

GOV. SHAPIRO STOPPED CARING ABOUT ELDERLY PEOPLE DYING FROM ABUSE AND NEGLECT

Would he care if it was HIS Mother, father or grandparents? How can Shapiro claim he cares about the people of PA? Does he hate the elderly because they have no more money he can tax to give to him to spend?

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FYI.....

Records reveal Shapiro admin stopped tracking why older adults die during abuse, neglect investigations
by Angela Couloumbis of Spotlight PA | April 2, 2025



COMMONWEALTH MEDIA SERVICES

HARRISBURG — The Shapiro administration last year stopped collecting information on why older adults in Pennsylvania die during open abuse and neglect investigations, and no longer examines whether delays or other investigative failures by county agencies might have played a role.

The state Department of Aging in 2021 launched a process to begin tracking the cause of death for every older adult who died during an active investigation, according to records reviewed by Spotlight PA and interviews with former state aging officials. It came at a time when those older adults were dying across Pennsylvania in alarmingly higher numbers.

That process included documenting each death and cross-referencing the information with other records

obtained from the state Department of Health that listed both primary and secondary causes of death.

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The goal was to strengthen the safety net for vulnerable older adults. If the main cause indicated the older adult may have died under suspicious circumstances, state aging employees would then review that person's protective services case file to see if something went awry with the investigation. That file, which is confidential, details all steps taken to determine whether an older adult is at risk of harm, and any services that were provided to mitigate the risk.

If they pinpointed a connection between the person's death and failures in the investigation, they would work with the appropriate county aging agency to correct those deficiencies.

But after 2023, Gov. Josh Shapiro's pick to lead the department, Jason Kavulich — who previously ran Lackawanna County's aging agency — put in motion a new policy that halted that process, and instead left reviews up to the county agencies.

"We can track the cause of death — and we did track the cause of death," said Peter Hans, who retired last year from the Department of Aging and whose job involved reviewing the quality of protective services investigations for older adults.

"We actually had a good system in place, and they took it away," added Hans, who conducted some of those fatality reviews. "How is this helping older adults?"

In an initial email, department spokesperson Karen Gray said the death review process "never existed"

before Kavulich took over the department.

When told that Spotlight PA had records documenting its existence, Gray wrote back saying the department was unaware of any “authorized” death review process that predated Kavulich’s tenure. Records reviewed by Spotlight PA show Kavulich’s predecessor was copied on emails about it.

Gray said such a review process is not “within the scope” of the department’s authority under Pennsylvania’s older adult protective services law — although the statute does not explicitly prohibit the department from tracking causes of death or reviewing whether investigative failures might have increased that risk of harm.

Gray also said determining whether an older adult died under suspicious circumstances would require department staff to investigate those causes of death “further,” which she said the department does not have the authority or the expertise to do.

Asked why the department wouldn’t want to know why so many older adults were dying during open investigations, she wrote: “The Department cares deeply about older adults and would welcome additional resources to help ensure older adults in protective services are taken care of — but as we have explained to you numerous times, we do not have the authority to conduct such investigations at the Department level.”

In Pennsylvania, investigations of suspected abuse or neglect involving older adults are carried out by the state’s 52 county-based aging agencies. Their effectiveness and accountability — as well as the state’s oversight of them — have come under increased scrutiny by lawmakers and others in recent months following an ongoing investigation by Spotlight PA.

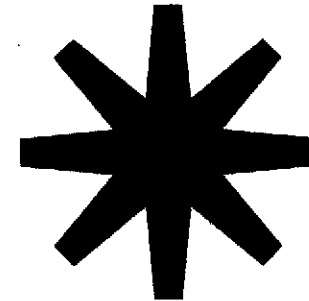
The news organization found that up to a third of those county agencies failed to conduct timely or quality investigations in a given year, potentially leaving vulnerable older adults at risk of harm and even death in some cases. A Spotlight PA investigation found a 75-year-old Philadelphia woman with dementia died after the local agency failed to swiftly investigate her case and provide desperately

needed services.

Yet the Department of Aging has not taken any punitive action against them. At the same time, older adults with open abuse or neglect investigations have been dying in staggering numbers.

In 2023, the last year for which the Department of Aging has complete numbers, 1,511 older Pennsylvanians died while their county aging agency had an open abuse or neglect case, according to data obtained by Spotlight PA through a public records request.

That is a 70% increase since 2018, when 888 older adults died during active protective services investigations.



A Flourish data visualization

In 2021, the number of deaths peaked at 1,754. That year, under former Secretary of Aging Robert Torres, the department began tracking the cause of death for every older adult who died during an active services investigation, according to interviews with former state aging officials and records reviewed by Spotlight PA.

It did so at the suggestion of staff at the Office of State Inspector General, which in 2018 conducted a review of the Department of Aging's protective services programs.

Torres was unavailable for comment.

