



DISTRICT OF COLUMBIA

MENTAL RETARDATION AND DEVELOPMENTAL
DISABILITIES

FATALITY REVIEW COMMITTEE

2007 ANNUAL REPORT



Adrian M. Fenty, Mayor
District of Columbia Government

Marie-Lydie Y. Pierre-Louis, MD, Chief Medical Examiner
Office of the Chief Medical Examiner

**DISTRICT OF COLUMBIA
MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES
FATALITY REVIEW COMMITTEE**

2007 ANNUAL REPORT

MISSION:

To reduce the number of preventable deaths of individuals with mental retardation and developmental disabilities through identifying, evaluating and improving programs and systems responsible for protecting and serving citizens

PRESENTED TO:

The Honorable Adrian M. Fenty, Mayor, District of Columbia
The Council of the District of Columbia

DECEMBER 2008

TABLE OF CONTENTS

EXECUTIVE SUMMARY	i
INTRODUCTION	1
SECTION I: TOTAL MORTALITY FINDINGS	2
SECTION II: SUMMARY OF 2007 CASE REVIEW FINDINGS	5
Age/Gender and Mortality	
Race and Mortality	
Place of Residence and Ward Data	
Location of Death	
Mobility and Feeding Impairments	
Neuropsychiatric Disorders	
Cause and Manner of Death	
SECTION III: MRDD FRC RECOMMENDATIONS	11
APPENDICES	
Appendix A: Mayor’s Order 2005-143	
Appendix B: Causes of Death – 2007 MRDD FRC Deaths Reviewed	
Appendix C: Glossary of Terms	

EXECUTIVE SUMMARY

The District of Columbia Mental Retardation and Developmental Disabilities Fatality Review Committee (hereinafter known as the MRDD FRC or the Committee) is pleased to present its seventh Annual Report. MRDD FRC was established in February 2001, by Mayor's Order 2001-27 and re-established in September of 2005 by Mayor's Order 2005-143 (see Appendix A). The Committee is charged with examining the events surrounding the deaths of individuals 18 years of age and older who were receiving services from the District of Columbia's Department on Disability Services (DDS) at the time of death.

During calendar year 2007, a total of 30 customers served by DDS died, representing 1.5 percent of the total DDS population for that year (N = 2018). During 2007, the Committee reviewed 18 deaths of DDS customers who died during calendar years 2006 and 2007. The following is a summary of the data included in the 2007 Annual Report.

KEY MRDD FRC DATA FINDINGS

TOTAL FATALITIES IDENTIFIED (N = 219)

- ◆ Between 2001 and 2007, a total of 219 deaths have been identified as meeting the MRDD FRC criteria for review, with an average of 31 deaths annually
- ◆ Consistent with the general population, the largest number of DDS customer deaths involve decedents over the age of 60 years
- ◆ At least two thirds of DDS customer deaths each year involve Black/African American decedents
- ◆ Annually there are larger numbers of male deaths
- ◆ The leading manner of death was Natural followed by Accident

FINDINGS FROM DEATHS REVIEWED IN 2007 (N = 18)

- ◆ Autopsies were performed on 15 (83%) of the 18 deaths reviewed
- ◆ Equal number of decedents were classified as profound and severely mentally retarded by IQ tests (N = 6 each)
- ◆ Of the deaths reviewed, 94% was attributed to Natural related causes; one death was determined to be a Suicide
- ◆ The majority of the decedents were over the age of 50 years (N = 13, 72%)
- ◆ Equal numbers of male and female deaths were reviewed in 2007
- ◆ Of the 18 deaths reviewed, 72% involved Black/African American decedents
- ◆ Of the deaths reviewed, 50% of the decedents died in a hospital setting
- ◆ Of the deaths reviewed, 15 involved decedents who resided in the District of Columbia; the majority resided in Ward Four (N = 4)

MRDD FRC RECOMMENDATIONS FROM 2007 CASES REVIEWED

Based on the 18 cases reviewed during calendar year 2007, the MRDD FRC issued recommendations to DDS and other appropriate agencies that related to improved health care and health case management, improved emergency response and case monitoring (see Section III: MRDD FRC 2007 Recommendations). The recommendations impact policy and clinical practice.

INTRODUCTION

*"Never doubt that a small group of
thoughtful, committed citizens can
Change the World.
Indeed, it's the only thing that ever has."*

Margaret Meade

The 2007 Annual Report is a summary of the work performed by the MRDD FRC during calendar year 2007. It provides a synopsis of the total population identified by the Committee annually as meeting the criteria for review and the data that is specific to the 18 deaths reviewed during calendar year 2007.

MRDD FRC was established in February 2001, under the auspices of the Office of the Chief Medical Examiner (OCME). It is a multi-disciplinary, multi-agency effort that was established for the purpose of conducting retrospective reviews of relevant service delivery systems and the events that surrounded the deaths of District wards and residents 18 years of age and older who received services and/or supports from DDS. One goal of the FRC is to make recommendations to improve care and service delivery to citizens of the District.

Committee membership is broad, representing a range of disciplines, public and private agencies as well as community organizations and individuals. Membership includes representation from health, mental retardation, mental health, social services, public safety, legal, law enforcement areas and the community. These professionals come together for the purpose of examining and evaluating relevant facets associated with services and interventions provided to deceased persons diagnosed with intellectual and other disabilities.

One of the primary functions of the MRDD FRC involves the collection, review and analysis of DDS consumer death related data in order to identify consistent patterns and trends that assist in increasing knowledge related to risk factors and guiding system change/enhancements. The fatality review process includes the examination of an independent investigative report of each customer's death that includes a summary of the forensic autopsy report; the decedent's social history (including family and caregiver relationships); living conditions prior to death; medical diagnosis and medical history; and services provided by DDS and its contractors. It also includes the assessment of agency policies and practices and compliance with District laws and regulations and national standards of care. Many reviews result in the identification of systemic problems and gaps in services that may impact the consumers' quality of life. Another important result of this process is the recognition of best practices, and recommendations to create and institutionalize these practices as a critical component of systemic change.

SECTION I: TOTAL MORTALITY FINDINGS

In order for a person to be eligible for DDS services he/she must have significant deficits in intellectual functioning and adaptive behavior that occurs in childhood. The District of Columbia Code defines mental retardation as “a significantly sub-average general intellectual level” determined in accordance with standard measurements as recorded in the Manual of Terminology and Classification in Mental Retardation, 1973 (Endnote 1, see page 12).

Eligibility criteria used by DDS to identify persons with mental retardation are as follows:

- ◆ Current cognitive assessment (within 3 years prior to application date) with accepted IQ test showing IQ of 75 or below. (If most recent testing or prior testing shows IQ of close to 70 or above, an accepted IQ test within the past year may be required.)
- ◆ Current adaptive assessment (within 3 years prior to application date) showing adaptive functioning in the Mild range or below, or indicating that the individual needs supports in at least 2 out of 10 areas of adaptive living.
- ◆ A cognitive assessment before the age of 18 years showing IQ of 75 or below.

