any open-meeting requirements of Florida's Sunshine Laws; and
- Broadening the definition of qualifying forms of abuse which may cause or contribute to the death of a vulnerable senior.

These next steps are explained in greater detail within the 2022 Summary of Findings and Recommendations sections of this report.

Status of 2021 Recommendations

As outlined in the EAFRT's *First Annual Report* (2021) submitted to the Florida Department of Elder Affairs in September 2021, the EAFRT spent much of its inaugural year training members and implementing appropriate case selection and review procedures. Unfortunately, as was also noted in last year's report, when it came time for actual case selections and reviews the EAFRT encountered several unanticipated challenges, which ultimately prevented the team from effectively conducting any fatality case reviews in 2021. The EAFRT attempted to address each of these areas of concern through the team's three primary recommendations provided in the *First Annual Report* (2021). Those recommendations and their respective statuses are outlined below.

It should be noted that the EAFRT also learned that some of these same areas of concern likely impeded the creation of elder abuse fatality review teams in other judicial circuits of the state.

Recommendation # 1: ***The EAFRT for the Fourth Circuit recommends the adoption of amended legislation to address certain exemptions from Florida's Sunshine Law and public records laws in order to protect the confidentiality of the victims and their families, consistent with the Domestic Violence Fatality Review Team exemptions and privacy protections provided in Florida Statute § 741.3165.***

Status of Recommendation #1: PROPOSED LEGISLATION UNSUCCESSFUL

The EAFRT brought the need for appropriate statutory exemptions to the attention of lawmakers, including the original sponsor of the legislation authorizing the creation of elder abuse fatality review teams in 2020, Senator Audrey Gibson. The team then worked with Senator Gibson and Representative Fred Hawkins to advance new legislation (Senate Bill 1594 and House Bill 1243) during the 2022 Florida Legislative Session.[13] Unfortunately, both bills died in committees during the 2022 Legislative Session.

CS/CS/HB 1243: Pub. Rec. and Meetings/Elder Abuse Fatality Review Teams

PUBLIC RECORDS/GENERAL BILL by State Affairs Committee ; Children, Families and Seniors Subcommittee ; Hawkins

Pub. Rec. and Meetings/Elder Abuse Fatality Review Teams; Specifies confidential or exempt information obtained by elder abuse fatality review team retains protected status; provides exemption from public records requirements for specified information in records held by review team; provides exemption from public meetings requirements for portions of review team meetings during which specified information is discussed; provides for future legislative review & repeal; provides statement of public necessity.

Effective Date: 7/1/2022
Last Action: 3/14/2022 House - Died in Health & Human Services Committee

[13] The most recent amended version of HB 1243 (c2) has been included as Appendix Item B of this report.

Recommendation # 2: ***The EAFRT also recommends an amendment to Florida Statute § 415.1103, specifically adding exploitation to the listed maltreatments related to deaths of elderly persons.***

Status of Recommendation # 2: NOT YET ADDRESSED

During the EAFRT's collaboration with Senator Gibson and Representative Hawkins on the previously mentioned 2022 legislation, it was the decided that the proposed bills would solely focus on the necessary public records and Sunshine law exemptions provided in Recommendation # 1 by the EAFRT. Consequently, the proposed expansion of the maltreatments listed within Florida Statute § 415.1103 remains unaddressed.

Recommendation # 3: ***The EAFRT recommends that the 2021-2022 Team consider expanding its review to include cases from 2020-2021 involving abuse neglect, or exploitation-related deaths of elderly persons.***

Status of Recommendation # 3: SUCCESSFULLY PERFORMED BY TEAM

Due to the many challenges with identifying appropriate cases for fatality reviews by the EAFRT, the team decided to expand the date of incident range for prospective cases (departing from the team's originally established case selection process limiting the date of incident to one year prior). The EAFRT expanded its date range beyond a single year to provide more qualifying cases for the team to review. This expansion allowed the EAFRT to identify the two qualifying cases that were ultimately reviewed and summarized within this report. However, as is noted in the following sections of this report, more must to be done in order for the EAFRT to effectively identify and evaluate prospective cases for review.

2022 Fatality Case Reviews

INTRODUCTION

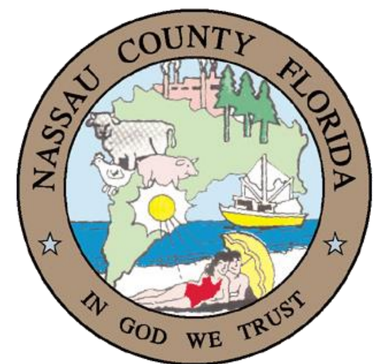
On September 25, 2020, the Fourth Judicial Circuit Elder Abuse Fatality Review Team (EAFRT) was established as the first elder abuse fatality review team in the state by the Honorable Melissa Nelson, State Attorney for the Fourth Judicial Circuit of Florida, to review elder abuse-related fatalities occurring in Clay, Duval, and Nassau counties.

The Fourth Judicial Circuit EAFRT is currently comprised of two co-chairs, twenty-one members, and four subcommittees (Executive, Membership, Report Drafting, and Case Review Subcommittees), which have each been integral in creating the composition, processes, and policies of Florida's inaugural elder abuse fatality review team.[14]

<u>CASE REVIEW SUBCOMMITTEE</u>

- Octavius H. Holiday, Jr., Assistant State Attorney, Deputy Director-Special Prosecution Division, Fourth Judicial Circuit.
- Renae Lewin, Victim Advocate, State Attorney's Office, Fourth Judicial Circuit, Nassau County.
- Eileen Rodden, Program Coordinator, The Women's Center of Jacksonville.
- Gary Porter, Sergeant, Jacksonville Sheriff's Office.
- A. J. Mack, II, Records Servicing Manger, VyStar Credit Union.

