DISTRICT OF COLUMBIA OFFICE OF THE CHIEF MEDICAL EXAMINER 1910 MASSACHUSETTS AVENUE, S.E., Bldg 27 WASHINGTON, DC 20003	OCME POLICY Last Updated: 2/1/08

DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF THE CHIEF MEDICAL EXAMINER
FATALITY REVIEW UNIT

Operating Protocols for Fatality Review Committees/Board

PART I: GENERAL PROTOCOLS -ALL FATALITY REVIEW COMMITTEES

I. AUTHORITY

The authority for this policy is based on the following enabling legislation, Mayor's Orders and Court Orders that governing the following fatality review Committees and/or Boards that operate with the District of Columbia:

- **Child Fatality Review Committee**
  - DC Law 14-028, Child Fatality Review Committee Establishment Act of 2001,
  - Mayor's Order 98-67, and
  - LaShawn A. Remedial Order and Implementation Plan

- **Mental Retardation and Developmental Disabilities Fatality Review Committee**
  - Mayor's Order 2005-143
  - Evans v Williams, Civil No. 76-293.

- **Domestic Violence Fatality Review Board**
  - DC Law 14-296 "Uniform Interstate Enforcement of Domestic Violence Protection Orders Act of 2002", Subchapter 5

II. STATEMENT OF PURPOSE

The purpose of this policy is to establish the guidelines, policies and procedures that govern the operation of three fatality review Committees/Boards that operate under the auspices of the Office of the Chief Medical Examiner, Fatality Review Unit. The three fatality review Committees/Boards include: the Child Fatality Review Committee (CFRC), Mental Retardation and Developmental Disabilities (MRDD) Fatality Review Committee and the Domestic Violence Fatality Review Board (DVFRB). The primary goal of the fatality review process is to examine past events and circumstances surrounding the deaths of specific populations of deaths in an effort to reduce the number of preventable deaths, promote improvement and integration of both the pubic and private systems responsible for serving this population and improve the quality of residents lives. A secondary goal is to assist the District in gaining empirical insight into fatalities occurring within our community, provide a mechanism for the community to become actively invested in the activities of the review process, and promote improved and integrated public and private systems serving families and children.

The goals of the fatality review process shall be achieved through the following objectives:

1. Expeditiously reviewing the deaths of all children ages 18 years and under who are District residents or under the care and custody of the Department of Columbia.
2. Collecting, reviewing and analyzing standardized data to improve the understanding of the causes and factors that are contributing to the death of a child.
3. Identifying and evaluating services to ensure that all systems, public and private, which are responsible for protecting or providing services to the District's children are accountable.
4. Developing and monitoring plans for the implementation of recommendations for systemic changes within the various governmental and private agencies and/or programs interfacing with families and children.
5. Developing and monitoring plans for the implementation of recommendations to improve and maximize systemic responses to incidents of abuse, neglect and maltreatment. This shall include proposing amendments to statutes, policies and procedures, modifications to relevant service delivery training, and coordination of services to reduce any form of fatal maltreatment.
6. Increasing the efficiency and effectiveness of public and private service delivery systems in the District of Columbia.
7. Improving and optimizing systematic responses to child abuse and neglect and public health problems within the District of Columbia by evaluating existing statutes, policies, and procedures.
8. Enhancing and supporting cooperation and communication among service delivery systems by establishing guidelines for interagency and interdisciplinary education and collaboration in the prevention of child fatalities.
9. Protecting family members, residents and/or client populations determined to be at risk following a fatality.

III. RESPONSIBILITIES OF FRC/B

The three fatality review Committees/Board shall be responsible for the following:

1. Identifying the fatalities eligible for review based on established case review criteria and/or determining the type of fatalities and the review to be conducted;
2. Conducting reviews through established case review processes (multi-agency in-depth, cluster and/or statistical);
3. Review and adopt recommendations that support the development and implementation of new or changes in current services, practices, policies and procedures of agencies and programs (public or private) that will further the protection of children from preventable causes of death;
4. Routinely (time period to be dictated by each fatality review Committee/Board) distribute adopted recommendations to District agencies, private institutions/ organizations, Mayor and/or the Council;
5. Annually (specific date is dictated by respective Committee/Board laws/mayor's order) issue a report that provides information and statistical data that resulted from the reviews, which were conducted during the previous calendar year. The annual report shall be

submitted to the Mayor and Council and shall be made available to the public and may require presentation to the presented publicly to the Council at a hearing.

