Harris County Adult Violent Death Review Team Report

June 2007

Executive Summary
DVDRT
2005-2006
Houston-Harris County

In the late 1990's Harris County domestic violence service providers realized the need to make formal what had been long-standing, albeit informal collaborations. This group of service providers, including women's programs, local law enforcement, the medical community, criminal justice professionals and a host of other concerned professionals, joined to formulate the Harris County Domestic Violence Coordinating Council (HCDVCC). As domestic violence work progressed across the United States, it became clear in many communities that there was a need to form fatality review teams; the purpose of which is to review domestic violence-related homicide cases and identify needs within each community with the ultimate goal of decreasing the incidence of preventable adult deaths.

In 2001 the Texas Legislature passed Senate Bill 515 amending Chapter 672 of the Texas Health and Safety Code to allow for the formation of adult fatality review teams in Texas counties. The HCDVCC was approached by the Harris County Public Health & Environmental Services Injury Surveillance Program regarding a partnership. From those discussions came the formation of the Adult Violent Death Review Team (AVDRT). In August of 2003 the AVDRT was designated as the official Harris County adult fatality review team by Harris County Commissioners Court. Subcommittees of the AVDRT include the Elder Abuse Fatality Review Team (EFFORT) and the Domestic Violence Death Review Team (DVDRT).

Each month the DVDRT conducts system-wide reviews of selected cases of adult unexpected deaths that have been caused by family violence, intimate partner violence, suicide and abuse occurring in Houston and Harris County.

Goals of the DVDRT include:

- To conduct formal, confidential and systematic evaluation and analyses of adjudicated cases of family violence occurring in Houston and Harris County, focusing on the flow of each case through the various agencies in the system to identify areas for improvement or strengthening of agency contacts and interagency response.

- To evaluate policies, protocols, and practices to identify gaps in service within agencies and the community.

- To build a database for analysis of aggregate population of deceased persons and perpetrators.

- To disseminate information on prevention strategies through a bi-annual quantitative and qualitative report to the AVDRT, HCDVCC, and as required to the Texas Department of Protective and Regulatory Services and to the community at large.

- To promote cooperation, communication, and coordination among agencies involved in responding to unexpected deaths.

- To develop an understanding of the causes and incidence of deaths due to interpersonal violence in the geo-political area served by the review team.

- To advise the legislature, appropriate state agencies, and local law enforcement agencies on changes to law, policy, or practice that will reduce the number of violent deaths.

Understanding of family violence has changed over the years as the definition is broadening. Where once it consisted mainly of a female victim and a male perpetrator, now family violence is considered to be family members abusing and/or killing other family members. As this report states, there have been several cases reviewed by the DVDRT that did not involved intimate partner violence but certainly met the definition of family (domestic) violence.

This report is dedicated to the emergency service personnel that respond to family violence calls. Police officers and emergency medical personnel often times are in danger themselves when responding to family violence calls. We applaud their dedication and thank them for their valuable service to our community.

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Part 1: Injury - The Public Health Problem

Injuries are a leading cause of death for Americans of all ages, regardless of gender, race or economic status.

In 2004, unintentional injuries were the leading cause of death for children, adolescents, and young adults (age 1–44 years). In 2004, homicide continued to be the leading cause of death for young African American males 15–24 years of age. In 2003, the suicide rate for older non-Hispanic white men was 2–4 times the rate for older men in other race/ethnicity groups and about 8 times the rate for older non-Hispanic white women.

But injury deaths are only part of the picture. Millions of Americans are injured each year and survive. For many of them, the injury causes temporary pain and inconvenience, but for some, the injury leads to disability, chronic pain, and a profound change in lifestyle.

In addition to the tragedy of fatal injury or devastating disability, injury in the United States places an immense economic burden on the healthcare system. It is a public health urgency that the nation gain's a better understanding of injury occurrence, both intentional and unintentional, in order to develop and implement appropriate and sustainable interventions.

Violent Injury

- Violence is a major public health problem in the United States. Homicide and suicide account for more than 50,000 deaths each year. *
- In the U.S. each year, about 1.5 million women and more than 800,000 men are raped or physically assaulted by an intimate partner.
- In 2001, almost 21,000 homicides and 31,000 suicides occurred in the U.S. Almost 1.8 million people were assaulted, while about 323,000 harmed themselves and were treated in hospital emergency departments.
- Homicide was the second leading cause of death for people ages 10 to 24 in 2001 in the U.S.. Suicide was the third leading cause of death for people ages 10 to 24 in 2001.
- Intimate partner violence results in nearly 2 million injuries and 1,300 deaths nationwide each year.

