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Elder Abuse: What Coroners Know and Need to Know

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This article presents findings from a survey examining knowledge of elder abuse among Georgia’s coroners. More than half of the 116 respondents indicated that they know “almost nothing” or “a little” about distinguishing signs of physical abuse from signs of aging (54%) and mandatory reporting laws and related elder abuse statutes (63%). When asked the frequency with which older adult cases were referred to the medical examiner, 49% indicated “rarely if ever.” Study findings reveal specific opportunities for enhancing training efforts aimed at coroners, who play a critical role in the identification of elder abuse.

KEYWORDS coroners, elder abuse, training needs

BACKGROUND

Research continues to advance understanding of the magnitude and nature of elder abuse in the United States. Elder abuse affects between 2 and 5 million American adults over the age of 65 (Laumann, Leitsch, & Waite, 2008; National Research Council, 2003; Pillemer & Finkelhor, 1988; Podnieks,
The abuse of elders, which includes physical abuse, neglect, exploitation, and abandonment, has been defined by the National Research Council (2003, p. 40) as “intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trusting relationship to the elder; or failure of a caregiver to satisfy the elder’s basic needs or protect the elder from harm.” The dramatic increase in longevity among Americans demands unwavering vigilance against abuses of this vulnerable segment of the population.

Elder abuse is Multifactorial, and therefore professionals from diverse disciplines of study can play a role in its identification and resolution. Professional fields that offer critical insights into elder abuse cases include banking, law, criminal justice, and social services (Choi & Mayer, 2000; Lachs & Pillemer, 2004; Payne, 2005). However, the responsibility for recognizing, identifying, and responding to elder abuse most commonly falls on health care professionals. A recent study involving family practice physicians found that roughly half of the respondents had identified cases of elder abuse within the last year (Oswald, Jogerst, Daily, & Bentler, 2005). The study also noted that Iowa, the state where the survey was administered, is one of a very few states that requires continuing education on elder abuse reporting. Many of the existing elder abuse screening and assessment instruments are designed to be administered by health care professionals within clinical settings (Fulmer, Guadagno, Bitondo, & Connolly, 2004).

Identification of elder mistreatment is often dependent on an investigation. Research has found that rates of investigation are highly dependent on the infrastructure in place to deal with elder mistreatment (Jogerst & Daly, 2008; Jogerst et al., 2003). At the state level, higher investigation rates have been associated with a mandatory reporting requirement and penalties for failure to report (Jogerst et al., 2003). Substantiation-to-investigation ratios are higher in states that have more abuse definitions in regulations and separate caseworkers for child and elder abuse investigations (Jogerst et al., 2003). At the county level, the location of adult protective services (APS) and county government resources are related to both rates of investigations and rates of substantiations (Jogerst & Daly, 2008). Unfortunately it is difficult to determine the percentage of reports that are being investigated; according to a study conducted by Jogerst and colleagues (2005), 34 of the states surveyed kept no records on the total number of reports of elder mistreatment.

The operational definition of elder mistreatment can make a substantial difference in the number of investigations that are initiated and in what is substantiated as abuse (Daly & Jogerst, 2005; Jogerst et al., 2003). The Centers for Disease Control and Prevention (CDC) defines elder mistreatment as “any abuse and neglect of persons age 60 and older by a caregiver or another person in a relationship involving an expectation of trust.” The CDC also provides several subcategories that fit into the definition of mistreatment: physical abuse, sexual abuse or abusive sexual contact, psychological or
emotional abuse, neglect, abandonment, and financial abuse or exploitation (CDC, 2009). Clear and specific operational definitions are especially important because social factors such as gender, marital fidelity, ageism, and expectations of caregiver skill affect individual perceptions of what constitutes abuse (Mouton et al., 2006).

One of the greatest challenges of identifying cases of elder abuse surrounds methods of evaluation. Jones, Dougherty, Schelbie, and Cunningham (1998) determined that victim complaints account for less than 30% of elder abuse reports and that most cases are detected by clinicians during urgent care visits. The complexities of evaluating cases of abuse often are confounded by natural aging processes such as compromised skin integrity or bruising, which may be attributed to medication (Mosqueada, Burnight, & Solomon, 2005; Muehlbauer & Crane, 2006; Strasser & Fulmer, 2007). Consequently, in some clinical settings expert abuse teams have been formed to initiate comprehensive assessments in suspicious cases (Fulmer et al., 2005). Since even clinicians may miss elder abuse among living older adults, professionals who interact with the deceased elderly may have an additional opportunity to identify signs of abuse. Specifically, coroners and medical examiners have a unique, final chance to observe undetected indications of abuse before a body is buried or cremated.