IV. CONFIDENTIALITY

A key tenet of the fatality review process is the necessity for keeping confidential all information presented to and considered by the Committees/Board. Any decedent/fatality information obtained/divulged during the case preparation, review and finalization process shall not be disclosed by FRU staff, members or other review participants in the fatality review processes for purposes other than those outlined in DC Law 14-028, DC Law 14-296, and Mayor 05-143. Review team participants in the Committee proceedings must sign a confidentiality statement prior to their consideration of any case information. In addition, strict measures shall be taken, in each instance, to limit the availability of case identification information to the fewest possible number of Committee members, and no written material produced by the Committee will contain full case identification information.

General Confidentiality Requirements

1. All information and records generated by the Committee, including statistical compilations and reports, and all information and records acquired by, and in the possession of the three Committees/Board shall be maintained in a confidential manner.
2. Except as permitted by relevant legislation and Mayor's Orders, information and records of the Committees/Board shall not be disclosed voluntarily, pursuant to a subpoena, in response to a request for discovery in any adjudicative proceeding, or in response to a request made under Title II of the District of Columbia Administrative Procedure Act, effective March 29, 1977 (D.C. Law 1-96; D.C. Official Code § 2-531 el seg.), nor shall it be introduced into evidence in any administrative, civil, or criminal proceeding.
3. Committee/Board information and records may be disclosed only as necessary to carry out the defined duties and purposes. The information and records may be disclosed by the Committees/Board to another similar state fatality review committee if the other committee is governed by confidentiality provisions which afford the same or greater protections as those provided in this title.
4. Information and records presented to a Committee/Board team during a fatality review proceeding shall not be immune from subpoena or discovery, or prohibited from being introduced into evidence, solely because the information and records were presented to a team during a child death review, if the information and records have been obtained through other sources.
5. Statistical compilations and reports of the Committee/Board that contain information that would reveal the identity of any person, other than a person who has consented to be identified, are not public records or information, and are subject to the prohibitions contained in this Section of the Protocols.
6. Additionally, at the direction of the Mayor only and for good cause, special findings and recommendations pertaining to other specific fatalities may be disclosed to the public.

7. Nothing shall be disclosed in any report of findings and recommendations that would likely endanger the life, safety, or physical or emotional well-being of a child, or the life or safety of any other person, or which may compromise the integrity of a Mayor's investigation, a civil or criminal investigation, or a judicial proceeding.
8. If the Mayor or the Committee/Board denies access to specific information based on this section, the requesting entity may seek disclosure of the information through the Superior Court of the District of Columbia.
9. The name or any other information identifying the person or entity who referred the decedent for concerns related to abuse/neglect allegations shall not be released to the public.

Confidentiality of Case Review Proceedings

1. Proceedings of the Committees/Board shall be closed to the public when the meeting is related to the review of cases of individual child deaths or where the identity of any person, other than a person who has consented to be identified, can be ascertained.
2. Committee/Board members and other persons who attend any meeting which is not open to the public, shall not disclose what occurred at the meeting to anyone who was not in attendance, except insofar as disclosure is necessary for that person to comply with a request for information from the Committee/Board or to carry out the duties of the committee.
3. Any member who discloses information in the performance of the functions of the Committee/Board shall take all reasonable steps to ensure that the information disclosed, and the person to whom the information is disclosed, are as limited as possible.
4. Members of the Committee/Board, persons attending a fatality review meeting, and persons who present information to the Committee/Board shall not be required to disclose, in any administrative civil, or criminal proceeding, information presented at or opinions formed as a result of a Committee/Board meeting
5. Information identifying a decedent, a member of his/her immediate family, the guardian or caretaker, or alleged or suspected perpetrators of abuse of a child, other forms of violence or the death of a decedent’s case being reviewed shall not be disclosed publicly.
6. Information identifying employees of District of Columbia government or private health-care providers, social service agencies, and educational, housing, and child-care provider shall not be disclosed publicly.
7. Information received from agencies/organizations in the process of planning for a case review meeting that includes identifying information on the decedent/family must be maintain in office files at all times and files must be maintained in a secured/locked manner.
8. On all written materials distributed during case review meetings, the case will be referred to by the FRU number, the child and family members by initials.
9. A FRU staff and Committee/Board members/non-members may not distribute any information during the review that contains identifiers of victims, perpetrators, family members, agency/program staff or other individuals associated with the case.

