AN ACT concerning aging.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Adult Protective Services Act is amended by changing Section 15 as follows:

(320 ILCS 20/15)

Sec. 15. Fatality Review Teams.

(a) State policy.

(1) Both the State and the community maintain a commitment to preventing the abuse, neglect, and financial exploitation of at-risk adults. This includes a charge to bring perpetrators of crimes against at-risk adults to justice and prevent untimely deaths in the community.

(2) When an at-risk adult dies, the response to the death by the community, law enforcement, and the State must include an accurate and complete determination of the cause of death, and the development and implementation of measures to prevent future deaths from similar causes.

(3) Multidisciplinary and multi-agency reviews of deaths can assist the State and counties in developing a greater understanding of the incidence and causes of premature deaths and the methods for preventing those deaths, improving methods for investigating deaths, and

identifying gaps in services to at-risk adults.

(4) Access to information regarding the deceased person and his or her family by multidisciplinary and multi-agency fatality review teams is necessary in order to fulfill their purposes and duties.

(a-5) Definitions. As used in this Section:

"Advisory Council" means the Illinois Fatality Review Team Advisory Council.

"Review Team" means a regional interagency fatality review team.

(b) The Director, in consultation with the Advisory Council, law enforcement, and other professionals who work in the fields of investigating, treating, or preventing abuse or neglect of at-risk adults, shall appoint members to a minimum of one review team in each of the Department's planning and service areas. Each member of a review team shall be appointed for a 2-year term and shall be eligible for reappointment upon the expiration of the term. A review team's purpose in conducting review of at-risk adult deaths is: (i) to assist local agencies in identifying and reviewing suspicious deaths of adult victims of alleged, suspected, or substantiated abuse or neglect in domestic living situations; (ii) to facilitate communications between officials responsible for autopsies and inquests and persons involved in reporting or investigating alleged or suspected cases of abuse, neglect, or financial exploitation of at-risk adults and persons involved in

providing services to at-risk adults; (iii) to evaluate means by which the death might have been prevented; and (iv) to report its findings to the appropriate agencies and the Advisory Council and make recommendations that may help to reduce the number of at-risk adult deaths caused by abuse and neglect and that may help to improve the investigations of deaths of at-risk adults and increase prosecutions, if appropriate.

(b-5) Each such team shall be composed of representatives of entities and individuals including, but not limited to:

(1) the Department on Aging;

(2) coroners or medical examiners (or both);

(3) State's Attorneys;

(4) local police departments;

(5) forensic units;

(6) local health departments;

(7) a social service or health care agency that provides services to persons with mental illness, in a program whose accreditation to provide such services is recognized by the Division of Mental Health within the Department of Human Services;

(8) a social service or health care agency that provides services to persons with developmental disabilities, in a program whose accreditation to provide such services is recognized by the Division of Developmental Disabilities within the Department of Human

Services;

(9) a local hospital, trauma center, or provider of emergency medicine;

(10) providers of services for eligible adults in domestic living situations; and

(11) a physician, psychiatrist, or other health care provider knowledgeable about abuse and neglect of at-risk adults.

(c) A review team shall review cases of deaths of at-risk adults occurring in its planning and service area (i) involving blunt force trauma or an undetermined manner or suspicious cause of death; (ii) if requested by the deceased's attending physician or an emergency room physician; (iii) upon referral by a health care provider; (iv) upon referral by a coroner or medical examiner; (v) constituting an open or closed case from an adult protective services agency, law enforcement agency, State's Attorney's office, or the Department of Human Services' Office of the Inspector General that involves alleged or suspected abuse, neglect, or financial exploitation; or (vi) upon referral by a law enforcement agency or State's Attorney's office. If such a death occurs in a planning and service area where a review team has not yet been established, the Director shall request that the Advisory Council or another review team review that death. A team may also review deaths of at-risk adults if the alleged abuse or neglect occurred while the person was residing in a domestic living situation.

A review team shall meet not less than 4 ~~6~~ times a year to discuss cases for its possible review. Each review team, with the advice and consent of the Department, shall establish criteria to be used in discussing cases of alleged, suspected, or substantiated abuse or neglect for review and shall conduct its activities in accordance with any applicable policies and procedures established by the Department.

(c-5) The Illinois Fatality Review Team Advisory Council, consisting of one member from each review team in Illinois, shall be the coordinating and oversight body for review teams and activities in Illinois. The Director may appoint to the Advisory Council any ex-officio members deemed necessary. Persons with expertise needed by the Advisory Council may be invited to meetings. The Advisory Council must select from its members a chairperson and a vice-chairperson, each to serve a 2-year term. The chairperson or vice-chairperson may be selected to serve additional, subsequent terms. The Advisory Council must meet at least 4 times during each calendar year.

The Department may provide or arrange for the staff support necessary for the Advisory Council to carry out its duties. The Director, in cooperation and consultation with the Advisory Council, shall appoint, reappoint, and remove review team members.

