Sacramento County Elder Death Review Team 2019-2021 Report

Acknowledgements

The 2019-2021 Sacramento County Elder Death Review Team's collected efforts contributed to this report. Sacramento County District Attorney Anne Marie Schubert wishes to acknowledge each team members' dedication to reducing elder abuse and neglect. The Elder Death Review Team is comprised of staff from the California Department of Health Care Services, Sacramento County Sheriff's Department, Sacramento Police Department, Elk Grove Police Department, Citrus Heights Police Department, Sacramento County District Attorney's Office, Sacramento County Coroner's Office, Sacramento County Department of Child Family and Adult Services (APS), Sacramento County In-Home Supportive Services, Attorney General Medi-Cal Fraud and Elder Abuse Bureau, California Department of Consumer Affairs, Alta California Regional Center, Sacramento County Department of Health and Human Services, Emergency Medical Services Authority, In Home Supportive Services Public Authority, and Centers for Elders' Independence.

Elder Death Review Team membership changed during the period covered by this report. We have included the various representatives from each agency who have played a part in EDRT during the term of this Report:

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- Alycia Berryman, Department of Social Services, Regional Manager
- Amanda Martin, California Department of Justice, Bureau of Medi-Cal Fraud and Elder Abuse, Supervising Deputy Attorney General
- Brian Benton, Sacramento Metropolitan Fire Department, Fire Captain
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Executive Summary

The Sacramento County Elder Death Review Team (EDRT) works toward reducing elder abuse and neglect in Sacramento County. The EDRT committee is chaired by Assistant Chief Deputy District Attorney Dawn Bladet. The team discusses Sacramento County's systemic needs in the areas of support, education, and improved collaboration. Team discussions have helped the Sacramento Regional Family Justice Center (SRFJC) focus on identifying and forging partnerships with agencies to improve services to the region's elderly population.

The needs of our County's older adults are growing. With the population continuing to age, the number of reports to Sacramento County Adult Protective Services (APS) continues to increase annually. Similar increases in requests for service are being seen at the Sacramento County Regional Family Justice Center where requests by seniors for services including restraining orders is on the rise.

The District Attorney's Office has sharply increased the number of elder abuse cases reviewed and filed in the last three years. In 2019, 154 cases filed, 2020, 114 cases filed, 2021, 168 cases filed. The majority of criminal cases involve abuse of older individuals or dependent adults as these are the cases investigated and brought to the District Attorney's Office by law enforcement. The next most common case prosecuted is elder neglect, followed by financial crimes against elders.

New legislation, effective January 1, 2022, reduces the age for APS eligibility from 65 to 60 years of age. Subsequently, the number of reports to Sacramento County Adult Protective Services (APS) continues to increase annually. APS received 17,119 calls to the APS Hotline during Fiscal Year (FY) 20/21, a 121% increase in calls since FY13/14. After-hours calls to the APS hotline in FY 20/21 accounted for an additional 2689 calls. APS opened 5464 new cases for investigation of abuse or neglect during FY20/21, a 72% increase from FY 13/14.

The population of older adults needing the County's In-Home Supportive Services (IHSS) program has increased by 19% since 2017. Sacramento County currently serves 32,676 recipients and the need for services is estimated to increase annually by 5.1% or an estimated 1650 recipients. The increase has been particularly challenging due to a severe shortage of IHSS care providers, exacerbated by the COVID pandemic. In 2017, Sacramento County IHSS had 25,700 registered care providers and as of February 2022, IHSS has 30,635 registered care providers an increase of 19.2%. Approximately 70% or 21,444 IHSS care providers are relatives of the IHSS recipient. Notably, this committee has seen that many incidents of neglect and abuse of elders occurs at the hands of a relative, many of whom are being paid by IHSS to provide care. Of the 33 cases studied, 7 involved abuse or neglect where care was being provided by an IHSS provider. 18 of the 33 case studies where preventable accident, neglect or abuse of a senior or dependent person took place, the responsible caregiver was a family member. 6 of the 33 deaths studied here occurred in a care facility.

IHSS is a Medi-Cal benefit offering in-home care assistance for eligible recipients. IHSS is a voluntary recipient managed program meaning the recipient is responsible for hiring, training, supervising and terminating their care providers. The hourly wage for Sacramento County IHSS care providers is $16.00 per hour.

This report covers calendar years 2019 through 2021. Due to a variety of factors encountered during the COVID-19 pandemic, no prior report was submitted during this time period. The recommendations for improvement found in this report address the issues seen in our ERDT case reviews and are the type of repetitive elder abuse issues seen by the committee members in their community work. While our committee focus is on elder deaths, our death reviews often include elder deaths combined with elder financial abuse.

Elder abuse is common. Abuse, including neglect and exploitation, is experienced by about 1 in 10 people aged 60 and older who live at home. From 2002 to 2016, more than 643,000 older adults were treated in the emergency department for nonfatal assaults and over 19,000 homicides occurred.[1]

EDRT commends the Sacramento County Board of Supervisors for continuing to fund a Financial Abuse unit at APS to help the elderly with financial abuse issues. Unfortunately, financial abuse is a common occurrence among the cases reviewed by EDRT, particularly with victims suffering from cognitive impairment. The APS Financial Abuse Unit has helped elders retain financial independence and provides protection against scam artists who range from strangers to friends or family.

On behalf of our members, we thank the Board of Supervisors for their continued support of the EDRT multi-disciplinary efforts and its mission of reducing elder homicide and elder abuse in all forms.

MAJOR FINDINGS, PURPOSE AND IMPLEMENTATION

The Sacramento County Elder Death Review Team (EDRT) was created in 1999. EDRT is a multi-disciplinary team that meets six times a year to discuss questionable deaths of elders in Sacramento County. New cases may be introduced by any member's agency, but most are brought to the attention of the team by the Coroner's Office. Each member signs an annual confidentiality agreement which promotes the free exchange of information between agencies. EDRT reviews help identify perpetrators, methods of abuse and areas in need of systemic improvement.

Members discuss their agencies' contact with the decedent and decedent's family and known care providers. EDRT often recommends additional agency investigations and collaborations. EDRT identifies fact patterns repeatedly connected to elder lethality and recommends through this report policies or procedures to improve services and prevent additional deaths. The team identifies specific systemic shortcomings found during their case reviews and makes formal recommendations to the Board of Supervisors for improvements per Penal Code 11174.9:

> *Recommendations made by the team shall be used by the county to develop education, prevention, and if necessary, prosecution strategies that will lead to improved coordination of services for families and the elder population.*

[1] https://www.cdc.gov/violenceprevention/elderabuse/fastfact.html

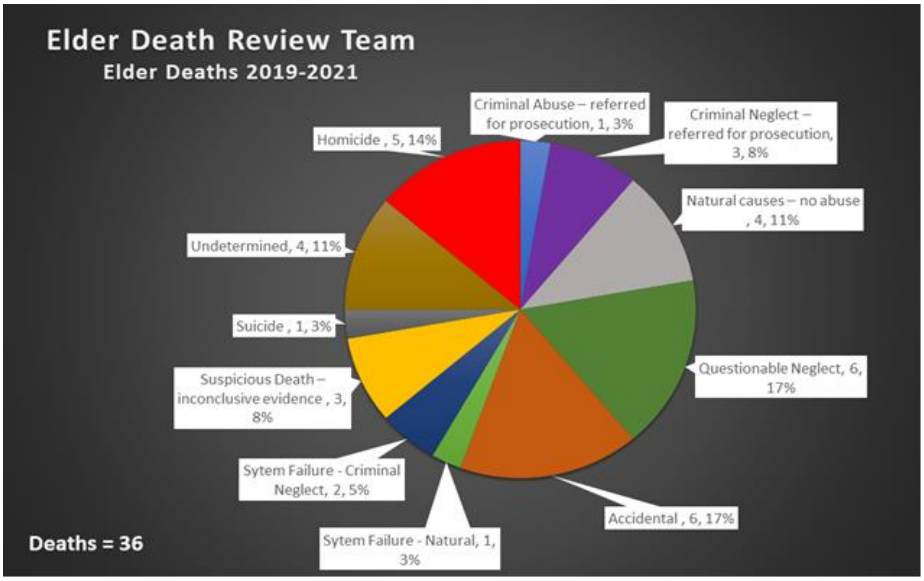
The team discusses Sacramento County's systemic needs in the areas of support, education, and improved collaboration. Team discussions have helped the Sacramento Regional Family Justice Center (SRFJC) focus on identifying and forging partnerships with agencies to improve services to the region's elderly population.

Sacramento County's senior population, now classified as those individuals age 60 and older, continues to grow rapidly since the last Census. Census numbers utilize the age 65 to categorize elder populations. According to Census estimates for 2021, the Sacramento County population over age 65 comprises 14.5% of the total county population, up from 11.2% in 2010. The increase in total population combined with the increase of county residents over age 65 increased the total elder population from 158,889 to 209,694 in seven years.[2] These elder population increases justify an increase in Sacramento County response to elder needs, including abuse and neglect.

The categories used by the EDRT Team to categorize cases reviewed are as follows:

- Criminal Abuse – referred for prosecution
- Criminal Neglect – referred for prosecution
- Natural causes – no abuse
- Preventable
- Questionable Neglect
- Accidental
- Suspicious Death – inconclusive evidence
- Suicide
- Undetermined
- Homicide
- System Failure

The breakdown of cases reviewed by the team during the applicable time period are shown in the below chart.



[2] United State Census Bureau (2021). https://www.census.gov/quickfacts/sacramentocountycalifornia.

EDRT individual case reviews brought to light several areas of concern that have impacted elder safety in Sacramento County. EDRT has proposed the additional education and protocols detailed below to prevent future premature deaths and injuries.

There are many factors that may increase or decrease the risk of elders experiencing abuse, neglect or preventable accidents. To prevent elder abuse, we must understand and address the factors that put people at risk for or protect them from violence.

