REPORT OF THE
DEPARTMENT OF SOCIAL SERVICES

VIRGINIA ADULT FATALITY REVIEW TEAM:

PREVENTING FATAL ABUSE AND NEGLECT OF VIRGINIA'S VULNERABLE ADULTS

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 30

COMMONWEALTH OF VIRGINIA
RICHMOND
2004

COMMONWEALTH of VIRGINIA

Office of the Governor

Jane H. Woods
Secretary of Health and Human Resources

(804) 786-7765
Fax: (804) 371-6984
TTY: (804) 786-7765

October 28, 2004

MEMORANDUM

TO: The Honorable Mark R. Warner
Governor, Commonwealth of Virginia

The General Assembly of Virginia

FROM: Jane H. Woods
Secretary of Health and Human Resources

SUBJECT: Chapter 749 and 1011 (2004 Acts of the Assembly)
Adult Fatality Review Team

The 2004 General Assembly passed legislation to amend the *Code of Virginia* relative to adult protective services. The amendments were intended to enhance protections for the Commonwealth's vulnerable adult population. The fourth enactment clause in Chapters 749 and 1011 of the 2004 Acts of Assembly directs the Secretary of Health and Human Resources, in consultation with the Departments of Social Services and Health, to develop a model protocol, procedures and cost estimates for the operation of adult fatality review teams. The fourth enactment clause further requires the Secretary to report on this information to the Governor and General Assembly by November 1, 2004.

The enclosed report addresses the need for a statewide adult fatality review team and provides an overview of adult fatality review teams in other states. The report includes preliminary protocols for Virginia's adult fatality review team, the team's mission and purpose, and cost estimates. Recommendations are offered to address, among other areas, procedures, team composition and products. The Virginia Adult Fatality Review Team Advisory Committee, comprised of a wide variety of representatives from local and state agencies, private organizations, advocates, and other interested parties, convened to develop the team protocols, procedures and cost estimates included in this report.

REPORT ON VIRGINIA ADULT FATALITY REVIEW TEAM: PREVENTING FATAL ABUSE AND NEGLECT OF VIRGINIA'S VULNERABLE ADULTS

PREFACE

The 2004 General Assembly passed legislation to amend the *Code of Virginia* relative to Adult Protective Services (APS). The amendments were intended to enhance protections for Virginia's vulnerable adult population and best practices in APS for the Commonwealth. The fourth enactment clause in Chapters 1011 and 749 of the 2004 Acts of Assembly directs the Secretary of Health and Human Resources, in consultation with the Departments of Social Services and Health, to develop a model protocol, procedures and cost estimates for the operation of adult fatality review teams. The fourth enactment clause further requires the Secretary to report on this information to the Governor and General Assembly by November 1, 2004.

The Virginia Adult Fatality Review Team Advisory Committee, comprised of a broad variety of representatives from local and state agencies, private organizations, advocates, and other interested parties, convened in order to meet the requirements of the mandate. (See Appendix D for members of the committee). The Advisory Committee established the model protocol and procedures, and the cost estimates were based on costs incurred from the maternal, family violence, and child fatality review teams staffed through the Office of the Chief Medical Examiner at the Virginia Department of Health. The Adult Services program staff at the Virginia Department of Social Services has been assigned the coordination and reporting function for the fatality review team.

REPORT ON VIRGINIA ADULT FATALITY REVIEW TEAM: PREVENTING FATAL ABUSE AND NEGLECT OF VIRGINIA'S VULNERABLE ADULTS

TABLE OF CONTENTS

REPORT ON VIRGINIA ADULT FATALITY REVIEW TEAM: PREVENTING FATAL ABUSE AND NEGLECT OF VIRGINIA'S VULNERABLE ADULTS

EXECUTIVE SUMMARY

The purpose of this report is to provide the Governor and General Assembly with information on the operation of adult fatality review teams, as required by the 2004 General Assembly. The 2004 General Assembly passed legislation to amend the *Code of Virginia* relative to Adult Protective Services (APS). The fourth enactment clause in Chapters 1011 and 749 of the 2004 Acts of Assembly directs the Secretary of Health and Human Resources, in consultation with the Departments of Social Services and Health, to develop a model protocol, procedures and cost estimates for the operation of adult fatality review teams. The fourth enactment clause further requires the Secretary to report on this information to the Governor and General Assembly by November 1, 2004.

All people deserve to live and die with dignity, but many older adults die from physical abuse or neglect by those who are responsible for their care. In other instances, many elders die from their own neglect and reluctance to seek help.

The Commonwealth of Virginia is taking an unprecedented step towards preventing needless deaths of vulnerable adults by investigating suspicious fatalities. Virginia will be the first state nationally to establish a fatality review team that investigates adult fatalities statewide. The following report is in response to the mandate that the Secretary of Health and Human Resources develop a model protocol and cost estimates for the operation of an adult fatality review team.

An adult fatality review team functions to examine suspicious deaths for the purpose of detection and prevention. By studying fatalities and determining the extent to which deaths were preventable, the Virginia Adult Fatality Review Team will be able to identify gaps in service delivery and interagency coordination. The process of reviewing the facts and circumstances of death will enable the Virginia Adult Fatality Review Team to advocate for improvements in policy, legislation, procedures, and best practices.

The Virginia Adult Fatality Review Team is modeled after the statewide child fatality review team, which was organized to reduce preventable child deaths by reviewing sudden, violent, and unnatural deaths. Similar to the child fatality review team, the Virginia Adult Fatality Review Team will conduct retrospective examinations of decedents' records through an interdisciplinary panel comprised of a wide array of agency and system representatives. The mission statement of the Virginia Adult Fatality Review Team is:

> "As a multidisciplinary team, we review and analyze violent and unnatural deaths of vulnerable adults in order to make recommendations for improved legislation, policy, interagency collaboration and coordination, and to enhance education, training, and service delivery so that ultimately, preventive measures are established and elderly

individuals and adults with disabilities are protected from experiencing a violent, unnatural, or preventable death."

Protocols of the Virginia Adult Fatality Review Team include:

- The overall goals of the Virginia Adult Fatality Review Team include: detect deaths attributable to abuse/neglect of elderly individuals and adults with disabilities; identify social patterns contributing to fatal outcomes; identify service gaps; develop intervention strategies; educate the community about fatal abuse/neglect; and prevent fatalities of vulnerable adults due to abuse/neglect.

- The team will be comprised of 16 members appointed by the Governor, based on recommendations by the Commissioner of the Virginia Department of Social Services (VDSS) and the Chief Medical Examiner of the Virginia Department of Health. The team will represent a wide array of private, local, and state organizations. The team will be co-chaired by the Chief Medical Examiner and the Commissioner of VDSS.

- Statutory language will be proposed to permit release of records to the Adult Fatality Review Team. The language will also assure the confidentiality of information and discussions, and provide that records and documents will be exempt from the Freedom of Information Act.

- The team will present findings and recommendations to the Governor and the General Assembly no later than October 1 of each year.

The estimated annual cost for the Virginia Adult Fatality Review Team will be approximately $95,000 for a coordinator's salary and benefits, equipment, materials, and supplies. The costs will be requested by the Virginia Department of Social Services, which will transfer the $95,000 to the Department of Health. The Department of Health will provide office space and supervision for the coordinator.

REPORT ON VIRGINIA ADULT FATALITY REVIEW TEAM: PREVENTING FATAL ABUSE AND NEGLECT OF VIRGINIA'S VULNERABLE ADULTS

Study Mandate

The 2004 General Assembly passed legislation to amend the *Code of Virginia* relative to adult protective services (APS). The amendments were intended to enhance protections for Virginia's vulnerable adult population and promote best practices in APS for the Commonwealth. This report was prepared in response to the fourth enactment clause in Chapters 1011 and 749 of the 2004 Acts of Assembly, as follows:

4. That the Secretary of Health and Human Resources, in consultation with the Departments of Social Services and Health and other state and local entities as appropriate, shall develop a model protocol and procedures for, as well as cost estimates for the operation of, adult fatality review teams to review suspicious deaths of vulnerable adults and provide ongoing surveillance of suspicious adult fatalities in order to create a body of information to help prevent future fatalities. The Secretary shall report to the Governor and General Assembly on the model protocol and cost estimate no later than November 1, 2004.

Introduction

The growth in the elderly populations has affected every segment of the social, political and economic landscape in America. Despite a trend toward an increased emphasis on a quality aging experience and a commitment to improving the lives of elderly individuals and adults with disabilities, abuse and neglect of vulnerable adults has gone largely unidentified and unnoticed.

Elders and adults with disabilities are prime targets for abuse and neglect because they may be too frail to resist and are often dependent on the abuser for caregiving. Deaths of elderly individuals and adults with disabilities, particularly those requiring skilled care, are generally not suspect. As a result, individuals are able to physically, sexually, emotionally, and financially abuse vulnerable adults, deny them food and water, and refuse them medical treatment, knowing that these at-risk victims will not or cannot report to authorities. In many instances, the abuse or neglect leads to the person's death but is hidden due to other prevailing illnesses and disabilities to which the death is attributed.

Adult fatality review teams are designed to unveil the secrecy of deaths due to abuse and neglect and build a strong basis for prevention efforts. The value of fatality teams is that they are comprised of various disciplines dedicated to preventing abuse and neglect of vulnerable adults, and fostering a concerted effort to expose abuse and neglect. "Multidisciplinary teams have become a hallmark of elder abuse prevention programs, reflecting growing consensus that no single agency or discipline has all the resources or expertise needed to effectively resolve all forms of abuse and neglect" (National Center on Elder Abuse, 2003, p. 3.).

Background

"Quiet killings" are those deaths occurring in hospitals, nursing homes, assisted living facilities, and home-based and health care settings that are categorized as either due to negligence or medical error and not viewed as criminal in nature. While there are numerous cases in which elders are intentionally murdered, many acts go undetected. In addition, elders often commit suicide through hidden, covert methods, such as refusing to take medication or not seeking needed medical treatment. Deaths are not investigated because the prevailing thought is that elders die, that old age and death are synonymous. Passive and overt suicide among elders does not incite the same proportion of tragic response as suicide among other age groups.