With the authority conferred by the State Attorney's Office of the Fourth Judicial Circuit of Florida (SAO 4), the EAFRT may review cases of elder abuse resulting in or contributing to the death of a vulnerable, older adult victim located in Clay, Duval, and Nassau Counties. Cases selected for fatality review are selected and referred to the EAFRT by the SAO 4.



[14] Note that all members of the EAFRT have signed a confidentiality agreement with respect to any case information discussed or reviewed by the team.

ASSESSING CASES FOR REVIEW

ELDER ABUSE

Elder abuse is generally understood to encompass multiple forms of abuse, neglect, and exploitation, which may be the result of an intentional act or conscious omission by the abuser towards an older adult victim.[15] Elder abuse generally includes physical, mental/emotional, financial and sexual abuse, in addition to neglect.[16]

Florida law has traditionally limited elder exploitation to financial crimes or abuse of fiduciary duties with respect to property or assets.[17] However, the crime of exploitation often includes several forms of abuse and neglect, including the failure by a caregiver to use the elderly victim's assets for the victim's health, safety, and welfare. Exploitation may also involve an abuse of a position of authority, such as a guardian, whose abuse may extend to making improper decisions regarding the care of the elderly victim. Depending on its form, elder exploitation could directly cause or indirectly contribute to a vulnerable victim's premature death.

ABUSE, NEGLECT, AND EXPLOITATION

Cases involving allegations of abuse, neglect, or exploitation of vulnerable, older adults may be investigated by law enforcement for violations under Chapter 825 of Florida Statutes, as well as by Adult Protective Services in accordance with Chapter 415 of Florida Statutes; sometimes these agencies will investigate the same allegations concurrently

Law enforcement is responsible for conducting the *criminal* investigation into elder abuse cases, as well as determining whether probable cause exists to charge an alleged perpetrator with a criminal offense. Once law enforcement has established probable cause, the case will be referred to the SAO for further review and a determination as to whether the evidence in the case is sufficient to support a criminal prosecution with a reasonable degree of success. The SAO is ultimately responsible for determining what criminal charges, if any, appropriately correspond with the alleged criminal conduct.

Adult Protective Services (APS) may conduct an investigation into the same maltreatment or offensive conduct as that which is the focus of a criminal investigation; however, the role of APS is separate and distinct from law enforcement. APS follows definitions of abuse, neglect, and exploitation provided within Chapter 415 of the Florida Statutes, which are similar to, but **not** the same as the criminal definitions for abuse, neglect, and exploitation found in Chapter 825. Based on these different definitions, in addition to several other jurisdictional factors, there are some situations involving *criminal* abuse, neglect, and exploitation in which APS lacks the jurisdictional capability to

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[15] Administration for Community Living. (n.d.). *What is Elder Abuse?*. Retrieved August 30, 2022, from https://acl.gov/programs/elder-justice/what-elder-abuse

[16] National Center for Injury Prevention and Control, Division of Violence Prevention. (n.d.). *Fast Facts: Preventing Elder Abuse*. Centers for Disease Control and Prevention. Retrieved August 30, 2022, from https://www.cdc.gov/violenceprevention/elderabuse/fastfact.html

[17] Fla. Stat. § 825.103.

investigate. APS is limited in what types of cases may be investigated for incidents occurring in health care or residential care settings.

While law enforcement is responsible for investigating and enforcing law from a criminal standpoint, APS is responsible for assessing a vulnerable adult's need for appropriate social and/or protective services after abuse, neglect or exploitation has been reported. The goal of the APS investigation into whether abuse, neglect, or exploitation has likely occurred in a specific case is to determine whether protective and/or social service intervention is necessary for the ongoing protection and wellbeing of the vulnerable adult. While APS is not responsible for conducting an investigation into whether a *crime* has occurred in any case of alleged abuse, neglect, or exploitation, APS is required to notify (when appropriate) local law enforcement and the state attorney with jurisdiction to investigate a crime, if there is sufficient evidence to reasonably believe a crime has occurred.

Law enforcement, APS, or both agencies may refer evidence of an alleged crime to the SAO for further review; however, the SAO will not normally open a criminal case unless and until law enforcement has investigated the conduct and established probable cause for charging the perpetrator with a crime. If a criminal investigation is not conducted in a particular incident OR if law enforcement closes an investigation as either "civil" or "unfounded," the case is unlikely to be brought to the attention of the SAO for a criminal charging review.

CASES RESULTING IN DEATH

Cases involving abuse, neglect, or exploitation may result in the death of the vulnerable, older adult victim – this may be immediate (occurring within hours or days of the abuse) or delayed (occurring weeks or months after the abuse, which contributed to the victim's death). When a vulnerable, older adult victim's death is caused by the culpable negligence of a caregiver, this may be criminally investigated as aggravated manslaughter (Fla. Stat. § 782.07). If the death is caused by an intentional act of abuse, any criminal investigation is more likely to proceed as a murder investigation under Florida Statute 782.04.