- Listen to older adults and their caregivers to understand their challenges and provide support.
- Report abuse or suspected abuse to local adult protective services, long-term care ombudsman, or the police.
- Use the National Center on Elder Abuse Listing of State Elder Abuse Hotlines, Educate oneself and others about how to recognize and report elder abuse.
- Increase education and outreach to see how the signs of elder abuse differ from the normal aging process.
- Check-in on older adults who may have few friends and family members.
- Provide over-burdened caregivers with support such as help from friends, family, or local relief care groups; adult day care programs; counseling; outlets intended to promote emotional well-being.
- Encourage and assist persons (either caregivers or older adults) having problems with drug or alcohol abuse in getting help.

Risk factors seen regarding physical abuse and neglect and financial victimization for the elder population include:

- Current diagnosis of mental illness or loss of cognitive function
- Current or past abuse of drugs or alcohol
- Current physical health problems
- Past experience of disruptive behavior, trauma and inadequate coping skills
- Poor or inadequate preparation or training for caregiving responsibilities
- Social isolation

Relationship Risk Factors including:

- High financial and emotional dependence upon a vulnerable elder
- Family conflict and strained relationships
- Lack of social support

Societal Risk Factors including:

There are specific characteristics of institutional settings such as nursing homes and residential facilities, that can increase the risk for perpetration including:

- Staffing problems and lack of qualified staff
- Staff burnout and stressful working conditions
- Sense of community, meaning, residents feel connected to each other and are involved in the community[3]

[3] https://www.cdc.gov/violenceprevention/elderabuse/riskprotectivefactors.html

Falls

Each year, 36 million falls occur among older adults age 65 and older.4 One out of five falls cause serious injury such as broken bones or a head injury. Over 950,000 older adults are hospitalized because of a fall injury every year,5 most often due to a head injury or hip fracture. More than 95% of hip fractures are caused by falling,6 and falls are the most common cause of TBI related deaths and hospital admissions.[4]

Help prevent injuries and death by falls by speaking openly with your loved ones and their healthcare provider(s) about fall risks and prevention. Try to keep the elder moving and working on their balance. Check with the elder's healthcare provider to see if it's safe for them to participate in strength and balance exercises. Have their eyes and feet checked and provide proper eyewear and footwear.

Most importantly, make sure their home or care facility is safe. This can be done by helping your loved one get rid of trip hazards like throw rugs and keep floors clutter free. Brighten their home with extra lighting or brighter light bulbs. Install grab bars in the bathroom(s)—next to the toilet and inside and outside of their bathtub or shower. Install handrails on both sides of staircases.

Water Safety

Water Safety was a factor in three of the 33 deaths in our 2019-2021 case reviews. Lack of water safety around swimming pools, tubs and showers can lead to drowning deaths. When elders struggle with balance and mobility, a swimming pool or a bathtub can pose a lethal danger. Pools should be fenced off and entry should only be permitted with supervision. Extra precautions also need to be taken indoors when bathing or showering. In addition to supervision, supportive devices such as bars should be used with elders and limiting water in baths can lessen risk of drowning.

Water safety prevention steps can save a life. *An average of 3,957 unintentional drowning deaths occurred each year from 2010–2019. (CDC.gov/drowning/facts 2021) The following list is recommended by the Center for Disease Control and Prevention (CDC):[5]

- **Supervise When In or Around Water.** Designate a responsible adult to watch elders with mobility or cognitive impairments while in the bath and while around pools or areas of open water. Because drowning occurs quickly and quietly, supervising adults should not be involved in any other distracting activity (such as reading, playing cards, talking on the phone, or mowing the lawn) while supervising elders.
- **Use the Buddy System.** Always swim with a buddy. Select swimming sites that have lifeguards when possible.
- **Seizure Disorder Safety.** If you or a family member has a seizure disorder, provide one-on-one supervision around water, including swimming pools. Consider taking showers with safe sitting options rather than using a bath tub for bathing. Wear life jackets when boating.
- **Learn Cardiopulmonary Resuscitation (CPR).** Any support person who cares for an

[4] https://www.cdc.gov/stillgoingstrong/about/common-injuries-as-we-age.html#falls
[5] Centers for Disease Control and Prevention (2016). https://www.cdc.gov/homeandrecreationalsafety/water-safety/waterinjuries-factsheet.html.

elder should be properly trained in CPR. In the time it takes for paramedics to arrive CPR skills could save someone's life.

- **Air-Filled or Foam Toys are Not Safety Devices.** Don't use air-filled or foam toys, such as "water wings", "noodles", or innertubes, instead of life jackets. These toys are not life jackets and are not designed to keep swimmers safe.
- **Avoid Alcohol.** Avoid drinking alcohol before or during swimming, boating, or coming near water in a backyard pool.
- **Know the Local Weather Conditions and Forecast Before Swimming or Boating.** Strong winds and thunderstorms with lightning strikes are dangerous.

If you have a swimming pool at home:

- **Install Four-Sided Fencing.** Install a four-sided pool fence that completely separates the pool area from the house and yard. The fence should be at least 4 feet high. Use self-closing and self-latching gates that open outward with latches that are out of reach of children.
- **Additional Barriers.** Automatic door locks and alarms to prevent access or alert you if someone enters the pool area or leaves the house
- **Clear the Pool and Deck of Toys.** Remove floats, balls and other toys from the pool and surrounding area immediately after use so elders are not at risk of tripping and falling into the pool area.

IHSS Care Providers

The EDRT review of cases shows that seven of the 33 cases detailed in this report showed instances where neglect or possible abuse occurred at the hands of an IHSS care provider. Discussions included how to help a dependent adult or elder when there is no avenue to remove them from the home? People with mental impairment still choose their IHSS provider unless they are conserved. Elders and dependent adults may want family members to care for them, but those family members may not be adequately equipped to provide this care. In addition, the elder or dependent adult with cognitive deficits may succumb to pressure from family members who wish to be the assigned caregiver for financial reasons regardless of their ability to provide the proper care. This highlights the risk factors outlined above regarding elder abuse and neglect.

A person is precluded from being an IHSS provider only if they are convicted of elder or dependent adult abuse, child abuse, or fraud against a government health care or supportive services agency. IHSS regulations require a social worker to conduct an annual home visit to assess the recipient's need for services, functional status and living situation.

Suggestions from the team include creating a tiered system- identifying at-risk elders who have mental capacity issues that preclude them from choosing appropriate caregiver. Also, expanding care provider eligivility exclusion categories to include those who have violent felonies on their record or current substance abuse issues. Increase monitoring by IHSS and unannounced visits would also be helpful, but require adequate funding. If IHSS determines that the dependent has needs that are too

great for staying in the home, they can reject granting a IHSS caregiver. We saw in this report some individuals who should have been in skilled nursing facilities rather than being cared for by inadequately trained family members.

FAMILY JUSTICE CENTER

Our Sacramento Regional Family Justice Center (SRFJC) provides services to our County's senior population, especially those experiencing abuse. Their role in assisting seniors has expanded over recent years and they will be increasing their presence on EDRT as we move forward.

Elder abuse is an intentional act or failure to act that causes or creates a risk of harm to an older adult. An older adult is someone age 60 or older. The abuse occurs at the hands of a caregiver or a person the elder trusts.

The impact of elder abuse can have several physical and emotional effects on an older adult. Victims are fearful and anxious. They may have problems with trust and be wary of others. Many victims suffer physical injuries. Some are minor, like cuts, scratches, bruises, and welts. Others are more serious and can cause lasting disabilities. These include head injuries, broken bones, constant physical pain, and soreness. Physical injuries can also lead to premature death and make existing health problems worse.

Emotional factors that may impact the power dynamic elders have with neglectful or abusive family members and caregivers. Many elders live in fear but are conflicted with love and often financial responsibility for their abuser.

Most of the elders served at SRFJC are being abused by an adult child who is on drugs and/or alcohol or suffer from mental health issues. Common types of elder abuse seen at the SRFJC include:

- **Physical abuse** is when an elder experiences illness, pain, injury, functional impairment, distress, or death as a result of the intentional use of physical force and includes acts such as hitting, kicking, pushing, slapping, and burning.
- **Sexual abuse** involves forced or unwanted sexual interaction of any kind with an older adult. This may include unwanted sexual contact or penetration or non-contact acts such as sexual harassment.
- **Emotional or Psychological Abuse** refers to verbal or nonverbal behaviors that inflict anguish, mental pain, fear, or distress on an older adult. Examples include humiliation or disrespect, verbal and non-verbal threats, harassment, and geographic or interpersonal isolation.
- **Neglect** is the failure to meet an older adult's basic needs. These needs include food, water, shelter, clothing, hygiene, and essential medical care.
- **Financial Abuse** is the illegal, unauthorized, or improper use of an elder's money, benefits, belongings, property, or assets for the benefit of someone other than the older adult.

The FJC has seen an increase in elders who have been strangulated by their abuser. As a result, it is imperative that our older population are educated on the serious consequences of strangulation and the importance of seeking medical attention.

There are numerous ways that the Family Justice Center helps to prevent elder abuse. At the Sacramento Regional Family Justice Center, counseling is provided for victims either one on one with a counselor or in our "Helping Hands" Elder Support group. Additionally, all elder clients receive safety planning, medical and legal advocacy (such as filing restraining order) and offer court support, along with other supportive services listed below.