In response to issues of detecting and preventing elder abuse and neglect, the 2004 General Assembly enacted changes to the Adult Protective Services section in the *Code of Virginia*. The changes to §§63.2-1603 through 63.2-1606 and §§63.2-1608 through 63.2-1610 require suspicious deaths to be reported to medical examiners and law enforcement. Additional professions were added to the list of mandated reporters, and the Virginia Department of Social Services (VDSS) was mandated to develop cost estimates and protocols for an adult fatality review team.

NEED FOR ADULT FATALITY REVIEW TEAMS

The need for an adult fatality review team in Virginia stems from several social issues in the Commonwealth and throughout the nation, including 1) an increased number of elderly persons; 2) a shortage of caregivers; 3) an increase in the number of adult abuse and neglect cases; 4) greater risk of adults with disabilities to be abused or neglected; 5) the difficulty in detecting adult abuse and neglect; and 6) the potentiality of death due to elder abuse and neglect.

Increase of Elderly Persons

Worldwide, the population is aging dramatically, with more people than ever before aged 65 and older. In the next generation, 75 million Americans will be over age 65, twice the number of elders in 1996 and 25 times the number that lived in 1900. By the end of the century, one-third of the population will be aged 65 and older, in comparison to only one-seventh of the population in 2000.

The fastest growing segment of the population is individuals over age 85. While the total population over age 65 increased by 188 percent during 1950 to 2000, the population over age 85 increased by 635 percent. From 2000 to 2020, the national population over age 85 is expected to double in the nation, an increase of 7 million persons (Bonnie, 2003).

In Virginia, the elderly population is growing faster than in most other states in the country. During the years 2000 to 2025, the number of elders in Virginia is expected to grow by 79 percent, similar to other southern states. Nationwide, the number of elders is expected to grow by 71 percent during 2000 to 2025 (U.S. Census, 2000).

Increases in the elderly population are attributable to improved hygiene and sanitation, enhanced knowledge of health and disease, advanced medical technology, and longer life expectancy. In 1900, for example, the average life expectancy was 49 years. In 2000, however, the average life expectancy was 77 years. By 2050, life expectancy is projected to range from 84 to 86 years old (Kinsella & Velkoff, 2001).

Shortage of Skilled Caregivers

While the population is aging, the needs of the elderly are increasing. Data from the 2000 Census indicates that 12 percent of elders have limitations with activities of daily living and still live in the community. Of those over age 85, about half (45 percent) need help with activities of daily living and about one-third (30 to 39 percent) have some form of dementia present.

Elders rarely (5 percent) move into nursing homes for care and increasingly want to "age in place" in their homes and communities. Unfortunately, health insurance restrictions, limited financial resources of most elders, and shortage of paid caregivers necessitates that elders increasingly rely on family members for caregiving tasks. Over 70 percent of home-based care is provided by spouses, children, other family members, and volunteers. The responsibility for elder caregiving frequently falls on family members who are already overwhelmed by family and employment demands, who lack knowledge about appropriate elder care, and have unrealistic expectations of their elderly family members. Frequently, family members providing caregiving are themselves emotionally or physically limited, and the elder has assumed some level of responsibility for housing or financially supporting the caregiver.

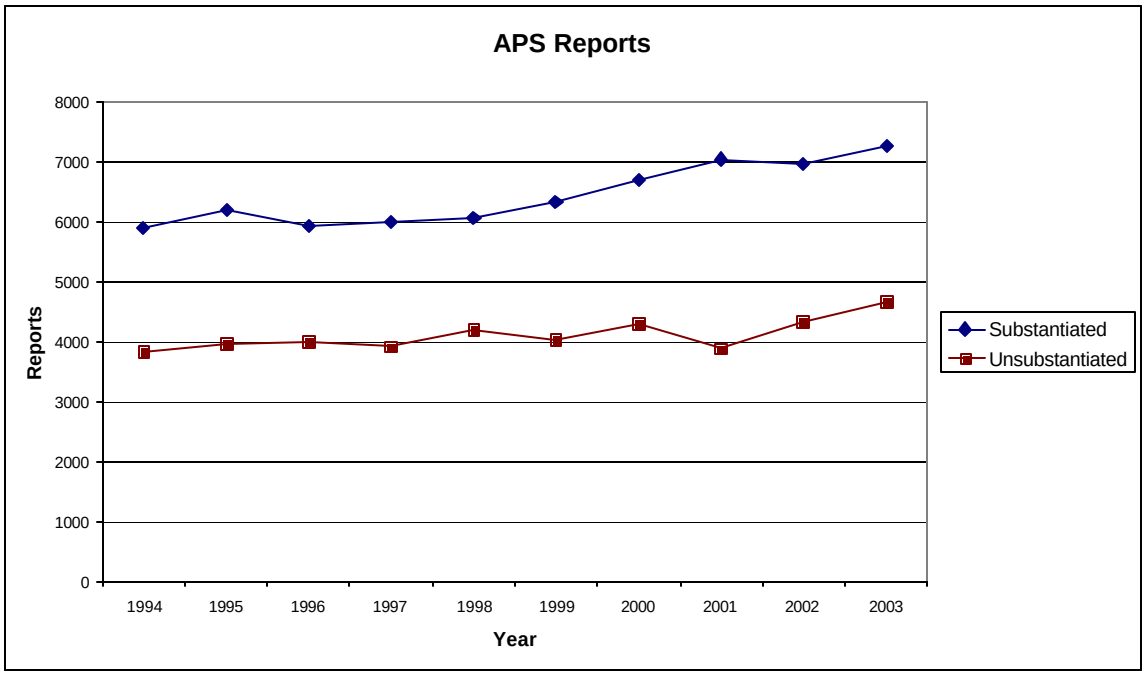
"One aspect of the changing age structure of families that has received recent attention is the so-called 'sandwich generation,' that is, people who find themselves caring for elderly parents while still caring for/supporting their own children or grandchildren and often participating in the labor force. In developed countries especially, more people will face the concern and expense of caring for their very old, frail relatives with multiple, chronic disabilities and illnesses…Some of the adult children may bear health limitations of their own" (Kinsella & Velkoff, 2001, p. 79).

Increase in Cases of Elder Abuse and Neglect

In Virginia during the last ten years, reports of abuse and neglect to Adult Protective Services (APS) escalated from 9,738 in 1994 to 11,949 in 2003, an increase of 23 percent. Chart 1 demonstrates the rise of APS reports, both substantiated and unsubstantiated cases.

The numbers of adult abuse and neglect cases are also increasing on a national level. Between 1986 and 2000, APS reports of abuse, neglect, and exploitation increased by nearly 300 percent nationwide, to reach one to two million reports annually (U.S. Congress Special Committee on Aging, 2001). "The numbers reflect that abuse is a gravely serious problem and growing," said Paula Mixson, chairperson of the National Association of Adult Protective Services Administrators (National Center on Elder Abuse, 2001).

Chart 1. Abuse, Neglect, and Exploitation Reports to Va. Adult Protective Services.



Victims of APS reports in Virginia are typically adults aged 60 and over (72 percent); 28 percent of the reports involved an adult aged 18 to 59 with a disability. The victim lived with a spouse or other relative (38 percent), alone (29 percent), in a nursing facility (14 percent), in an assisted living facility (9 percent), in a facility licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services (3 percent), or in other living arrangements (7 percent) (Virginia Department of Social Services, 2003). Elders over age 80 are the most common targets for abuse and neglect, being victimized about three times more often than other elders (National Center on Elder Abuse, 1998).

Based on findings of the National Elder Abuse Incidence Study, the National Center on Elder Abuse estimates that for every incident of elder abuse or neglect reported and substantiated, over five other incidents of elder abuse or neglect are unreported. As the elderly population skyrockets, and as elders have to increasingly rely on untrained family members with physical, emotional, and health limitations, elders are often placed in a precarious situation in which they are at risk of abuse and neglect.

Greater Vulnerability of Adults with Disabilities to be Abused or Neglected

Individuals with disabilities have greater risk of suffering abuse or neglect than other adults. While only 17 percent of Virginians aged 16 to 64 years old have disabilities (U.S. Census, 2000), about 28 percent of the APS abuse and neglect victims in Virginia are adults with disabilities (VDSS, 2003). The disproportionate number of elder abuse/neglect reports clearly indicates that individuals with disabilities are at greater risk of abuse and neglect than other

adults. In a study of 1,000 callers to a dementia hotline, (Coyne, Potenza, & Berbig, 1996), 12 percent of the family caregivers indicated that they physically abuse the family member with dementia. Family caregivers who were most abusive were found to be providing many hours of care daily to very functionally impaired family members. The study underscores how family members are often overwhelmed by the responsibility of caring for family members with disabilities, and how being overwhelmed can result in physical abuse.

The Difficulty in Detecting Adult Abuse and Neglect

When Attorney General Janet Reno convened a discussion of fatal elder abuse and neglect (U.S. Dept. of Justice, 2002), the 27 experts gathered described how fatal abuse and neglect cases are typically undetected. Research findings have identified patterns of bruises, fractures, pressure sores, malnutrition, and dehydration that may indicate possible abuse and neglect, yet there is little opportunity for interagency communication and examination of fatalities. The committee cited concerns about the limited information and training on fatality issues and the lack of opportunity for health care, social services, and law enforcement to collaborate, and recommended multidisciplinary groups be formed to discuss concerns and suspicions about abuse and neglect.

Death Due to Abuse and Neglect

The risk of death due to elder abuse and neglect is escalating exponentially due to the increased number of elderly persons, particularly those over age 80; the shortage of adequate caregivers, both family members and paid staff; and increasing rates of adult abuse and neglect. Older adults who are mistreated are over three times more likely to die within the next decade than those of the same age with no reported mistreatment (Lachs, 1998).