Unfortunately, elder abuse-related deaths frequently go undetected and uninvestigated for a variety of reasons and often pose significant challenges for APS, law enforcement, and prosecution. One of the most common impediments to detecting elder abuse-related deaths comes down to the attitudes and biases of professionals with respect to aging and death. In other words, when older adults die, there is a general assumption that the cause of death is natural and due to prior disease or age-related health problems. When younger adults and children die, professionals are more likely to investigate into the cause of death due to the "untimely" nature of the death, but when a senior dies (depending on the circumstances) there is less insistence for a thorough death investigation or autopsy to be performed.[18]

Additionally, first responders are not typically trained on the process of "viewing the body" or examining a decedent's remains for possible signs of elder abuse or neglect. There may even be a general discomfort or unwillingness by first responders to conduct a thorough inspection of an elderly

[18] Mosqueda, L., & Wiglesworth, A. (2012, October). *Coroner Investigations of Suspicious Elder Deaths*. (Doc. No. 239923) [Data set]. U.S. Department of Justice, Office of Justice Programs. https://www.ojp.gov/pdffiles1/nij/grants/239923.pdf

decedent's body beneath clothing, etc.[19] But if the first responder and others on scene do not take any additional steps of death investigation, it is unlikely any autopsy will be performed on the decedent, and therefore improbable for any further criminal investigation and enforcement to occur.

There are additional procedural barriers which may prevent a vulnerable, older adult victim's death from being investigated appropriately. For example, in most cases of abuse, neglect, or exploitation in which a vulnerable adult victim passes away, APS will lack or lose jurisdiction (when the death occurs during the APS investigation) to investigate the case. – Absent situations in which other vulnerable adults (other than the decedent) remain at risk of abuse, neglect, or exploitation in the immediate future, APS no longer has a role in assessing for necessary protective or social services intervention.

Medical examiners are often critical to the successful criminal investigation and prosecution of an elder abuse-related death. In fact, many law enforcement agencies will await the findings of a medical examiner to determine whether a criminal investigation may even be warranted into a death. However, the medical examiner is unlikely to conduct any inspection or autopsy into a vulnerable, older adult's death, unless it is flagged from the beginning by law enforcement or first responders as suspicious.[20] This creates an unwinnable Catch-22 in elder abuse-related death detection.

Based upon the respective roles in which APS, law enforcement, and prosecutors play in almost any investigation (as outlined above), there is a normal chain of events which must ordinarily occur before a case is criminally charged or prosecuted. APS and law enforcement are tasked with conducting independent investigations, each of which are valuable to any subsequent case review by a prosecutor. Law enforcement holds the key to whether most investigations will ever be reviewed by a prosecutor because only law enforcement can make a determination of probable cause. The prosecutor is normally the last person involved in this chain of events and must generally rely upon the evidence that is gathered and collected during the investigation. And if a medical examiner has not conducted an examination into the cause of death for a vulnerable, older adult victim who died as a result of elder abuse, the prosecutor is likely to be unable to successfully prosecute a murder or manslaughter charge in that case.

[19] Mosqueda, L., & Wiglesworth, A. (2012, October). *Coroner Investigations of Suspicious Elder Deaths*. (Doc. No. 239923) [Data set]. U.S. Department of Justice, Office of Justice Programs. https://www.ojp.gov/pdffiles1/nij/grants/239923.pdf

[20] *See* Fla. Stat. § 406.11.

CASE SELECTION AND REVIEW PROCESS

The Case Review Subcommittee (CRS) met and attempted to review cases on numerous occasions; however, only two *very limited* case reviews were conducted during two of these meetings, which have been summarized in this report. The CRS meetings were hampered by both public meeting requirements under Sunshine Law and the lack of any protections for confidential victim-related or other case-related information relevant to a fatality case review. The public accessibility to meetings and the public discoverability of confidential and sensitive case information that would ordinarily be discussed by a fatality review team (such as a domestic violence fatality review team[21]) prevented the CRS from discussing any salient details of cases qualifying for review.

Additionally, the CRS meetings were substantially delayed and further impeded by the current language in Florida Statute § 415.1103, which exclusively places the responsibility and capability for case selection, records production, and records redactions on the SAO. Based on this language, members of the CRS were unable to assist the SAO with identifying appropriate and qualifying cases for fatality review and were further blocked from requesting critical investigative records maintained by agencies other than the SAO. Due to the significant burden placed on the already overburdened SAO, the CRS first was delayed in the case identification process and then was further delayed and substantially impaired by the extensive record redactions required of the SAO – redactions only rendered necessary because of the absence of any public records and public meeting exemptions provided under Florida Law.

After the considerable efforts made (along with the disproportionate number of man-hours spent) by both the SAO and CRS, the CRS ultimately conducted *very limited reviews* of two elder abuse cases. However, due to the extensive redactions of the records provided to the CRS for review (rendering the documents nearly illegible) and CRS being effectively barred from requesting any other records pertaining the cases, the CRS was unable to conduct any fatality review that might *identify potential gaps, deficiencies, or problems in the delivery of services to elderly persons by public and private agencies.*[22]

Therefore, the CRS has utilized these case examples instead to highlight and recommend potential changes in law, rules, and policies with the goal of supporting the care of elderly persons and the prevention of future elder abuse deaths.[23]

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[21] *See* Fla. Stat. § 741.316.

[22] Fla. Stat. § 415.1103 (3)(c).

[23] "An elder abuse fatality review team shall do all of the following… Develop recommendations and potential changes in law, rules, and policies to support the care of elderly persons and to prevent elder abuse deaths." Fla. Stat. § 415.1103 (3)(e).

CASE REVIEW COMMITTEE MEETINGS

FIRST CASE REVIEW MEETING (FEB. 11, 2022)

On February 11, 2022, from 9:00 am to 10:20 am, commenced the initial meeting reviewing closed cases resulting in the death of a person sixty-five (65) or older involving abuse and/or neglect within the Fourth Judicial Circuit of Florida.