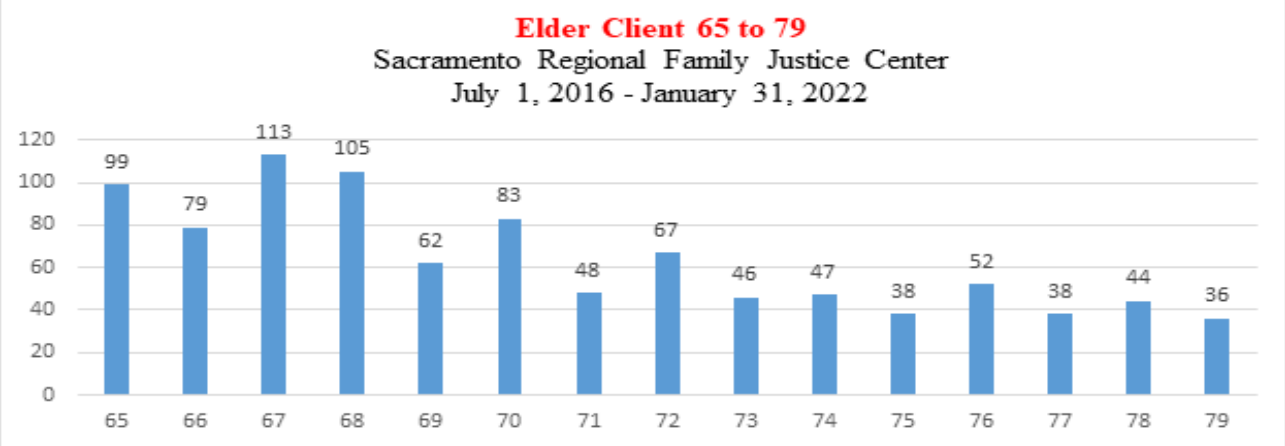
The FJC team is trained to listen to older adults and their caregivers to understand their challenges and provide additional support. Our staff receive yearly training and education from formerly named APS on how to recognize and report elder abuse and learn how the signs of elder abuse differ from the normal aging process.

Additionally, the SRFJC has a partnership with the local APS program whereby an APS Social Worker/Supervisor meets bi-monthly with the SRFJC staff to provide case reviews and identify ways to better serve our elderly abused clients.

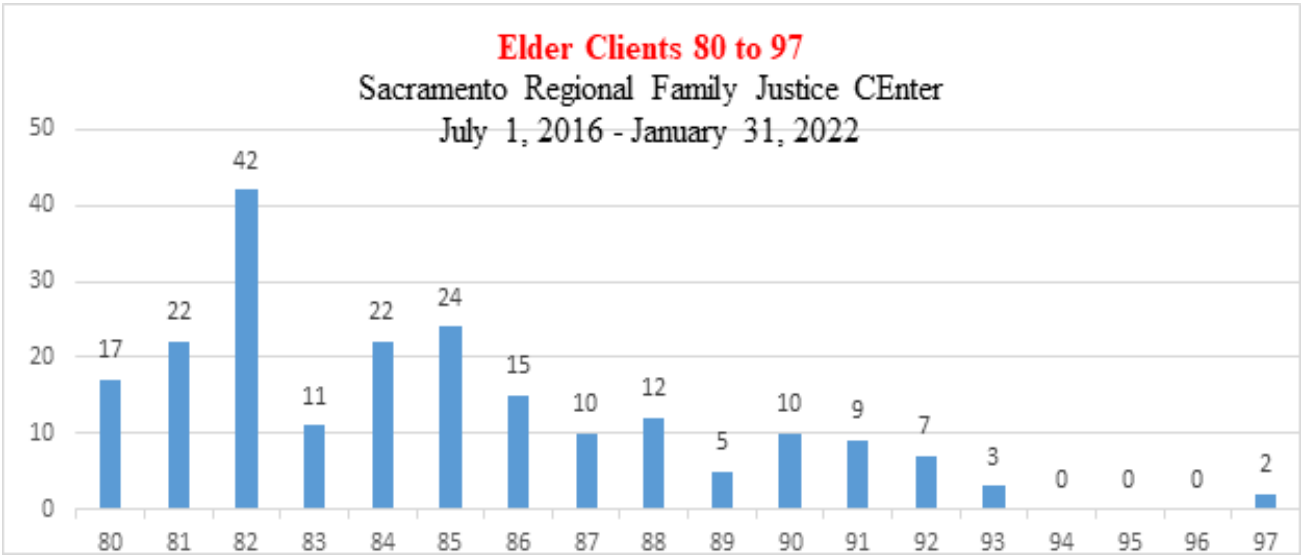
As a result of the recent Covid-19 pandemic, elder abuse cases have risen as stated in the chart contained in this report.

1168 Elder Abuse Clients Served at the FJC

July-2016 – January 2022



957 Elder Abuse Clients served were between the ages of 65 years to 79 years of age.



211 Elder Abuse Clients served were between of ages of 80 to 97.

Number of Elder Abuse Restraining Orders

2019: **104 (pre-Covid)**

2020: **237**

2021: **213**

2022: **33** (January – March)

Total Elder Abuse Restraining Orders: **587**

CASE SUMMARIES

(Summary of Cases, Findings and Case Specific Recommendations

The following cases were selected to illustrate the range of cases reviewed by the EDRT Committee. These cases were selected because many of the issues presented were found repeatedly in previous cases reviewed by the EDRT Committee. EDRT case reviews brought to light areas of concern that have impacted elder safety. EDRT has proposed the recommended education and protocols detailed below to prevent premature deaths and injuries. The year of review by EDRT, rather than the date of death is the reason for inclusion in this report.

HOMICIDES

Case #12

Summary:

H.P. was a 65-year-old female bludgeoned with sledgehammer by her husband while sleeping. S.P. then hung himself. The deaths occurred on December 21, 2019. Speculation was that the husband was upset that since during decedent's retirement she spent more time with her sister and less time with him. Detectives came to meeting and said small sledgehammer found in the laundry room and victim found in the living room on couch and her cell phone was found busted in the bottom of bathtub. Daughter had received a call from father saying they were all going to die. In 2016 the victim had reported she was a victim of sexual physical and emotional abuse at the hands of her husband.

Findings:

H.P. mechanism of death was homicide. S.P. mechanism of death was suicide by hanging. Categorization of death was homicide.

Recommendations:

It is unclear if H.P. got the services she needed as a domestic violence survivor in 2016. This case was included in the Domestic Violence Death Review Team.

Case #15

Summary:

M.S. was 87-year-old Caucasian female knocked down and lost consciousness during a robbery where suspect fled the scene. The victim never regained consciousness and passed away on December 2, 2017.

Findings:

Mechanism of death was homicide. Case Closed. Defendant pled to Second degree murder, two counts of Robbery (PC 211) and Burglary (PC 459 2nd) and received 15 years to life. Categorization of death homicide.

Recommendations:

Because of their vulnerabilities, older adults are attractive targets for those intent on committing violent crime. This case was a tragic example of how a knock to the ground in a forcible robbery can result in death for an elder who is frail and more susceptible to injury.

Case #18

Summary:

L.W. was an 85-year-old male with history of asthma, but was mostly in good health. He dropped his wife off at commissary while he went to the dentist. While at gas station, a male punched him in the face for parking too close to his vehicle. Elder had a bruised eye and nose. He refused medical treatment and went to pick up wife. They shopped and headed home, and he complained of chest pain and jaw pain. He was found that night unresponsive in his chair at home and passed away on December 12, 2016.

Findings:

MOD homicide. Suspect apprehended and prosecuted. Categorization of death was homicide.

Recommendations:

Any complaint of chest pain needs to be taken seriously and victim should have been taken to the hospital. An earlier call for assistance may have altered the outcome here. Because of their vulnerabilities, elders are attractive targets for those intent on committing violent crime. This case was a tragic example of how an assault over parking resulted in death for an elder who more susceptible to injury and death.

Case #25

Summary:

B.H. was an 88-year-old female who lived with her son and he depended on her for financial support. Before her death, elder made a call to a nephew and said something wasn't right. Nephew could hear fighting in the background and elder never returned to the phone. Nephew's wife went to go check on elder, and she was deceased, lying in a pool of blood. This was on January 16, 2016. Son was trying to flee residence. Report shows victim was hit over head with a brick. Elder's son admits to murder by saying "I did it."

Findings:

Mechanism of death was homicide. This case was referred to the District Attorney's Office and filed as a homicide, but defendant was found incompetent and never restored to competency. He was conserved and then passed away. Categorization of death was homicide.

Recommendations:

Elders are susceptible to exploitation by family members, especially in situations like this one where the elder's son was financially dependent on the elder. Ensuring our Elders are educated on services like the Family Justice Center may help in situations where they fear their caregiver or are being manipulated, neglected or abused by them.

WATER DEATHS

Case #1

Summary:

R.C. was a 58-year-old dependent male adult with severe heart disease, cachexia, emphysema, and evidence of myocardial infarction (heart attack) found by his sister in the bathtub on November 30, 2017. She heard a yell from the bathroom where her brother was taking a shower. She checked on him and he did not want help. The sister checked 15 minutes later and he was unresponsive. R.C. had second to third degree burns presumably caused by the bathtub water heat. His family had drained the tub and he had been moved to the living room by the time the fire department responded. He appeared malnourished, emaciated with ribcage and pelvic bones and burns visible. The fire department indicated rigor was not consistent with dying within the hour as family indicated. It appeared the family delayed care and delayed the report to authorities. Mechanism of death was found to be undetermined and the coroner ruled out homicide. Categorization of death was questionable neglect.

Findings:

Hot water exposure is a theme we have seen in prior EDRT reports. A dependent adult or elder bathing alone without safety features presents safety issues. R.C.'s condition at the time of his death demonstrated that he was not receiving proper nutrition or medical care by those entrusted to provide these services to him. The team's review of the R.C. case included participation and follow-up by multiple agencies. Law enforcement conducted additional investigation, medical members of the team conducted evidence review and the case was evaluated by the District Attorney's Office. There was insufficient evidence to support the filing of any criminal charges, however, there were issues identified and addressed as a result of the team's review. Service gaps and system problems were identified by members of the Elder Death Review Team as well as agency reviews independent of the team. Though multiple systems were involved with the care and protection of R.C., several of those systems failed to adequately recognize and/or address risk factors and implement appropriate preventative measures.

Recommendations include: Educating caregivers and the public on dangers of bathing accidents with elder and dependent adults. Additional oversight and intervention with the family of R.C. may have identified his lack of nutrition and current medical condition which were contributing factors to his death.