During 1999 to 2002, 25 to 30 elders over age 64 in Virginia were murdered each year, averaging one elder homicide by a caretaker each year. Included in this count are 3 to 7 homicides of elders per year committed by spouses or other intimate partners (Va. Dept. of Health, 2003). These findings indicate that elderly individuals are too often being exposed to severe physical abuse. As a result, many elders have died a preventable death, as indicated in the following headlines in Virginia newspapers that describe fatal abuse and neglect.

- **Death at Nursing Home Under Investigation (**August 25, 2004. Hampton Roads, VA). Police are investigating the death of a 79-year-old woman late last month at a nursing home off Battlefield Boulevard. Charges are pending and could include involuntary manslaughter. The July 26 death of Ziffie Hicks, who was strapped into a wheelchair and left unattended inside Chesapeake Healthcare Center, also is being looked into by state regulators and nursing home administrators, court records show. Hicks slid down in the chair and was found several minutes later hanging by the "seat belt" in the chair, according to a search warrant affidavit filed in circuit court. *The Virginian-Pilot*.

- **Jury Indicts Man on Murder Charges; He's Accused of Killing Great-Grandparents in Lee County Case.** (August 7, 2004. Lee County, VA). Lee investigators found the bodies of Sherman O. Bush, 87, and his wife, Hazel, 84, lying on the kitchen floor of

their house in the Jasper area on Feb. 17, 2004. An autopsy report introduced during Jimmy Allen Ayers' preliminary court appearance in June concluded that the elderly couple died from shotgun blasts. *Richmond Times-Dispatch.*

- **Husband Convicted of Elder Abuse.** (Sept. 10, 2000. Martinsville, VA). Paul Michael Stolbun, 80, and his son, Peter Martin Stolbun, who lived with his parents, were indicted on charges of elder abuse after Elizabeth Stolbun died. Peter Stolbun has since left the area. Last November, after several attempts, a social worker with the Henry County-Martinsville Department of Social Services walked into the Stolbun home and found Mrs. Stolbun, 75, lying in a twin bed in her own filth. She died in surgery Nov. 26, 1999. *Richmond Times-Dispatch.*

- **Police Probe Death of Couple.** (July 26, 1994. New Kent, VA). An elderly New Kent County couple was found fatally wounded yesterday at their Woodhaven Shores home in a case police are investigating as a murder-suicide. The call was received at the 911 center at 9:06 a.m. from a person reporting a murder-suicide. When Lt. Joe McLaughlin arrived at the scene, he found the Browns dead from an apparent murder-suicide involving a shotgun. *Richmond Times-Dispatch.*

- **Slain Great-Grandmother had Given Money to Suspect** (September 26, 1991. Norfolk, VA). The teenager who killed his 83-year-old great-grandmother three weeks ago choked her with apron strings and beat her to death nine months after he bought cocaine with money she had given him to buy a car. These details emerged Wednesday at a pretrial hearing in General District Court. But the teenager's mother, Sheila Collins, asked the judge in the case to set bail for her son, saying the victim had probably made the teenager angry enough to kill. *The Virginian-Pilot*.

- **Mecklenburg Says Man Shot Wife, Self (**July 13, 1981. Mecklenburg, VA). A Chase City man apparently shot his wife to death before turning the shotgun on himself Friday night, the Mecklenburg County Sheriff's Department said yesterday. Helen Collier King, 73, and Eston Carter King, 70, were found dead on a bed in their home on state Route 92 west of Chase City after gunshots were heard at about 8:40 Friday night, Sheriff Harold T. Harris said. *Richmond Times-Dispatch.*

Elders are committing suicide at alarming and increasing rates. The rate of suicide among individuals over age 65 is higher than any other age group, and elders are much more likely to successfully kill themselves than younger people. Depression, chemical imbalances, poor health, and social isolation are cited as the major factors contributing to suicides among the elderly. Nationwide, about 13 out of every 100,000 elders commit suicide annually. News reports of elder suicides in Virginia include the following.

- **Police Say Elderly Pair Died in Double Suicide.** (Jan. 5, 1998. Manassas, VA). John and Jeanne Joseff killed themselves in the bedroom of their apartment Thursday. Mrs. Joseff, 87, recently had learned of a serious illness. Her husband was 84. *Richmond Times-Dispatch.*

- **Ettrick Man, 71, Found Shot To Death (**August 23, 1988. Ettrick, VA). A 71-year-old Ettrick man shot himself to death yesterday afternoon beneath Campbell's Bridge, which carries state Route 36 across the Appomattox River between Petersburg and Ettrick, police said. *Richmond Times-Dispatch.*

"The elderly usually act on a decision to commit suicide and rarely make idle threats to take their lives," said Dr. Nancy J. Osgood, a nationally known expert on suicide by the elderly and a Virginia Commonwealth University gerontologist, in the October 15, 1989 *Richmond Times Dispatch*. In the cases studied by Dr. Osgood, virtually all the suicides followed a pattern that started by withdrawal from institutional and family life that culminates in not eating. Some of the cases were overt suicidal acts, such as wrist-slashing, shooting, asphyxiation, jumping or hanging. The majority of the suicide cases, however, involved accidents, self-mutilations, or refusing to eat, drink or take medication, in which the suicide is more hidden and covert.

FATALITY REVIEW TEAMS

Fatality Review Teams in the Nation

Originated by the automobile industry and the medical profession, fatality review teams operate to examine deaths in order to improve systems. Hospitals use morbidity and mortality reviews to examine medical procedures and prevent future medical problems. Car manufacturers investigate fatal car accidents to improve car safety and design. Child abuse and domestic violence professionals have incorporated fatality review concepts to analyze deaths in order to identify systemic issues that may contribute to fatal abuse and neglect. As a result, fatality review teams improve interagency case management, identify gaps in service delivery, clarify data to be collected, and suggest protocols and policy.

One commonality of fatality review teams is that they study deaths after the fact. Their purpose is not retribution or to recommend criminal penalties. The fatality teams do not function to assign blame to an agency, a system, or an individual, but to analyze strategies to reduce the potential for similar fatalities in the future. Often, review teams do not receive case records until after all litigation has ended or applicable criminal penalties have been ordered. Fatality teams operate on state, local, or multi-jurisdictional levels. The advantage of state review teams is that many different types of cases and interagency issues may be examined. The ability to candidly examine fatalities and agency responses can be difficult in local review teams when team members were also involved in the fatality case. A statewide fatality review team permits a statistically significant number of deaths to be reviewed and produces enough data to determine trends. Virginia has developed a statewide model for reviewing child and adult abuse fatalities.

Child Abuse Fatality Review Teams

Some of the states that have formed child fatality review teams are Virginia, Arizona, Georgia, Tennessee, and California. The Commonwealth of Virginia established a child fatality review team in 1995, for the purpose of analyzing the deaths of children and determining if the deaths could have been prevented. The team is comprised of 16 members and chaired by the Chief Medical Examiner. Members of this team include the Commissioner of the Department of

Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), the VDSS program manager of Child Protective Services, Superintendent of Public Instruction, State Registrar of Vital Records, and Director of Criminal Justice Services.

Members are also appointed by the Governor to serve three-year terms, including those employed by local law enforcement, local fire departments, local departments of social services, the Medical Society of Virginia, Virginia College of Emergency Physicians, Virginia Pediatric Society, Virginia Sudden Infant Death Syndrome Alliance, local emergency response, the Office of the Commonwealth's Attorney, and community services boards. The protocol for this team is to analyze deaths of children that occur in an unnatural and violent manner, sudden deaths of children within the first 18 months of life and deaths in which no cause or manner was determined. The child fatality review team generates a report each year with system recommendations.

Domestic Violence Fatality Review Teams

A number of states have formed domestic violence fatality review teams, including Virginia, Florida, Minnesota, Iowa, Tennessee and Washington, among others. In Virginia, a fatality review team was developed in March 2001, funded by a grant awarded by the Violence Against Women Act Grant Office and administered by the Virginia Department of Criminal Justice Services and the Virginia Supreme Court, Office of the Executive Secretary. Members of the fatality review teams consist of representatives from law enforcement, the medical examiners office, public health, probation and parole, mental health, social services, domestic violence programs, and the Office of the Commonwealth's Attorney. A thorough protocol manual was developed by the advisory team for each fatality review team to use as guidance and structure. The team provides a yearly compilation report including a five-year trend analysis.

Adult Abuse Fatality Review Teams

Adult abuse fatality review teams are the latest type of fatality review team to be formed. In 2000, Attorney General Janet Reno led groundbreaking discussion on medical forensic elements of elder abuse and neglect. The experts present, including forensic pathologists, adult protective services, law enforcement, and medical professionals, determined that "…medical and forensic science relating to elder abuse and neglect in the year 2000 is about the equivalent of where child abuse was 30 years ago," and pleaded for a "multidisciplinary research agenda to ascertain the real scope of the problem and whether interventions and treatments are working" (U.S. Dept. of Justice, 2002).

Some of the states that have started implementing these multidisciplinary teams include Arizona, Arkansas, Oregon, Maryland, Texas, and California. The teams review adult fatalities in specific localities as pilot projects. There are currently no statewide adult fatality review teams in the nation other than the review team currently being developed in Virginia.

Arkansas passed legislation in 1999 for an elder fatality review team to investigate deaths within long-term care facilities located in Pulaski County. The coroner inspects every death in long-term care facilities within Pulaski County, regardless if the apparent cause of death is

natural. Information reviewed includes incident reports, medical records, death certificates, autopsy reports, notification of death forms, and additional provider information. Minutes and forms completed by the team are confidential and not subject to disclosure as a public record. A case in which there is reasonable cause to suspect the death occurred due to abuse/neglect is reported to the police and prosecuting attorney's office for an investigation. As a result of the review, the Pulaski County coroner's office discovered that approximately eight percent of all deaths in the long-term facilities were directly attributable to abuse or neglect.