The Advisory Council has, but is not limited to, the following duties:

(1) To serve as the voice of review teams in Illinois.

(2) To oversee the review teams in order to ensure that the review teams' work is coordinated and in compliance with State statutes and the operating protocol.

(3) To ensure that the data, results, findings, and recommendations of the review teams are adequately used in a timely manner to make any necessary changes to the policies, procedures, and State statutes in order to protect at-risk adults.

(4) To collaborate with the Department in order to develop any legislation needed to prevent unnecessary deaths of at-risk adults.

(5) To ensure that the review teams' review processes are standardized in order to convey data, findings, and recommendations in a usable format.

(6) To serve as a link with review teams throughout the country and to participate in national review team activities.

(7) To provide the review teams with the most current information and practices concerning at-risk adult death review and related topics.

(8) To perform any other functions necessary to enhance the capability of the review teams to reduce and prevent at-risk adult fatalities.

The Advisory Council may prepare an annual report, in consultation with the Department, using aggregate data gathered by review teams and using the review teams'

recommendations to develop education, prevention, prosecution, or other strategies designed to improve the coordination of services for at-risk adults and their families.

In any instance where a review team does not operate in accordance with established protocol, the Director, in consultation and cooperation with the Advisory Council, must take any necessary actions to bring the review team into compliance with the protocol.

(d) Any document or oral or written communication shared within or produced by the review team relating to a case discussed or reviewed by the review team is confidential and is not admissible as evidence in any civil or criminal proceeding, except for use by a State's Attorney's office in prosecuting a criminal case against a caregiver. Those records and information are, however, subject to discovery or subpoena, and are admissible as evidence, to the extent they are otherwise available to the public.

Any document or oral or written communication provided to a review team by an individual or entity, and created by that individual or entity solely for the use of the review team, is confidential, is not subject to disclosure to or discoverable by another party, and is not admissible as evidence in any civil or criminal proceeding, except for use by a State's Attorney's office in prosecuting a criminal case against a caregiver. Those records and information are, however, subject to discovery or subpoena, and are admissible as evidence, to

the extent they are otherwise available to the public.

Each entity or individual represented on the fatality review team may share with other members of the team information in the entity's or individual's possession concerning the decedent who is the subject of the review or concerning any person who was in contact with the decedent, as well as any other information deemed by the entity or individual to be pertinent to the review. Any such information shared by an entity or individual with other members of the review team is confidential. The intent of this paragraph is to permit the disclosure to members of the review team of any information deemed confidential or privileged or prohibited from disclosure by any other provision of law. Release of confidential communication between domestic violence advocates and a domestic violence victim shall follow subsection (d) of Section 227 of the Illinois Domestic Violence Act of 1986 which allows for the waiver of privilege afforded to guardians, executors, or administrators of the estate of the domestic violence victim. This provision relating to the release of confidential communication between domestic violence advocates and a domestic violence victim shall exclude adult protective service providers.

A coroner's or medical examiner's office may share with the review team medical records that have been made available to the coroner's or medical examiner's office in connection with that office's investigation of a death.

Members of a review team and the Advisory Council are not subject to examination, in any civil or criminal proceeding, concerning information presented to members of the review team or the Advisory Council or opinions formed by members of the review team or the Advisory Council based on that information. A person may, however, be examined concerning information provided to a review team or the Advisory Council.

(d-5) Meetings of the review teams and the Advisory Council may be closed to the public under the Open Meetings Act. Records and information provided to a review team and the Advisory Council, and records maintained by a team or the Advisory Council, are exempt from release under the Freedom of Information Act.

(e) A review team's recommendation in relation to a case discussed or reviewed by the review team, including, but not limited to, a recommendation concerning an investigation or prosecution, may be disclosed by the review team upon the completion of its review and at the discretion of a majority of its members who reviewed the case.

(e-5) The State shall indemnify and hold harmless members of a review team and the Advisory Council for all their acts, omissions, decisions, or other conduct arising out of the scope of their service on the review team or Advisory Council, except those involving willful or wanton misconduct. The method of providing indemnification shall be as provided in the State Employee Indemnification Act.

(f) The Department, in consultation with coroners, medical examiners, and law enforcement agencies, shall use aggregate data gathered by and recommendations from the Advisory Council and the review teams to create an annual report and may use those data and recommendations to develop education, prevention, prosecution, or other strategies designed to improve the coordination of services for at-risk adults and their families. The Department or other State or county agency, in consultation with coroners, medical examiners, and law enforcement agencies, also may use aggregate data gathered by the review teams to create a database of at-risk individuals.

(g) The Department shall adopt such rules and regulations as it deems necessary to implement this Section.

(Source: P.A. 98-49, eff. 7-1-13; 98-1039, eff. 8-25-14; 99-78, eff. 7-20-15.)