EFFORT

ELDER ABUSE FATALITY REVIEW TEAM

BIENNIAL REPORT

2019 - 2020

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INTRODUCTION

Victims experiencing elder abuse suffer mortality rates *double* that of those older adults not experiencing elder abuse. Forms of elder abuse include physical abuse, caregiver neglect, and financial exploitation. Given the increase in the aging population, it is expected that the prevalence of elder abuse will continue to rise in the United States. The Harris County Elder Fatality Review Team (called EFFORT) formed in 2004 in accordance with Chapter 672 of the Texas Health and Safety Code with the intent to identify and provide recommendations to prevent premature elderly deaths caused from elder abuse. EFFORT members review suspicious deaths in vulnerable adults, who are aged 65 years and older or have disabilities. The purpose of this multidisciplinary team is to explore systemic course of care issues that could have mitigated the risk of death and to make recommendations to local leaders and policy-makers, who can implement measures to reduce premature elderly deaths due to elder abuse or mistreatment of disabled/vulnerable adults.

Agencies Involved

CHI St. Luke's Health - Baylor St. Luke's Medical Center
Harris County District Attorney's Office
Harris County Institute of Forensic Sciences
Harris County Sheriff's Department
Houston Police Department
Memorial Hermann Hospital, Texas Medical Center
Texas A & M University
Texas Department of Family and Protective Services
Texas Health and Human Services Commission
Texas Office of the Attorney General – Medicaid Fraud Control Unit
UTHealth, McGovern Medical School
UTHealth, Texas Elder Abuse and Mistreatment Institute
UTHealth, Consortium on Aging

PURPOSE OF EFFORT

The purpose of EFFORT is to decrease the incidence of premature elderly deaths in adults aged 65 years of and older or those adults considered disabled/vulnerable by:

a. Promoting cooperation, communication, and coordination among agencies involved in responding to unexpected deaths;

b. Developing an understanding of the causes and incidence of unexpected deaths in the county or counties in which the review team is located; and

c. Advising the legislature, appropriate state agencies, and local law enforcement agencies on changes to law, policy, or practice that will reduce the number of unexpected deaths.

To achieve this purpose, EFFORT members:

a. Meet monthly to review fatality cases suspected to have resulted from abuse, neglect, and/or exploitation and recommend methods to improve coordination of services and investigations between agencies that are represented on the team;

b. Collect and maintain data, as appropriate; and

c. Submit a biennial report required under Section 672.008 of Chapter 672 of the Texas Health and Safety Code.

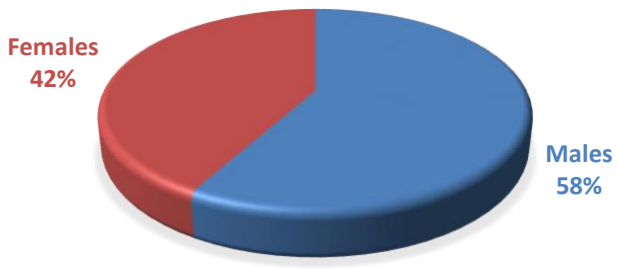
STATISTICS

EFFORT continues to see an increasing number of cases involving suspicious deaths of older adults.

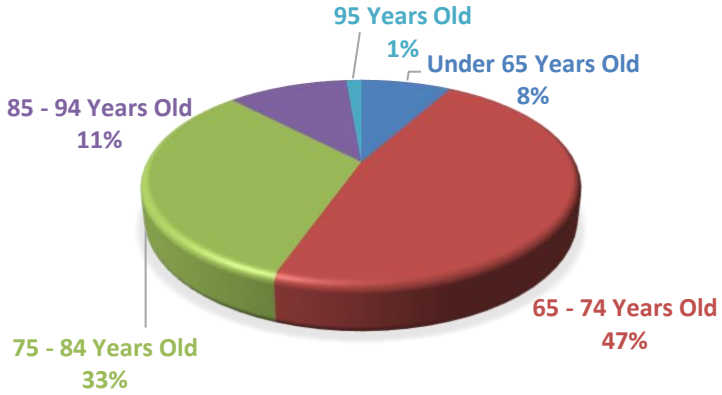
EFFORT Cases Quantified

During the 2019 – 2020 timeframe, 74 deaths were identified for further review by the EFFORT team out of the 522 elderly deaths that were undergoing an autopsy at the IFS. Cases included for review were adults 65 years of age or older or disabled/vulnerable adults, undergoing a complete autopsy, and with circumstances of abuse or neglect surrounding the death.

