CHAPTER 2020-17

Senate Bill No. 400

An act relating to elder abuse fatality review teams; creating s. 415.1103, F.S.; authorizing a state attorney, or his or her designee, to initiate an elder abuse fatality review team in his or her judicial circuit; providing conditions for review team membership, establishment, and organization; specifying requirements for a review team's operations and meeting schedules; defining the term "closed case"; requiring that the administrative costs of operating a review team be paid by team members or the entities they represent; authorizing elder abuse fatality review teams in existence on a certain date to continue to exist; requiring such existing teams to comply with specified requirements; specifying review team duties; requiring each review team to annually submit to the department a summary report containing specified information by a certain date; requiring the department to annually prepare a summary report based on the review teams' information and submit such report to the Governor, the Legislature, and the Department of Children and Families; providing immunity from monetary liability for review team members under certain conditions; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 415.1103, Florida Statutes, is created to read:

415.1103 Elder abuse fatality review teams.—

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

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

1. Law enforcement agencies.

2. The state attorney.

3. The medical examiner.

4. A county court judge.

5. Adult protective services.

6. The area agency on aging.

7. The State Long-Term Care Ombudsman Program.

8. The Agency for Health Care Administration.

9. The Office of the Attorney General.

10. The Office of the State Courts Administrator.

11. The clerk of the court.

12. A victim services program.

13. An elder law attorney.

14. Emergency services personnel.

15. A certified domestic violence center.

16. An advocacy organization for victims of sexual violence.

17. A funeral home director.

18. A forensic pathologist.

19. A geriatrician.

20. A geriatric nurse.

21. A geriatric psychiatrist or other individual licensed to offer behavioral health services.

22. A hospital discharge planner.

23. A public guardian.

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

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

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

(e) Each review team shall determine its local operations, including, but not limited to, the process for case selection. The state attorney shall refer cases to be reviewed by each team. Reviews must be limited to closed cases in

which an elderly person's death was caused by, or related to, abuse or neglect. All identifying information concerning the elderly person must be redacted by the state attorney in documents received for review. As used in this paragraph, the term "closed case" means a case that does not involve information considered active as defined in s. 119.011(3)(d).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 2. This act shall take effect July 1, 2020.

Approved by the Governor June 9, 2020.

Filed in Office Secretary of State June 9, 2020.