Section I of this Report provides a general overview of decedent demographics for the DDS deaths that occurred during calendar years 2001 through 2007 and determined to meet the criteria for review by the FRC.

Table 1 below illustrates for a seven year period the total number of customers served by DDS, the total number of consumer deaths annually and the trend related to the percentage of DDS clients that have died during this period. During calendar years 2001 through 2007, the number of consumers served ranged from 1,547 to 2018 (Endnote 2, see page 12), while the number of DDS deaths during the same seven year span ranged from 26 to 36 annually. As Table 1 illustrates, the percentage of DDS clients who died between 2001 and 2007 has consistently ranged from 1.5 to 2.0% annually.

Year	Population	Number of Deaths	Percentage
2007	2018	30	1.5%
2006	1974	30	1.5%
2005	1993	34	1.7%
2004	1915	36	1.9%
2003	1790	31	1.7%
2002	1703	26	1.5%
2001	1547	32	2.0%

Table 2 below summarizes the status of the 219 deaths identified as meeting the MRDD FRC criteria for review by calendar years since the Committee’s inception. Of the 219 deaths identified, 166 have been reviewed and 53 are pending review.

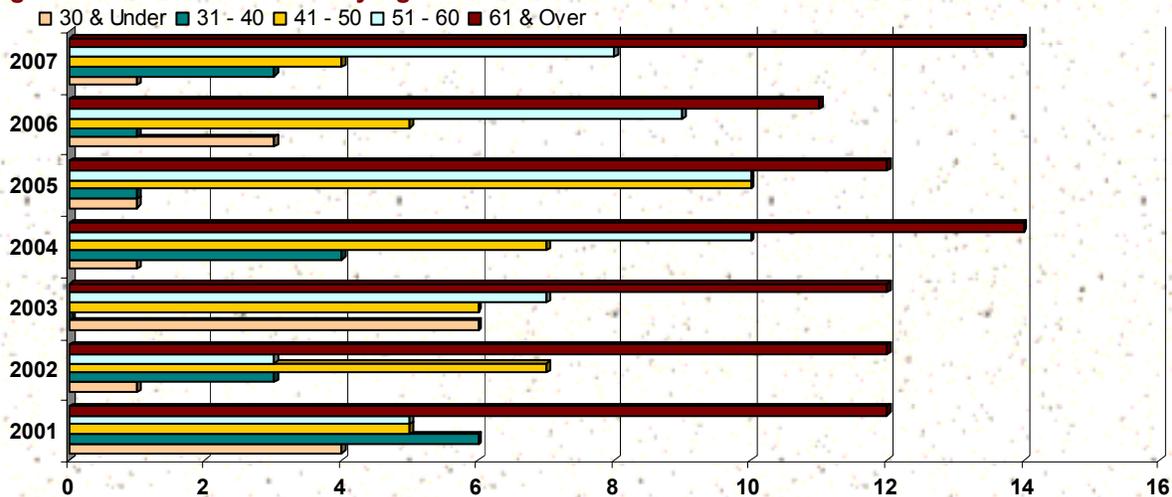
Table 2: Status of Deaths Identified and Review By Calendar Year			
Year	# Deaths Identified By Year	# Deaths Reviewed By Year	# Deaths Pending Review
2007	30	21	9
2006	30	19	11
2005	34	24	10
2004	36	26	10
2003	31	23	8
2002	26	21	5
2001	32	32	0
Total	219	166	53

DEMOGRAPHIC DECEDENT DATA - TOTAL MORTALITY POPULATION IDENTIFIED

Age of Decedents

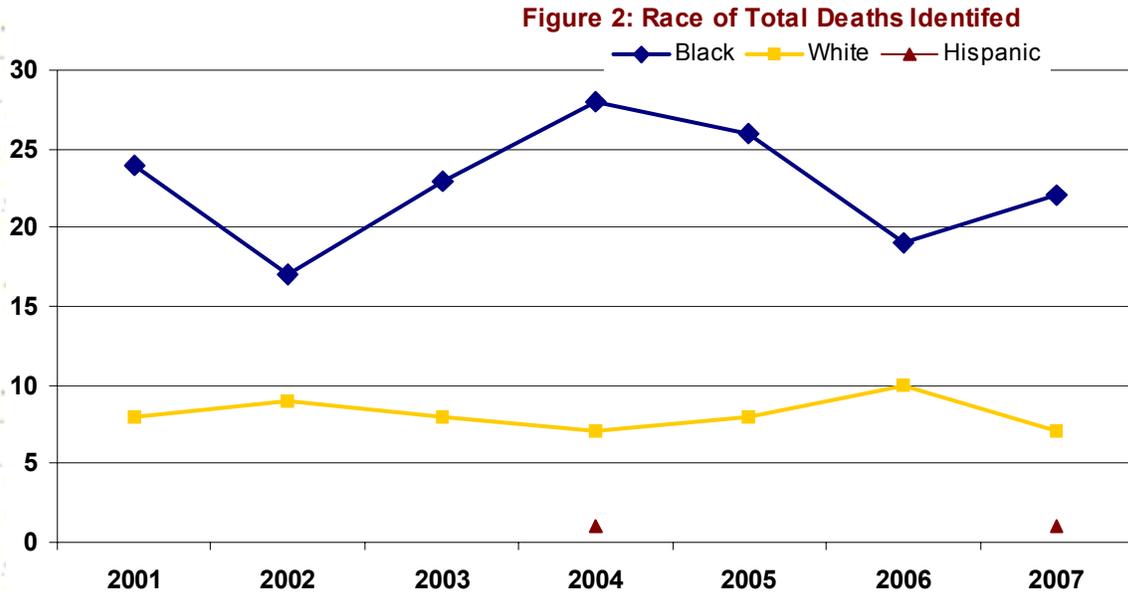
Based on cases reviewed, the relationship between age and mortality has historically demonstrated the expected trend, with the mortality rate increasing as DDS consumers begin to age. Figure 1 illustrates the fact that as consumers reach 50 years of age or older, they are at greater risk of dying. Annually the majority of the deaths reviewed have involved DDS consumers who were 61 years of age or older. Overall, this trend among the DDS population has remained constant since the inception of the fatality review process in 2001. Additionally, the trend among the DDS population is also consistent with the expected national trend of mortality increasing with age for the broader population. The average age of death for DDS consumers during calendar years 2001 - 2007 was 59 years.