*References for all statistics presented can be found at the end of this report.

- Animal cruelty usually occurs within a context of family violence and is an indicator of other types of abuse.

The Gaps in Understanding

Currently, local, state and national policy makers and program developers do not have comprehensive information about violent deaths.

State and local agencies have detailed information that answers fundamental questions about patterns and trends in violence, yet this information is fragmented and inaccessible. Creating a system to pool these valuable data would help answer such fundamental questions as:

- Are violent deaths in schools increasing or decreasing?
- What proportion of homicides result from illicit drug deals?
- How often do murder-suicides occur?
- How frequently are homicides associated with child maltreatment?
- How frequently does interpersonal violence or family violence result in homicide?

A comprehensive review of injury deaths and evaluation of the contributing factors is one method of obtaining the detailed information necessary to understand how and why violent injuries occur. Recently, the mortality or fatality review model has been applied to injuries, both intentional and unintentional.

Fatality Review Overview

The concept of death review is not a new one. The purpose, the thorough review of deaths in order to improve systems, has been utilized by the automobile industry and medical profession for many years. Hospitals conduct internal reviews on the morbidity and mortality of patients in order to identify medical procedures which may have contributed to the outcome. If problems with procedures are recognized, changes can be implemented. The automotive industry's review the circumstances of fatal motor vehicle crashes in order to improve automobile safety and design.

Identifying causes of disease or injury is the hallmark of public health practice. Since the early 1990's, public health agencies have utilized the death review process to better describe all the circumstances contributing to a death (usually an unexpected death). Information learned during a review can lead to the development of public health inventions focused on reducing or eliminating death due to a specific cause. Adult fatality review is patterned after the child fatality review process, which has identified several interventions that have had some success. Examples of interventions developed in the U.S. as a result of child fatality

review are warning signs for drowning on five gallon buckets and the "Back to Sleep" campaign for sudden infant death syndrome (SIDS) deaths.

Like the child fatality review initiative throughout the nation, many states and metropolitan areas have begun adult fatality review teams as well. Injury, a leading cause of death among adults, tends to be the major focus of most teams. Specifically, the intentional injury categories of homicide and suicide receive the greatest focus, primarily in the context of domestic or family violence. The American Academy of Family Physicians has stated that "family violence is the intentional intimidation or abuse of children, adults or elders by a family member, intimate partner or caretaker to gain power and control over the victim. Abuse has many forms including physical and sexual assault, emotional or psychological mistreatment, threats and intimidation, economic abuse and violation of individual rights." Anyone can become a victim of family violence, with children and elders among the most vulnerable.

An important feature of these death review teams is the variety and diversity of participants. Professionals from health oriented disciplines (physicians, medical examiners, mental health counselors, public health epidemiologists) are joined by others who would have some additional information about cause or circumstances of a death. These other professionals can include law enforcement, district attorney, family protective services, adult and juvenile probation, crisis intervention and school district personnel.

Houston-Harris County Fatality Review

Currently there are three death review teams conducting in depth reviews of specific types of deaths in the Houston area. The Houston-Harris County Child Fatality Review Team (HHCCFRT) collects data on all child deaths (ages 0-17), and conducts in-depth reviews of SIDS or sudden unexplained infant deaths (SUIDS) and all intentional and unintentional injury deaths. The Harris County Domestic Violent Death Review (DVDRT) Team conducts in depth retrospective review of domestic or intimate partner (family related) violent deaths. The third team, the Elder Abuse Fatality Review Team (EFFORT) has a focus on the abuse or maltreatment of the elderly.

The HHCCFRT formed in 1994 and has been collecting data on child death since 1995 when the Texas Legislature amended the Family Code Chapter 264 to authorize the operation of teams across the state. The team has published several reports presenting fatality statistics and recommendations. The reports are available at www.hcphes.org .