Case #9

Summary:

P.M. was 81-year-old female found submerged in her routine bath by her grandson on November 23, 2017. Her grandson checked in on her every 5 minutes, and when she did not respond he entered the bathroom and found her face down in the tub.

Findings:

Cause of death was asphyxia due to drowning. Family said she didn't have mobility issues. Categorization of death is accidental.

Recommendations:

This is unfortunately not an uncommon scenario for elders to have bathing accidents. The team recommends prevention education including safety equipment in the bathtub- such as a grab bar. It is mentioned there was no safety equipment in the bathtub. Also perhaps use only shallow water for elders bathing alone.

Case #26

Summary:

C.M. was a 89-year-old female found dead in a shallow canal near her home on January 16, 2016, partially submerged in water. Victim suffered from dementia and had history of wandering away from home when on walks by herself. She lived at home and was being cared for by her son but he worked during the day. Her daughter was home and this had happened before (she had wandered) and so family was on notice of this issue.

Findings:

Mechanism of death was accident, as was categorization of death.

Recommendations:

There should have been better supervision. There are special locks that could have been on the exits to this house to prevent the elder with dementia from getting out. They make mats to put by doors that sound alarms when stepped on. Also, GPS tracking devices (watch) for when dementia patients leave their private house unsupervised will assist in locating elders who do wander off.

OTHER PREVENTABLE ACCIDENTAL DEATH

Case #14

Summary:

J.S. was a 87-year-old male found non-responsive by his son with whom he lived. J.S. was a recovering alcoholic. J.S. was wheelchair bound the last two years but was able to wheel himself around the residence. It was noted there was a safety strap on his wheelchair. On 10/23/19, the son left the residence to run errands, returned and found the elder unresponsive in his wheelchair. It appeared he slid down the wheelchair and his neck was pressed against the strap leading to asphyxia.

Findings:

Mechanism of death was natural. Categorization is accidental.

Recommendations:

The death may have been prevented by using a vest strap rather than a sole safety strap that was used in this case. A vest strap could be safer and could prevent sliding. Education regarding appropriate restraints of elders should be enhanced.

Case #16

Summary:

V.W. was a 92-year-old female with dementia. Her downstairs neighbor called 911 due to smoke coming from unit. Fire department responded and found the elder dead and the smoke originated from stove. Granddaughter assisted with care. Elder had a history of cooking and forgetting about the stove. Granddaughter removed knobs from the stove to prevent her from cooking but had cooked and forgotten to take them back off. Date of death was March 17, 2018.

Findings:

Mechanism of death was Carbon Monoxide poisoning. Categorization is Accidental.

Recommendations:

Adding a safety feature to prohibit unauthorized dependent elders from turning stove on without supervision. Specifically, if the person has a smoke alarm that goes off, there are items on the market like FireAvert that will automatically turn off the stove. (Stove Fire Prevention | Fire Avert | Stove Shut Off for Electric and Gas Stoves & Ovens | MindCare Store)

NEGLECT and ABUSE

Case #2

Summary:

I.E. was a 85-year-old with dementia was living at her daughter's house. She was taken to the emergency room (ER) unresponsive and stabilized before being admitted to the Intensive Care Unit (ICU) on March 3, 3018. She had bruising to her right neck, left neck, shoulder, arm, wrist, and front chest and neck. She had a pressure ulcer that was unstageable, (described as a Stage 3 ulcer). The family claimed the bruising was from the family dogs. However, there was a prior substantiated APS report by her granddaughter for neglect by her daughter who was not feeding, bathing, or helping her with her medications. It was suspected that the daughter may have been using methamphetamine. At the assessment, APS observed bruising, but elder said she was happy to live with her daughter.

Findings:

Coroner's office said bruising was significant and they had a hard time believing it came from a 20lb dog. Neglect was suspected by coroner.

The elder's own doctor had not seen her in a year but implied the elder was cognitively impaired and did not believe she was being abused by the daughter a year prior. Cause of death was cardiac arrest due to sepsis and UTI. Categorization is suspected neglect.

Recommendations:

Related to this case, the team discussed the issue of caregiver preference by an elder. This was a common theme throughout the cases examined in this report. When an elder is cognitively impaired, but insists they are happy with their existing caregiver about whom there is suspicion of neglect or abuse, what can be done? When faced with physical evidence of abuse or neglect, such as bruising with suspicious explanation and prior substantiated report of neglect, how can more significant intervention take place? Are there ways that an elder's absence from regular medical care appointments can be flagged for follow-up from medical providers, so that lengthy time periods do not pass without an outside provider seeing an elder living with dementia? Educating medical providers on maintaining good communication with elders and understanding their needs would be of benefit.

Case #5

Summary:

A.J. was a 29-year-old dependent male (paraplegic from spinal cord injury in 2009) who was found unresponsive by the fire department laying supine in bed. There was no visible trauma or suspicious circumstances observed. It was noted that his eyelids were stuck together with dried yellow discharge. Pink residue or vomit was found in his decedent's mouth. Victim was wheelchair bound. His mother was his caretaker and a paid IHSS worker.

In 2012, decedent's mother dropped him off in the emergency department and stated she could no longer care for him. His mother was admitted to the hospital for a psych evaluation. It was also noted that his mother had DUI convictions. There were three APS reports alleging neglect by the mother, one of those confirmed in 2012, but no details mentioned. There had been no reports since 2012.

Findings:

Mechanism of death is natural. Team finding was Undetermined.

Recommendations:

Where there is a family caregiver being paid through IHSS, there is no way to remove her from being a provider without a criminal conviction. There were several instances discussed in this report where the responsible caregiver was being paid through IHSS and there is no mechanism to intervene in the caregiving relationship even where there is suspicion of neglect or abuse. A recommendation is for IHSS to have more authority to remove individuals from caregiver situations where caregiving concerns exist of the capacity to provide the necessary care for an elder/dependent adult.

Case #11

Summary:

Y.N. was a 56-year-old female dependent who had deficits from a stroke and a severe genetic malformation. A doctor that had only seen her once was concerned because decedent was dependent on her brother (IHSS caregiver) for care and he was not taking her to the doctor. Doctor had seen the dependent a year prior and prescribed medicine for her high thyroid level and the brother was supposed to bring her back in 3 months but never did. The doctor was not sure if the brother ever filled the prescription and stated that failure to medicate a thyroid issue can result in death.

APS advised one prior referral where they had a paratransit driver drive her home, but no one was home to take her. Her brother had removed her from a day program. The brother reported Y.N. could ambulate but was fragile and she was not on any medications. The brother reported the medications were too much for her, so he stopped giving them to her without consulting a physician. Also, there is a note that her brother admitted he was not taking care of her. Y.N.'s death occurred June 3, 2018.

Findings:

Mechanism of death was natural due to untreated thyroid. Categorization of death was questionable neglect.

Recommendations:

Once again, how can you help a dependent when there is no avenue to remove them from the home? People with mental deficits still choose their IHSS caregiver unless they are conserved. Elders and dependent adults may want family members to care for them, but those family members may not be adequately equipped to provide this care. In addition, the elder or dependent adult with cognitive deficits may succumb to pressure from family members who wish to be the assigned caregiver for financial reasons regardless of their ability to provide the proper care.

A person is precluded from IHSS caretaking only if they are convicted of elder abuse, child abuse or welfare fraud. IHSS is required to visit the home once a year to check on the recipient.

Ideas discussed include:
Creating a tiered system- identifying at-risk elders who have mental capacity issues that preclude them from choosing appropriate caregiver. Increase monitoring by IHSS and have them go out multiple times a year unannounced.

Case #19

Summary:

N.W., a 71-year-old female was transported to Mercy San Juan after being found down in her home asystole (no movement in heart). It was a hoarder home. She was found by her brother. Her friend (Power of attorney) was concerned she had been assaulted by her son who stole her money. Son sent threatening texts to power of attorney friend before and after death. Power of attorney said elder was afraid of her son and he was controlling. Son was home the day of her death. Son said he was with her the day of her death. Said he was in the garage when he got a call from her and found her in the bedroom on her knee. She said she needed sugar and he brought her some sugar and a salad. And she asked him to call 911 (he did). Son said she took care of herself. APS report from 2 months prior said she was noted to be of sound mind by her physician. Confirmed finding self-neglect in APS report.

Findings:

Mechanism of death was undetermined. Categorization of death was questionable neglect.

Recommendations:

Intervention may have been possible if power of attorney reported to authorities the threats and suspicions she had. There is often little that can be done when self-neglect is observed by APS which in this hoarder home was clearly present.

Case #21

Summary:

S.C. Decedent/elder was a 79 year old 380lb wheelchair-bound female (unclear what mental capacity was). She was taken to the hospital with sepsis and severe untreated wounds (deep bedsores on buttocks that opened to body cavity) and was not expected to make it through the night. She passed away April 4, 2017. Caretaker was victim's daughter, an IHSS worker. Daughter did not want victim admitted to hospital because she was worried about not receiving IHSS checks. There is a note that case was not submitted to the coroner because hospital said COD natural although she had sepsis which is which is typically due to untreated wounds. APS had seen home where care was being provided was in deplorable condition. There were bugs and rotting food, unused medical equipment. Neglect and bed sores led to a referral to the District Attorney.

Findings:

Criminal neglect is the categorization of this case. The criminal neglect case was successfully prosecuted.

Recommendations:

Once again, an IHSS family caregiver was responsible for care and criminally neglectful for providing it. She did not want the elder to be hospitalized for fear of losing her IHSS income. The best interest of the elder was not the motivation of this caregiver. Changes need to be made to the IHSS program. A person is precluded from IHSS caretaking only if they are convicted of elder abuse or child abuse. IHSS only has someone come out once a year to check on elders and they give notice of that check up to the caregiver.

Ideas discussed by the team include:
Creating a tiered system- identifying at risk elders who have mental capacity issues that preclude them from choosing appropriate caregiver or elders who have violent felons taking care of them. Have IHSS go out multiple times a year without giving notice to ensure proper care is being given.