Florida Statute 415.1103 (Elder abuse fatality review teams) allows members of the Case Review Committee for the Elder Abuse Fatality Review Team (EAFRT) to review closed cases of SAO files in which a person age sixty (60) or older died and elder abuse or neglect could be a contributing factor.

The EAFRT Case Review Subcommittee met to review two (2) cases. The meeting was held at the Jacksonville Office of the State Attorney, Fourth Judicial Circuit, 311 West Monroe Street, 4th floor conference room, Jacksonville, Florida 32202 and via Zoom.

The following individuals attended the meeting:

- Octavius H. Holiday, Jr., Assistant State Attorney, Deputy Director-Special Prosecution Division, Fourth Judicial Circuit (in-person).
- Renae Lewin, Victim Advocate, State Attorney's Office, Fourth Judicial Circuit, Nassau County (in-person).
- Eileen Rodden, Program Coordinator, The Women's Center of Jacksonville (via Zoom).
- Gary Porter, Sergeant, Jacksonville Sheriff's Office (via Zoom).
- A. J. Mack, II, Records Servicing Manger, VyStar Credit Union (in-person).

Two (2) cases were provided by the State Attorney's Office for review by the committee. The documents had been noticeably redacted and the CRS was therefore prevented from reviewing the complete case file or record. Also, due to the absence of public records exemptions, photos and other reports were not permitted for review by the CRS.

The first case reviewed was **Case # 1 – Clay County, Florida**

Victim:	**Unknown (redacted)**
Defendant:	**Not available**
Relationship:	**Mother / Son**
Arrest Charge:	**Neglect of an Elderly Person**
Filed Charge:	**Aggravated Neglect of an Elderly Person**
Amended Charge:	**Aggravated Manslaughter**
Disposition:	**Pled Guilty; Adjudicated Guilty. Eleven and a Half (11.5) Months Jail. Followed by Five (5) Years Community Control (House Arrest), plus Mental Health Evaluation and follow-up**

Based on the information available from the file, the victim was under the care of the defendant. The conditions of the victim's residence were filthy and poor. The victim had open wounds with maggots, feces on the bed, had not been showered or fed. Emergency staff had to enter and exit the residence multiple times in order to withstand the conditions in the residence.

The victim was transported to the local hospital and later to a local care facility. The victim died at the local care facility.

Local Law Enforcement conducted the criminal investigation.

Obstacles to Case # 1 Review:

1. **<u>Unable to perform complete case review due to the requirement that all documents must be redacted.</u>**
2. **Unable to review Adult Protective Service reports**
3. **Unable to review Medical Examiner and other health care reports**
4. **Unable to determine if the defendant had any underlying mental health conditions.**
5. **Unable to create a timeline of events to determine if service providers could have noticed a lack of care earlier.**
6. **Unable to determine if victim was in hospice care.**
7. **No information provided as to the times and type of care provided to the victim by the facility in relation to the time of death.**
8. **Unable to determine if the victim was receiving services from an aging services provider, including in-home care service.**
9. **Unable to determine if law enforcement was previously called to the residence to provide wellness check(s) on the victim.**
10. **Unable to determine the residency of caregiver.**

The second case reviewed was **Case # 2 – Duval County, Florida**

Victim:	**Unknown (redacted)**
Defendant:	**Not available**
Relationship:	**Mother / Daughter**
Arrest Charge:	**Battery on a Person 65 Years of Age or Older**
Filed Charge:	**Aggravated Battery on a Person 65 Years of Age or Older**
Disposition:	**Adjudicated Guilty; Two (2) Years Community Control (House Arrest). Followed by Five (5) Years Probation - Random Urinalysis, Drug and Alcohol Screening.**

Based on the information provided in the file, the victim was pushed by her daughter (defendant) during an altercation between defendant and her daughter (victim's granddaughter).

The altercation between the defendant and her daughter (victim's granddaughter) involved the use of pills and consumption of alcohol.

Local Law Enforcement conducted the investigation.

The injuries suffered by the victim contributed to her death.

Obstacles to Case # 2 Review:

1. **Unable to perform complete case review due to redactions.**
2. **Unable to review relevant Adult Protective Service reports.**
3. **Unable to review Medical Examiner reports.**
4. **Unable to review all law enforcement reports**
5. **Missing documentation as to the case disposition.**
6. **Unable to determine if the victim received services from an aging services provider, including in-home care service.**
7. **Unable to determine if law enforcement was previously called to the residence.**

SECOND MEETING (APRIL 22, 2022)

On Friday, April 22, 2022, from 8:30 a.m. to 9:30 a.m., the Elder Abuse Fatality Review Team Case Review Committee held the second meeting to discuss and make edits to the draft copy of the 2022 EAFRT Case Review Report. The meeting was held at the Office of the State Attorney, Fourth Judicial Circuit, 4th Floor Conference room, 311 W. Monroe Street, Jacksonville, Florida 32202 and via Zoom.

The following CRS members attended the meeting:

- Octavius H. Holiday, Jr., Assistant State Attorney, Deputy Director-Special Prosecution Division, Fourth Judicial Circuit (in-person and via Zoom).
- Renae Lewin, Victim Advocate, State Attorney's Office, Fourth Judicial Circuit, Nassau County (via Zoom).
- Eileen Rodden, Program Coordinator, The Women's Center of Jacksonville (via Zoom).
- Gary Porter, Sergeant, Jacksonville Sheriff's Office (via Zoom).
- A. J. Mack, II, Records Servicing Manger, VyStar Credit Union (via Zoom).