Houston-Harris County Adult Fatality Review

In 2004. there were 12,312 deaths among Texas residents due to injury. This represents a crude rate 54.8 per 100,000 population. (The crude death rate is an estimate of the proportion of the population that dies during a certain period of time.) Violent injury accounted for over a

quarter (30.2%) of these deaths. The crude death rates for suicide (2,300) and homicide (1,416) for the same period were 10.2 and 6.2 per 100,000 respectively. In 2004, Harris County recorded 366 murders or a crude rate of 10.0; substantially higher than the state as a whole. For the same period, Harris County reported 364 suicides (9.99), essentially an equivalent rate to that of homicide. Table 1 provides a crude comparison for homicide and suicide for Texas and the four most populous counties; Harris, Dallas, Tarrant and Bexar.

Table 2 shows the relationship that victims had with the offender at the time of the homicide. Conventional thought has usually associated domestic or family violence as occurring between intimate sexual partners. However, Table 2 also shows that other family members are almost as likely to commit these crimes. Community leaders in Harris County recognized the need to respond to violent injury, particularly family violence. Efforts began in 1996 with the formation of the Harris County Domestic Violence Coordinating Council (HCDVCC). The continuing mission of the HCDVCC is to develop and implement a Harris County community wide plan to end domestic violence. The Council has set the following goals to meet this challenge:

- Develop cooperation and coordination among all the participants who serve domestic and family violence victims.
- Evaluate the current institutional response to domestic and family violence in order to develop and maintain a community protocol handbook.
- Identify additional service needs in the community and work to fill those needs.
- Educate the public about domestic and family violence policies and available resources.
- Strengthen and coordinate interventions and prevention efforts.
- Encourage efficient use of community resources and simplify and increase access to services.

Also recognizing the need to address violent injury, the 79th Texas Legislature passed a bill that amended the Health and Safety Code Chapter 672 to allow for the formation of multi-disciplinary, multi-agency adult fatality review teams in Texas counties. Per the legislation teams may, among others, include the following individuals:

- Criminal prosecutor – family violence cases
- Law enforcement officer
- Public health professional
- Adult protective services worker
- Mental health service provider
- Family violence shelter representative
- District Attorney's Office Victim Witness Advocate

Table 1: Frequency and Rate of Homicides & Suicides (Violent Injury Deaths)
For Texas and selected counties, 2002-2004

		Texas		Harris		Dallas		Tarrant		Bexar	
Homicide	Year	N	Rate[1]	N	Rate[1]	N	Rate[1]	N	Rate[1]	N	Rate[1]
	2002	1412	6.5	363	10.3	258	11.3	72	4.7	123.	8.5
	2003	1519	6.7	380	10.6	256	11.2	86	5.5	107	7.3
	2004	1403	6.2	366	10.0	275	12.0	81	5.1	103	6.9
Suicide											
	2002	2304	10.6	387	10.9	230	10.1	121	7.9	137	9.5
	2003	2355	10.6	348	9.7	217	9.5	166	10.6	146	10.0
	2004	2290	10.2	364	10.0	203	8.7	152	9.6	132	8.9