10. Duplication of documents from any official FRU case (decedent) record by individuals other than FRU staff shall not be permitted.
11. Final reports resulting from a case review are not public documents and shall be maintained only in the specific decedent's FRU record. Final reports shall only be made available to Committee/Board members who chaired the specific meeting to review or assist with the preparation of the Annual Report. Review of these reports may only occur in the FRU office only.
12. Information contained in the FRU decedent case record that was received from Committee/Board member agencies and other external sources identifying the decedent, his/her family and any party or agency involved with the decedent/family at the time of or prior to the death may be destroyed immediately after the case review meeting or the completion of the data base. However, all documents with the exception of those identified in the Records Maintenance section of this policy shall be destroyed no later than one year after the Annual Report has been issued.
13. Committee/Board Annual Reports are public documents and as such shall not contain any identifying information related to the decedents, their families.
14. FRU staff and Committee/Board members shall not seek press coverage related to any fatality case information and/or circumstances surrounding a death.

Document Flow During Fatality Review Meetings

The following procedures shall be followed by all Committees/Boards related to ensuring that all confidential documents are secured during and after the fatality review meeting:

1. All confidential documents shall be returned at the close of fatality review meetings.
2. The CFRC Program Support Staff responsible for managing the flow of documents during the meeting is responsible for ensuring that all confidential documents are accounted for at the close of the meeting.
3. All case summaries, confidentiality forms and any other sensitive information shall be numbered.
4. Numbered documents must be placed in a folder with the corresponding number.
5. Participants shall be required to sign the attendance sheet by the number that corresponds with the folder received and the numbered confidentiality form signed.
6. At the end of the meeting when folders are returned, the appropriate FRU support staff is responsible for accounting for all confidential documents that were contained in each folder.

V. SUBPOENA POWER

The Committees/Boards 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 necessary for a case review meeting. In situations when agency/programs are not cooperating with any of the Committees/Board, the Coordinators shall immediately consult with the OCME General Counsel, who shall make the final decision regarding the need to issue a subpoena. The Coordinators shall provide the General Counsel with all

critical information requested to make this decision and to serve the subpoena. In the event that the subpoena will not provide information in time to be included in the case summary, programs/agencies may be required to attend the case review meeting to provide the information verbally. The Coordinators has the option of either postponing the case review until all information needed is obtained or to hold a second review to provide updated members related to addition information received.

Subpoenas shall be served personally not less than five (5) business days before the date the individual is required to appear and/or to produce required documents. Information shall be produced by any 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 General Counsel or Board from among the staff of the Board or any of the offices or organizations represented on the Board, provided that the special process server is not directly involved in the investigation, or
2. By a special process server, at least 18 years of age, engaged by the Board.

If, after reasonable attempt, a personal server be obtained, a subpoena may be issued by registered or certified mail no less than eight (8) business days before the date of the meeting. If the agency/program neglects or refuses to comply with the requirements of the subpoena, the Committees/Board may report that fact to the DC Superior Court and the Court may require compliance.

VI. TYPE OF REVIEWS

There are three types of reviews that may be utilized for reviewing deaths. The determination related to the type of review shall be the primary responsibility of the Committee/Board Coordinator and may involve input from the full Committee/Board or Committee/Board Chairs. The following is a description of the types of reviews:

- ***Multi-agency Review*** – In-depth individual reviews utilizing a multi-agency, multi-disciplinary approach to evaluating causative factors and appropriateness of interventions. This approach requires full research of each case, determining the agencies/programs involved, reviewing agency/program, and preparing a case summary for distribution during the case review meetings. Representatives from all involved agencies/programs, as well as the community based programs/organizations shall be requested to attend meeting.