Can we create a system to determine if IHSS does not meet the elder/dependent's needs and that they need a higher level of care? If IHSS determines that the elder has needs that are too great for staying in the home they can reject granting a IHSS caregiver and recommend a facility for care.

Case #22

Summary:

D.E. was an 81 year old female with a history of dementia. She was moved into an apartment where one of the tenants was being paid to care for her. One of tenants called the fire department because they noticed she was not breathing. There were inconsistencies between the stories the tenants gave to the paramedics. One said she was alive that morning, but there were early signs of

decomposition, and the room had an odor to it. Her mattress and bathrobe had dried feces on it. The room was capable of being locked from the outside. One tenant was informally caring for the elder while elder's son was supposed to find a nursing home but that tenant found an apartment for himself and left the elder at the apartment and for weeks such that no one was really caring for elder. No listed APS reports- appears no county agency was aware of the situation in order to help.

Findings:

Cause of death was severe Cachexia (unintentional weight loss) with undetermined etiology. Categorization is questionable neglect.

Recommendations:

In cases involving dementia patients in particular, outreach needs to be done with elders and their families. Encouraging families to seek guidance and assistance from our county agencies and to ensure the safe care for elder relatives is an important goal. Safety in the home, care needs and transitions to more in-depth care plans should be discussed with families who have elders in their care who are experiencing dementia. This was a situation where a family member's care endangered the elder and because there was no involvement with outside agencies, no one was aware the elder was being neglected.

Case #23

Summary:

A.G. was a 78 year old female with end stage dementia. She was bed bound for several years. She was cared for by her daughter, an IHSS paid caregiver. On November 9, 2016, she was found in bed unresponsive with significant pressure sores and decubitus ulcers and gangrene.

Findings:

Cause of death was acute bronchial pneumonia due to complications of end stage dementia. Pneumonia is often the result of bedsores. Categorization was Criminal Neglect. The case was reviewed by the Elder Abuse Prosecutor who was unable to find an expert to opine that the injuries and resulting death would be characterized as caused by neglect independent of the coroner's finding of pneumonia as the cause of death.

Recommendations:

People with dementia still choose their caregiver for IHSS even if they don't have capacity to choose. Only those who are conserved don't choose their caregiver. A person is precluded from IHSS caretaking only if they are convicted of elder abuse or child abuse. IHSS only has someone come out once a year to check on elders and they give notice of the check up to the caregiver.

Ideas discussed include:

Creating a tiered system- identifying at risk elders who have mental capacity issues that preclude them from choosing appropriate caregiver or elders who have violent felons taking care of them. Have IHSS go out multiple times a year without giving notice and ensure proper care is being given.

Another critical issue highlighted by this case is that there is no way to report this caregiver to IHSS and get her taken off the list. She can be an IHSS caregiver again because there is no criminal conviction for the specified crimes.

We also recognized the need to ensure cooperation between the Coroner's Office, law enforcement and the District Attorney's office in order to have cases of suspected criminal neglect in elder deaths referred for investigation and prosecution at the earliest possible time. A goal of EDRT in the coming year is to discuss strategies to improve upon communication and elder death case referrals.

Case #24

Summary:

R.G. was 80-year-old man with history of dementia, Parkinson's, and a prior hip fracture. Elder found unresponsive pronounced dead at the scene on May 22, 2016. Elder had multiple decubitus ulcers (stages 3 and 4), one that contained insect larva. IHSS caregiver had prior APS allegations of financial abuse and concerns regarding a burn to elder's thigh back in 2014. IHSS caregiver (non-relative) admitted not turning elder in bed. Rat feces on ground.

Findings:

Cause of death is acute pneumonia with other significant conditions, heart disease, dementia. Pneumonia would have been due to the ulcer injuries. Category of death is criminal neglect. This was an information only report taken by law enforcement and never submitted to DA for filing.

Recommendations:

Here, an IHSS caregiver with prior allegations of financial and physical abuse neglected this elder's care. This case demonstrates the lack of oversight and vetting of IHSS caregivers. There should be a process in place to review caregivers' where there is a lack of confidence in the services they provide. Where an elder has died or been injured or deemed neglected in their care, they should be removed from the program.

This is a case that law enforcement should have referred to the District Attorney's Office. We recognize the need to ensure cooperation between the Coroner's Office, law enforcement and the District Attorney's office so that cases of suspected criminal neglect in elder deaths are referred

for investigation and prosecution at the earliest possible time. A goal of EDRT in the coming year is to discuss strategies to improve upon communication and elder death case referrals.

Case #31

Summary:

J.W. was a 58-year-old female with history of fibromyalgia and alcohol abuse, sent to hospital with decubitus ulcers, ruptured stomach, and necrotic skin. Victim died shortly after arriving in the ER. Husband was primary caretaker. Victim found in bed naked, soaked in urine and feces. EMTs had to peel her off the mattress, and they did, they were removing part of her flesh that was adhered to it. Last doctor visit was 2013. Defendant claimed victim did not want to go to the hospital. One item of medicine for victim located in whole house and dated 2009. House full of empty beer bottles, horrific smells and hoarder type of home. No family members reachable for victim. Isolated victim no contact with hospital in years, no APS reports.

This case was referred to the District Attorney and successfully prosecuted with a resolution that included mental health treatment and alcohol rehabilitation for the victim's husband.

Findings:

Cause of death is multiple decubitus ulcers with infectious complications. Categorization was Criminal Neglect.

Recommendations:

It is difficult to intervene when the elder refuses proper care as reported and the caregiver does not seek services or assistance when they clearly are not equipped to offer proper care. Increased access to mental health services is one area that may have provided some relief to both the victim and her husband in this case.

Case #32

Summary:

A.H. was a 27-year-old male with down syndrome. He lived with his brother and his IHSS caregiver. 911 is called after receiving text message that victim "is dying" and he "passed away." Fire medics find victim deceased on couch with rigor mortis and bruising to head and shoulder. There is fresh blood on toilet seat cover and shower curtain and hallway wall and carpet. Cause of death blunt force trauma to head which could be caused by accidental falls. Brother says victim slipped in shower. Then says he was upset victim would not take shower and he pushed him to the shower and victim fell. Says he heard victim's neck pop, but victim was alive when he moved him to couch. Brother did not call 911.

APS history – victim ran away to hospital August and September of 2020 and said brother pushes and slaps him and IHSS caregiver hits him with a hanger.

The case was referred to the District Attorney's Office and charged as an involuntary manslaughter under the theory of failure to seek medical assistance.

Findings:

Cause of death was multiple decubitus ulcers with infectious complications. Categorization was Criminal Neglect.

Recommendations:

There is no system in place to remove dependents from the home even though there is notice of concerning circumstances. IHSS issue is highlighted again. This worker was on drugs caring for the victim and leaves him with the brother while she is getting drugs. Earlier intervention in this care situation could have saved this victim's life. Changes in the IHSS caregiver program would also go a long way to improve quality of life for those who require this kind of care and protect them from harm.

Case #33

Summary:

E.O. was an 89-year-old male. Relative calls police after finding him deceased where he lived with his son. Police find decomposed body with maggots wrapped in blanket on floor.
Son said his father died a month and a half ago, but he didn't call police because he didn't want to be alone. APS reports of financial abuse but always closed as elder did not consent to services. We pursued the financial aspect of the case and found money being withdrawn from bank account after decedent's death, but ATM videos were destroyed before we could get them to see who was withdrawing the funds.

Findings:

Autopsy- can't provide any information because body was too decomposed. Categorized as undetermined. Categorization of death was questionable neglect.

Recommendations:

There is difficulty providing help if an elder refuses services. Again, there are laws in place about reporting deaths, but they don't cover natural deaths, nor require a specific timeframe for reporting. A law that requires all deaths to be reported within 24 hours of occurrence would at least allow prosecution for this delay and possible destruction of evidence.

CARE FACILITY DEATHS

Case #3

Summary:

C.H. was a 45-year-old female dependent adult (CVA/stroke and diabetes) with a medical history of bipolar disorder and methamphetamine use. C.H. was found by staff in a board and care home supine partially on floor and partially on a mattress on April 13, 2018. There were questions as to how the decedent ended up in this position. She had bruising on face and arm. The board and care home where she resided claims decedent would forget that she could not walk and that she had daily falls. Bed was as low to ground as possible (not mentioned how low it was).

Findings:

Autopsy showed no intracranial hemorrhage, but severe coronary artery disease was noted. Mechanism of death was natural. Daily falls indicates negligence by board and care. Categorization of the case was suspected neglect. It is unclear if CDSS community Care Licensing (CCL) Board was notified. Categorization of death was questionable neglect.

Recommendations:

The board and care home should be using an alarm that goes off when there is movement for individuals who are bedbound. (It is an alarm clipped to clothes that is attached to bed and goes off when someone tries to get out of bed). There should be compliance checks in this regard and incidents of falls should be well documented to see if there are patterns with any given patient. When incidents such as this occur, CCL should be notified as a matter of course and follow-up with the facility should be done.

Case #4

Summary:

M. H was a 100-year-old female with Alzheimer's lived in assisted living facility. She was found outside the facility on the ground deceased on February 12, 2019. Last time she was seen was at 4:00 a.m. during the night check. At 5:10 a.m. she was not in her room. Victim was found outside face down between some bushes in her sleepwear. M.H. lived on the second floor by a building exit. The assisted living facility thinks she walked downstairs and fell. The elder was getting worse and would have been moved to a memory care unit soon. However, the elder was still independent and had freedom to move in and out of facility at the time of this event.

Findings:

Mechanism of death was undetermined. No lethal blunt force injury found. Categorization questionable neglect.

Recommendations:

Should there have been a process in place to identify memory issue and move someone like this out of assisted living earlier? Also, the age of this elder alone is a red flag. A recommendation is to have this individual living on a ground level floor. Patients with Alzheimer's can wear devices that will trigger alarms if they attempt to leave their room and/or the facility to protect their safety.