The department created spreadsheets documenting every instance in which an older adult died during an

active protective services investigation. It then cross-referenced that information with death records it obtained through an agreement with the state Department of Health that listed both primary and secondary causes of death.

After Kavulich was appointed by Shapiro in 2023, aging department staff gathered the necessary signatures to renew the agreement to continue receiving those death records. However, sources say, top department officials did not follow through on it.

In February 2024, the Department of Aging revised its policy on older adult deaths, effectively halting the prior review process. According to an email from that month obtained by Spotlight PA, a top aging department official informed the 52 county agencies that going forward, they should conduct reviews internally.

The email says that when caseworkers are made aware that an older adult died under “suspicious” circumstances during an active investigation, they must report it to their supervisor. Caseworkers and their supervisors are to then review the handling of the protective services investigation, and report any problems to the director of their county agency. As part of those reviews, they are not required to look for links between deficiencies in the investigation and the reason the older adult died.

Asked about that, Gray said the “department is a social services agency, not a law enforcement agency or a medical examiner,” and follows state regulations on dealing with suspicious deaths.

Those regulations require county agencies to report certain suspicious deaths — including ones where there is reasonable cause to suspect the death was caused by abuse — to law enforcement and the county coroner. Gray said the department continues to monitor whether county agencies properly follow those rules, and has separately also launched a revamped system for monitoring the overall quality of protective services for older adults.

The February 2024 email does not define what constitutes a suspicious death. In its most recent annual report, the Department of Aging says a suspicious death is unexpected, with circumstances or causes

that are “medically or legally unexplained.”

The email discusses the possibility of having county aging agencies create teams internally to review suspicious deaths. Those teams, according to the email, would include “culturally diverse professionals or experts.”

Gray said the department does not have the authority to require county agencies to assemble such teams. Instead, in February of last year, it provided guidance to the counties on how to develop and implement them, with the goal being to “identify any gaps or barriers in the system and make corrective recommendations to improve or enhance delivery of victim services.”

Sheri McQuown, a former protective services specialist for the Department of Aging, said the changes in fatality reviews only benefit the county aging agencies, which she believes will be able to shirk accountability.

“How many times do you think a [county aging agency] will find a death suspicious if they failed to complete a proper investigation?” said McQuown, adding: “This administration has chosen to remove multiple layers of accountability.”

>> *Read aging spokesperson Karen Gray's full responses.*

‘It might never see the light of day’

The practice of conducting elder fatality reviews began to gain traction in the early 2000s, according to the American Bar Association, which has a commission that promotes the development of such review teams through manuals and other resources.

Since then, jurisdictions that have created such fatality review teams recommend they include professionals from multiple disciplines, such as law enforcement and the medical examiner’s office, as well as older adult protective services and geriatric practitioners, said Bill Benson, a longtime policy

consultant in the adult protective services field.

“If you are trying to understand why a person died, it really does take different talents,” he said.

Benson said some states have laws explicitly creating older adult fatality review teams. Florida, which like Pennsylvania has a large and rapidly growing population of older adults, has a law that allows the state’s equivalent of district attorneys (called state attorneys) to create such teams in their jurisdiction.

Florida’s law also makes recommendations on who should serve on those teams, and what those teams should accomplish. One of those goals is identifying potential gaps, deficiencies, or problems in how public and private agencies delivered services to the older adults, and whether those problems were related to their death.

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Benson said most states that have fatality review teams don’t just investigate deaths of older adults who were in the care of protective services. They instead cast a wider net to include any older adult who died under suspicious circumstances, including nursing home residents. Some of those teams also produce reports summarizing findings and making recommendations for strengthening the safety net for older adults, he said.

Pennsylvania does not have a law establishing elder fatality review teams, although it does have one for deaths involving children suspected of being abused. The state Department of Human Services, for instance, is required to review cases involving deaths or near deaths of children when abuse is suspected.

In child death or near-death cases, there are two levels of reviews: the first by the county protection agency, which convenes a team of professionals to review the death; and the second by the Department of Human Services. The reviews, according to the department's website, "seek to identify areas that require systemic change in order to improve the delivery of services to children and families."

The Department of Human Services publishes quarterly summaries about child deaths and near fatalities on its website. Those summaries include the age and gender of the child, the county the child lived in, the cause of death, and brief statements of facts about the case.

The Department of Aging does not publish data involving deaths of older adults on its website. It also does not make that information available in its annual reports on protective services.

Benson said fatality reviews should not be viewed as punitive, but as a learning opportunity for better protecting older adults.

"It's an important quality assurance measure," he said. "Somebody dies on your watch ... you ask, 'Why did this person die? And was there something that we didn't do?'"

It's troubling when those reviews receive no external oversight, he said, or don't include professionals from multiple disciplines who can inject more objectivity into the process.

"The trouble comes if it's purely internal, and there is reason to believe the death had something to do with poor practice," said Benson.

The danger, he said, is secrecy, especially if those reviews expose serious problems.

"It might never see the light of day," he said.