California passed legislation in 2001, allowing counties to implement interagency review teams to identify and review suspicious elder deaths. The elder abuse fatality review teams are comprised of experts in forensic pathology, coroners and medical examiners, district attorneys, law enforcement employees, and other state and local private partnerships.

The state of Oregon is currently writing legislation to develop adult fatality review teams. Bend, Oregon has developed the Elder Abuse Fatality Review Team, and is addressing issues of confidentiality in acquiring case information.

Arizona has implemented the Death Analysis Review Team in Pima County for adult abuse cases. The team consists of members from law enforcement, public health, social service agencies, health care providers, Office of the Pima County Attorney, Office of the Arizona Attorney General, Office of the Medical Examiner, Pima County's Sheriff's Department, Tucson Police Department, Pima County Elder Abuse Task Force, Department of Health Services, Adult Protective Services, Public Fiduciary Office, and a forensic psychiatrist. The team is chaired by either a representative of the County Attorney's Office, the Attorney General's Office, or the Pima County Elder Abuse Task Force.

Maryland has developed an adult services fatality protocol for implementation of local and state review of deaths of the elderly. Local departments of social services in Maryland conduct independent investigations into the deaths of every elderly person who is suspected to have suffered from an unnatural or suspicious death. The local social services agency conducts a preliminary review within two working days of receiving the report of suspicious death. The state review of elder adult fatalities focuses on reviewing facts surrounding reported deaths to identify potential policy and practice issues.

In the state of Texas, legislation was passed that allows counties to establish adult fatality review teams. They review any deaths of adults that appear to have occurred "without anticipation or forewarning and to have been caused by suicide, family violence or abuse."

The Adult Fatality Review Team in Virginia is designed to investigate fatalities on a statewide basis in order to have a broad perspective of the systems involved in fatalities of vulnerable adults; i.e., adults at least 18 years old with disabilities and elders at least 60 years old. The statewide perspective enables the review team to address legislation, policy, and procedures that may lead to fewer preventable deaths

Research

In a national study of elder abuse fatality review teams, the National Committee for the Prevention of Elder Abuse found that the teams were multidisciplinary, comprised of professionals from an array of systems representing law enforcement, adult protective services, adult services, the courts, medical examiners and other state/local agencies. The study focused on teams that reviewed cases in which elders died due to suspected abuse or neglect.

Findings from the study (Teaster, n.d.) include:

- The most (at least 90 percent of respondents) frequently cited functions of fatality review teams include providing expert consultation to service providers; identifying service gaps and systems problems; and updating members about new services, programs, and legislation.

- Other respondents (at least 80 percent) frequently cited functions of the team include advocating for change, planning and carrying out training events, and planning and implementing coordinated investigations or care planning.

- Over one-fourth (26 percent of respondents) require members to attend a certain number of meetings. "Typically, team members are encouraged to provide alternative attendees in their absence if they are unable to attend" (Teaster, n.d., p. 8).

- Most fatality review teams (74 percent) meet monthly.

- Slightly over half (52 percent) of elder fatality review teams require contracts or memoranda of understanding from team members.

- Most elder fatality review teams have summarized proceedings of meetings (55 percent) and/or case review guidelines (52 percent).

- Some teams have policy and procedures manuals (32 percent), job descriptions (29 percent), orientation manuals (29 percent), and/or term limits (23 percent).

    - Orientation materials include general information on elder abuse, pertinent laws, research, policies, confidentiality agreements, by-laws, etc. One team produced an orientation video.
    -
    - Of those with term limits, most allow members to serve more than one term.

- Leadership is typically through Adult Protective Services (32 percent) or Area Agencies on Aging (13 percent), with other state, university, local government or non-profit entities leading the other teams.

- "The most common source of support to teams is APS programs, which provide support to 38.7 percent of the teams surveyed" (Teaster, n.d., p. 14). The vast majority of APS support (92 percent) is in-kind staff support, meeting space, and printing/mailing.

- About half (48 percent) of the teams receive financial support from other sources such as AARP, foundations, Office of the Attorney General, colleges, hospitals, state attorneys, mental health providers, law enforcement, and the medial examiners.

- The most common challenge is a shortage of certain disciplines participating in meetings (48 percent). Another common challenge is finding and maintaining an adequate number of cases to review (23 percent).

- Other problems include failure of certain groups to present cases (16 percent), confidentiality (13 percent), animosity among members (10 percent), failure to agree upon follow-up (10 percent), and members feeling time is wasted (7 percent).

- Many teams (36 percent) have state laws permitting information sharing and/or immunity state laws protecting meeting information from being used as evidence in civil actions or disciplinary hearings.

"In conclusion, MDTS (multi-disciplinary teams) play a key role in communities' response to elder abuse and are highly valued by those who participate. Among the benefits they cited were strengthening community relationships, eliminating or ameliorating turf wars, promoting team work and cooperation, providing assistance on cases referred for guardianship, helping clients secure improved medical care, and enhancing members' understanding of services" (Teaster, n.d., p. 19).

The Commission on Law and Aging of the American Bar Association (2004) funded three demonstration projects with $5,000 seed money each "in order to foster examination of and improvement in the responses of APS, law enforcement officers, prosecutors, victim assistance providers, health care providers, and others to the growing number of victims of elder abuse" (Stiegel, 2004, p. 18). Findings from the pilot studies in Houston, Texas; Pulaski County, Arkansas; and Orange County, California include:

- Barriers for successful elder abuse fatality review teams include lack of funding, limited resources and support, problems maintaining confidentiality, "turf issues," need for statutory/regulatory changes, lack of support from law enforcement, prosecutors, and/or medical examiners, ambiguous case review criteria, and negative media coverage.

- Successful fatality review teams typically allow for candid discussions about system flaws and endorse a confidential environment.

- Team composition is most often comprised of adult protective services, the Attorney General, coroner, facility regulators, geriatricians, law enforcement, ombudsman, medical examiner, nursing, prosecution, and victim assistance programs.

ESTABLISHMENT OF VIRGINIA ADULT FATALITY REVIEW TEAM

Adult fatality review teams are comprised of professionals who assess the extent to which the deaths of elderly individuals and adults with disabilities were preventable. They examine deaths in order to improve the system that caused, contributed to, or failed to prevent a needless death. Adult fatality review teams are typically patterned after child and domestic violence fatality review teams which analyze abuse-related deaths in order to change the systems' response to victims and avoid similar outcomes. The overarching goal of adult fatality review teams is to reduce the number of preventable deaths.

Statutory Authority

During the 2004 session of the General Assembly, Senator Janet D. Howell and Delegate Adam P. Ebbin sponsored Senate Bill 318 and House Bill 952 respectively to revise and add new provisions to existing adult protective services law, including additional reporting and investigation procedures, and the development of an adult fatality review team. The bills passed by an overwhelming majority. (See Appendix B for a summary of the bills.)

The concept for the Virginia Adult Fatality Review Team is an outgrowth of the statewide Virginia Child Fatality Review Team and the multi-jurisdictional Family and Intimate Partner Violence Fatality Review teams that were both established through the *Code of Virginia* §32.1-283.1. (See Appendix C.) The statute authorizes the Chief Medical Examiner to develop model protocols for fatality review teams and to provide technical assistance to review teams. The protocols developed by the Office of the Chief Medical Examiner for Family Violence Prevention fatality teams provide a framework for the Virginia Adult Fatality Review Team.

The fourth enactment clause requires the Secretary of Health and Human Resources, in consultation with VDSS and the Virginia Department of Health, as well as other state and local entities, to establish procedures and cost estimates for the operation of an adult fatality review team to review suspicious deaths of vulnerable adults. (See Appendix A for the study mandate.) Vulnerable adults are individuals at least 18 years old with disabilities and elder adults who are at least 60 years old.

To consider the issues of adult fatality review, VDSS formed an interdisciplinary advisory committee to discuss the issues and recommend protocols. The advisory committee includes representatives from the Office of the Secretary of Health and Human Resources; Virginia Departments of DMHMRSAS, Health Professions, Health, and Social Services; the Alzheimer's Association; Virginia Association of Counties; Virginia Hospital and Healthcare Association; State Long-Term Care Ombudsman; Virginia Commonwealth University; Virginia Coalition for the Aging; Virginia Health Care Association; Virginia Association of Non-Profit Homes for the Aging; the Office of the Attorney General; and local government.

Meeting of APS Advisory Committee to Establish Virginia Adult Fatality Review Team

The Virginia Adult Fatality Review Team Advisory Committee convened on July 28, 2004, to discuss protocols and composition of the Virginia Adult Fatality Review Team. The meeting was well attended, with almost all of the 45 professionals invited attending. The members expressed strong interest and commitment to the fatality team process and indicated great willingness to continue planning efforts.

At the meeting, members were given an opportunity to discuss and recommend draft protocols. Preliminary decisions were made about the team's mission, case selection process, and structure. Additional planning meetings will be conducted in the near future to discuss policies and procedures for selecting cases, confidentiality assurances, data collection, and reporting.

PRELIMINARY VIRGINIA ADULT FATALITY REVIEW TEAM PROTOCOLS

Mission Statement

The Virginia Adult Fatality Review Team will examine deaths associated with suspected abuse and/or neglect of vulnerable adults. Individuals 18 to 59 years who have a disability or are at least 60 years old are considered vulnerable adults. Responsibility for preventing adult abuse and neglect fatalities lies within the community and not with any single agency or entity. Use of an adult fatality review team to carefully examine fatalities provides the opportunity for education and prevention and will lead to improved coordination of services and safety throughout the Commonwealth.

The Virginia Adult Fatality Review Team Advisory Committee recommended a mission statement that addresses a multidisciplinary approach, focuses the scope of fatality reviews to violent and unnatural deaths, and clarifies the purpose of the team. (See Recommendations.)

> "As a multidisciplinary team, we review and analyze violent, suspicious, and unnatural deaths of vulnerable adults in order to make recommendations for improved legislation, policy, interagency collaboration and coordination, and to enhance education, training, and service delivery so that ultimately, preventive measures are established and elderly individuals and adults with disabilities are protected from experiencing a violent, unnatural, or preventable death."