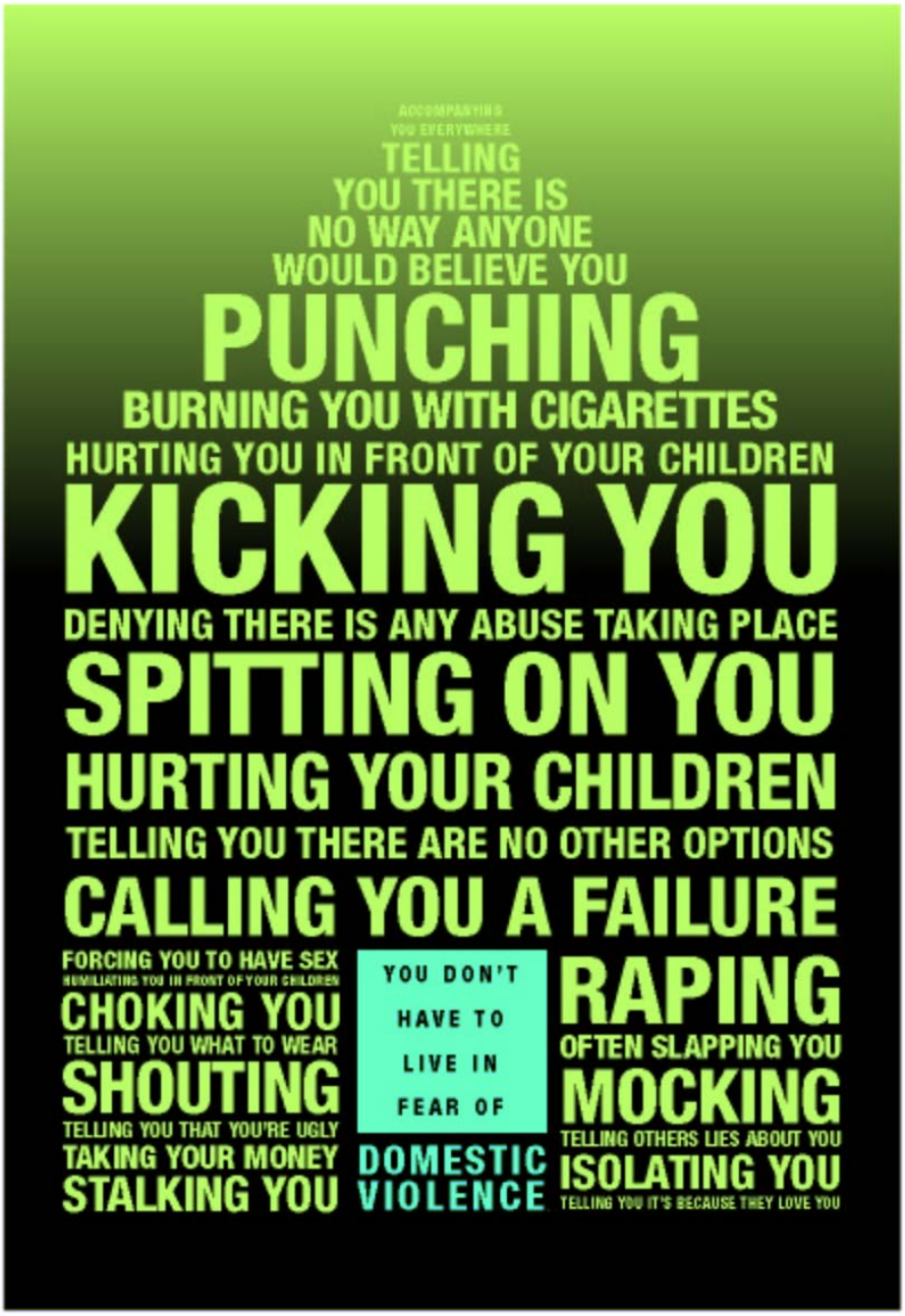
[1] rate per 100,000; calculated with the mid-year population estimate (Texas State Data Center) for each year
Source: Texas Department of State Health Services, Vital Statistics Annual Reports

Tsble 2: Victim Relationship to Offender
2000-2005 Homicides for Harris County and Texas

Victim's relationship to offender	2000		2001		2002		2003		2004		2005	
	HC	T	HC	T	HC	T	HC	T	HC	T	HC	T
Male partner[1]	6	27	6	25	4	36	2	33	9	31	9	32
Female partner[2]	12	104	22	113	25	117	24	132	13	104	24	124
Same sex partner[1,2]	1	1	2	3	1	1	1	2	0	0	1	1
Other family[3]	20	91	31	155	22	124	24	143	21	134	18	121
Other relationship[4]	54	349	69	341	61	302	92	365	76	363	94	386
Unk. relationship	143	521	131	549	151	552	106	508	118	519	89	415
Stranger	74	188	75	185	102	228	112	293	130	255	205	377
Total homicides	310	1281	336	1371	366	1360	361	1481	367	1406	440	1456

Husband, common law husband, ex-husband, boyfriend
[2] Wife, common law wife, ex-wife, girlfriend
[3] Mother, father, son, daughter, brother, sister, in-law, stepfather, stepmother, stepson, stepdaughter, other family
[4] Neighbor, acquaintance, employee, employer, friend, other known to victim
Source: Texas Department of Public Safety, Crimes Statistics

In Harris County the HCDVCC, in partnership with Harris County Public Health & Environmental Services, brought together various local agencies to form the Houston-Harris County Adult Violent Death Review Team (AVDRT). So far two teams have been formed and are operating under the umbrella of AVDRT and the HCDVCC. These are the Harris County DVDRT and EFFORT teams previously mentioned.