Studies Calling for Increased Professional Training

Current research in the field of elder mistreatment recommends increased professional training in a variety of fields including medical professionals (Jones et al., 1998; Oswald et al., 2005; Yaffe, Wolfson, & Lithwick, 2009), policy makers (Dunlop, Rothman, Condon, Hebert, & Martinez, 2001), public health officials (Ingram, 2004), and medical examiners/coroners (Lindbloom et al., 2005). A recent report compiled for the National Institute of Justice, the research, development, and evaluation agency of the United States Department of Justice (U.S. DOJ), outlined the need for increased training in all professions that can potentially detect cases of elder mistreatment. The report emphasized the need for both intradisciplinary training, with members from the same discipline conducting the training, and cross training, with members from another discipline conducting training in order to increase the knowledge base (Stiegel, 2007).

Research on Coroners and Medical Examiners

There is limited research on the role of medical examiners or coroners in elder mistreatment cases. In a survey study conducted by Kim, Mitchell, and Dyer (2007), medical examiners of Harris County (n = 11) were asked about abuse or neglect as a contributing cause of death for cases referred to
the morgue. Eight of the respondents reported that they did not determine elder abuse or neglect as a cause of death within the past year, and six indicated that medical records were helpful in investigations “all the time.” It is important to note that medical examiners, in contrast to coroners, are trained medical doctors who can perform autopsies to assess markers of abuse and causes of death (McNamee & Murphy, 2006).

A 10-year (1992–2001) retrospective case review of morbidity and mortality among elders (aged 60 and over) was conducted at a State Medical Examiner’s Office serving a major metropolitan region in Kentucky and Indiana (Shields, Hunsaker, & Hunsaker, 2004). The study addresses cases in two categories: (1) medicolegal autopsies and (2) examinations of living subjects pursuant to a Clinical Forensic Medicine Program. The authors present 74 postmortem cases, in which 52 deaths were attributed to a homicidal act and 22 deaths were suspicious for neglect. Of the 22 living subjects presented, 19 cases constituted physical and/or sexual assault, and three individuals suffered from neglect. The study summarizes the characteristic features of elder abuse in both postmortem and living cases and underscores the necessity of multiagency collaboration for accuracy in case work. A well-established elder abuse task force promotes the collaborative interaction necessary to formulate policies for prevention of abuse and death within this vulnerable population (Shields et al., 2004).

The role of coroners and medical examiners in identifying cases of elder mistreatment was examined in a U.S. DOJ report (Lindbloom et al., 2005) outlining the use of forensic sciences in investigating mistreatment deaths in long-term care facilities. Four focus groups were conducted, with 8 coroners, 30 medical examiners, and 2 forensic pathologists from 27 different states. Among the coroners, one was a veterinarian, two were emergency medical technicians, two were physicians, one was a licensed funeral home director, and two did not list specific degrees or professions. There was little consistency in the authority of medical examiners or coroners to investigate potential cases. One of the participants had full authority, one only had the authority to investigate if the body was to be cremated, and some were able to investigate if something was suspicious in the cause of death or if the funeral director brought something to his/her attention. Most investigations were initiated if the cause of death was accident or injury or if the family reported abuse. Very few investigations were initiated on the basis of potential markers of physical abuse or neglect. Analysis of the focus groups revealed several barriers to the investigation of mistreatment grouped into three categories: attitudinal barriers, knowledge deficits, and administrative barriers. Attitudinal barriers included the belief that nursing home mistreatment deaths are rare, ageism, and a resistance to screening tools. Administrative barriers included reliance on death certificates and concern about their accuracy, limited resources and manpower, and a lack of prosecution if abuse was substantiated (Lindbloom et al., 2005).
The Theoretical Perspective Linking Coroners With Elder Mistreatment Research

Older adults who experience abuse suffer decreased quality of life and functional status. Dong (2005) found that elderly victims of abuse report poorer functional status and increasing dependency, greater social isolation, poorer health, and increased reports of helplessness and stress, as well as psychological deterioration. Abuse and neglect also have been identified as independent predictors for higher mortality (Dong et al., 2009; Lachs, Williams, O’Brien, Pillemer, & Charlson, 1998). This trend has important implications for public health professionals, who can provide enhanced training, education, and response systems for all professionals involved in elder abuse cases. Coroners play an integral role in identifying elder abuse and mistreatment. Although their patients are deceased, they can be trained to enhance their ability to detect indicators of abuse in the elderly, such as emaciation, bruising, broken bones, and burns, among others. This can be vital in the identification and prosecution of abusers.