- ***Cluster Fatality Reviews*** - Cohort studies of groups of deaths based on similar characteristics, causes/manners of death, trends or other contributing factors (including victim/family characteristics or behavior patterns, environmental conditions, socioeconomic factors, systems factors, etc.) and/or health conditions. Cluster fatality reviews may be held on victims/decedents of any age and will be directed towards obtaining general information and statistical data that appear consistent throughout the cluster grouping that may be a prevailing community problem or there is some demonstration that the problem is a

contributing risk factor for specific types of fatalities. The focus is directed towards general information and statistical data that appear consistent throughout the cluster grouping that may be a prevailing community problem and there is some demonstration that the problem is a contributing risk factor for specific types of fatalities.

- ***Statistical Review*** – The process of gathering basic data and information to facilitate the completion of the Data Instruments/Databases. Statistical reviews are conducted on all fatalities, including cases that do not meet the selection criteria to undergo a multi-agency/multidisciplinary or cluster review. The purpose of the statistical review is to gather basic data to expand the Committee's/Board's knowledge about the ways decedents/victims are dying and demographic information the decedents and their families and perpetrator. In order to ensure consistency in data to be captured, the relevant Committee/Board data instrument shall be completed on each case, which captures the minimal information required.

PART II: PROTOCOLS SPECIFIC TO CHILD FATALITY REVIEW COMMITTEE

I. CASE SELECTION CRITERIA

The CFRC shall review or maintain statistical data on the following child/youth deaths:

- All children between the age of birth through 18 years of age who are residents or wards of the District of Columbia;
- Children/youth whose families were known to the child welfare system four years prior to the death;
- Youth known to the juvenile justice system two years prior to the death; and
- Youth over the age of 18 years who were known to mental retardation and developmental disabilities system two years prior to the death.

II. TYPE OF REVIEW TEAMS

The type and level of review shall depend on the age, cause/manner of death and type of case (i.e., Child Welfare, Juvenile Justice, Community). Two (2) primary Fatality Review Teams shall be established to operate under the auspices of the CFRC, Child Fatality Review and Infant Mortality Review. Both Teams are multidisciplinary and includes representatives from multiple public and private agencies that reflect the needs of the population being reviewed. Based on the need as determined by a Review Team, any child identified may be reviewed by both Fatality Review Teams. Each Review Team is responsible for reviewing the following cases:

- *Multi-Disciplinary Infant Mortality Review Team* shall be responsible for conducting comprehensive individual anonymous reviews of deaths of children under the age of one (1) year. The criteria for selecting cases that minimally require an in-depth IMR review is as follows:
    - All deaths investigated and certified by the Office of the Chief Medical Examiner; and
    - Twenty percent of deaths of infants with 500 grams or greater birth weight.

- *Multi-Agency Child Fatality Review Team* shall be responsible for conducting comprehensive individual and open reviews of deaths of children one (1) year of age or older and infants known to the child welfare system. These reviews shall require multi-disciplinary participation, based on the agencies, institutions, programs or individual professionals who were involved with the family prior to, at the time of or after the child's death. The criteria for selecting cases that minimally require an in-depth CFR review is as follows:
    - 60 % of infant deaths known to the child welfare system.
    - Children under the age of 14 years in which evidence illustrates that one or more of the following factors may have been present:
        - ✓ The cause is determined to be blunt force trauma, child abuse syndrome or other causes associated with child abuse, including sexual;
        - ✓ The cause is determined to be malnutrition, dehydration, failure to thrive or other causes associated to neglect;
        - ✓ The cause is related to head trauma, fractures;
        - ✓ The cause is drowning;
        - ✓ The cause is asphyxia, suffocation or strangulation;
        - ✓ The autopsy revealed evidence of ingestion of drugs, alcohol or another harmful substance (including pre and/or post-natally);
        - ✓ The child suffered from burns or smoke inhalation;
        - ✓ The cause was determined to be gunshot wound;
        - ✓ The manner was determined to be suicide; or
        - ✓ The cause and manner of death were suspicious in nature.

    - Children over the age of 14 years in which evidence illustrates that one of the following factors may have been present:
        - ✓ The manner of death was determined to be suicide;
        - ✓ 60% of the manners determined to be homicides; or
        - ✓ The cause and manner of death were suspicious in nature.

III. NOTIFICATION SOURCES

Notification of cases for review may be initiated from a variety of sources. This will include, but not be limited to, member agencies represented on the CFRC, including the child welfare and juvenile justice or other service system that provides assistance to children and families, Metropolitan Police Department, Medical Examiners Office, and hospitals.