Figure 1: Number of Deaths By Age - Calendar Years 2001 - 2007

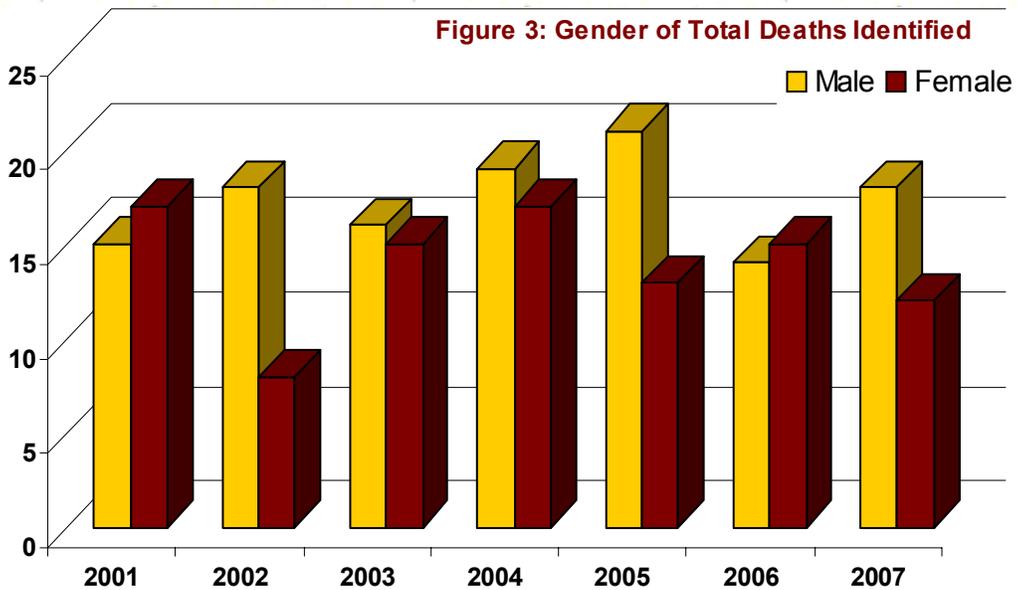


RACE AND GENDER OF DECEDENTS

- ◆ Consistent with the overall DDS population, the majority of the MRDD FRC deaths involved Black/African American decedents. Between 2001 through 2007, the Black/African American decedent population ranged from 65% to 78%.



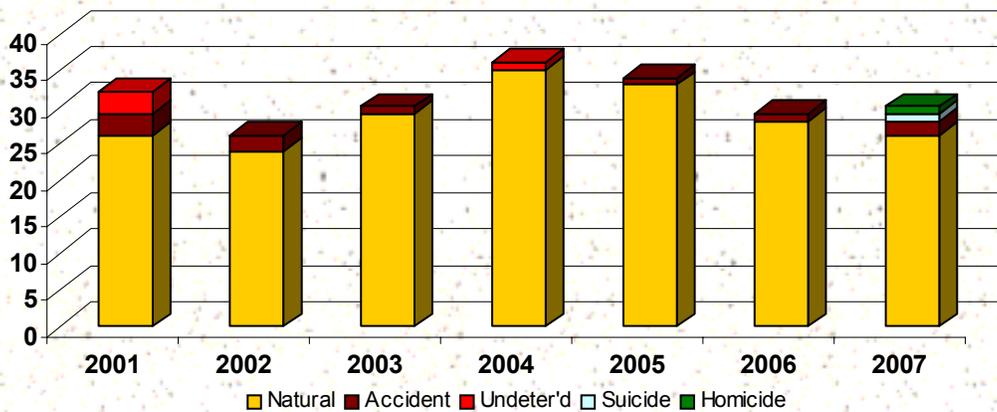
- ◆ With the exception of calendar years 2001 and 2006, the number of male deaths exceeded the number of female deaths.



MANNER OF DEATH - TOTAL DEATHS IDENTIFIED

Historically, the leading manner of death for MRDD FRC cases identified is Natural. Since the inception of this Committee, Natural deaths have represented from 81% to 97% of the total fatalities identified annually. The second leading manner of death is Accident. Accidental deaths of DDS consumers have occurred in every calendar year with the exception of 2004. Between calendar years 2001 and 2007, the number of Accidental deaths ranged from one to three. The largest number of accidental deaths occurred in calendar year 2001 (N = 3). Four deaths had an Undetermined manner of death; three in 2001 and one in 2004. During this seven year span, there was one Homicide and one Suicide death, both occurred in calendar year 2007.

Figure 4: Manner of Death - Calendar Years 2001 - 2007

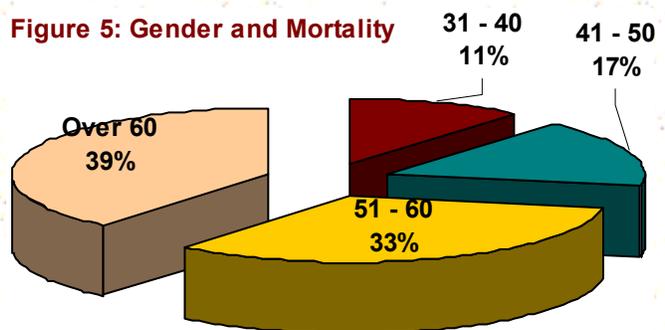


SECTION II: SUMMARY OF 2007 CASE REVIEW FINDINGS

During calendar year 2007, the MRDD FRC reviewed the deaths of 18 customers diagnosed with intellectual and developmental disabilities served by DDS. These reviews were limited to deaths that occurred in 2006 and 2007 and the majority involved 2006 fatalities (N = 15, or 83%). *Section II* will cover the data and findings that resulted from the 18 cases reviewed.

AGE/GENDER AND MORTALITY

The ages of the 18 decedents whose deaths were reviewed ranged from 34 to 89 years; the average age was 60. As Figure 5 illustrates, 13 (72%) of 18 cases reviewed involved DDS consumers over the age of 50 years, with slightly higher numbers of deaths (N = 7) in the 61 and over age category. There were three decedents between the ages of 41 through 50 and two 31 through 40 years. Of the 18 deaths reviewed none of the decedents were younger than 31.



Based on the 18 deaths reviewed, there were equal numbers of female and male decedents (N = 9). Table 3 depicts the age ranges of the decedents by gender and year of death for the 18 cases reviewed during 2007.

	2006 (N = 16)		2007 (N = 2)	
	Male	Female	Male	Female
Under 41	0	1	1	0
41 – 50	1	1	1	0
51 – 60	2	4	0	0
61 & Over	4	3	0	0

- ◆ The two deaths that occurred in 2007 involved male decedents, ages 34 and 49.
- ◆ Of the 16 deaths reviewed that occurred in 2006, the majority of the females were between the ages of 51 through 60 years and most of the males were 61 years or older.

RACE AND MORTALITY

Consistent with previous FRC review years and the overall DDS population served, the majority of the deaths reviewed in 2007 were Black/African American decedents. Seventy-two percent (N = 13) of the 18 decedents were Black/African American and 28% were Caucasians (N = 5). Table 4 illustrates the race by gender and year of death of the 2007 cases reviewed.

Race	2006 (N=16)		2007 (N=2)	
	Male	Female	Male	Female
Black	5	6	2	0
Caucasian	2	3	0	0

Of the 16 deaths that occurred in 2006, the majority involved females (N = 9, or 58%). Six females were Black/African American and three were Caucasian. The remaining seven 2006 deaths included five Black/African American males and two Caucasian males. The two deaths reviewed that occurred in 2007 were Black/African American males. The following data describes the mean age and race of decedents by year of death for the 18 cases reviewed during calendar year 2007:

- ◆ Average age of the 2006 Black/African American female decedents (N = 6) was 60 years
- ◆ Average age of the 2006 Black/African American male decedents (N = 5) was 58 years
- ◆ Average age of the 2006 Caucasian female decedents (N = 3) was 61 years
- ◆ Age of the one Caucasian 2006 male was 81 years
- ◆ Average age of the two 2007 Black/African American male decedents was 42 years.