Coroners’ ability to identify abuse might change their classification of death, leading to further examination of the practices of the caregiver(s) and a greater awareness by the health care profession that elder abuse is a significant, underreported problem. Lindbloom and colleagues (2005) assert that proper classification of elder deaths can lead to better awareness of mistreatment in long-term care facilities. A later report, analyzing the effect of mandatory reporting on the markers of mistreatment and quality of care in nursing homes, argues that properly classified elder deaths can improve care quality and standards in long-term care facilities (Lindbloom et al., 2008).

METHODS

The authors developed survey questions based upon a review of the literature and the professional responsibilities of coroners and deputy coroners within Georgia. The questionnaire was not piloted with coroners—but was reviewed by the state Division of Aging staff so that items could be revised for clarity, alignment with study purpose, and ease of administration. The survey items asked coroners to estimate their perceived levels of “possessed” and “needed” knowledge on elder abuse topics, as well as training preferences and demographics. The survey was developed using Psychdata, which is a professional online survey research and data management system. E-mails of all coroners and deputy coroners listed in the Directory of the Georgia Coroners Association (2007) \((n = 198)\) received multiple messages containing the survey link. The principal investigator sent three e-mail messages within 6 weeks to coroners inviting survey participation.
The first section asked coroners to rate how they would describe their colleagues’ “needed” and “possessed” knowledge on the following elder abuse topics:

- Basic dynamics of elder abuse
- Theoretical perspectives of elder abuse
- Signs or indicators that may identify elder abuse victims
- Documentation of elder abuse
- Communication with the Office of Regulatory Services
- Georgia laws and legal options related to elder abuse
- Communication with APS
- Characteristics of elder abuse victims
- Evidence collection in elder abuse cases
- Information about mandatory reporting laws
- Mandatory reporting and associated statutes
- Distinguishing signs of physical abuse

Respondents were asked to identify the level of knowledge “possessed” or “needed” on a scale of 1–4, where 1 was equal to “almost none,” and 4 was equal to “a lot.”

The second section asked participants to identify several demographic variables about themselves. These items included gender, race, age, level of education, how many years worked in their current position, county in which they worked, and whether they were a coroner or a deputy coroner. Coroners then were asked if they felt the rate of elder abuse in their county was the same, higher, or lower than in other locations in Georgia. Finally, respondents were asked to identify the preferred delivery method for elder abuse training.

Analysis

Paired samples t-tests were conducted between the “possessed” and “needed” responses for each of the elder abuse topics to test for significant differences between the means of each pair. A logistic regression was run to determine the predictive value of urbanicity, gender, race, and age on the rates of elder mistreatment reports. The analysis was performed in SPSS version 17.

RESULTS

There were 116 participants who responded to the survey. The number of survey completions declined following each e-mail message. The first survey invitation yielded 56 completions, the second 38, and the third and final
<table>
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<th>Pair</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Standard Error</th>
<th>95% Confidence Intervals</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
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<td>−1.10435</td>
<td>1.08720</td>
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</table>

invitation 22. Of the respondents, 81% (94) were male and 19% (22) were female. Eighty-eight percent (102) were Caucasian, 6% (7) were African American, 0% were Hispanic or Asian, and 6% (7) responded “other.” In response to the educational attainment question, 10% (11) were high school graduates, 36% (41) had some college, 29% (33) had a 2-year degree, 11% (12) had a 4-year degree, and 14% (16) had graduate level education. Fifty-three percent (62) were coroners and 47% (54) were deputy coroners. The age of the participants ranged from 25 to 77, with a mean of 50 years. The number of years working in the position currently held ranged from 1 to 35 with a mean of 11. Fifty respondents (43%) were from rural counties, 61 (52%) were from urban counties, and 5 (4%) did not answer.