The primary sources of notification are the Office of State Health Statistics/Office of Information Systems, Medical Examiners Office, MPD/Criminal Investigation Division, Child and Family Services Agency, Court Social Services Division and Department of Youth Rehabilitation Services. The type of information to be provided shall include the following:

- ***Office of State Health Statistics/Office of Information Systems*** – OIS shall provide

CFRC with monthly reports, which identifies the children who have died during that month. The report shall include but not be limited to: the decedent's name date of birth, date of death, cause/manner of death, state of birth, state of residences and hospital where child died. When possible the monthly report shall also include the mother's name. This print-out provides vital information required to assist the Coordinator in initiating the records search process in the various agencies to determine those agencies which were involved with the child/family either prior to or at the time of the child's death. Because of the close proximity of several state counties, this print-out includes those children who died in the District of Columbia but were residents from other states. Therefore, one of the first steps associated with reviewing the print-out is to identify those children who are District residents and eliminating those who appear to be from other jurisdictions. Because the District frequently uses Maryland and Virginia homes as a placement resource for committed children, it is recommended that those children who were born in the District but are in Maryland or Virginia not be eliminated until, based on a member agency record search, it is determined that they were not in a commitment status. Therefore, it is recommended that only those children who were born and reside in another state or country be immediately excluded for consideration for review.

- ***Medical Examiners Office*** – the CFRC staff shall review the OCME intake log and FACTS case management system to identify new deaths reported. CFRC staff shall on a weekly basis review the OCME medical records of specific decedents to obtain vital information to assist in determine whether the decedent meets the CFRC criteria for review.

- ***Child Welfare and Juvenile Justice Systems –*** when any agency (CFSA, DYRS, MPD or CSSD) becomes aware of a child/youth death written notification should be provided to CFRC within five days of notification. Initial notification shall be provided within five (5) days of the child's death and shall consist of a completed Critical Event or Unusual Incident Report. Within five days of reporting the death, the agency shall provide the CFRC with additional information related to the agencies involvement with the decedent/family. This information shall include but not be limited to the following:
    - Child's name, date of birth and date of death;
    - Parents' names, dates of birth and address;
    - Siblings, names dates of birth, including any previous sibling deaths;
    - Circumstances surrounding the death and agencies involved at the time of the death;
    - Case history including, the date and reason cases became active with the agency, the services provided, any problems related to youth/family cooperating and compliance with service requirements, whether case was active with the court and the current status of the case;
    - List of service providers involved with the family/child, when available and appropriate.

Other Agency Notification may be received from additional District agencies (i.e., MPD/SVU/ Major Crash, DOH, etc.), hospitals or community-based organizations. These notices may be provided to any CFRC staff in writing or by telephone. When notification is made by telephone, the CFRC staff person taking the call shall complete an FRU "Child Death Notification Form" (Attachment 1). This completed form should be immediately provided to the Staff Assistant in order for the notification process to be complete. The form shall be provided to the Staff Assistant immediately or within 24 hours of receiving the notification.

Additionally, notification of a child/youth death may occur through the ***Media*** (television and newspaper). Any CFRC staff person who obtains information on a child death through the television news or newspaper should provide this information to the Staff Assistant. This can be completed by providing a copy of the article/orbituary or by completing a "Child Death Notification Form" documenting the information obtained from the media.

IV. REVIEW TEAM COMPOSITION

The composition of the two (2) primary Review Teams (Infant Mortality and Child Fatality) shall be multi-disciplinary and may vary depending upon the type of death and review required. Each Team shall have broad cross representation of the service areas/professions identified by the member agencies/ organizations. Committee members may designate representatives from their respective agencies/organizations who have the requisite administrative or program knowledge and experience.

A minimum of two (2) community members shall participate on each review. All effort shall be made to involve community members from the wards of the decedent cases being reviewed. Community members may not delegate this responsibility or designate an alternate.

In addition, the Review Teams may include other participants, who are not official CFRC appointees. These persons shall be identified through the data gathering process as individuals or representatives from agencies/organizations who were involved with the families/children and are required to provide an understanding of the history of their involvement, services provided and services necessary to more appropriately address the child's needs. The identification of participants for the Review Teams shall be determined by the CFRC Coordinator and/or the Chair of a the review meeting. Other persons may also be invited to participate, on an as needed basis, when the discussion involves issues where special expertise is required.