PLACE OF RESIDENCE AND WARD DATA

The 18 deaths reviewed involved decedents who resided in their natural homes, foster homes, Intermediate Care Facilities for persons with Mental Retardation (ICF/MR), supervised apartments and nursing homes. Over half of the 2007 deaths reviewed (N = 11, or 61%) involved consumers who resided in facilities funded by DDS (foster homes, supervised apartments and ICF/MR facilities). Sixty-four percent of these deaths involved decedents who resided in ICF/MR facilities (N = 7). Deaths of DDS consumers residing in skilled nursing facilities (N = 4) or in

Place of Death	2006 N=16	2007 N=2
Own Home (independent)	2	1
Nursing Home	3	1
Foster Home	2	0
Supervised Apartment	2	0
ICF/MR	7	0

their own homes (N = 3 living independently in own apartment or family home) accounted for the remainder of the seven 2007 deaths reviewed.

Ward of residence refers to the decedent's residential address at the time of the death. Table 6 illustrates the decedents' District Ward or State of residence at the time of death by year of death for the total number of cases (N = 18) reviewed in 2007. Of the 18 deaths reviewed, 15 involved decedents who resided in the District. Of the District residents, the largest numbers of decedents reviewed resided in Wards Four (N = 4) and Five; equal numbers resided in Wards Six and Seven and Eight (N = 2 each). The two decedents whose deaths occurred in 2007 resided in their own homes/apartments in Wards Five and Eight. Of the 18 deaths reviewed, three decedents resided in Maryland. Two of the decedents

Table 6: Ward/State of Residence By Year of Death

Ward/State	2006 (N=16)	2007 (N=2)
One	0	0
Two	0	0
Three	1	0
Four	4	1
Five	3	0
Six	2	0
Seven	2	0
Eight	1	1
Maryland	3	0

resided in nursing homes and one in a foster home.

Table 7: Location of Death By Year

Place of Death	2006 (N=16)	2007 (N=2)
Hospital	8	1
Nursing Home	4	0
Hospice	1	0
ICF/MR	2	0
Own Home	1	1

LOCATION OF DEATH

The deaths of the 18 cases reviewed occurred in locations that included hospitals, nursing homes, residential settings, hospice and the decedent's own home. Table 7 presents the number of decedents by year and location of death. Of the 18 cases reviewed in 2007, over half (N = 9, or 56%) died in a hospital. Four decedents died in their last place of residence, including two in their family/own home (living independently) and two in DSS funded facilities (ICF/MR). Four decedents died in skilled nursing facilities and one in a hospice facility.

MOBILITY AND FEEDING IMPAIRMENTS

Mobility and feeding impairments are recognized problems that place individuals at higher risk of morbidity and mortality. Historically, MRDD FRC data supports the fact that individuals who require special assistance with ambulating and feeding have a greater risk of death. The independent Reports provided to the FRC provide detailed information related to these risks and the Committee considers these factors as part of the case evaluation process.

Table 8: Feeding and Mobility

Feeding Method		Mobility	
G-Tube	2	Wheelchair	5
With Assistance	4	Bedridden	1
Independent	12	With support	4
		Without support	8

Based on the 18 deaths reviewed, five involved decedents who used wheelchairs; and four who could function with support (i.e., leg braces, walker, cane, etc.). Nearly half of the cases

reviewed (44%) involved decedents who were completely mobile and were able to function without support. Two of these decedents resided independently.

NEUROPSYCHIATRIC DISORDERS

Table 9 below provides a numerical summary of the first two axes of the Multiaxial Diagnostic System, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR). Axis I is for reporting clinical disorders and other conditions that may be a focus of clinical attention. This includes reporting of disorders usually first diagnosed in infancy, childhood or adolescence, excluding mental retardation. Axis II is for reporting mental retardation and personality disorders.

Mental Retardation has been distinguished by level of severity in cognitive functioning and adaptive functioning. When significant neurologic dysfunction is associated with other organ system anomalies, an individual’s life expectancy may be shortened. It is not uncommon that severity of cognitive impairment is correlated to other health risks.

As Table 9 depicts, of the 18 cases reviewed during 2007, 10 decedents carried Axis I

Table 9: Neuropsychiatric Disorders by Axis				
Axis I Disorders		Axis II Mental Retardation Level of Severity	Cognitive (N = 18)	Adaptive (N = 18)
Disruptive Behavior Disorder, NOS	1	Profound	6	8
Dementia	1	Severe	6	5
Schizophrenia	3	Moderate	4	3
Major Depressive Disorder	2	Mild	2	2
Obsessive Compulsive Disorder	2			
Post-Traumatic Stress Disorder	1			
Intermittent Explosive Disorder	1			
Impulse Control Disorder, NOS	1			

diagnoses (Endnote #3, see page 12). The Axis I diagnostic disorders represented were: Dementia, Schizophrenia, Major Depressive Disorder, Obsessive Compulsive Disorder, Post-Traumatic Stress Disorder, Intermittent Explosive Disorder N.O.S., and Impulse Control Disorder.

Although the District records levels of Mental Retardation in terms of both cognitive and adaptive functioning, diagnostic levels are more usually made in terms of cognitive functioning. The following degrees of severity reflect the levels of intellectual (cognitive) impairment: of the deaths reviewed (N = 18), six (33%) were diagnosed with Profound Mental Retardation, six (33%) were Severe, four (22%) were Moderate and two (11%) were Mild.

CAUSE AND MANNER OF DEATH

Pursuant to Mayor’s Order 2006-123, “Autopsies of Deceased Clients of the Mental Retardation and Developmental Disability Administration”, the requirement that autopsies be performed on all persons with mental retardation or developmental disability who received services from DDS was eliminated.

Of the 18 cases reviewed in 2006, 15 decedents were autopsied (88%), and two had an external examination; one death was not referred to the DC OCME until after burial. The two decedents who were not autopsied died during calendar year 2006 and one died in Virginia and the death certificate was issued from that state.

MANNER OF DEATH

Manner of death refers to the circumstantial events surrounding the death. The manner of death, as determined by the forensic pathologist, is an opinion based on the known facts concerning the circumstances leading to and surrounding the death, in conjunction with the findings at autopsy and laboratory tests.

Consistent with previous years, the majority of the 18 deaths reviewed in 2007 were determined to be Natural deaths (N = 17, or 94%). There was one death attributed to Suicide that involved an Black/African American male under the age of 35 years who lived independently. There were no fatalities attributed to Homicide, Accident or Undetermined manners of death.