The t-tests for the “possessed” and “needed” responses were significant for all 12 questions at the level $p < 0.001$. Table 1 shows the results of the t-tests for each of the pairs and Figure 1 presents a comparison of mean scores for each question. The logistic regression examined rates of elder mistreatment reports (as the dependent variable) using urbanicity, gender, race, and age as the independent variables. Of the four variables tested, only urbanicity showed significance ($p = 0.006$), with a $B$ of −1.36, a standard error of 0.494, and an odds ratio of 0.257. Finally, the vast majority of respondents indicated that they thought the rate of elder abuse in their locality was either the same as or lower than in other places in Georgia ($n = 69, 92$%), whereas only six respondents (8%) stated that they felt the rate of elder abuse was higher in their locality than other places in Georgia.

In terms of learning preferences, of the 116 respondents, the overwhelming majority (88) said they would prefer a classroom or instructor-led delivery method for elder abuse training, followed by 35 preferring asynchronous web-based training and 31 preferring videotapes. (See Figure 2 for detailed results on the remaining categories.) One person did write in a
FIGURE 1 Comparison of “possessed” versus “needed” mean scores; EA designates elder abuse and ORS represents Office of Regulatory Services (color figure available online).

FIGURE 2 Preferred method of training delivery.

response in the “other” section that most coroners preferred a classroom setting but that he/she would prefer something web-based. No significant correlations between learning preferences and demographic characteristics, duty, or setting were detected.
LIMITATIONS

This study was based on a small and homogenous sample and was further limited by the voluntary nature of the survey: the answers provided by the respondents may not be indicative of the nonrespondents. It also would have been helpful for training development to understand the ways that coroners and deputy coroners came to "possess" the domains of knowledge that were assessed in this survey. Additionally, policies, regulations, responsibilities, and qualifications of coroners are determined by individual states and/or local municipalities. Georgia is typical of many other states in that coroners are elected and do not need to have medical credentials. However, in some states, such as Kentucky, coroner duties are assumed by a sheriff who also can make arrests and bear arms, or in other jurisdictions, such as California, an appointed medical examiner—who must be a physician—oversees the duties of coroners. Due to the varied range of coroner requirements and roles across the county, the generalizability of these study results is limited to locales that follow Georgia's code.

DISCUSSION

This exploratory study is important because little research has focused on coroners and their knowledge of elder abuse. In light of coroners' mandate to report elder abuse in the state of Georgia, the study highlights educational opportunities for public health professionals and researchers to consider. The impact of premature death, violence, and suffering at the end of life is an urgent matter that warrants increased focus and attention. Including coroners in future scientific inquiry, research, and training is paramount.

Although it may be that factors such as age, gender, and race play no role in the rates of reporting elder mistreatment, these results also could be attributed to the homogeneity of the sample. The vast majority of responding coroners were middle-aged or older, white, and male. In further research, a more diverse sample may lead to different results. Although it was not included in this regression model, the majority of coroners included in this study (65%) had either a high-school diploma or some college. Analyzing the role of education in a similar model also might be worthwhile in future research.

All of the paired samples t-tests between the perceived levels of knowledge attained and needed were significant. These results point to a large disparity between what coroners currently know and what they feel they should know about elder mistreatment. These results substantiate previous research that calls for increased education and professional training in all fields that may be able to identify this problem (Dunlop et al., 2001; Ingram, 2004; Lindbloom et al., 2005; Oswald et al., 2005; Yaffe et al., 2009) As the
Lindbloom et al. (2005) study revealed, there is a substantial “knowledge deficit” in this field. Analysis of focus groups disclosed that the majority of coroners did not know how to distinguish evidence of physical abuse and neglect from the normal course of chronic disease and physical decline. Furthermore, most of the coroners did not have such expertise (Lindbloom et al., 2005).

These sample coroners had very specific preferences for training methods to increase their knowledge of elder mistreatment. Eighty-eight of the 116 coroners stated that they would prefer a classroom or instructor-led session. There was, however, a strong minority (43) that preferred some form of web-based learning. These preferences are helpful to those planning further education and training in identifying elder mistreatment. Combined with the results of the t-test, they reveal specific opportunities for enhancing training efforts aimed at coroners who play a critical role in identifying and addressing elder abuse.

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