Goals

The main responsibility of the Virginia Adult Fatality Review Team is to examine deaths of vulnerable adults with suspected abuse and/or neglect victimization in order to determine the extent to which the deaths are preventable. Overall goals of the fatality review team include:

- Prevent fatalities of vulnerable adults due to abuse and neglect, including suicide.

- Uncover deaths attributable to abuse or neglect that were mistakenly categorized as natural deaths.

- Expand knowledge and expertise needed to distinguish natural from unnatural deaths.

- Identify social trends and patterns that may lead to fatal outcomes.

- Distinguish events precipitating fatalities to develop prevention and intervention strategies.

- Identify gaps in services to improve inter-systems coordination, collaboration, and communication.

- Develop intervention strategies to reduce fatalities through improved service delivery procedures, legislation, policy, and other mechanisms.

- Educate agencies and the community about abuse and neglect of vulnerable adults.

Purpose

The purpose of an adult fatality review team is to operate through a systems approach to heighten an understanding of circumstances involved in suspicious deaths, to provide information to legislators and policy makers, to make recommendations for prevention and intervention and ultimately, to make changes to the Commonwealth's policy and practices so that vulnerable adults do not die needlessly. The general purpose of the Adult Fatality Review Team is determining how systems and agencies can collaborate on preventing future fatalities, not to assign blame or seek retribution for vulnerable adults who died.

Tasks of the Virginia Adult Fatality Review Team

The Virginia Adult Fatality Review Team will:

- Develop information and expertise needed to distinguish natural from unnatural deaths.

- Distinguish events leading up to deaths that will assist in developing prevention and intervention strategies.

- Enhance medical professionals' skills in evaluating cases and making cause of death determinations.

- Identify problems and unmet needs in the service delivery network.

- Recommend changes to policy, practice, regulation, and legislation.

- Identify gaps in communication and coordination among agencies.

- Collect data for use in developing state reports.
- Conduct meetings that strictly prohibit any breach of confidentiality.
- Develop prevention strategies.

The Virginia Adult Fatality Review Team may identify risk factors associated with deaths and increase awareness of elder victimization and abuse/neglect fatalities.

Cost Estimate

Virginia Department of Social Services is requesting $95,000 annually to administer the Adult Fatality Review Team. The cost estimate is based on hiring a coordinator at $60,000, with fringe benefits of $16,800. The coordinator, preferably a Geriatric Nurse or other highly skilled professional, will collect, interpret, and summarize case information that is very extensive. Medical record reviews encompass banker boxes of medical records per case. There will be six team meetings per year and the team will review special classes of death (e.g., homicides, suicides, accidents, and special classes such as chokings, drownings, etc.).

Case Review Process

"Fatality review is a nonjudgmental evaluation of the events leading up to the family or intimate partner violence fatality, and it is not to be utilized as an avenue to find fault or place blame" (Powell, 2001, p. 3). Reviewing cases of suspected abuse/neglect fatalities can provide greater understanding of adult abuse/neglect, provide greater opportunity to improve policy and procedures, increase interagency and intersystem collaboration and cooperation, and institute social reforms.

Scope

Cases will be selected from law enforcement, adult protective services, medical examiners, and other agencies throughout the state. The Virginia Adult Fatality Review Team will not limit its scope of cases to specific jurisdictions, but will choose all cases of suspected adult abuse and neglect throughout the Commonwealth. The team may limit the scope of individual meetings to specific types of death. Based on advice from the Office of the Chief Medical Examiner, the Virginia Adult Fatality Review Team will investigate a wide scope of fatalities initially to assure an adequate pool of cases, and may eventually select a more narrow scope.

Only cases in which a vulnerable adult resident of Virginia died due to unnatural causes will be selected, such as physical abuse, neglect, drug overdose, starvation, dehydration, physical injury, suicide, and similar cases. Vulnerable adults include adults aged 18 to 59 with disabilities and elder adults aged at least 60. Based on Volume VII, Section IV, Chapter A of the APS policy manual, "Adult with a disability means an adult 18 years of age or older whose physical or mental capacity is diminished to an extent that he or she needs supervisory assistance, and/or assistance with activities of daily living (ADLs) such as bathing, dressing,

eating/feeding, transferring, toileting, and toileting, and/or continence or an instrumental ADL such as shopping, money management, using the telephone, or meal preparation."

Case Selection

Case selection policy is based on policy from the Virginia Family Violence Prevention Review Team and Virginia Code 32.1-283 (A), which states "A 'fatal family violence incident' means any fatality, whether homicide or suicide, occurring as a result of abuse between family members or intimate partners." In the case of the Virginia Adult Fatality Review Team, fatalities will be considered for review if there is known or suspected abuse or neglect by a family member or another person in a caregiving role. Cases and records will be referred by law enforcement, adult protective services, medical examiners, and other agencies.

The Virginia Adult Fatality Review Team will select cases in which the elder died due to questionable circumstances, probable neglect or abuse, and other causes of death that cannot be attributable to natural causes. Cases to be selected include cases in which at least one of the following factors is present.

- Murder by a family member, caregiver, or employee of a facility for aged individuals.
- Cases involving suicide, or assisted suicide.
- Deaths in which certain bruising patterns, fractures, or other injuries are present.
- Inconsistent reporting information.
- Unexpected or unattended deaths.
- Previous or current APS report on decedent.
- Forensic findings that suggest abuse and/or neglect.
- Criminal investigations that suggest death due to abuse or neglect.
- Death due to dehydration or malnourishment.
- Other lethality indicators.

Confidentiality

The Virginia Adult Fatality Review Team's ability to discuss and review cases in a confidential and nonjudgmental manner is of paramount importance to the success of the team. The chairpersons will protect the confidentiality of all documents and will assure case summaries do not identify names, addresses, or other personal information. Each team member will be required to sign a statement assuring confidentiality. The meeting chairperson will reiterate the

importance of confidentiality and will restate the confidentiality agreement at every meeting. Guests must gain permission from the chairpersons prior to attending meetings.

Retrospective Review

According to Dr. Virginia Powell of the Office of the Chief Medical Examiner, an adult fatality review team is a retrospective examination of a decedent's records in order to both understand the precise circumstances of the fatal events as well as to identify specific interventions that would reduce similar deaths in the future. VDSS will develop a standardized format for reviewing cases in collaboration with the Office of the Chief Medical Examiner and other members of the advisory committee. The review of vulnerable adult death cases is not designed to investigate mistakes or be punitive, but to lend to private, local, and state entities an opportunity for analyzing inter-system gaps. Reviews will be conducted after investigations and prosecution have concluded.

Team Structure

The Virginia Adult Fatality Review Team will be co-chaired by the Commissioner of VDSS and the Chief Medical Examiner of the Virginia Department of Health, or their designees. The Adult Fatality Review Team coordinator will present cases to the team, record team recommendations and decisions, write and distribute minutes, and write the annual report. The coordinator will be responsible for reviewing extensive social, medical, and mental health records in combination with autopsy reports.

Membership

Members of the Virginia Adult Fatality Review Team will be selected from the following professions and organizations.

- State and local staff of the Adult Protective Services Program
- VDSS, Division of Licensing
- Geriatric psychiatrist
- Virginia Department of Health, Center for Quality Health Care Services and Consumer Protection
- Virginia Department for the Aging
- Geriatric physician
- Department of Mental Health, Mental Retardation and Substance Abuse Services
- Medical Society of Virginia

- Office of Vital Records
- Long-term care agency
- Local Commonwealth's Attorneys
- Office of the State Long-Term Care Ombudsman
- Law enforcement
- Criminologist
- Mental health agencies
- Professional associations
- Emergency Medical Services
- Health care professionals
- Provider organizations
- Gerontologist
- Clergy
- Advocates

Meetings

Meetings will be held at the Office of the Chief Medical Examiner six times annually.

Decision Making

The Virginia Adult Fatality Review Team will utilize a consensus model for decision-making. The participation of all team members will be solicited in making decisions and recommendations.

RECOMMENDATIONS

1. Mission.

The mission of the team is to understand trends or patterns of injury to effectively identify at-risk populations and to develop recommendations for prevention. A clearly stated mission statement identifies the purpose of the Virginia Adult Fatality Review Team, focuses the team,

and establishes meeting parameters. The July 28, 2004, meeting of the Virginia Adult Fatality Review Team Advisory Committee resulted in the following recommended mission statement:

> "As a multidisciplinary team, we review and analyze violent, suspicious, and unnatural deaths of vulnerable adults in order to make recommendations for improved legislation, policy, interagency collaboration and coordination, and to enhance education, training, and service delivery so that ultimately, preventive measures are established and elderly individuals and adults with disabilities are protected from experiencing a violent, unnatural, or preventable death."

2. Statutory authority.

A statute will establish the authority for the team to review suspicious deaths, outline the membership of the team, provide authorization to access records, and assure the confidentiality of records and team documents. The statute should be similar to §§ 32.1-283.1 – 283.3 of the *Code of Virginia*, which established the State Child Fatality Review Team.

Like §32.1-283.3 for the State Child Fatality Review Team (cited below), the statute will exempt the Virginia Adult Fatality Review Team from the Freedom of Information Act:

> F. All information and records obtained or created regarding the review of a fatality shall be confidential and shall be excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 9 of § 2.2-3705.5. All such information and records shall be used by the team only in the exercise of its proper purpose and function and shall not be disclosed. Such information or records shall not be subject to subpoena, subpoena duces tecum or discovery or be admissible in any criminal or civil proceeding. If available from other sources, however, such information and records shall not be immune from subpoena, subpoena duces tecum, discovery or introduction into evidence when obtained through such other sources solely because the information and records were presented to the team during a fatality review. No person who participated in the review nor any member of the team shall be required to make any statement as to what transpired during the review or what information was collected during the review. Upon the conclusion of the fatality review, all information and records concerning the victim and the family shall be returned to the originating agency or destroyed. However, the findings of the team may be disclosed or published in statistical or other form which shall not identify individuals. The portions of meetings in which individual cases are discussed by the team shall be closed pursuant to subdivision A 22 of § 2.2-3711. All team members, persons attending closed team meetings, and persons presenting information and records on specific fatalities to the team during closed meetings shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific death. Violations of this subsection shall be punishable as a Class 3 misdemeanor.