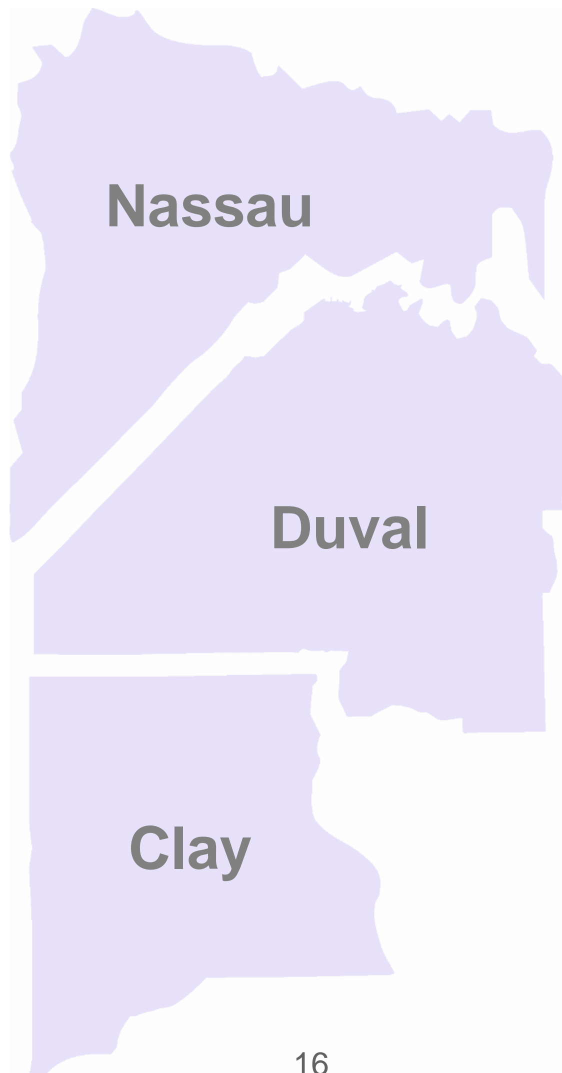
The CRS reviewed the case information previously summarized at the February 11, 2022, meeting.

The CRS Discussed the addition of Dr. Buchsbaum to the CRS for future case reviews.

The CRS identified multiple barriers to conducting a thorough review of the closed SAO 4 case files.

CRS Recommendations and Findings Submitted to EAFRT:

- **The EAFRT should request to have the same exemptions as a Domestic Violence Fatality Review Team.**
- **Domestic Violence Fatality Review Teams can review SAO case information with appropriate public records exemption protections in place and can meet without being obligated to notice or keep public a case review meeting under Florida's Sunshine Law.**
- **The Domestic Violence Fatality Review Team is permitted to review SAO case files without redactions in preparation of their report.**
- **Going forward, we recommend the CRS and EAFRT be allowed to review the entire case file, including all supporting documentation and records, without redactions.**
- **If the CRS was privy to any identifying information of the parties involved, it would work with the rest of the EAFRT to ensure the final draft report to be released does not disclose those identifiers or other confidential information, which may be redacted as needed, and approved by the EAFRT Executive Committee.**
- **The EAFRT should have the opportunity to include case statistics and tracking in the Fourth Circuit (Duval, Clay, or Nassau Counties) to assess for patterns and identify areas for improvement.**



2022 Summary of Findings

Finding # 1: The current language provided in Fla. Stat. § 415.1103 inhibits effective case identification and significantly restricts the case selection process for elder abuse fatality review teams.

Elder abuse fatality review teams may only be initiated at the direction of the state attorney's office (SAO) for each judicial circuit of the state.[24] After the creation of an elder abuse fatality review team, Florida Statute § 415.1103 (e) provides that each team "…shall determine its local operations, including, but not limited to, the process for case selection."

Had the statute stopped with this instruction (for teams to determine the best methods for case selection), this EAFRT would likely have identify significantly more qualifying cases for review. However, the statute goes on to instruct, "The state attorney shall refer cases to be reviewed by each team...".[25] This additional language, which places the responsibility for case selection and record provision exclusively on the SAO, prevents the EAFRT from locating otherwise qualifying cases that may have not been opened or prosecuted criminally by the SAO.

By giving the EAFRT multiple sources for identifying cases which qualify for review, such as Adult Protective Services, local law enforcement, the county medical examiner, Agency for Health Care Administration, Long Term Care Ombudsman, etc., in addition to the SAO, the EAFRT would be able to provide a more accurate assessment as to the scope of elder abuse-related fatalities occurring within the Fourth Judicial Circuit.

Finding # 2: The current language provided in Fla. Stat. § 415.1103 prevents the EAFRT from locating, identifying, and requesting records from sources other than the SAO, and places an undue burden upon the SAO with respect to records productions.

In addition to limiting the source for case referrals, Florida Statute § 415.1103 further specifies that the records to be reviewed by the team must first be redacted and provided to the team by the SAO. This restriction prevents the EAFRT from reviewing the services provided by all agencies and providers leading up to and at the time of the death. Without permitting the EAFRT to request missing and important records, the EAFRT will be unable to *identify potential gaps, deficiencies, or problems in the delivery of services to elderly persons…* as required by statute.

[24] *See* Fla. Stat. § 415.1103 (1)(a).

[25] *See* Fla. Stat. § 415.1103 (1)(e).

Finding # 3: The lack of public records exemptions limits what information may be reviewed and held by the EAFRT for review.

Due to the risk of revealing confidential and sensitive victim-related and case-related information, the EAFRT will be unable to possess or review any information unless it is completely redacted beforehand by the SAO. The EAFRT should have the same public records exemptions and victim confidentiality protections as are provided to domestic violence fatality review teams under Florida Statute § 741.316 and § 741.3165.