Case #8

Summary:

R.K was a 75-year-old male who reported abuse by operator/caretaker. He described being hit and kicked. Elder underwent emergency surgery for laceration of spleen. He died 4 days after injury due to aspiration and cardiac arrest at Kaiser South on May 21, 2016. The board and care operator/caretaker had a history of being aggressive. There was an accusation that the victim slapped caregiver before being beat by him. Cause of death was blunt force injury to upper torso causing injury to spleen that led to aspiration. It was reported that other residents were afraid of the same operator/caregiver.

Findings:

After review of the submitted investigative reports, the DA declined to file a case because of the self-defense claim presented a scenario where there was not a reasonable likelihood of conviction. The fact that the elder died was not reported to DA at time of that decision. It was unclear if the issue with the abusive caretaker was referred to the licensing board for protective measures to be taken in the future. Categorization of death was criminal abuse.

Recommendations:

Allegations of abuse by residents of a board and care facility should be investigated and licensing notified. Also, corrective action is needed on substantiated claims of abuse by operator/caregivers.

Case #13

Summary:

D.R. was 91-year-old female with dementia found lying supine on bed complaining of lower back pain. It was uncertain whether she had fallen. ER found pelvic fractures and a subdural hematoma. There was an allegation that she was pushed by a staff member at the care home. The care home told her son that she had an unwitnessed fall, but the son noted that the elder was placed in a care facility due to a history of falls.

Staff members say she fell and called for help. D.R. reported said she hit her head. Later that same night (3.5 hours later) she needed to use restroom and could not walk, and paramedics were

called. She had fractures and injuries.

Findings:

Cause of death was blunt force injuries. Facility cited for delay in care which caused death. Categorization of death is accidental, with suspected neglect.

Recommendations:

A care home should have safety measures in place to alert workers to falls. If someone has a history of falling there is an alarm that can be attached to their clothes, the bed or wheelchair and when motion is detected an alarm will sound. Also, if an elder falls, he or she should be taken to the hospital to be checked for injuries.

Case #20

Summary:

L.C.was a 96-year-old female who was moved from a skilled nursing facility (SNF) to Gramercy Court SNF 8/16/18. Victim died on 9/14/18. On 9/6/18, family received a call from SNF stating the victim was in pain and stated they were going to give her morphine. The doctor requested that her medications stop and her feeding stop. Niece went along with doctor but asked how the change in her condition occurred so quickly in 1 week. When hospice came on 9/8/18, they saw bruising and swelling, but SNF said there had been no falls. They requested she be taken to the hospital where they found multiple leg fractures in both legs and her right ribs. Traumatic fractures were not from a fall. Physician thought it was abuse from SNF.

Findings:

Mechanism of death was homicide. Referred to District Attorney for filing. Case was declined because no named suspect could be identified and no time frame given for infliction of injuries. Death is suspicious because elder could not move on her own. No cameras were in the facility and roommates were not credible and had dementia. Categorization of death was suspected homicide.

Recommendations:

Referrals to licensing for investigation and intervention should be made in these cases where suspicious circumstances led to death of an elder in a SNF.

HOSPITAL DISCHARGE WITHOUT CARE PLAN

Case #6

Summary:

D.J., a 68-year-old male was taken to Sutter General due to difficulty breathing and diagnosed with stage 4 lung cancer. He was discharged with orders to follow up with his PCP. He had trouble walking, was unable to bathe, had no outside support, no phone, and difficulty swallowing. Elder had a social worker and was going to be set up with home health care. His health rapidly declined after his discharge and before he received any home care. He returned to hospital and died shortly thereafter on June 24, 2018.

Findings:

Mechanism of death is natural. Team finding was Undetermined.

Recommendations:

Home health care did not see decedent on the same day that he was sent home from the hospital. If someone had been sent on the same day, they could have seen his declining health and helped. Notes from our discussion reflect that APS is seeing this more often - people being released from hospital with no plan of care set up. There should be a requirement home health care sees patients the same day as discharge in home to assess their immediate and long term needs at home. Hospitals should not release patients without these protections in place.

MISCELLANEOUS

Case #7

Summary:

L.J. was a 87-year-old male with dementia found naked by his grand-daughter with an altered level of consciousness in his bedroom on December 25, 2017. He lived with family. He had a history of taking off his clothes due to dementia and would say he was hot but then would be cold. He had a home health nurse visit twice a week. He appeared well cared for. There is no mention of the house being cold. Only APS reports involved financial concerns and was closed as inconclusive.

Findings:

A physician signed Cause of death as cardiopulmonary arrest due to hypothermia due to Alzheimer's. Coroner cause of death hypothermia. Categorization of death was accident.

Recommendations:

There were no specific recommendations noted by the Team. The elder was found in the family home and appeared well-cared for. Education for caregivers regarding temperature regulation for dementia patients should be provided when a caregiving situation is arranged for an elder in this condition.

Case #10

Summary:

J.M. was a 97-year-old female diagnosed with cancer in 2017. Doctor did not state the cancer would become terminal if left untreated. Daughter of elder believed this was not the cause of death because the cancer was localized, not infected or metastatic. Daughter claims care was lacking at the care facility where the elder resided. Elder was developing bedsores on her coccyx and facility prescribed her Morphine despite daughter's pleas not to give her the medication.

Findings:

Final cause of death is acute pneumonia with no underlying trauma or injuries that contributed. Categorization of death is natural. Cancer had in fact metastasized to victim's lungs which caused her death.

Recommendations:

N/A

Case #17

Summary:

E.W. was a 70-year-old female experienced pain at dialysis and had been missing appointments and had swelling and blistering on her legs & critically anemic. On 9/20/18 a nurse made a report to APS that daughter was not letting family take her to medical appointments. She had vascular and pressure sores on heels, hips, and sacrum. APS noted she received care from IHSS worker. Autopsy revealed no obvious signs of neglect or abuse her underlying co-morbidities were the primary contributors to the cause of death which occurred on September 26, 2018.

Findings:

Mechanism of death was natural. Categorization was initially Questionable Neglect, but later updated to Natural Death.

Recommendations:

Here again observations were made by APS that were concerning for neglect by family and/or an IHSS caregiver. The previous observations made in this regard are equally valid in this case study.

Case #27

Summary:

H.P. was 101-year-old found in her home on January 12, 2018, severely decomposed. Most of her family lived out of state and had not heard from her since before Thanksgiving. Every time they called her, her adult son said she was sleeping. Family requested a welfare check. Defendant was combative and uncooperative. Police got a search warrant and found victim in advanced stage of decomposition in bed. This was a failure to report the death. He said she died 2 months prior and left her due to her wishes to be left wherever she died. There was no evidence of non-natural causes of death.

2016 report to APS where a neighbor called to report the son yelled at elder like she was a dog all day long. Son had an alcohol addiction, but decedent wanted to stay living with him per APS.

Findings:

Mechanism of death was undetermined. Coroner says death likely natural but unknown due to decomposition. Our categorization of the death was suspicious death, inconclusive.

Recommendations:

How does the County provide services to families who reject assistance? This is an issue the Team discussed, but could identify no simple solution for. Regarding the delay in death reporting, there are a variety of reasons that could lead a family member to delay reporting a death. The research done by the Team found that Gov Code 27491 lists types of death that must be reported to the coroner, but does not say a timeframe. The delay in reporting the death caused the loss of evidence, which is suspicious and may have possibly led to discovery of a crime, as decomposition prevented an accurate determination of cause of death.

Case #28

Summary:

L.S. was a 77-year-old female who died at in-patient unit in Kaiser on 5/14/18. She came to Kaiser with severe dehydration and decubitus ulcers. Her adult son was her caretaker. Hospital said it was a natural death: sepsis due to bacteremia (bacteria in the blood).

There were four prior APS reports: Sept 2016, Feb 2017, August 2017, May 2018 reporting physical abuse and neglect by her son. All were unfounded except neglect was founded in May 2018 (elder facial swelling cuts on lips and urine on her and decubitus ulcers) However, Kaiser

records showed son was taking her to doctor appointments.

Findings:

Pathologist findings showed the elder died from sepsis, bronchopneumonia, decubitus ulcers and a UTI. It was uncertain which condition caused the sepsis. Mechanism and categorization of death is natural.

Recommendations:

N/A

Case #29

Summary:

R.S. was an 81-year-old male in a care home in Carmichael. Daughter said she last visited 8/10/18, 10 days prior to death on August 20, 2018. Daughter saw victim's hair parted differently, moved the hair, and saw a bruise. Daughter asked staff about the bruise, and staff said there was no record of a fall. Elder's physician said she had a forehead contusion and bruise on her clavicle.

Findings:

Autopsy performed. Coroner report found neglect unfounded and determined she passed away in her sleep. Mechanism and categorization of death is natural.

Recommendations:

N/A

Case #30

Summary:

T.S. was a 85-year-old male found deceased on his couch. He lived with adult son (his caretaker) and grandson. Grandson found him dead while father was out walking. Victim had swelling in left arm, skin discolorations. No medications observed in the house, and there should have been some. Victim had a history of Alzheimer's, amongst other conditions. Victim had not showered in over a month due to sores on back and hip being too painful. Ulcers ranged from stage 1-4. Son reported that elder did not want to be moved in the past 2 weeks. Son claimed elder refused to be taken to hospital. Had not been to doctor in 2 years. No mention of APS or anything showing county had notice of care issues.

Findings:

Autopsy states no trauma noted, UGI bleeding and severe coronary artery disease. Mechanism of death and categorization is natural.

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Recommendations:

It is difficult to intervene when the elder refuses proper care as reported.

RECENT IMPROVEMENTS IN SACRAMENTO COUNTY'S RESPONSE TO ASSISTING ELDERS

Since our last report, Sacramento County has improved the response to elders in need of assistance. WEAVE recently received a grant for an elder advocate to respond to elder needs in Sacramento. This WEAVE Elder Advocate is located at the Sacramento Regional Family Justice Center and works with APS to provide emotional support, crisis counseling, advocacy, and resource referrals. This advocate will provide training to local government and community agency staff on elder abuse, domestic violence, sexual assault and chair a monthly collaborative meeting for community agencies.