Part 2: Domestic Violent Death Review Team Report

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Domestic Violence Related Fatalities

In 2003 the Domestic Violence Death Review Team (DVDRT) was formed as a subcommittee of the AVDRT with the specific charge of reviewing family violence-related homicides.

DVDRT Team Members

Donna Amtsberg , LMSW, DVDRT Chair
Director, Family Violence Center and Counseling Center
Northwest Assistance Ministries

Debra Schield, DVDRT Co-Chair
Detective, Interpersonal Violence Division
Harris County Sheriff's Office

Cindy Kilborn, MPH, DVDRT Coordinator
Chief Epidemiologist
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El Buchanan, BS, BSN, RN, SANE-A
Terri O'Shea, RN, MSFS
Forensic Nurse Examiners
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Michelle Permenter, Assistant Director
Victim Witness Division
Beth Barron, JD, Prosecutor, Assist. District Attorney
Jennifer Varela, LMSW
Jane Waters, JD, Chief Prosecutor
Family Criminal Law Division
Harris County District Attorney's Office

Lt. Joe Levingston
Homicide Division, Family Violence Unit
Houston Police Department

Chris Green
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Ross Carn-Bennett, RN, CFN, CMI-III, SANE-A
Forensic Nursing Services
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Lauren S. Crim
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Sheri Kendall, MSEd, LPC, Director
Battering Intervention and Prevention Program
Aid to Victims of Domestic Abuse

Toby Myers, EdD, LCSW, LPC
Shalom Bayit
Jewish Family Services

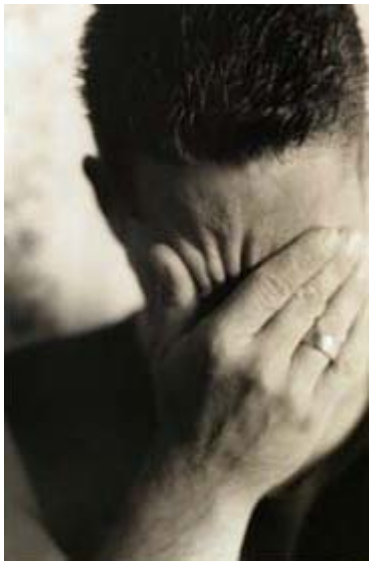
Barb Brashear, LSW
The Bridge

Rhonda Gerson
Community Advocate

Mission

The mission of the DVDRT is to better understand the community and system in which domestic violence occurs and perpetuates and to use this knowledge to influence provision of targeted services and policy development.

Goals and Objectives



- To conduct formal, confidential, and systematic evaluation and analyses of adjudicated cases of interpersonal violence occurring in Houston and Harris County, focusing on the flow of each case through the various agencies in the system to identify areas for improvement or strengthening of agency contacts and interagency response;
- To evaluate policies, protocols and practices to identify gaps in service within agencies and the community;
- To build a database for analysis of aggregate population of deceased persons and perpetrators;
- To disseminate information on prevention strategies through an annual quantitative and qualitative report to the AVDRT, HCDVCC, and as required to the Texas Department of Family Protective Services (DFPS) and to the community at large;
- To promote cooperation, communication, and coordination among agencies involved in responding to unexpected deaths;
- To develop an understanding of the causes and incidence of deaths caused by interpersonal violence in the counties where the review team is located; and
- To advise the legislature, appropriate state agencies, and local law enforcement agencies on changes to law, policy, or practice to reduce the number of violent deaths.

The Texas Family Code defines family violence as an act by a member of a family or household against another member that is intended to result in physical harm, bodily injury, assault, or a threat that reasonably places the member in fear of imminent physical harm. The Texas Department of Public Safety reported 187,811 family violence incidents for 2005. The number of incidents increased by 3.1 % from the 2004 reported family violence incidents (182,087). A slight increase was reported for Harris County with 31,246 incidents reported in 2005 as apposed to 31,055 in 2004.

There were 43 domestic violence related deaths in Harris County in 2004 and 269 deaths in Texas. In 2005, moderate increases were noted for each; Harris County had 52 deaths and the state with 278 deaths.

The DVDRT began official retrospective case reviews in September of 2003. Cases for review are selected from adjudicated (trial completed) family violence homicide cases handled the previous year. By the request of the District Attorney's Office, a case list is requested each January. To date the team has comprehensively reviewed 20 domestic violence related homicides.