Finding # 4: The public meeting requirements under Sunshine Law prevents the EAFRT from thoroughly discussing case information or conducting meaningful case reviews.

Given the sensitive and potentially inflammatory information that the EAFRT is responsible for reviewing in a fatality case review – such as victim identify information, victim injuries (including photos), victim medical records, service provider notes and reports, dispatch reports, Central Abuse Hotline records, etc. – all EAFRT meetings during which cases are reviewed should be confidential and closed to the public. In order to encourage frank and meaningful discussion by the EAFRT members, the EAFRT requires Sunshine Law exemptions similar to those already provided to domestic violence fatality review teams.

Finding # 5: As noted in the *First Annual EAFRT Report* (2021), exploitation is a form of elder abuse, which may contribute to a vulnerable, older adult victim's death.

The EAFRT should have access to a variety of elder abuse cases, not only for purposes of fatality case review, but also for data and statistic collection regarding the scope of elder abuse issues occurring within the Fourth Judicial Circuit.

2022 Summary of Recommendations

2022 TEAM RECOMMENDATIONS

The EAFRT for the Fourth Judicial Circuit of Florida hereby recommends the following:

1. **The language contained within Florida Statute § 415.1103 should be amended to allow all members of the team to identify and refer cases for fatality review by the EAFRT.**

2. **The language within Florida Statute § 415.1103 should be amended to allow any member of the EAFRT to contribute relevant case-related records accessible to him or her through the agency or organization the member represents on the team (so long as permitted by Florida law and agency rules or standards), as well as to allow the EAFRT to request any additional records necessary to conducting a fatality case review.**

3. **The adoption of new or amended legislation to add all public records law exemptions necessary to protecting the confidentiality and integrity of the case-related information and victim information.**

4. **The adoption of new or amended legislation exempting all EAFRT's from Sunshine Law public meeting requirements for any meeting at which specific case review information is anticipated to be discussed.**

5. **The language of Florida Statute § 415.1103 should be amended to add exploitation to the listed maltreatments-related to a victim's death, which would authorize a fatality case review by the EAFRT.**

Elder Abuse Fatality Review Team Membership (2021-2022)

- **Chairperson: Judge Gary P. Flower,** Duval County Court Judge (Executive Subcommittee, Report Drafting Subcommittee)
- **Chairperson: Linda Levin, M.S.G.,** CEO, ElderSource, Inc. (Executive Subcommittee)
- **A.J. Mack II,** Records Servicing Manager, VyStar Credit Union (Case Review Subcommittee)
- **Bobby Fultz,**[26] Former Law Enforcement Liaison Manager, VyStar Credit Union
- **Carl Harms,** Program Specialist, Victim Services, Office of the Florida Attorney
- **Cindy R. Chambers,** Program Administrator, Victim Services, Office of the Florida Attorney General (Case Review Subcommittee, Report Drafting Subcommittee)
- **Diane Clark, J.D.,** Lead Education Specialist, Co-Project Director, AccessJax (Membership Committee, Report Drafting Subcommittee)
- **Eileen Rodden,** Program Coordinator, Women's Center of Jacksonville (EAFRT Coordinator, Case Review Subcommittee, Membership Subcommittee, Report Drafting Subcommittee)
- **Gary S. Porter, Sergeant,** Special Assault Unit, Jacksonville Sheriff's Office (Case Review Subcommittee)
- **Gloria Crawford,** Chief, Senior Services Division, City of Jacksonville
- **Gregory Patient,** Circuit 4 Program Administrator, Adult Protective Services, Florida Department of Children and Families
- **Jody Brandenburg,** President Hardage-Giddens Funeral Homes and Cemeteries
- **Karen C. Murillo,** [27] Advocacy Manager, AARP Florida (Report Drafting Subcommittee)

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[26] Former Law Enforcement Liaison Manger Bobby Fultz was a member of the EAFRT prior to changing employment to work for the St. John's County Sheriff's Office in July 2022.

[27] Karen C. Murillo formerly served on the EAFRT in her position as an Assistant Statewide Prosecutor and Senior Protection Coordinator for the Florida Office of the Attorney General prior to joining AARP Florida in May 2022.

- **Kristin Gonzalez, DNP, APRN,** Baptist AgeWell Center for Senior Health
- **Mike Jorgensen,** Managing Partner, Senior Counsel, Attorneys at Law, PA
- **Nicholas May,** Victim Services Director, Fourth Judicial Circuit State Attorney's Office
- **Octavius Holliday,** Special Prosecution Deputy Director, Human Rights Section/C.C.S.U., Fourth Circuit State Attorney's Office (Case Review Subcommittee)
- **Patrick Vitellaro,** Detective, Robbery Homicide Unit, Clay County Sheriff's Office
- **Paul Kellam, CPM,** Northeast Region Director, Adult Protective Services, Florida Department of Children and Families
- **Randy Wyse,** President, Jacksonville Association of Firefighters
- **Renae Lewin,** Victim Specialist, Fourth Circuit State Attorney's Office (Case Review Subcommittee)
- **Dr. Robert M. Buchsbaum, M.D.,** Forensic Pathology Specialist, Fourth Circuit Medical Examiner's Office
- **Tracie Rayfield,** Ombudsman Manager, First Coast District, Florida Long-Term Care Ombudsman Program
- **Teresa Miles,** Executive Director, Women's Center of Jacksonville