Sacramento County offers easy access to elder care information resources. The County 211 system provides both health and senior services referrals accessible via phone or the internet.
The Department of Health and Human Services (DHHS) also has information for seniors. Sierra Sacramento Valley Medical Society Alliance publishes and DHHS distributes a comprehensive publication entitled Community Resources for Older Adults as well as a multitude of resources related to housing and financial abuse. The California Department of Social Services provides easy to access consumer videos that include information on the availability of services and support. The District Attorney's Office has a pamphlet on elder abuse and support services entitled "Elder and Independent Abuse: Recognizing the Warning Signs." This pamphlet can be found on the Sacramento County DA website, SacDA.org and attached to this report. The Sacramento Bee has a Senior Resource Directory available on their website. In Home Support Services (IHSS) Public Authority offers free classes to the public on daily care and elder abuse prevention to anyone who has an interest in learning.

FINAL NOTE

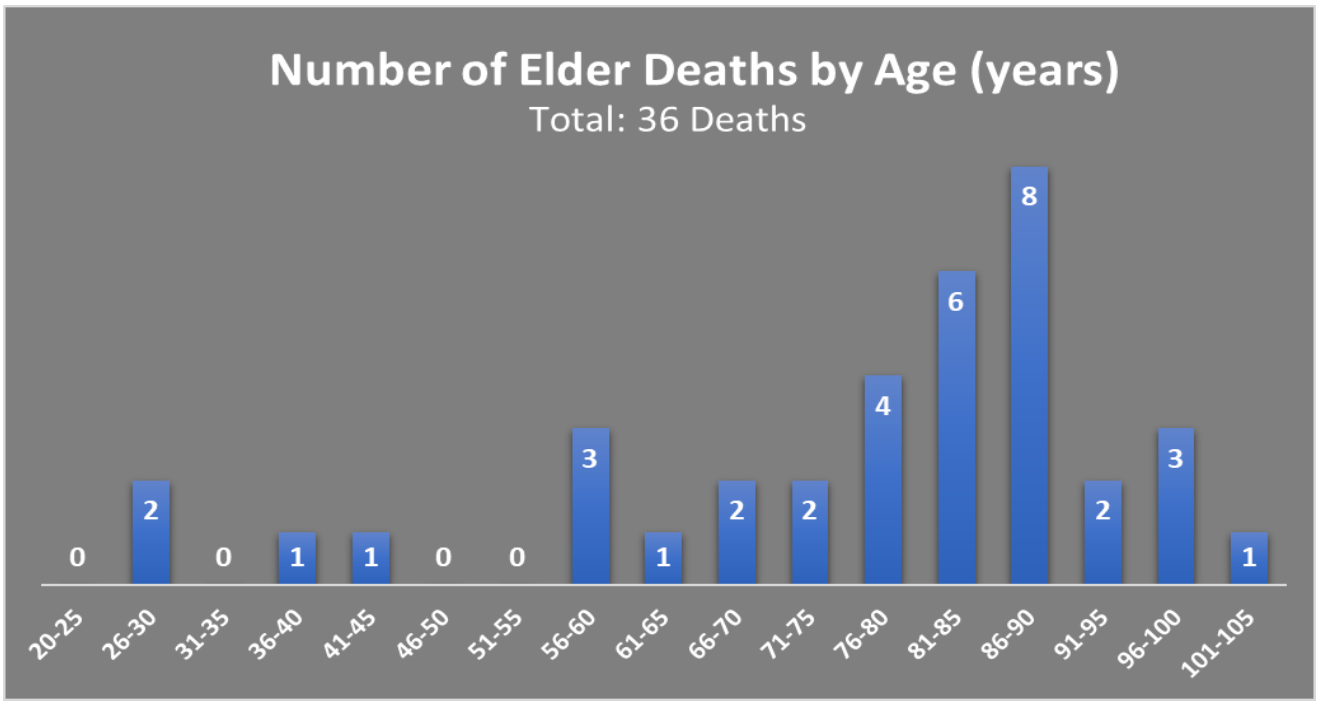
While the cases summarized above represent themes identified where death was preventable, many of cases reviewed by EDRT resulted in findings that the decedent died due to natural causes with no abuse. Other cases were homicide scenarios where control over circumstances is limited.

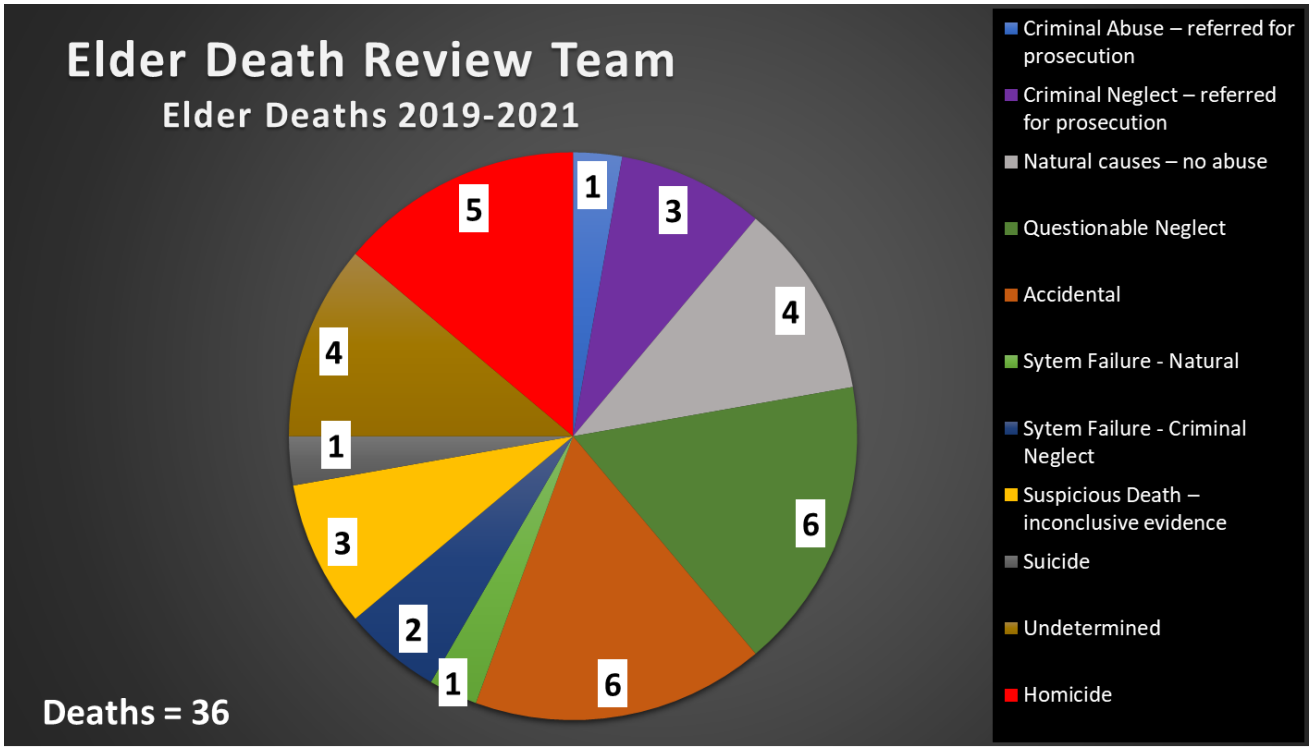
Only cases that have been resolved and had some elements of care concerns are included in the statistics for this report. If a criminal case is pending, the case was not included, but will be included in a subsequent report once the case is resolved and the criminal justice process complete. The date of death is not determinative of inclusion of the report, rather the year of discussion with the EDRT team is when a case will be documented.

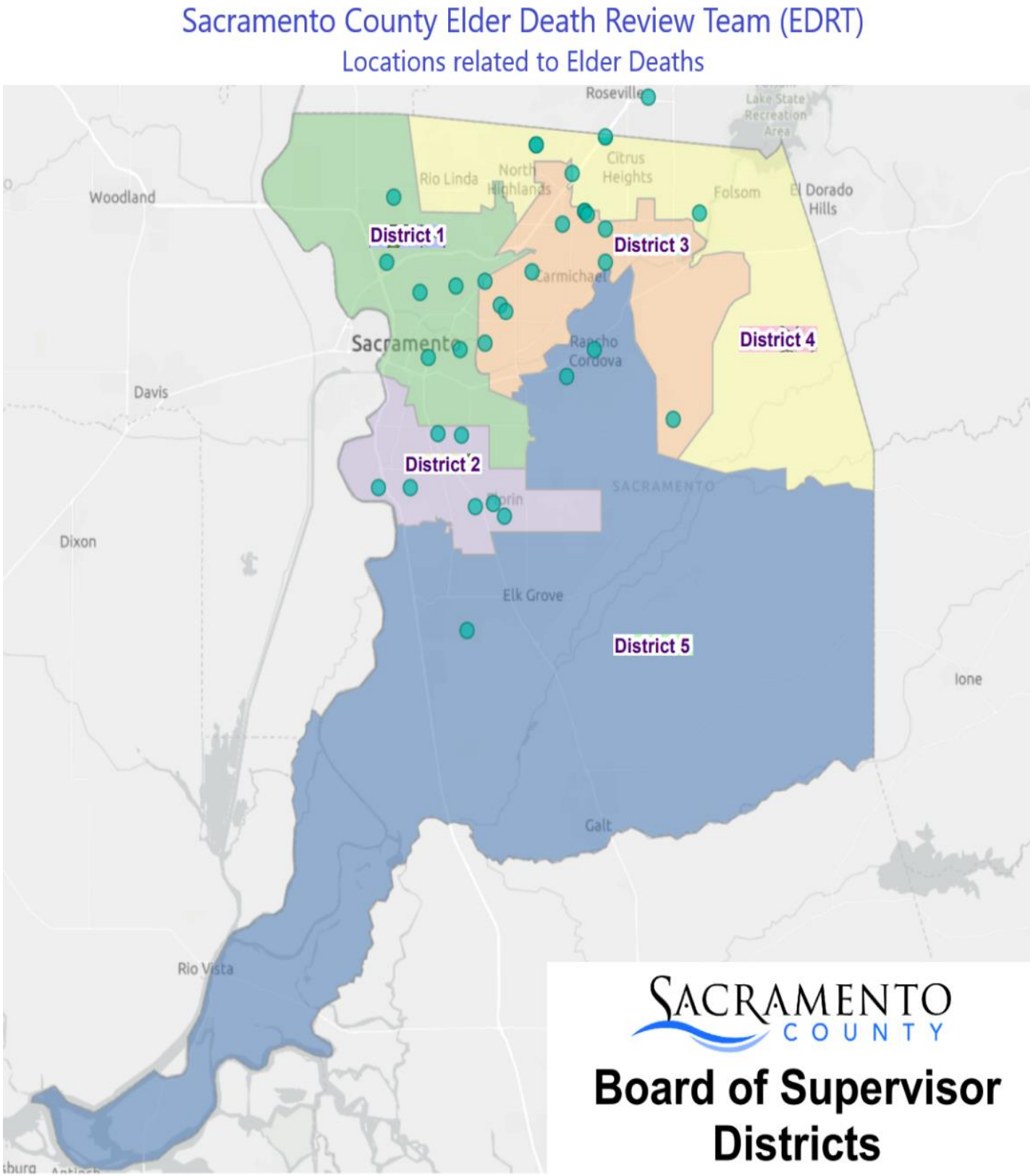
The final page of the report is a map which displays the geographical locations in Sacramento County where the elder abuse cases referenced in this report occurred. Due to the small sample size and limited correlation to elder abuse cases that do not end in death, the map should not be used to project the future needs of Sacramento County's elder population.