CAUSE OF DEATH

As Table 10 indicates, of the 18 deaths reviewed during 2007, seven resulted from diseases of

Table 10: Causes of Death - 2007 Deaths Reviewed	# of Deaths (N=18)
Cardiovascular System	7
Nervous System	4
Infection	3
Gastrointestinal System	2
Respiratory System	1
Intoxicating/Poisoning	1

the Cardiovascular System, mainly Hypertension and Arteriosclerosis. Hypertensive and Arteriosclerotic Disease was also a contributing factor in two deaths. In four cases the primary nervous system disorder was directly responsible for the demise. Infectious diseases caused three deaths; ailments of the Gastrointestinal System claimed two lives, and disorders of the Respiratory System one. One death was the consequence of an overdose of a therapeutic drug.

The Manner of Death was Natural in 17 or 94% of the deaths. The overdose death was the result of a suicidal gesture.

SECTION III: MRDD FRC 2007 RECOMMENDATIONS

During calendar year 2007, based on the review of 18 cases, the MRDD FRC issued four new recommendations. These recommendations focused on issues of improved health care and health care management, improved emergency response, and case monitoring. Additionally, during 2007 case review meetings several cases highlighted concerns related to previously issued recommendations. These areas included guardianship, end of life, better monitoring of consumer's weight and improved case management skills. However, as a result of information provided by DDS related to efforts that were underway to improve overall services and address these problems, it was the consensus of the Committee to not reissue/generate recommendations.

<i>FRC Recommendation</i>	<i>Status</i>
DDS/DDA should ensure that appropriate policies, procedures and monitoring mechanisms are established to obtain monthly weights for all consumers and to provide timely notification of weight changes to the primary care provider.	DDS responded timely; lengthy response is on file
DDS/DDA should develop a mechanism to monitor all out of state consumers in a routine and consistent manner.	DDS responded timely; lengthy response is on file
DDS/DDA should develop or revise current policies and procedures to ensure that appropriate and timely intervals are established to monitor consumers on tube feedings and those with consistent weight loss; and require timely notification to the primary provider.	DDS responded timely; lengthy response is on file
DDS/DDA should ensure that current policies require direct care staff to contact 911 immediately when vital signs of distress are noted and that contact with supervisory RN's should be made after 911 has been initiated.	DDS responded timely; lengthy response is on file

ENDNOTES

Endnote # 1 (Page 2)	District of Columbia, Official Code, 2001 Edition, Title 7, Section 7-1301.03 (19).
Endnote # 2 (Page 2)	Information on the total consumer population was provided by the Department of Disability Services.
Endnote # 3 (page 9)	Of the 10 decedents with Axis I diagnoses, two had two Axis I diagnoses: one with Major Depressive Disorder and Post-Traumatic Stress Disorder, the other with Intermittent Explosive Disorder and Obsessive Compulsive Disorder. Each of these individuals, therefore, is represented under two disorders.

APPENDICES

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

Mayor's Order 2005-143
September 30, 2005

SUBJECT: Re-establishment – District of Columbia Mental Retardation and
Developmental Disabilities Fatality Review Committee

ORIGINATING AGENCY: Office of the Mayor

By virtue of the authority vested in me as Mayor of the District of Columbia by section 422(2) of the District of Columbia Home Rule Act (Home Rule Act), approved December 24, 1973, 87 Stat. 790, D.C. Official Code § 1-204.22 (2) and (11)(2001), it is hereby **ORDERED** that:

I. RE-ESTABLISHMENT

There is hereby re-established in the Executive branch of the government of the District of Columbia the District of Columbia Mental Retardation and Development Disabilities ("MRDD") Fatality Review Committee (hereinafter referred to as the "Committee").

II. PURPOSE

The Committee shall examine events and circumstances surrounding the deaths of District wards over the age of 18 years with mental retardation or a developmental disability in order to: gather and analyze empirical evidence about fatalities in this population; safeguard and improve the health, safety and welfare of District wards over the age of 18 years with mental retardation or a developmental disability; reduce the number of preventable deaths; and promote improvement and integration of both the public and private systems serving District wards over the age of 18 years with mental retardation or a developmental disability. For purposes of this Mayor's Order, a District ward over the age of 18 years with mental retardation or a developmental disability may be defined as an individual committed by a court to the care and custody of the District government, or who is under the supervision or care of the District government or of programs contracted by the District government to deliver such care, for reasons of mental retardation or developmental disability.

III. DUTIES

The duties of the Committee shall include:

- a. Expediently reviewing deaths of District wards over the age of 18 years with mental retardation or a developmental disability, especially those who reside in group homes, foster homes, nursing homes or any other residential or health care facilities licensed or contracted by the District;
- b. Identifying the causes and circumstances contributing to deaths of District wards with mental retardation or a developmental disability;
- c. Reviewing and evaluating services provided by public and private systems that are responsible for protecting or providing services to District wards over the age of 18 years with mental retardation or a developmental disability, and assessing whether said entities have properly carried out their respective duties and responsibilities; and
- d. Based on the results of the reviews (both individual and in the aggregate), identifying strengths and weaknesses in the governmental and private agencies and/or programs that serve District wards over the age of 18 years with mental retardation or a developmental disability and making recommendations to the Mayor and the agencies and programs directly to implement systemic changes to improve services or to rectify deficiencies. The recommendations may address, but are not limited to, proposing statutes, policies or procedures (both new or amendments to existing ones); modifying training for persons who provide services to District wards over the age of 18 years with mental retardation or a developmental disability; enhancing coordination and communication among entities providing or monitoring services for District wards over the age of 18 years with mental retardation or a developmental disability; and facilitating investigations of fatalities.

IV. FUNCTIONS

The functions of the Committee shall include:

- a. Developing and issuing procedures governing its operations within ninety (90) days of the effective date of this Mayor's Order. The procedures shall include, at a minimum, the following:
 1. Methods by which deaths of District wards over the age of 18 years with mental retardation or a developmental disability are identified and reported to ensure expeditious reviews;

2. A process by which fatality cases are screened and selected for review;
 3. A method for ensuring that all information identifying District wards over the age of 18 years with mental retardation or a developmental disability, their families and others associated with the cases or the circumstances surrounding the deaths, including witnesses and complainants, is protected against undue disclosure. This is to ensure that steps are taken to protect the right to privacy of an individual and his or her family in conducting investigations, disseminating information to Committee members, reporting as required by the Mayor's Order, and maintaining case records for the Committee;
 4. A method for gathering individual and cumulative data from the reviews;
 5. A method for reviewing whether recommendations generated by the Committee are being implemented and identifying problems related to obstacles/barriers to implementation; and
 6. A method for evaluating the work of the Committee that takes into account community responses to the deaths of District wards with mental retardation or a developmental disability.
- b. On or about December 31st of each year, producing an annual report that provides information obtained from the reviews of deaths that occurred during the previous calendar year. The annual report shall be submitted to the Mayor and made available to the public. The information to be contained in the report shall include at a minimum:
1. Statistical data on all fatalities of District wards with mental retardation or a developmental disability reviewed by the Committee, including numbers reviewed, demographic characteristics of the subjects, and causes and manners of deaths;
 2. Analyses of the data generated by the reviews, to demonstrate the types of cases reviewed (which may include illustrative case vignettes without identifying information), similarities or patterns of factors causing or contributing to the deaths, and trends (including temporal and geographic); and
 3. Recommendations generated from the reviews, including service enhancements, systemic improvements or reforms, and changes in laws,

policies, procedures or practices that would better protect District wards with mental retardation or a developmental disability and that could prevent future deaths.