Team members meet once a month to discuss all aspects of a case based on all records available at that time. Members representing agencies that may have records concerning either the victim or perpetrator bring those for discussion. Efforts are made to contact members of the victim's family or friends by the DVDRT field interviewer in an attempt to gain addition insight on domestic/family circumstances.

Descriptive Analysis of Data

The data in the tables below describe the characteristics of the individuals involved in these homicides and some of the circumstances present at the time of the incident.

Additional characteristics of cases reviewed included the type of weapon used, the relationship of the victim and perpetrator (V/P) and their current status of habitation. The majority of weapons used were guns (12) of some type with 10 hand guns, one shotgun and one rifle. Five deaths involved knives and the remainder were two blunt injury objects (pipe, hammer) and a strangulation death (hands). Current spouse was the most common relationship between victim and perpetrator. There were 9 homicides among current spouses, while only two among ex-spouses. The girlfriend-boyfriend relationship accounted for four deaths; one current relationship and three among former relationships. There was also one same sex relationship death

Demographics			
		Victim	Perpetrator
Age Range		17-77	18-69
Sex	Male	7	18
	Female	13	2
Race	White	9	11
	Afr. Amer.	5	6
	Hispanic	3	3
	Other	0	0
	U	0	0
	M	3	0

Y=yes; N=no; U=unknown; M=missing data

Habitation status had 10 V/P pairs currently living together at time of homicide, one case was separated and divorce pending, and five had the status as separated with no divorce. Three V/P pairs never lived together and data on one case was missing.

Social Characteristics			
		Victim	Perpetrator
History of substance abuse	Y	8	8
	N	7	3
	U	5	9
	M	0	0
Drugs used at time of incident	Y	2	2
	N	9	9
	U	6	9
	M	3	0
History of mental ill-ness	Y	3	7
	N	7	2
	U	9	8
	M	1	1
History of abuse as a child	Y	0	1
	N	2	1
	U	14	6
	M	4	12

Y=yes; N=no; U=unknown; M=missing data

Law Enforcement Encounters			
		Victim	Perpetrator
Criminal record	Y	10	13
	N	5	5
	U	4	2
	M	1	0
Protection orders against	Y	0	1
	N	20	19
	U	0	0
	M	0	0
On probation	Y	0	0
	N	0	18
	U	0	1
	M	0	1
On parole	Y	0	2
	N	0	8
	U	0	3
	M	0	7

Y=yes; N=no; U=unknown; M=missing data

initial report of the DVDRT which contains actual review data, many gaps in information have been recognized during the analysis process. Numerous cases have unknown or missing information which may represent the fragmentation of current records. Fragmentation of information among and between agencies is a key reason for implementation of fatality review teams. Team members have seen the importance of as complete as possible case reviews, as these data can be used to improve agency procedures and influence policy makers at all levels.

Recommendations

Members of DVDRT are committed to continuing and improving the review process by attending the monthly meetings on a regular basis. They have recognized the importance of very thorough data and have committed to gather all available information. Additional gaps in information gathering, services provided in communities or other circumstances that may have contributed to family violence have prompted the DVDRT to make the following recommendations:

- Improve access to domestic violence service providers
- Promote knowledge in the community that every citizen is obligated to report suspected child abuse
- Insure that all hospital social workers have adequate domestic violence service provider (resources) information for distribution to victims
- Train Family and Protective Services workers and private therapists to recognize signs of domestic violence and make appropriate referrals
- Review what kind of interaction probation officers have with parolees and probationers in possible domestic violence situations
- Involve psychological services personnel from area school districts in the review process when appropriate
- Stop or reduce harassing calls placed by inmates of area correctional facilities

Case scenarios

A few scenarios from the cases reviewed are provided here to illustrate the variety of situations and circumstances present in these homicides.

The decedent was a 78 year old female who was strangled and suffocated by her husband of 54 years. There had been no previous reports of domestic violence. The victim had a history of leg and hip problems which may have been violence related. The defendant was sentenced to 8 years and fined $10,000.

The decedent was a 24 year old female who was stabbed approximately 46 times by her boyfriend. The couple did not live together but did have a 2 year old daughter. There was a long history of violence by the boyfriend toward the victim including threats against the victim's family members. The defendant was sentenced to life.