3. Team composition

The recommended Virginia Adult Fatality Review Team will have 16 members and their terms will be staggered. The team will be co-chaired by the Chief Medical Examiner and the Commissioner of the Virginia Department of Social Services, or their designees. The Governor will appoint the members based on recommendations by the Commissioner of VDSS and the Chief Medical Examiner. The program manager of the Adult Services Program will serve ex-officio on the team. Team members selected will be able to understand the circumstances of death and systems implications. Members will understand law, policy and best practice. All members of the team will be in position to advocate for system improvements.

The core team members will include:

- Chief Medical Examiner, Virginia Department of Health
- Commissioner, VDSS
- State and local staff of the Adult Protective Services program
- Representative from Department of Mental Health, Mental Retardation and Substance Abuse Services
- Representative from the Medical Society of Virginia
- Geriatric psychiatrist
- Geriatric physician
- A local Commonwealth's Attorney
- Representative from Emergency Medical Services
- Representative from the Office of the State Long-Term Care Ombudsman
- Representative from Center for Quality Health Services and Consumer Protection, Department of Health
- Representative from a long-term care provider
- Advocates
- Law enforcement

Other members of the Virginia Adult Fatality Review Team may include:

- Representative from VDSS Division of Licensing

- Representative from Virginia Department for the Aging
- Representative from the Office of Vital Records
- Criminologist
- Representatives from professional associations
- Provider organizations
- Gerontologist
- Clergy

4. Team products

Products developed from the Virginia Adult Fatality Review Team will include databases, summary reports, press releases, and educational materials. The Adult Fatality Review Team coordinator will ensure that these products are delivered. In order to maintain confidentiality of the discussion and findings, information published will be presented only in aggregated form and will not include identifying information of the cases reviewed.

The team will develop prevention strategies and recommend changes to legislation, policy, and service delivery procedures. The team's recommendations will be reported no later than October 1 of each year to the Governor and the General Assembly.

CONCLUSION

The greatest challenge in addressing issues of adult abuse, neglect, and exploitation is creating heightened awareness of the problem and the risk inherent for vulnerable adults. Detecting and studying cases of suspected abuse or neglect, coupled with ongoing essential services and support, will culminate into an era in which elderly individuals and adults with disabilities are safe from abuse, violence, and preventable death.

The development of the Virginia Adult Fatality Review Team is an essential step in protecting the safety of vulnerable adults. The multidisciplinary team will analyze every suspicious death of a vulnerable adult and discuss how improved legislation, policy, service delivery, interagency communication and coordination, and other systems can prevent similar deaths in the future. Through this multi-agency collaboration and fatality review process, the Commonwealth will be working together to assure that all elderly individuals and adults with disabilities are safe, that an adequate violence preventive infrastructure and services are accessible to vulnerable adults, and that individuals can enjoy a productive and quality life.

REFERENCES

Bonnie, R. J., & Wallace, R. B. (Eds.). (2003). *Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America*. DC: National Research Council of the National Academies Press.

Coyne, A. C., Potenza, M., & Berbig, W. (1996). Abuse in Families Coping with Dementia, *Aging, 367*, 92-97.

Elderly Often Mask Suicidal Behaviors (October 15, 1989). *Richmond Times Dispatch* at http://www.timesdispatch.com/

Kinsella, K. & Velkoff, V. (2001). *An Aging World*, U.S. Census Bureau.

Lachs, M. et al. (August 5, 1998). *Journal of the American Medical Association*.

National Center on Elder Abuse (2001). *A Response to the Abuse of Vulnerable Adults: The 2000 Survey of State Adult Protective Services.* American Public Human Services Association, Washington DC.

National Center on Elder Abuse (2003). *Multidisciplinary Elder Abuse Prevention Teams: A New Generation.* Washington DC.

National Center on Elder Abuse (1998.) *National Elder Abuse Incidence Study (NCAIS),* American Public Human Services Association. Washington DC.

Stiegel, L. (2004). *Promising Practices in the Development of Elder Abuse Fatality Review Teams: A Replication Manual, Draft Report*. American Bar Association.

Teaster, P. & Nerenberg, L. (n.d.). *A National Look at Elder Abuse Multidisciplinary Teams, Report for the National Committee for the Prevention of Elder Abuse*. National Center on Elder Abuse.

U.S. Census (2000). www.census.gov.

U.S. Congress Special Committee on Aging (2001). *Saving our Seniors: Preventing Elder Abuse, Neglect, and Exploitation: Hearing before the Special Committee on Aging*. DC: GPO.

U.S. Dept. of Justice (2002). *Elder Justice: Medical Forensic Issues Concerning Abuse and Neglect, Draft Report*. www.ojp.usdoj.gov

Virginia Department of Health, Office of the Chief Medical Examiner (2002). *Family and Intimate Partner Violence Homicide.* Richmond, VA.

Virginia Department of Social Services, Adult Services Programs (2001, 2002). *Adult Services Annual Program Report.* Richmond, VA.

Virginia Department of Social Services, Adult Services Programs (2003). *Adult Services Annual Survey*, Richmond, VA.

Virginia Department of Social Services (2004). *Information Resource Book*, Richmond, VA.

APPENDIX A
Study Mandate

Chapters 1011 and 794, 2004 Acts of Assembly

4. That the Secretary of Health and Human Resources, in consultation with the Departments of Social Services and Health and other state and local entities as appropriate, shall develop a model protocol and procedures for, as well as cost estimates for the operation of, adult fatality review teams to review suspicious deaths of vulnerable adults and provide ongoing surveillance of suspicious adult fatalities in order to create a body of information to help prevent future fatalities. The Secretary shall report to the Governor and General Assembly on the model protocol and cost estimate no later than November 1, 2004.

APPENDIX B
SUMMARY OF CHAPTERS 749 AND 1011
OF THE 2004 ACTS OF ASSEMBLY

Senate Bill (SB) 318 and House Bill (HB 952) amend the *Code of Virginia* at § 63.2-1603 through 1610 regarding Adult Protective Services (APS) by:

1) Clarifying population served and adding that reports of suspected abuse, neglect, or exploitation may be made to the local department of social services (local department) OR the 24-hour, toll-free APS hotline;
2) Requiring local departments to initiate an investigation within 24 hours of the report and clarifying what is meant by a "valid" report;
3) Requiring the local department to refer matters as appropriate to the appropriate licensing, regulatory, or legal authority for administrative action or criminal investigation;
4) Allowing the local departments, with informed consent, to take or cause to be taken photographs, video recordings, or appropriate medical imaging of the adult and his environment that are relevant to the investigation;
5) Clarifying that APS will not investigate in state correctional facilities;
6) Expanding the list of APS situations in which law enforcement must be notified to include sexual abuse; death, serious bodily injury or disease believed to be caused by abuse or neglect; and any other criminal activity involving abuse or neglect that places the adult in imminent danger of death or serious bodily harm;
7) Changing the timeframe for reporting of suspected adult abuse, neglect, or exploitation by mandated reporters to "immediately" except reports by nursing facility inspectors employed by the Department of Health in the course of a survey;
8) Adding persons to the list of APS mandated reporters;
9) Noting that a mandated reporter providing professional services in a hospital, nursing facility, or similar institution may, in lieu of reporting directly to APS, notify the person in charge, who shall report such information immediately upon determination that there is reason to suspect abuse, neglect, or exploitation;
10) Adding accounting firms to the list of financial institutions who may report voluntarily;
11) Prohibiting employers of mandated reporters from preventing a mandated reporter to report directly to APS;
12) Requiring employers of mandated reporters to ensure that employees are notified that they are mandated reporters and trained on reporting responsibilities;
13) Adding criminal penalties for persons 14 years of age or older who make a false report;
14) Authorizing the Commissioner of the Department of Social Services to impose civil money penalties for cases of non-reporting by all mandated reporters except law-enforcement officers (the courts would take these cases);
15) Requiring mandated reporters to report immediately to the appropriate medical examiner and law-enforcement agency when there is reason to suspect that an adult died as a result of abuse or neglect and authorizing the medical examiner to order an autopsy;
16) Relieving a mandated reporter from reporting to APS if he has actual knowledge that the same matter has already been reported;

17) Requiring all law-enforcement departments and other state and local departments, agencies, authorities, and institutions to cooperate with APS in the detection, investigation, and prevention of adult abuse, neglect, and exploitation;
18) Allowing emergency APS to be provided through an appropriate court order for a period of 15 days (instead of 5);
19) Requiring the Department of Social Services to develop a plan and cost estimate by November 1, 2004, to prepare, disseminate, and present educational programs and materials on adult abuse, neglect, and exploitation to all categories of newly mandated reporters and that the penalty provisions shall not apply to newly mandated reported until the delivery of such training; and
20) Requiring the Secretary of Health and Human Resources to develop a model protocol and procedures for, as well as cost estimates for the operation of, adult fatality review teams by November 1, 2004.

APPENDIX C
CODE OF VIRGINIA § 32.1-283.1-283.3
State Child Fatality Review Team

§ 32.1-283.1. State Child Fatality Review Team established; membership; access to and maintenance of records; confidentiality; etc.