V. COMPOSITION

- a. **Members shall be appointed by the Mayor based on individual expertise in relevant disciplines and their familiarity with the laws, standards, and services related to the protection of the health and welfare of District wards over the age of 18 years with mental retardation or a developmental disability. As such, the composition of the Committee shall reflect medical and clinical professionals from various disciplines who serve consumers with mental retardation or developmental disabilities. An effort shall be made to ensure representation from each geographical ward of the District.**
- b. **The Committee membership shall consist of:**
 1. **Five (5) members representing the following District government agencies:**
 - A. **Metropolitan Police Department, Special Victims Unit;**
 - B. **Office of the Chief Medical Examiner (OCME);**
 - C. **Office of the Inspector General (OIG), Medicaid Fraud Unit;**
 - D. **Department of Human Services (DHS), Mental Retardation and Developmental Disabilities Administration (MRDDA); and**
 - E. **Fire and Emergency Medical Service Department (FEMSD).**
 2. **A minimum of six (6) and no more than eight (8) public members from the community who shall not be employees of the District government, up to three (3) of whom shall be clinicians with experience in the evaluation and treatment of persons with mental retardation and developmental disabilities. The public members shall include at least:**
 - A. **Two (2) faculty members from schools of social work at colleges or universities located in the District;**

- B. Two (2) physicians who practice in the District with experience in the evaluation and treatment of persons with mental retardation or developmental disabilities;
- C. One (1) psychiatrist and one (1) psychologist or other mental health professional who is licensed to practice in the District with experience in the evaluation and treatment of persons with mental retardation or developmental disabilities.

VI. TERMS

- a. Public members appointed to the Committee shall serve for three (3) year terms, except that of the members first appointed, one-half shall be appointed for three (3) year terms and one-half for two (2) year terms. The date on which the first members are installed shall become the anniversary date for all subsequent appointments.
- b. Members appointed to represent District government agencies shall serve only while employed in their official positions and shall serve at the pleasure of the Mayor.
- c. A public member shall not serve more than two (2) consecutive full terms.
- d. A member appointed to fill an unexpired term shall serve for the remainder of that term.
- e. A member may hold over after the member's term expires until reappointed or replaced.
- f. A public member may be excused from a meeting for an emergency reason. A public member who fails to attend three (3) consecutive meetings shall be deemed to be removed from the Committee, and a vacancy created. Such vacancies shall be filled by the Mayor as outlined in section V of this Mayor's Order.
- g. A public member may be removed by the Mayor for personal misconduct, neglect of duty, conflict of interest violations, incompetence, or official misconduct. Prior to removal, the public member shall be given a copy of any charges and an opportunity to respond within 10 business days following receipt of the charges. Upon a review of the charges and the response, the Director of the Office of Boards and Commissions, Executive Office of the Mayor, shall refer the matter to

the Mayor with a recommendation for a final decision or disposition. A public member shall be suspended by the Director of the Office of Boards and Commissions, Executive Office of the Mayor, on behalf of the Mayor, from participating in official matters of the Committee pending the consideration of the charges.

VII. ORGANIZATION

- a. The Mayor shall appoint the Chief Medical Examiner and the Administrator, Mental Retardation and Developmental Disabilities Administration, Department of Human Services, as Co-Chairpersons of the Committee, and they shall serve in these capacities at the pleasure of the Mayor.
- b. The Committee may establish its own bylaws and rules of procedure.

VIII. COMMITTEE COORDINATOR: ROLES AND RESPONSIBILITIES

The Chief Medical Examiner shall appoint a Committee Coordinator who shall serve as the focal point for receiving case notifications and information, as well as for the appropriate dissemination of information to the Committee.

IX. FULL COMMITTEE

- a. A majority of the members shall be present to constitute a quorum.
- b. Meetings of the full Committee shall be held for the purposes of:
 - 1. Conducting case reviews or assessing additional data from prior cases that have since become available;
 - 2. Considering recommendations arising from available case reviews;
 - 3. Preparing an annual report; and
 - 4. Conducting any other business necessary for the Committee to operate or fulfill its duties.

- c. Case review meetings of the full Committee shall be held monthly, if there are cases for review. After procedures have been established and tested, the Committee may consider holding case review meetings every other month (bi-monthly), if practicable. The full Committee may also convene additional meetings as needed for additional case reviews, or for other specific purposes of the Committee, including the development of recommendations or preparation of the annual report.
- d. The Committee shall conduct multi-disciplinary reviews of the events and circumstances surrounding the deaths of District wards over the age of 18 years with mental retardation or a developmental disability as defined in section II, above, in order to provide the data to fulfill the purposes and duties of the Committee as enumerated in sections II and III, respectively.
- e. Case reviews will occur at the first Committee meeting after the Committee receives notification of the fatality, or at the first meeting after sufficient materials are received for conducting the review. The review may be preliminary, pending conclusion of the investigation and prosecution, or release by the prosecutor to conduct the review, at which time a comprehensive review shall be conducted.
- f. The case review process shall include presentation of the case summary, followed by presentations of relevant information concerning the death by any agencies or persons involved with District wards over the age of 18 years with mental retardation or a developmental disability or investigating the event.
- g. Following presentation of the facts, the Committee will discuss the case and any issues that it raises, guided by the following principles and questions:
 - 1. What factors or circumstances caused or contributed to the death? (This may include consideration of social service delivery and coordination to District wards over the age of 18 years with mental retardation or a developmental disability and their families and compliance with, or development of, applicable or needed laws, procedures and regulations.)
 - 2. What responses and investigations resulted from the death? (This includes whether all necessary agencies were notified and responded, and whether any corrective actions were instituted.)

3. Were the services, interventions and investigations concerning the District ward over the age of 18 years with mental retardation or a developmental disability appropriate and adequate for his/her needs? (In other words, did the systems and agencies provide and plan effectively for the District ward over the age of 18 years with mental retardation or a developmental disability?)
 4. Were the staff involved with the District wards over the age of 18 years with mental retardation or a developmental disability adequately prepared, trained, and supported to perform their duties correctly?
 5. Was there adequate communication and coordination among the various entities involved with the District ward over the age of 18 years with mental retardation or a developmental disability?
 6. Are the applicable statutes, regulations, policies and procedures adequate to serve the needs of the target population? If not, what changes to them are needed?
- h. Based on the case discussion, the Committee shall formulate applicable recommendations as enumerated above in section III (d) and section IV (a) and (b)(3), for further consideration and possible inclusion in the annual report.