The decedent was a 20 year old female who was shot in the head after having told her boyfriend that she wanted a separation. The boyfriend had a long history of criminal behavior including physical abuse of previous girlfriends. The couple had a 3 month old child together. The victim was found dead in her bathroom by a friend concerned about her safety. The defendant was sentenced to 40 years.

The decedent was a male in his 50's who died from a gunshot wound to the back by his son. The family had a long history of mental heath issues, including schizophrenia, bipolar disorder, and emotional breakdowns. There was also a history of domestic violence and criminal histories including assaults and alcohol/drug abuse. The son repeatedly beat his father on many occasions in front of other witnesses. The defendant was sentenced to 35 years.

The decedent was a male in his late 50's with multiple gunshot wounds to the face, chin, neck, chest, and arms. The defendant was the victim's cousin, whose criminal history included a previous murder, as well as numerous offenses in Texas, Louisiana, and Florida. The defendant was sentenced to life.

Part 3: Elder Abuse Fatality Review Team Report

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Elder Death Review Team

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Sabrina Pickens, MSN, APRN-BC
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Det. Mark Schmidt
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Maria Vogel, MSN, NP-C
Baylor College of Medicine and Harris County Hospital District

Kelly Young
Houston Area Women's Center

Mission

The mission of the Harris County Elder Abuse Fatality Review Team (EFFORT) is to strive for justice for all elder and vulnerable adult citizens who die as a result of interpersonal violence and/or neglect.

Goals and Objectives

The goal of EFFORT is to refine and coordinate an intervention effort with the purpose of improving services, decreasing the incidence of preventable elder deaths, and increasing the prosecution of perpetrators.

- To bring together an interdisciplinary team (IDT) composed of a public health professional, a victim witness professional, a representative of the Texas Department of Protective and Regulatory Services, a medical examiner, a geriatrician, law enforcement, and a nurse;
- To conduct formal, confidential, and systematic evaluation and analyses of cases of interpersonal violence occurring in Houston and Harris County, focusing on the flow of each case through the various agencies in the system to identify areas for improvement or strengthening of agency contacts and interagency response;
- To evaluate policies, protocols and practices to identify gaps in service within agencies and the community;
- To build a database for analysis of aggregate population data of deceased persons and perpetrators;
- To disseminate information on prevention strategies through an annual quantitative and qualitative report to the Adult Violent Death Review Team (AVDRT) and as required to the Texas Department of Protective and Regulatory Services and to the community at large;
- To promote cooperation, communication, and coordination among agencies involved in responding to unexpected deaths;
- To develop an understanding of the causes and incidence of deaths caused by interpersonal violence in Houston/Harris County where the review team is located;

- To advise the legislature, appropriate state agencies, and local law enforcement agencies on changes to law, policy, or practice that will reduce the number of deaths attributed to violence;
- To identify research questions that need investigation to inform decision making to end violence against elders; and
- To identify interventions that are applicable to informing health professionals and the public about violence against elders.

The Problem

In the U.S. there is no definitive way to assess the true extent of elder abuse. There is no systematic or uniform way of tracking cases, and the definitions used to edintify elder abuse can vary. Based on 2003 information from the National Center on Elder Abuse, it is estimated that between 1 and 2 million Americans age 65 or older have been injured, exploited or otherwise mistreated by someone on whom they must depend on for care or protection. This number is most certainly increasing as the "baby boom" generation moves into age 65 and greater.

It is also estimated that for every recognized case of elder abuse there may be as many as 5 unrecognized cases. The many Harris County agencies involved with elements of elder abuse have recognized the need to better understand the dynamics of this serious public health issue facing our community. The need for EFFORT continues as the team approaches the ultimate goal of better recognizing the circumstances leading to elder abuse and reducing the number of morbidity or mortality due to elder abuse in Harris County.

Case Review Process

The EFFORT team meets on a monthly basis to review cases on unexpected adult deaths which meet the criteria established reviews. The deceased must be a disabled person 15-64 years of age or an adult 65 years of age or older and the death is a result of injuries sustained during interpersonal violence (intimate partner violence, family violence, suicide, abuse or neglect) of an incapacitated adult. The team reviews deaths which occur within Harris County. Team members from each agency bring all knowledge or information they have to contribute to case review and all review activities are confidential. All pertinent information is maintained in a database for ease of analysis.