Florida House Bill 1243

CS/CS/HB 1243 2022

1 A bill to be entitled
2 An act relating to public records and public meetings;
3 creating s. 415.1104, F.S.; specifying that
4 information obtained by an elder abuse fatality review
5 team which is confidential or exempt from public
6 records requirements retains its protected status;
7 providing an exemption from public records
8 requirements for personal identifying information of
9 an elder abuse victim and other specified information
10 contained in records held by a review team; providing
11 an exemption from public meetings requirements for
12 portions of review team meetings during which
13 confidential or exempt information is discussed;
14 providing for future legislative review and repeal;
15 providing a statement of public necessity; providing
16 an effective date.
17
18 Be It Enacted by the Legislature of the State of Florida:
19
20 Section 1. Section 415.1104, Florida Statutes, is created
21 to read:
22 415.1104 Elder abuse fatality review teams; public records
23 and public meetings exemptions.—
24 (1)(a) Any information that is confidential or exempt from
25 s. 119.07(1) and s. 24(a), Art. I of the State Constitution and

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26 is obtained by an elder abuse fatality review team pursuant to
27 s. 415.1103 retains its confidential or exempt status.
28 (b) Any information contained in a record held by an elder
29 abuse fatality review team which reveals the identity of a
30 victim of elder abuse and the address or location of such
31 victim's residence; the identity of a person providing direct
32 care to the victim and the address or location of such person's
33 residence; and the identity of any person reporting abuse,
34 neglect, or exploitation to the central abuse hotline is
35 confidential and exempt from s. 119.07(1) and s. 24(a), Art. I
36 of the State Constitution.
37 (2) Any portion of a meeting of an elder abuse fatality
38 review team during which information made confidential or exempt
39 pursuant to subsection (1) is discussed is exempt from s.
40 286.011 and s. 24(b), Art. I of the State Constitution.
41 (3) This section is subject to the Open Government Sunset
42 Review Act in accordance with s. 119.15 and shall stand repealed
43 on October 2, 2027, unless reviewed and saved from repeal
44 through reenactment by the Legislature.
45 Section 2. The Legislature finds that it is a public
46 necessity that information that is confidential or exempt from
47 s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the
48 State Constitution remain confidential or exempt when held by an
49 elder abuse fatality review team and that any information
50 contained in a record held by an elder abuse fatality review

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51 team which reveals the identity of a victim of elder abuse and
52 the address or location of such victim's residence; the identity
53 of a person providing direct care to the victim and the address
54 or location of such person's residence; and the identity of any
55 person reporting abuse, neglect, or exploitation to the central
56 abuse hotline be made confidential and exempt from public
57 records requirements. Without the public records exemption,
58 sensitive personal information concerning victims of elder abuse
59 and persons providing direct care to such victims, as well as
60 persons reporting abuse, neglect, or exploitation to the central
61 abuse hotline, would be subject to public disclosure and open
62 communication and coordination among the parties involved in
63 elder abuse fatality review teams would be hampered. The
64 Legislature further finds that it is a public necessity that any
65 portion of a meeting of an elder abuse fatality review team
66 during which confidential or exempt information is discussed be
67 made exempt from s. 286.011, Florida Statutes, and s. 24(b),
68 Article I of the State Constitution. The failure to close
69 portions of meetings during which confidential or exempt
70 information is discussed would defeat the purpose of the public
71 records exemption and would have a chilling effect on the
72 ability of the task force members to discuss the information
73 that the members have been tasked with reviewing and analyzing.
74 As such, the Legislature finds that without the exemptions from
75 public records and public meetings requirements, the elder abuse

76 fatality review teams would be unable to operate in an effective
77 and efficient manner.
78 Section 3. This act shall take effect July 1, 2022.

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Elder Abuse Fatality Review Teams

Florida Statute § 415.1103 – Elder abuse fatality review teams.

(1)(a) A state attorney, or his or her designee, may initiate an elder abuse fatality review team in his or her judicial circuit to review deaths of elderly persons caused by, or related to, abuse or neglect.

(b) An elder abuse fatality review team may include, but is not limited to, representatives from any of the following entities or persons located in the review team's judicial circuit:

1. Law enforcement agencies.
2. The state attorney.
3. The medical examiner.
4. A county court judge.
5. Adult protective services.
6. The area agency on aging.
7. The State Long-Term Care Ombudsman Program.
8. The Agency for Health Care Administration.
9. The Office of the Attorney General.
10. The Office of the State Courts Administrator.
11. The clerk of the court.
12. A victim services program.
13. An elder law attorney.
14. Emergency services personnel.
15. A certified domestic violence center.
16. An advocacy organization for victims of sexual violence.
17. A funeral home director.
18. A forensic pathologist.
19. A geriatrician.
20. A geriatric nurse.
21. A geriatric psychiatrist or other individual licensed to offer behavioral health services.
22. A hospital discharge planner.
23. A public guardian.

24. Any other persons who have knowledge regarding fatal incidents of elder abuse, domestic violence, or sexual violence, including knowledge of research, policy, law, and other matters connected with such incidents involving elders, or who are recommended for inclusion by the review team.

(c) Participation in a review team is voluntary. Members of a review team shall serve without compensation and may not be reimbursed for per diem or travel expenses. Members shall serve for terms of 2 years, to be staggered as determined by the co-chairs.

(d) The state attorney may call the first organizational meeting of the team. At the initial meeting, members of a review team shall choose two members to serve as co-chairs. Chairs may be reelected by a majority vote of a review team for not more than two consecutive terms. At the initial meeting, members of a review team shall establish a schedule for future meetings. Each review team shall meet at least once each fiscal year.

(e) Each review team shall determine its local operations, including, but not limited to, the process for case selection. The state attorney shall refer cases to be reviewed by each team. Reviews must be limited to closed cases in which an elderly person's death was caused by, or related to, abuse or neglect. All identifying information concerning the elderly person must be redacted by the state attorney in documents received for review. As used in this paragraph, the term "closed case" means a case that does not involve information considered active as defined in s. 119.011(3)(d).