A. There is hereby created the State Child Fatality Review Team, hereinafter referred to as the "Team," which shall develop and implement procedures to ensure that child deaths occurring in Virginia are analyzed in a systematic way. The Team shall review (i) violent and unnatural child deaths, (ii) sudden child deaths occurring within the first 18 months of life, and (iii) those fatalities for which the cause or manner of death was not determined with reasonable medical certainty. No child death review shall be initiated by the Team until conclusion of any law-enforcement investigation or criminal prosecution. The Team shall (i) develop and revise as necessary operating procedures for the review of child deaths, including identification of cases to be reviewed and procedures for coordination among the agencies and professionals involved, (ii) improve the identification, data collection, and record keeping of the causes of child death, (iii) recommend components for prevention and education programs, (iv) recommend training to improve the investigation of child deaths, and (v) provide technical assistance, upon request, to any local child fatality teams that may be established. The operating procedures for the review of child deaths shall be exempt from the Administrative Process Act (§ 2.2-4000 et seq.) pursuant to subdivision 17 of subsection B of § 2.2-4002.

B. The 16-member Team shall be chaired by the Chief Medical Examiner and shall be composed of the following persons or their designees: the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services; the Director of Child Protective Services within the Department of Social Services; the Superintendent of Public Instruction; the State Registrar of Vital Records; and the Director of the Department of Criminal Justice Services. In addition, one representative from each of the following entities shall be appointed by the Governor to serve for a term of three years: local law-enforcement agencies, local fire departments, local departments of social services, the Medical Society of Virginia, the Virginia College of Emergency Physicians, the Virginia Pediatric Society, Virginia Sudden Infant Death Syndrome Alliance, local emergency medical services personnel, Commonwealth's attorneys, and community services boards.

C. Upon the request of the Chief Medical Examiner in his capacity as chair of the Team, made after the conclusion of any law-enforcement investigation or prosecution, information and records regarding a child whose death is being reviewed by the Team may be inspected and copied by the Chief Medical Examiner or his designee, including, but not limited to, any report of the circumstances of the event maintained by any state or local law-enforcement agency or medical examiner, and information or records maintained on such child by any school, social services agency or court. Information, records or reports maintained by any Commonwealth's Attorney shall be made available for inspection and copying by the Chief Medical Examiner pursuant to procedures which shall be developed by the Chief Medical Examiner and the Commonwealth's Attorneys' Services Council established by § 2.2-2617. In addition, the Chief Medical Examiner may inspect and copy from any Virginia health care provider, on behalf of the

Team, (i) without obtaining consent, the health and mental health records of the child and those perinatal medical records of the child's mother that related to such child and (ii) upon obtaining consent from each adult regarding his personal records, or from a parent regarding the records of a minor child, the health and mental health records of the child's family. All such information and records shall be confidential and shall be excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 9 of § 2.2-3705.5. Upon the conclusion of the child death review, all information and records concerning the child and the child's family shall be shredded or otherwise destroyed by the Chief Medical Examiner in order to ensure confidentiality. Such information or records shall not be subject to subpoena or discovery or be admissible in any criminal or civil proceeding. If available from other sources, however, such information and records shall not be immune from subpoena, discovery or introduction into evidence when obtained through such other sources solely because the information and records were presented to the Team during a child death review. Further, the findings of the Team may be disclosed or published in statistical or other form which shall not identify individuals. The portions of meetings in which individual child death cases are discussed by the Team shall be closed pursuant to subdivision A 22 of § 2.2-3711. In addition to the requirements of § 2.2-3712, all team members, persons attending closed team meetings, and persons presenting information and records on specific child deaths to the Team during closed meetings shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific child death. Violations of this subsection shall be punishable as a Class 3 misdemeanor.

D. Upon notification of a child death, any state or local government agency maintaining records on such child or such child's family which are periodically purged shall retain such records for the longer of 12 months or until such time as the State Child Fatality Review Team has completed its child death review of the specific case.

E. The Team shall compile annual data which shall be made available to the Governor and the General Assembly as requested. These statistical data compilations shall not contain any personally identifying information and shall be public records

§ 32.1-283.2. Local and regional child fatality review teams established; membership; authority; confidentiality; immunity.

A. Upon the initiative of any local or regional law-enforcement agency, fire department, department of social services, emergency medical services agency, Commonwealth's attorney's office, or community services board, local or regional child fatality teams may be established for the purpose of conducting contemporaneous reviews of local child deaths in order to develop interventions and strategies for prevention specific to the locality or region. Each team shall establish rules and procedures to govern the review process. Agencies may share information but shall be bound by confidentiality and execute a sworn statement to honor the confidentiality of the information they share. Violations shall be punishable as a Class 3 misdemeanor. The State Child Fatality Review Team shall provide technical assistance and direction as provided for in subsection A of § 32.1-283.1.

B. Local and regional teams may be composed of the following persons from the localities represented on a particular board or their designees: a local or regional medical examiner, a local social services official in charge of child protective services, a director of the relevant local or district health department, a chief law-enforcement officer, a local fire marshal, the attorney for the Commonwealth, an executive director of the local community services board or other local mental health agency, and such additional persons, not to exceed five, as may be appointed to serve by the chairperson of the local or regional team. The chairperson shall be elected from among the designated membership. The additional members appointed by the chairperson may include, but are not restricted to, representatives of local human services agencies; local public education agencies; local pediatricians, psychiatrists and psychologists; and local child advocacy organizations.

C. Each team shall establish local rules and procedures to govern the review process prior to conducting the first child fatality review. The review of a death shall be delayed until any criminal investigations connected with the death are completed or the Commonwealth consents to the commencement of such review prior to the completion of the criminal investigation.

D. All information and records obtained or created regarding the review of a fatality shall be confidential and shall be excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 9 of § 2.2-3705.5. All such information and records shall be used by the team only in the exercise of its proper purpose and function and shall not be disclosed. Such information or records shall not be subject to subpoena, subpoena duces tecum, or discovery or be admissible in any criminal or civil proceeding. If available from other sources, however, such information and records shall not be immune from subpoena, subpoena duces tecum, discovery or introduction into evidence when obtained through such other sources solely because the information and records were presented to the team during a fatality review. No person who participated in the reviews nor any member of the team shall be required to make any statement as to what transpired during the review or what information was collected during the review. Upon the conclusion of the fatality review, all information and records concerning the victim and the family shall be returned to the originating agency or destroyed. However, the findings of the team may be disclosed or published in statistical or other form which shall not identify individuals. The portions of meetings in which individual cases are discussed by the team shall be closed pursuant to subdivision A 22 of § 2.2-3711. All team members, persons attending closed team meetings, and persons presenting information and records on specific fatalities to the team during closed meetings shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific death. Violations of this subsection shall be punishable as a Class 3 misdemeanor.

E. Members of teams, as well as their agents and employees, shall be immune from civil liability for any act or omission made in connection with participation in a child fatality review team review, unless such act or omission was the result of gross negligence or willful misconduct. Any organization, institution, or person furnishing information, data, testimony, reports or records to review teams as part of such review, shall be immune from civil liability for any act or omission in furnishing such information, unless such act or omission was the result of gross negligence or willful misconduct.

§ 32.1-283.3. Family violence fatality review teams established; model protocol and data management; membership; authority; confidentiality, etc.

A. The Chief Medical Examiner shall develop a model protocol for the development and implementation of local family violence fatality review teams (hereinafter teams) which shall include relevant procedures for conducting reviews of fatal family violence incidents. A "fatal family violence incident" means any fatality, whether homicide or suicide, occurring as a result of abuse between family members or intimate partners. The Chief Medical Examiner shall provide technical assistance to the local teams and serve as a clearinghouse for information.

B. Subject to available funding, the Chief Medical Examiner shall provide ongoing surveillance of fatal family violence occurrences and promulgate an annual report based on accumulated data.

C. Any county or city, or combination of counties, cities or counties and cities may establish a family violence fatality review team to examine fatal family violence incidents and to create a body of information to help prevent future family violence fatalities. The team shall have the authority to review the facts and circumstances of all fatal family violence incidents that occur within its designated geographic area.

D. Membership in the team may include, but shall not be limited to: health care professionals, representatives from the local bar, attorneys for the Commonwealth, judges, law-enforcement officials, criminologists, the medical examiner, other experts in forensic medicine and pathology, family violence victim advocates, health department professionals, probation and parole professionals, adult and child protective services professionals, and representatives of family violence local coordinating councils.

E. Each team shall establish local rules and procedures to govern the review process prior to the first fatal family violence incident review conducted. The review of a death shall be delayed until any criminal investigations or prosecutions connected with the death are completed.

F. All information and records obtained or created regarding the review of a fatality shall be confidential and shall be excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 9 of § 2.2-3705.5. All such information and records shall be used by the team only in the exercise of its proper purpose and function and shall not be disclosed. Such information or records shall not be subject to subpoena, subpoena duces tecum or discovery or be admissible in any criminal or civil proceeding. If available from other sources, however, such information and records shall not be immune from subpoena, subpoena duces tecum, discovery or introduction into evidence when obtained through such other sources solely because the information and records were presented to the team during a fatality review. No person who participated in the review nor any member of the team shall be required to make any statement as to what transpired during the review or what information was collected during the review. Upon the conclusion of the fatality review, all information and records concerning the victim and the family shall be returned to the originating agency or destroyed. However, the findings of the team may be disclosed or published in statistical or other form which shall not identify individuals. The portions of meetings in which individual cases are discussed by the team shall be closed pursuant to subdivision A 22 of § 2.2-3711. All team members, persons attending

closed team meetings, and persons presenting information and records on specific fatalities to the team during closed meetings shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific death. Violations of this subsection shall be punishable as a Class 3 misdemeanor.

G. Members of teams, as well as their agents and employees, shall be immune from civil liability for any act or omission made in connection with participation in a family violence fatality review, unless such act or omission was the result of gross negligence or willful misconduct. Any organization, institution, or person furnishing information, data, testimony, reports or records to review teams as part of such review, shall be immune from civil liability for any act or omission in furnishing such information, unless such act or omission was the result of gross negligence or willful misconduct.