On November 14, 2006 CBS Nightly News with Katie Couric aired a segment on elder mistreatment. The EFFORT team was interviewed in a portion of this segment, which can be accessed at www.cbsnews.com/stories/2006/11/14/eveningnews/main2181379.shtml

Case scenarios

EFFORT reviewed a total of 10 cases during January through December 2006. Below is a summary of four of the 10 cases.

The decedent was a woman in her 70's who had been cared for by her daughters, one a nurse and the other, a paid caregiver by a local home health agency. The woman had been discharged from the hospital after hip surgery, was walking and doing well. After several months at home, the woman was admitted to a long term care facility covered with decubitus ulcers, emaciated and malodorous where she died. The facility notified APS. The nurse lost her license.

The decedent was a 72 year old healthy male whose son, a drug addict and alcoholic, kicked the decedent to death in the front yard of their home. The Father refused to allow the son admission to the house because he was drunk and was known for violence when he drank. The son was arrested and charged with injury to an elder.

The decedent was a 82 year old woman with multiple bruises throughout her body who had been living with her son and daughter-in-law. She was transferred to a nursing home for respite care and later died. The nursing home waited more than 24 hours to report the death to the Medical Examiner's Office. The autopsy was performed after the decedent was embalmed thereby making it difficult to determine elder mistreatment.

The decedent was a 79 year old man who was found dead at his home by his caregiver after a self-inflicted gunshot wound to his head. He was recently diagnosed with a terminal illness. No suicide note was found. His spouse reports no psychiatric history or prior history of suicidal ideation or attempts. The spouse slept in the same bed as the decedent and reportedly got up once during the night and returned to bed quietly as to not disturb the decedent. The spouse awoke in the morning and got ready for work. She left at 0800 as the caregiver arrived at the same time therefore the decedent was never left alone. The caregiver reported the decedent was very weak due to his illness and could not even hold a glass of water without assistance. The caregiver checked on the decedent at 0855 and found him unresponsive with his head in a pool of blood. A Ruger single action 0.45 "Black Hawk" revolver was found under the bed.

Recommendations

EFFORT will continue to meet on a monthly basis. EFFORT continues to work toward advocating for the adoption of the recommendations of 2004, and additional recommendations have been identified. Education of health professionals and the public and improved communication between agencies continue to rank high in priority. EFFORT noted a number of cases where health facilities' staff failed to notify the appropriate agency when faced with egregious and obvious cases of elder neglect or suspicious elder deaths. EFFORT also continues to recommend the creation of community action boards to address the recommendations of elder fatality review teams. These boards could advocate for funds to implement review team recommendations and to sustain review team efforts.

On June 22, 2006, EFFORT sponsored a community forum "Why Tolerate the Intolerable? Elder Abuse, Neglect, and Exploitation: A Forum for Community Leaders and Policy Makers" in Houston, TX. The Forum, supported with funding from the Harris County Area Agency on Aging and Harris County Protective Services was intended to raise awareness and the need for community action to improve the plight of abused, neglected and exploited elders. The forum was well attended with representatives from different agencies.

Additional recommendations from EFFORT include:

- Establish rigorous oversight and enforcement of regulations requiring that healthcare workers and paid family caregivers be appropriately trained and supervised.
- Make it mandatory for hospitals to report "suspicious cases" of elder deaths to the Medical Examiner's Office.
- Explore how issues related to family care giving that significantly influence the quality of care provided to an elderly person in the home can be addressed, for example:
    - The mental health and/or capacity of the caregiver. Is he/she mentally capable or has the mental capacity to provide care?
    - The training of the caregiver. Does he/she know how?
    - The issue of "undue influence" by another. Is the caregiver too threatened or intimidated to provide proper care?
- Ensure opportunities for different agencies to meet and discuss issues regarding elder

deaths.

- Explore the development of an Elder Resource and Assessment Center. The purpose of this center would be to create a common ground for communication integration among different disciplines by the efficient use of public agencies to better serve vulnerable elders. This center would support the following three priorities:

    1. A centralized intake system that would coordinate evaluation medical, psychological or law enforcement services, as needed;
    2. Educational trainings for health care professionals, public agencies and family members;
    3. Research dissemination.

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National Center on Elder Abuse

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Harris County Domestic Violence Coordinating Council
Adult Fatality Review
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