(f) Administrative costs of operating the review team must be borne by the team members or entities they represent.

(2) An elder abuse fatality review team in existence on July 1, 2020, may continue to exist and must comply with the requirements of this section.

(3) An elder abuse fatality review team shall do all of the following:

(a) Review deaths of elderly persons in its judicial circuit which are found to have been caused by, or related to, abuse or neglect.

(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.

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

(d) Whenever possible, develop communitywide approaches to address the causes of, and contributing factors to, deaths reviewed by the team.

(e) Develop recommendations and potential changes in law, rules, and policies to support the care of elderly persons and to prevent elder abuse deaths.

(4)(a) A review team may share with other review teams in this state any relevant information that pertains to the review of the death of an elderly person.

(b) A review team member may not contact, interview, or obtain information by request directly from a member of the deceased elder's family as part of the review unless a team member is authorized to do so in the course of his or her employment duties. A member of the deceased elder's family may voluntarily provide information or any record to a review team but must be informed that such information or any record is subject to public disclosure unless a public records exemption applies.

(5)(a) Annually by September 1, each elder abuse fatality review team shall submit a summary report to the Department of Elderly Affairs which includes, but is not limited to:

1. Descriptive statistics regarding cases reviewed by the team, including demographic information on victims and the causes and nature of their deaths;

2. Current policies, procedures, rules, or statutes the review team has identified as contributing to the incidence of elder abuse and elder deaths, and recommendations for system improvements and needed resources, training, or information dissemination to address such identified issues; and

3. Any other recommendations to prevent deaths from elder abuse or neglect, based on an analysis of the data and information presented in the report.

(b) Annually by November 1, the Department of Elderly Affairs shall prepare a summary report of the review team information submitted under paragraph (a). The department shall submit its summary report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Department of Children and Families.

(6) There is no monetary liability on the part of, and a cause of action for damages may not arise against, any member of an elder abuse fatality review team due to the performance of his or her duties as a review team member in regard to any discussions by, or deliberations or recommendations of, the team or the member unless such member acted in bad faith, with wanton and willful disregard of human rights, safety, or property.

Domestic Violence Fatality Review Teams

Florida Statute § 741.316 – Domestic violence fatality review teams; definition; membership; duties.

(1) As used in this section, the term “domestic violence fatality review team” means an organization that includes, but is not limited to, representatives from the following agencies or organizations:

(a) Law enforcement agencies.

(b) The state attorney.

(c) The medical examiner.

(d) Certified domestic violence centers.

(e) Child protection service providers.

(f) The office of court administration.

(g) The clerk of the court.

(h) Victim services programs.

(i) Child death review teams.

(j) Members of the business community.

(k) County probation or corrections agencies.

(l) Any other persons who have knowledge regarding domestic violence fatalities, nonlethal incidents of domestic violence, or suicide, including research, policy, law, and other matters connected with fatal incidents.

(m) Other representatives as determined by the review team.

(2) A domestic violence fatality review team may be established at a local, regional, or state level in order to review fatal and near-fatal incidents of domestic violence, related domestic violence matters, and suicides. The review may include a review of events leading up to the domestic violence incident, available community resources, current laws and policies, actions taken by systems and individuals related to the incident and the parties, and any information or action deemed relevant by the team, including a review of public records and records for which public records exemptions are granted. The purpose of the teams is to learn how to prevent domestic violence by intervening early and improving the response of an individual and the system to domestic violence. The structure and activities of a team shall be determined at the local level. The team may determine the number and type of incidents it wishes to review and shall make

policy and other recommendations as to how incidents of domestic violence may be prevented.

(3)(a) There may not be any monetary liability on the part of, and a cause of action for damages may not arise against, any member of a domestic violence fatality review team or any person acting as a witness to, incident reporter to, or investigator for a domestic violence fatality review team for any act or proceeding undertaken or performed within the scope of the functions of the team, unless such person acted in bad faith, with malicious purpose, or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

(b) This subsection does not affect the provisions of s. 768.28.

(4) All information and records acquired by a domestic violence fatality review team are not subject to discovery or introduction into evidence in any civil or criminal action or administrative or disciplinary proceeding by any department or employing agency if the information or records arose out of matters that are the subject of evaluation and review by the domestic violence fatality review team. However, information, documents, and records otherwise available from other sources are not immune from discovery or introduction into evidence solely because the information, documents, or records were presented to or reviewed by such a team. A person who has attended a meeting of a domestic violence fatality review team may not testify in any civil, criminal, administrative, or disciplinary proceedings as to any records or information produced or presented to the team during meetings or other activities authorized by this section. This subsection does not preclude any person who testifies before a team or who is a member of a team from testifying as to matters otherwise within his or her knowledge.

(5) The domestic violence fatality review teams are assigned to the Department of Children and Families for administrative purposes.

Public Record Exemptions – Domestic Violence Fatality Review Teams

Florida Statute § 741.3165 – Certain information exempt from disclosure.

(1)(a) Any information that is confidential or exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution and that is obtained by a domestic violence fatality review team conducting activities as described in s. 741.316 shall retain its confidential or exempt status when held by a domestic violence fatality review team.

(b) Any information contained in a record created by a domestic violence fatality review team pursuant to s. 741.316 that reveals the identity of a victim of domestic violence or the identity of the children of the victim is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(2) Portions of meetings of any domestic violence fatality review team regarding domestic violence fatalities and their prevention, during which confidential or exempt information, the identity of the victim, or the identity of the children of the victim is discussed, are exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.