X. SUBPOENA POWER

- a. When necessary for the discharge of its duties, the Committee shall have the authority to issue subpoenas to compel witnesses to appear and testify and to produce books, papers, correspondence, memoranda, documents, or other relevant records. The Mayor hereby delegates the said authority to the Committee, to the extent necessary and appropriate to effectuate the Committee's duties, pursuant to D.C. Official Code §1-301.21(a)(2001).
- b. Except as provided in paragraph (3) of this section, subpoenas shall be served personally upon the witness or his or her designated agent, not less than five (5) business days before the date the witness must appear or the documents must be produced, by one of the following methods, which may be attempted concurrently or successively:

1. By a special process server, at least 18 years of age, designated by the Committee from among the staff of the Committee or any office or organization designated by the Committee; provided, that the special process server is not directly involved in the investigation; or
2. If, after a reasonable attempt, personal service on a witness or witness' agent cannot be obtained, a special process server identified in paragraph (1) may serve a subpoena by registered or certified mail not less than eight (8) business days before the date the witness must appear or the documents must be produced.
3. If a witness who has been personally summoned neglects or refuses to obey the subpoena issued pursuant to this section, the Committee may apply to the Superior Court of the District of Columbia for an order compelling the witness so summoned to obey the subpoena.

XI.

CASE REVIEW CRITERIA AND PROCEDURES

- a. All deaths of District wards over the age of 18 years with mental retardation or a developmental disability shall be reviewed by the Committee.
- b. Factors of particular concern for review include:
 1. All violent or unexplained manners of death (i.e., homicide, suicide, accident or undetermined), which include all deaths caused by injuries, including:
 - A. Fractures;
 - B. Blunt trauma, including fractures;
 - C. Burns;
 - D. Asphyxia or drowning;
 - E. Poisoning or intoxication;
 - F. Gunshot wounds; or
 - G. Stabbing or cutting wounds;

2. Abuse, either physical or sexual;
 3. Neglect, including medical and custodial;
 4. Malnourishment or dehydration; and
 5. Circumstances or events deemed suspicious.
- c. The Committee may, at its discretion, review groups of sudden, unexpected or unexplained deaths of District wards with mental retardation or a developmental disability without regard to age, in order to examine aggregate data in order to address specific issues or trends.
- d. The deaths of District wards over the age of 18 years with mental Retardation or a developmental disability who live in facilities outside the District, or who die outside the District, will be subject to review by the Committee, and will be included in the annual report, both for statistical analysis and recommendations. The Co-ordinator shall serve as liaison to his or her counterparts in foreign jurisdictions for the purpose of gathering information and obtaining documents (e.g., police or autopsy reports) to complete the review.

XII. CASE NOTIFICATION PROCEDURES

- a. District agencies and service providers contracted by the District to serve District wards over the age of 18 years with mental retardation or a developmental disability shall provide written notification to the Committee within 24 hours of any death of a District ward over the age of 18 years with mental retardation or a developmental disability, or within 24 hours of becoming aware of such a death. The sources of case notifications will include but are not limited to the:
1. Mental Retardation and Developmental Disabilities Administration (MRDDA), Department of Human Services (DHS);
 2. Contracted service providers (e.g., group home staff);
 3. Office of Inspections and Compliance (OIC), DHS;
 4. Office of the Chief Medical Examiner (OCME);

5. Metropolitan Police Department (MPD);
 6. Office of the Inspector General (OIG);
 7. Office of the Attorney General (OAG);
 8. Department of Health (DOH); and
 9. Department of Mental Health (DMH).
- b. Case notification reports should include for the affected District ward over the age of 18 years with mental retardation or a developmental disability:
1. Demographic data (name, age/date of birth, race, gender);
 2. Address;
 3. Parents/guardians;
 4. Circumstances of the death (date, time, location, activities, risk factors, witnesses or sources of information);
 5. Agencies investigating the death; and
 6. History of the involvement of government agencies or contacted service providers.
- c. MPD, DHS (OIC and MRDDA), DOH and OIG shall provide the Committee copies of all death reports resulting from any investigations that are conducted concerning District wards over the age of 18 years with mental retardation or a developmental disability. The OCME shall provide the Committee copies of all autopsy reports resulting from autopsies and death investigations conducted on District wards over the age of 18 years with mental retardation or a developmental disability. These reports shall be provided within five (5) days after they are completed.

XIII. NOTIFICATION OF PARTICIPANTS

- a. Notification shall be provided in writing to all review participants two (2) weeks prior to the review. Notification shall include sufficient information for the case to be researched, the record identified and reviewed and adequate information related to the nature of the agency's involvement collected

for presentation during the review meeting. Any agreed information shall be provided to the Committee Coordinator prior to the review.

- b. Similar written notification shall be provided to all independent and/or community individuals invited to the review meeting. These may include experts from various relevant disciplines or service areas.

XIV. RECORDS

All records and reports shall be maintained in a secured area with locked file cabinets. Three (3) years after the annual report has been distributed, all supporting documentation in each fatality record shall be destroyed. The only material that will be maintained in a fatality record will be the following:

1. Initial Data Form;
2. Final Report; and
3. Death Certificate.

XV. CONFIDENTIALITY

- a. A key tenet of the Committee is the necessity for keeping confidential all information obtained by, presented to and considered by the Committee, consistent with the confidentiality provisions of D.C. Official Code § 7-1305.12 (2001).
- b. Any information gathered in preparation for or divulged during committee reviews shall not be disclosed except as provided in subsection (d) of this section and applicable law, including the Freedom of Information Act, D.C. Official Code § 2-531 *et seq.* (2001).
- c. All participants in the Committee proceedings shall be required to sign a confidentiality statement during all Committee case review meetings and in general meetings where any specific case is discussed. Case-specific information distributed during the meeting shall be collected at the end of each review. Any participant who is not willing to sign a confidentiality statement or to abide by the confidentiality requirements shall not be allowed to participate in case review meetings.

- d. **Methods for ensuring that all information identifying third persons such as witnesses, complainants, agency, institution, or program staff or professionals involved with the family are protected against disclosure are:**
 - 1. **The same procedures established for District wards over the age of 18 years with mental retardation or a developmental disability and their families above shall be followed for these entities.**
 - 2. **Access to primary documents will be limited to the staff of the Committee and the chair of the review meeting.**
 - 3. **Initials only will identify third persons in materials for distribution.**

XVI. RECOMMENDATIONS

- a. **Draft recommendations shall be developed by the Committee Coordinator based on issues raised during the reviews.**
- b. **Draft recommendations shall be distributed to agencies and members for review and comment. Recommendations shall be finalized based on the comments received, including discussion at meetings of the full Committee.**
- c. **Final recommendations shall be incorporated into the annual report and forwarded to the Mayor. Interim recommendations may be forwarded to the affected entities for expeditious implementation, at the approval of the Committee.**
- d. **Representatives of agencies, institutions and programs may be invited to full Committee meetings to present their plans for, or progress made towards, implementing the recommendations.**

XVII. COMPENSATION

Members of the Committee shall serve without compensation, except that a public member may be reimbursed for expenses incurred in the authorized execution of official Committee functions, if approved in advance by the Chief Medical Examiner or designee, and subject to the appropriation of and the availability of funds.