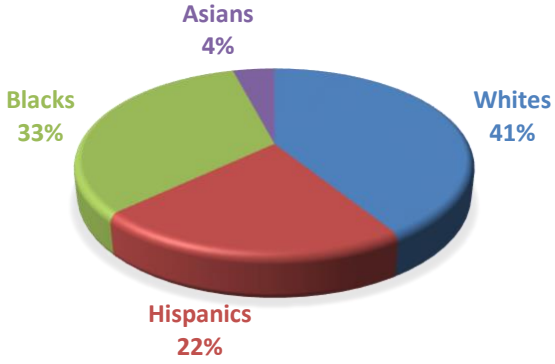
PERCENT OF CASES BY SEX



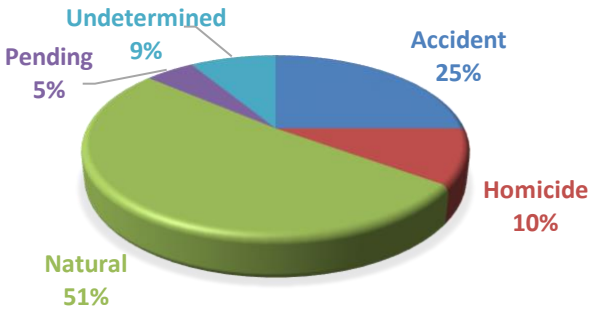
PERCENT OF CASES BY AGE



PERCENT OF CASES BY RACE/ETHNICITY



PERCENT OF CASES BY CAUSE OF DEATH



TRENDS AND RECOMMENDATIONS

Three trends were identified in the 2019 - 2020 timeframe. For each of these trends, EFFORT has the following recommendations.

Composite Case 1

A 65-year-old black male died at a Houston hospital from an infected bug bite on his left wrist about 12 hours after admission. Other concerning conditions included muscle atrophy, malnutrition, pressure ulcers on his hip, and lesions on his back and on his wrists, which were likely from restraints. The condition that he was found in indicates severe neglect by the staff at the unlicensed facility. Due to social isolation, the patient's family was unaware of his health condition.

Trend 1: Persons living in unlicensed/unregulated boarding homes are often subjected to inadequate caregiving as well as abuse, neglect, and exploitation.

Substandard conditions in these unregulated boarding homes result in suffering and premature mortality in some cases. Due to the rising number of cases of abuse, neglect, and exploitation at the hands of these unlicensed/unregulated boarding home operators, the City of Houston issued an ordinance requiring registration. The ordinance requires unlicensed boarding homes within the City of Houston to register and be equipped with smoke alarms, fire extinguishers, and first aid supplies. Boarding home operators are also required to undergo criminal background checks. Following implementation of the ordinance, many boarding home owners moved their operations to suburban areas just beyond the city limits, but remain in suburban Harris County.

Recommendations for Trend 1:

a. Provide more resources for prevention and protection of individuals living in unlicensed facilities.

b. Provide public awareness training about unlicensed boarding homes and include information about community resources available to help (i.e. APS or law enforcement).

c. Increase awareness about the importance of calling the Houston Police Department when abuse is suspected.

Composite Case 2

A 62-year-old disabled white male was found deceased in the shower at a local motel where he lived with his two caregivers and their children. The decedent made outcries of physical abuse at the hands of these caregivers. Upon examination of the body, investigators found the cause of death consistent with drowning. The case was referred to protective services on two occasions prior to the death, but workers only spoke to the caregiver by phone due to COVID-19 restrictions. A face-to-face interview with the alleged victim was never conducted in the hospital or where he lived.

Trend 2: Area hospitals are continuing to discharge vulnerable older adult patients to unlicensed and unsafe boarding homes.

These individuals often become victims of abuse, neglect, and exploitation.

Recommendations for Trend 2:

a. Craft a community response from the results of this study.

b. Provide education and training on safe discharge planning to hospital staff and elder service providers in the community.

c. Develop a boarding home ordinance in Harris County similar to the one developed in the city of Houston. It would be monitored and regulated by the sheriff's department.

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Composite Case 3

A 67-year-old black female died at her residence in her bedroom. She was known to stay in her room for extended periods of time without leaving it. Her daughter was a paid caregiver for her mother. At the time of her death, she was noted to be emaciated and unclean. Her surroundings were dirty and filled with garbage. A neighbor called Adult Protective Services during the summer of 2020 when she did not see the victim out and about. Adult Protective Services and Health and Human Services (who are responsible for the daughter as a paid caregiver) made phone calls to the home. However, due to COVID-19 restrictions, a home visit was not made. The patient died as a result of medical neglect.

Trend 3: APS had less on-site visits to homes during the pandemic.

During the pandemic, on-site visits by APS became less frequent and often restricted to those cases that involved individuals in immediate danger. Visits and information shifted to being collected through digital methods, which sometimes led to less information being collected.

Recommendations for Trend 3:

a. APS should use technology to investigate suspected abuse, neglect, and exploitation cases.

b. Increase glass door evaluations by APS. Glass door evaluations are a visual from the porch/yard of the client and their environment without going inside their home.

c. Develop policies and procedures during epidemics and disasters where the most serious APS cases can be safely investigated and services can be provided.

d. Healthcare providers should maintain communication with older adult clients during this period of social isolation and make referrals as necessary to ensure their healthcare needs are met.

e. Educate and train older adults and families on how to use technology for telehealth.

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