STATISTICAL REVIEW

(Information from the charts below reflect only the cases reviewed within this report.)






Sacramento County Elder Death Review Team (EDRT)
Locations related to Elder Deaths
Roseville
Lake State Recreation Area
Citrus Heights
Rio Linda
North Highlands
Folsom
El Dorado Hills
Woodland
District 1
District 3
Carmichael
Sacramento
Rancho Cordova
District 4
Davis
District 2
SACRAMENTO
Dixon
Elk Grove
District 5
Ione
Galt
Rio Vista
SACRAMENTO COUNTY
Board of Supervisor Districts

RESOURCES

Elder and Dependent Adult Abuse

Recognizing the warning signs

Signs of self-neglect or abuse

Some seniors are unable to maintain a healthy standard of living due to physical or cognitive impairments. Identifying the signs will help seniors who are not able to care for themselves to get the help they need.

Physical Signs:

- Uncombed or matted hair
- Poor skin condition or hygiene
- Refusal of necessary medical care
- Dressing inappropriately for the weather
- Dishevelled personal appearance
- Lack of clean clothing
- Having a strong odor of feces or urine
- Appearing malnourished or dehydrated

Behavior Warning Signs:

- Withdrawn
- Confused or forgetful
- Helpless or frightened
- Angry
- Secretive
- Hesitant to talk freely
- Refusing to allow visitors inside the residence

External Signs:

- Inadequate or disconnected heating, plumbing, or electrical service
- Very dirty residence
- Extremely cluttered home; pathways or entrances blocked by objects
- Animal droppings in the home
- Lacking fresh food; eating spoiled food or going hungry
- Living in an unsafe situation

Any person who suspects that elder or dependent abuse has occurred or sees that someone may be in need of services, please report it. Call Adult Protective Services at (916) 874-9377. Or 911 if you notice a life-threatening situation.

Important Resources

Community Resources

Sacramento Co. Adult Protective Services
Investigates allegations of abuse and neglect for seniors and dependent adults, and provides referrals to local social service programs.
916.874.9377 **www.dhhs.saccounty.net/sas**

Sacramento Regional Family Justice Center
Provides trauma-informed individual counseling as well as referrals to group counseling for both adults and children.
916.875.4673 **www.hopethriveshere.org**

McGeorge School of Law Elder and Health Law Clinic
Free legal assistance to low income seniors.
916.340.60806 **www.mcgeorge.edu**

Sacramento Co. In-Home Supportive Services
Helps aged, blind, or disabled persons to remain in their homes with paid caregivers with paid caregivers.
916.874.9471 **www.dhhs.saccounty.net/sas**

Sacramento Co. Senior Volunteer Services
Offers volunteer opportunities for adults over age 55 to stay active and make a difference in the lives of others.
916.875.3631 **www.dhhs.saccounty.net/sas**

Sutter Health - SeniorCare PACE
Offers a broad range of comprehensive, coordinated services.
916.446.3100
checksutterfirst/seniorserrvices/seniorcare.html

Victims of Crime Resources Center
Resources and referrals to victims, families, service providers, and advocates.
800.842.8467 **www.1800victims.org**

Law Enforcement Resources

Sacramento County District Attorney's Office Victim Witness Assistance Program
www.sacda.org/helpingvictims/victim-witness
916.874.5701

Citrus Heights Police Department
www.citrusheights.net/222/Police
916.727.5500

Elk Grove Police Department
www.elkgrovepd.org
916.714.5115

Folsom Police Department
www.folsom.ca.us/city_hall/depts/police
916.355.7234

Galt Police Department
ci.galt.ca.us/city-departments/police-department
916.366.7000

Rancho Cordova Police Department
www.ranchocordovapd.com
916.875.9600

Sacramento City Police Department
www.cityofsaramento.org/Police
916.264.5471

Sacramento County Sheriff's Department
www.sacsheriff.com
916.874.5115

To request a District Attorney Speaker on Elder and Dependent Adult Abuse, please visit www.sacda.org or email speakers@sacda.org.

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Personal Community Resource Reference

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www.sacda.org/helpingvictims/victim-witness
916.874.5701

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Folsom Police Department
www.folsom.ca.us/city_hall/depts/police
916.355.7234

Galt Police Department
ci.galt.ca.us/city-departments/police-department
916.366.7000

Rancho Cordova Police Department
www.ranchocordovapd.com
916.875.9600

Sacramento City Police Department
www.cityofsaramento.org/Police
916.264.5471

Sacramento County Sheriff's Department
www.sacsheriff.com
916.874.5115

To request a District Attorney Speaker on Elder Abuse, please visit www.sacda.org or email speakers@sacda.org.

901 G Street • Sacramento, CA 95814
916.874.6218
CA Relay Service 800.735.2929 TDD or 711

Facebook.com/SacCountyDA @SacCountyDA

Sacramento County
District Attorney's Office

Elder and Dependent Adult Abuse

District Attorney
Anne Marie Schubert
Sacramento County
District Attorney's Office
sacda.org

IN-HOME SERVICES

- 211 Sacramento
  211; 916-498-1000 or 800-500-4931
- The Senior Connection - Eskaton
  916-334-1072
- www.Healthfinder.gov

For domestic and/or personal care for elder or dependent adults in their home:

- Area 4 Agency on Aging
  916-486-1876
  www.a4aa.com
- In-Home Supportive Svcs., IHSS
  916-874-9471
- Sutter SeniorCare PACE
  916-424-8412

HOME REPAIR

Home repair assistance for seniors and the disabled:

- Contractors State Licensing Board
  (license verification/problems with contractors) 1-800-321-2752
- Home Assistance/Repair for Seniors
  (and disabled) 916-264-1506 or
  tsater@shra.org
- Rebuilding Together
  916-455-1880
- Sacramento Housing & Redevelopment Agency
  916-264-1500

For heating or cooling problems:

- Sacramento Municipal Utility District, SMUD
  1-888-742-7683
- SMUD Energy Assistance Team
  916-874-0979 or seat@saccounty.net
- Pacific Gas & Electric, PG&E
  1-800-743-5002

OTHER AVAILABLE RESOURCES...

For help finding a residential or long term care facility:

- Community Care Licensing
  916-263-4700

For seniors over 59 who need food delivered:

- Senior Nutrition Services
  916-444-9533

For free specialized telephone equipment for disabled consumers of any age:

- California Phones
  1-800-806-1191 - Call Center
  1-800-806-4474 – TTY
  www.ddtp.org

To report suspected abuse of an elder or dependent adult:

- Adult Protective Services
  916-874-9377
- Sacramento County Sheriff's Dept.
  916-874-5306
- Sacramento Police Department
  916-808-0650

If you suspect abuse or neglect at a long term care facility:

- Ombudsman Services of Northern CA
  916-376-8910 **OR** 1-800-231-4024
  www.osnc.net

Questions on conservatorships:

- Court Investigators Office
  916-875-3400

For transportation assistance:

- Regional Transit
  916-321-2877 **OR** 916-483-4327 TDD
- Paratransit
  916-429-2744
- South County Transit
  1-800-338-8676
- California Dept. of Developmental Svcs. (for eligible consumers)
  916-654-2054 TTY or 916-654-1690

For employment assistance:

- Sacramento Employment and Training Agency (SETA)
  916-263-3700 **OR** 1-800-735-2929 TTY
  www.seta.net

Low cost auto insurance for low income good drivers:

- 1-866-602-8861

To find out if a charity is legitimate:

- California Attorney General's Office
  (916) 322-3360
  www.ag.ca.gov/charities/

Find out if a sales person/company is legitimate before investing:

- Department of Corporations
  1-866-275-2677
  www.corp.ca.gov

Sacramento County
District Attorney's Office &
Department of Health & Human Services

Independent Living Resource Guide

Service Categories:

- Medical
- Mental Health
- Financial
- Respite
- Legal
- In-Home Svcs
- Home Repair
- Other

IF THERE IS AN EMERGENCY CALL 911

Provided by:
The Sacramento County
Elder Death Review Team
EDRTCoordinator@SacCounty.net