XVIII. ADMINISTRATION

The Office of the Chief Medical Examiner shall provide administrative support for the Committee, including the services of the Coordinator.

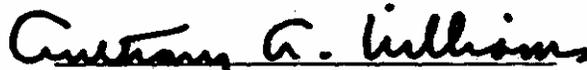
XIX. LEGAL APPLICATION

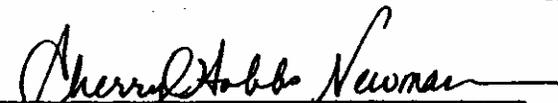
Nothing in this Mayor's Order shall be deemed to create legal rights or entitlements on the part of District wards over the age of 18 years with mental retardation or a developmental disability, their families, or estates, or to give rise to causes of action prosecutable by said persons.

XX. RECISSIONS

Mayor's Order 2000-82, dated May 30, 2000, and Mayor's Order 2001-27, dated February 14, 2001, are superseded and rescinded in their entirety.

XXI. EFFECTIVE DATE: This Order shall become effective immediately.


ANTHONY A. WILLIAMS
MAYOR

ATTEST: 
SHERRYL HOBBS NEWMAN
SECRETARY OF THE DISTRICT OF COLUMBIA

CAUSES OF DEATH - 2007 MRDD FRC DEATHS REVIEWED

2006 Deaths Reviewed:

<i>Age/Race Sex</i>	<i>Cause of Death</i>	<i>Manner of Death</i>
89/White/Male	Complications of Schizencephaly; Other Significant Conditions: Hypertensive and Arteriosclerotic Cardiovascular Disease	Natural
74/Black/Female	Complications of Aortic Valve Disease/Aortic Stenosis	Natural
38/Black/Female	Seizure Disorder Associated with Down Syndrome	Natural
73/Black/Male	Complications of Hypertensive and Arteriosclerotic Cardiovascular Disease	Natural
52/Black/Male	Colonizing Aspergillosis Complicating Chronic Granulomatous Pulmonary Disease	Natural
84/Black/Female	Pulmonary Thromboembolism, Right Lung due to Thrombosis of Inferior Vena Cava with Greenfield Filter in Situ; Other Significant Conditions: Hypertensive and Arteriosclerotic Cardiovascular disease, Noninsulin Dependent Diabetes Mellitus, and Hypothyroidism with Severe Multinodular Goiter	Natural
46/White/Female	Bronchopneumonia due to Down's Syndrome	Natural
73/White/Male	Pneumonia; Other Significant Conditions: Progressive Cognitive Decline*	
55/Black/Female	Primary Cerebellar Intraparenchymal Brain Hemorrhage due to Hypertensive Cardiovascular Disease	Natural
52/Black/Male	Acute Staphylococcal Pneumonia With Complications due to Disseminated Methicillin Resistant Staphylococcus Aureus Bacteria From Infected Decubitus Ulcer of Right Hip Due to Progressive Dementia with Mental Retardation	Natural
42/Black/Male	Seizure Disorder of Undetermined Etiology; Other Significant Conditions: Complications of Congenital Aortic Stenosis Operated	Natural
53/White/Female	Colon Cancer	Natural
71/Black/Male	Complications of Hypertensive Cardiovascular Disease including End-Stage Chronic Renal Failure, Stroke with Recent Onset Seizure Disorder, and Acute Bronchopneumonia	Natural
55/Black/Female	Complications of Seizure Disorder	Natural
42/Black/Female	Cerebral Infarct due to Atherosclerotic Cardiovascular Disease; Other Significant Conditions: Profound Mental Retardation	Natural
83/White/Female	Cardiac Arrhythmia due to Coronary Artery Atherosclerosis; Other Significant Conditions: Anemia; Osteoporosis; Gastric Reflux	Natural

2007 Deaths Reviewed:

<i>Age/Race Sex</i>	<i>Cause of Death</i>	<i>Manner of Death</i>
49/Black/Male	Small Bowel Obstruction due to Intraluminal Foreign Body	Natural
34/Black/Male	Acute Acetaminophen Intoxication	Suicide

* Cause of death for cases with an asterisk were determined by jurisdictions other than the District of Columbia

GLOSSARY OF TERMS

<i>TERMS</i>	<i>DEFINITIONS</i>
Autopsy Report	A detailed report consisting of the autopsy procedure, microscopic and laboratory findings, a list of diagnoses, and a summary of the case
CRF/MR	Community Residential Facility for individuals diagnosed with an intellectual disability (MR)
Group Home	Licensed homes for persons with mental retardation that range in size from four (4) to eight (8) customers
Hospice	A program or facility that provides special care for people who are near the end of life and for their families
ICF/MR	A licensed residential facility certified and funded through Title XIX (Medicaid) for consumers diagnosed with an intellectual disability (MR)
Level of Disability	Cognitive and adaptive impairment ranging from mild to profound
Life Expectancy	The average expected length of life; the number of years somebody is expected to live
Natural Home	Consumers residing in the home of a parent, family members or independently
Neurological Conditions	Disorders of the neuromuscular system (the central, peripheral, and autonomic nervous systems, the neuromuscular junction, and muscles)
Nursing Home	A long-term healthcare facility that provides full-time care and medical treatment for people who are unable to take care of themselves
Skilled Care	An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons
Specialized Home Care	A private home living environment for three (3) or less individuals (also includes foster care)
Supervised Apartments	Typically a living arrangement for one to three customers with mental retardation, with drop-in twenty-four hour supervision. Supervised Apartments may be single units grouped in a cluster within an apartment complex, or scattered throughout a complex
Ward	An administrative or electoral division of an area/city, e.g., Wards 1-8 in the District or Individuals under the custody and care of the District of Columbia.

ACKNOWLEDGEMENT

We wish to acknowledge the dedication and unwavering support of the public servants, private agency/program representatives, university, and community volunteers who serve as members of the District of Columbia Mental Retardation and Developmental Disabilities Fatality Review Committee. It is an act of courage to acknowledge that the deaths of individuals diagnosed with *mental retardation and other developmental disabilities* is a community problem. The willingness of Committee members to step outside of their traditional professional roles to examine the circumstances that may have contributed to these deaths and to seriously consider ways to improve the quality of life and prevent future fatalities is an admirable and difficult challenge. This challenge speaks to the commitment of members to our goal of improving services and making life better for the residents of this city. Without this level of dedication, the work of the Committee would not be possible.

We would like to thank the members of the Committee for volunteering your time, giving of your resources, support and dedication to achieving our common goal. A special thank you is extended to the community volunteers and educators who continue to serve the citizens of the District throughout every aspect of the fatality review process.



Government of the District of Columbia
Office of the Chief Medical Examiner,
Fatality Review Unit
Mental Retardation and Developmental Disabilities Fatality Review Committee
2000 14th Street, N.W., Suite 400
Telephone: (202) 481-3401/Fax: (202) 481-3426
For Additional Copies of the Report Contact MRDD FRC