Adult Protective Services Fatality Review

Policy 8.17 **Effective: November 01, 2023**

Introduction

If a case involves the death of a vulnerable adult, which may have been the result of abuse or neglect, the case will be referred to the fatality review team. The Adult Protective Services Program Director is required to review all cases on deceased clients to determine if a fatality review is needed.

Scope

The purpose of this policy is to establish a process of conducting a comprehensive, systematic review of the death of a vulnerable adult that is due to abuse, neglect, and/or exploitation and to identify contributing factors. The findings will be used to prevent such deaths to improve the health and safety of vulnerable adults.

Policy

Criteria for Fatality Review

The Notice of Death (NOD) must be reviewed by the team coordinator (TC), regional supervisor (RS), and Field Director prior to the Program Director's review. A fatality review is initiated through the NOD process in the case management system (CMS) and upon the Program Director's approval. See Fatality Review Workflow. A death certificate is required to initiate the fatality review process. See Guidelines for Completing an Investigation.

The Tennessee Department of Human Services (TDHS) has established criteria for formal review of client's fatalities. As such, while all client fatalities are screened by the Program Director, not all client fatalities receive a formal review. Fatality reviews may be conducted in the following circumstances:

1. An open case in which there is a client fatality that is alleged to be the result of abuse, neglect, or exploitation, (A/N/E) including cases in which custodial orders or non-custodial services orders were obtained.
2. The death was due to A/N/E.
3. There are allegations suggesting A/N/E.
4. The death was unexplained or sudden.
5. Pursuant to the Program Director's discretion.

Note: At the Program Director's discretion, Adult Protective Services (APS) reserves the right to review any case (media, legal involvement, etc.), regardless of whether the date of closure has exceeded sixty (60) days.

Team Meetings

1. Every member of the Fatality Review Team shall sign an HS-3468 APS Confidentiality and Nondisclosure Agreement Letter.
2. The name of the reporter shall not be shared with the review team.
3. The Program Director, in consultation with the field and Office of General Counsel (OGC) as necessary, must make the determination whether the Fatality Review Team is needed.
4. The Fatality Review Team meeting must be scheduled within ninety (90) days of the decision that a review must be held.
5. A review of pertinent documentation as listed on the HS-3123 APS Fatality Review Summary Report and the HS-3124 APS Fatality Review Team Minutes must be completed (in the CMS) for each review.
6. Minutes of each review must be uploaded to the CMS within three (3) business days of the review.

Fatality Review Outcome Discussion

1. After the Fatality Review, APS staff must complete tasks in the CMS as assigned in the APS Fatality Review procedures. If further action is required, staff must ensure the action plan is completed.

2. The Field Director will then submit these through the CMS to the Program Director who will then review and provide a summary to the:
    a. TDHS Commissioner,
    b. Deputy Commissioner,
    c. Assistant Commissioner (AC),
    d. General and Deputy Counsel, and
    e. Any internal executive staff, as needed

The Program Director will be responsible for ensuring that the recommendations in the report are followed, as appropriate.

Supporting Documents

Guidelines for Completing an Investigation

Advisory Review Team Invitation Letter Instructions

HS-3123 APS Fatality Review Summary Report (System generated)

HS-3124 APS Fatality Review Team Minutes Instructions

HS-3468 APS Confidentiality and Nondisclosure Agreement Letter

APS Fatality Review Procedures

Fatality Review Workflow

Definitions/Acronyms

Term	Definition
A/N/E	Abuse/Neglect/Exploitation
AC	Assistant Commissioner
APS	Adult Protective Services
CMS	Case Management System
NOD	Notice of Death
OGC	Office of General Counsel
RS	Regional Supervisor
TC	Team Coordinator
TDHS	Tennessee Department of Human Services
VAPIT	Vulnerable Adult Protective Investigative Team The Vulnerable Adult Protective Investigative Team (established by Tennessee Code Annotated 71-6-125), also known as VAPIT, was written into law on January 1, 2017. In Tennessee, the district attorney general (DAG) of each judicial district is required to establish a VAPIT team to address and respond to elder abuse. VAPIT meetings are held regularly (quarterly at a minimum) and includes a multi-disciplinary team appointed by the DAG. The VAPIT conducts coordinated responses and investigations of instances of suspected abuse, neglect or exploitation (A/N/E) of vulnerable adults, and typically reviews all 1215 notification forms by APS. An annual report summarizing the work of VAPIT for the previous year must be filed by each DAG.

Supersedes

APS Fatality Review Policy, eff. date 11/01/2022

Approval History

Approved By	Approver Title	Approved Date	Effective Date
Clarence Carter	Commissioner	10/25/2023	11/01/2023
Clarence Carter	Commissioner	10/27/2022	11/01/2022
Clarence Carter	Commissioner	09/17/2021	10/01/2021

Revision History

Date	Version	Location of Change	Description/Reason for Change
10/25/2023	11/01/2023	Policy Section and Definitions	Fixed grammar, removed references to self-neglect, changed "Field Operations Director" to "Field Director", linked some items that were mistakenly not initially linked, added job title acronyms
10/27/2022	11/01/2022	Policy Section	Criteria for Fatality Review: Added Death Certificate Waiver as a way to initiate. Team Meetings: Fixed time frame for minutes to be uploaded from five (5) to three (3) days to match CMS
09/17/2021	10/01/2021	N/A	New Policy

Approved By	Clarence H. Carter	**Approval Date**	10/25/2023
Authority	Tenn. Code Ann. § 71-6-103	**Effective Date**	11/01/2023
Application	APS Intake and Investigative Staff		