APPENDIX D
COMMITTEE MEMBERS

Jane H. Woods
Secretary
Health and Human Resources
202 North Ninth Street, Suite 622
Richmond, VA 23219
jane.woods@governor.virginia.gov

Virginia Adult Fatality Review Team Advisory Committee

Maurice A. Jones
Commissioner
Virginia Department of Social Services
7 North 8th Street
Richmond, VA 23219
maurice.jones@dss.virginia.gov

Mike Asjodi
APS Social Worker
Nottoway County DSS
P.O. Box 26
288 W. Courthourse Road
Nottoway, VA 23955
434-645-8494
mma043@piedmont.dss.va.us

Betty Bowden
Adult Services Area Specialist (ret.)
1944 Charla Lee Lane
Virginia Beach, VA 23455
757-460-3481
mbmowden418@aol.com

Thomas Butcher
APS Supervisor
Richmond City DSS
900 E. Marshall St.
Richmond, VA 23219
804-746-7516
Fax: 804-646-7016
butchebt@ci.richmond,va.us

Maxine Byrd
Adult Services Supervisor
Newport News DSS
6060 Jefferson Avenue
Newport News, Va 23605
757-926-6387
Fax: 757-926-6580
Mmb700@eastern.dss.state.va.us

Susan Carson, R.N.
Department of Forensic Medicine
Forensic Nurse Examiners Coordinator
MCV
PO Box 980401
Richmond, VA 23298
804-628-0623
Fax: 804-828-2203
Mcv4ren6rn@aol.com

Katina Chambers
Alzheimers Association
Greater Richmond Chapter
4600 Cox Road, Suite 130
Glen Allen, VA 23060
804-967-2583
Fax: 804-967-2588
Katina.chambers@alz.org

Barbara Craig
Norfolk Human Services
AS/APS
220 W. Brambleton Ave.
Norfolk, VA 23510

Lynne Anne Daurelle, Ph.D.
Psychologist II
Central Virginia Training Center
210 Pocahontas Drive
Forest, VA 24551
434-534-9142
drmrdd@aol.com

Randy Davis
State Director
TRIAD Citizen Outreach
Office of the Attorney General
900 East Main Street
Richmond, VA 23219
rdavis@oag.virginia.gov

Captain Cecil Dye
Commander
Bureau of Criminal Investigation
Department of State Police
P. O. Box 27472
Richmond, VA 23261-7472
804-553-3475

Wendy Emmanuel
Senior Social Worker
Louisa DSS
PO Box 425
Louisa, VA 23093
540-967-1320 x35
Fax: 540-967-0749
Wae109@northern.dss.state.va.us

Marcella Fierro, M.D.
Chief Medical Examiner
Office of the Chief Medical Examiner
Virginia Department of Health
400 East Jackson Street
Richmond. VA 23219
804-
Fax: 804-371-8595
Marcella.fierro@vdh.virginia.gov

Lynn Gray
AS/APS Social Worker
Loudoun County DSS
102 Heritage Way NE Suite 200
Leesburg, Va 20176-4544
703-771-5857
Fax: 703-771-5915
lgray@loudoun.gov

Carter Harrison
Public Policy Coordinator
Alzheimers Association
4600 Cox Road, Suite 130
Glen Allen, VA 23060
804-967-2594
Carter.harrison@alz.org

Chris Head
Home Instead
41 Summers Way, Suite 102
Roanoke, VA 24019
540-966-3399
chris.head@homeinstead.com

Nancy Hofheimer
Director
Center for Quality Health Care Services and
Consumer Protection
Virginia Department of Health
3600 W. Broad Street, Suite 216
Richmond, VA 23230
804-367-2100
Fax: 804-367-2118
Nancy.hofheimer@vdh.virginia.gov

Kira Holland
Senior Social Worker
Radford DSS
928 First Street
Radford, VA 24141-4706
540-731-3663
Fax: 540-731-5000
Krh750@western.dss.state.va.us

The Honorable Janet Howell
State Senator – 32rd District of Virginia
Virginia Senate – General Assembly
P.O. Box 2608
Reston, VA 20195
703-709-8283
Fax: 703-435-1995
senhowell@aol.com

Paul Huizinga
Curriculum Developer
VISSTA
104 North Linden Street
PO box 842027
Richmond, VA 23284-2027
804-827-1857
Fax: 804-828-1207
Pghuizinga@vcu.edu

Carol Jellie
AS/APS Supervisor
Henrico DSS
PO Box 27032
8600 Dixon Powers Drive
Richmond, VA 23273-7032
804-501-4014
Fax: 804-501-4006
Jel03@co.henrico.va.us

Karen Kirby
Social Work Supervisor
Chesterfield-Colonial Heights DSS
PO Box 430
Chesterfield, VA 23832
804-748-1185
Fax: 804-717-6566
Kqv041@central.dss.state.va.us

Karen Lawson
Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, VA 23219
804-225-2536
Fax: 804-371-4986
Karen.lawson@dmas.virginia.gov

Detective William Lightfoot
Richmond Police Department
200 West Grace Street
Richmond, VA 23220
804-646-6764
Fax: 804-646-5159
lightfootwh@ci.richmond.va.us

Deborah Lloyd, RN
Division of Licensing Programs
Virginia Department of Social Services
7 North 8th Street, 2nd Floor
Richmond, VA 23219
Deborah.lloyd@dss.virginia.gov

Laura Lunceford
Social Worker
Culpeper DSS
219 E. Davis Street, Suite 10
Culpeper, VA 22701
540-727-0372, x413
Fax: 540-727-7584
Lal047@northern.dss.state.va.us

Joyce Martin
AS/APS Supervisor
Charlottesville DSS
PO Box 911
120 7th Street, NE
Charlottesville, VA 22902-0911
434-970-3472
Fax: 434-970-3699
martinj@charlottesville.org

Ruth Micklem
Co-Director
Virginians Against Domestic Violence
1010 North Thompson Street, Suite 202
Richmond, VA 23230
804-377-0335
Fax: 804-377-0339
vadvcopps@tni.net

Virginia Powell, Ph.D.
Manager, Fatality Review and Surveillance Programs
Office of the Chief Medical Examiner
Virginia Department of Health
400 East Jackson Street
Richmond. VA 23219
804-786-6045
Fax: 804-371-8595
Virginia.powell@vdh.virginia.gov

Karen Roberto, Ph.D.
Director, Center for Gerontology
Virginia Tech
237 Wallace Hall (0426)
Blacksburg, VA 24061
Telephone: 540-231-7657
Fax: 540-231-7157
kroberto@vt.edu

Nancy Roberts
Deputy Secretary
Office of the Secretary of Health and Human Resources
Ninth St. Office Building, Suite 622
202 N. 9th Street
Richmond, VA 23219
Nancy.roberts@governor.virginia.gov

David Sadowski
Executive Director
Crater District Area Agency on Aging
23 Seyler Drive
Petersburg, VA 23805
Telephone: 804-732-7020
craterdist@aol.com

Anne See
Elderly Services Paralegal
Blue Ridge Legal Services
PO Box 551
Harrisonburg, VA 22803
540-433-1830
Fax: 540-433-2202
a.see@brls.org

Janis Selbo
Chair, League AS Subcommittee
Director, Fauquier DSS
PO Box 300
Warrenton, VA 20188
540-351-1100
Jks061@northern.dss.state.va.us

Ron Snodgrass
Bristol DSS
621 Washington Street
Bristol, VA 24201
276-645-7450
Fax: 276-645-7475
Res520@western.dss.state.va.us
Amt019@piedmont.dss.state.va.us

Susan Van Horn
Adult Services Supervisor
Chesapeake DSS
100 Outlaw Street
Chesapeake, VA 23320
757-382-2290; fax 757-543-1644
sxv550@eastern.dss.state.va.us

Sgt. Barbara Walker
Assistant Director of Education and Training
VCU Police Academy
940 West Grace Street
PO Box 842024
Richmond, VA 23284-2024
bjwalker@vcu.edu

Robin Zimmerman
Social Worker
Bedford DSS
119 E. Main Street
Bedford, VA 24523
540-586-7750 x287
Fax: 540-586-7781
Rez019@piedmont.dss.state.va.us

VDSS Staff:

Terry A. Smith
Adult Services Program Manager
Virginia Department of Social Services
7 N. 8th Street
Richmond, VA 23219
804-726-7538
Terry.smith@dss.virginia.gov

Venus Bryant
Administrative Assistant
Virginia Department of Social Services
7 N. 8th Street, 4th Floor
Richmond, VA 23219
804-726-7533
Home Office fax: 804-726-7895
venus.bryant@dss.virginia.gov

Dorothy Endres
Virginia Beach Office
Pembroke Office Park
Pembroke IV, Suite 300
Virginia Beach, VA 23462-5496
757-491-3980
Dorothy.endres@dss.virginia.gov

Barbara Jenkins
Henrico Office
1604 Santa Rosa Road
Wythe Bldg., Suite 130
Richmond, VA 23229
804-662-9783
Barbara.jenkins@dss.virginia.gov

Marjorie Marker
Adult Services Program Consultant
Virginia Department of Social Services
7 North Eighth Street
Richmond, VA 23219
Telephone: 804-726-7536
Fax: 804-726-7895
marjorie.marker@dss.virginia.gov

Carol McCray
190 Patton Street
Abingdon, VA 24210
276-676-5636
carol.mccray@dss.virginia.gov

Susan J. Murdock, Project Lead
Adult Services Program Consultant
Virginia Department of Social Services
7 North 8th Street
Richmond, VA 23219
Telephone: 804-726-7616
Fax: 804-692-2215
susan.murdock@dss.virginia.gov

Bill Parcell
Adult Services Program Consultant
Virginia Department of Social Services
Roanoke Office
170 W. Shirley Avenue, Suite 200
Roanoke, VA 24011
540-857-7448
William.parcell@dss.virginia.gov

Richard Pyle
Adult Services Program Consultant
Virginia Department of Social Services
1604 Santa Rosa Road
Richmond, VA 23229
804-662-9786
Richard.pyle@dss.virginia.gov

David Stasko
Adult Services Program Consultant
Virginia Department of Social Services
Warrenton Office
170 W. Shirley Avenue, Suite 200
Warrenton, VA 22186
540-347-6313
david.stasko@dss.virginia.gov