All child fatality review meetings shall be closed to the general public. However, since training and education are among the primary goals of the CFRC, team members may bring trainees to the meetings with the prior approval of the Coordinator and the Review Team

Chair. Each Review Team is encouraged to utilize the services of consultants having expertise in professional areas not represented on the CFRC membership. All participants, including non-CFRC member shall be required to complete a Confidentiality Statement for each review meeting.

In order to ensure confidentiality, child fatality review meetings shall be closed to the general public. Additionally, only appointed members or his/her designee may regularly participate. Alternates and guests must be approved in advance by the Coordinator or Review Team Chair.

The ***Child Fatality Review Team*** composition may vary depending manner of death. However, as a minimum the following agencies/programs shall be invited:

- Department of Health;
- Department of Human Services;
- Child and Family Services Agency;
- Department of Youth Rehabilitation Services;
- Department of Mental Health;
- Office of Chief Medical Examiner;
- Metropolitan Police Department;
- Office of Attorney General;
- U. S. Attorney's Office;
- Social Services Division, D.C. Superior Court;
- D. C. Public Schools;
- Fire and Emergency Medical Services Department;
- Hospital where child died and/or received significant medical care;
- An independent hospital representative or pediatrician (does not include the representative from the hospital where the child died or received prior medical services); and
- A minimum of one (1) child advocacy agency and one (1) representative from a School of Social Work;
- A minimum of two (2) community representatives who are not employed by the District and who had no prior contact with the family/child. All effort shall be made to include the CFRC community representative from the ward in which the child lived.

If a case is determined to be a child welfare fatality (involves a decedent/family known to the child welfare system), in addition to the above representation, the Fatality Review Team shall also include:

- Representative from Children's Rights;
- Representative from Center for the Study of Social Policy (LaShawn Monitor)
- CFSA Deputy for Clinical Practice;
- CFSA Fatality Coordinator/Supervisor; and

- A minimum of one (1) community representatives designated by CFSA Director.

The composition of the ***Infant Mortality Review Team*** shall vary depending on the circumstances of the death. However, at a minimum the following persons shall be present at all IMR:

- Neonatologists from the nurseries from at least two (2) District hospitals,
- Perinatologist,
- D.C. Medical Society,
- March of Dimes,
- Department of Health (Maternal and Perinatal/Infant Care Administration; APRA, Healthy Start, Vital Records),
- Office of the Chief Medical Examiner,
- Fire and Emergency Medical Services Department
- Metropolitan Police Department
- Children's Hospital SIDS Project,
- March of Dimes,
- Healthy Families,
- American Pediatric Academy,
- Fetal and Newborn Committee
- Infant Early Intervention Program,
- A minimum of one (1) child advocacy agency;
- A minimum of two (2) community representatives who are not employed by the District and who had no prior contact with the family/child. All effort shall be made to include the CFRC community representative from the ward in which the child lived.

The composition of the ***Cluster Fatality Review Team*** shall vary based on the prevailing issues of the cluster grouping (i.e., gunshot wounds related to gang violence, health problems originating from prenatal exposure to a substance, etc.). The review participants shall have extensive expertise and experience in the problem area being addressed. Presentation/ participation from individuals or agencies (public or private) that were directly involved with the family during the time period prior to or associated with the child's death will not be necessary for these reviews, however, individuals, who are not Child Fatality Review Committee members may also participate. Non-CFRC members must have expertise in a particular area that is being addressed and is not present among Committee membership. Each cluster review shall include, at a minimum, five (5) Child Fatality Review Committee members, at least two of which shall be community representatives (not affiliated with any public agency). Cluster review participants shall be designated by the Coordinator.

V. REVIEW TEAM CHAIRS

Fatality review meetings may be chaired by any member of the CFRC. However, the chair may not be from an agency/organization, which is or has been involved in the case(s) being

reviewed. Chairs shall be designated by the CFRC Coordinator.

VI. FREQUENCY OF MEETINGS

The frequency of meetings is as follows:

- General meetings of the full Child Fatality Review Committee shall be held at a minimum annually. A minimum of 15 members shall be present in order to constitute a quorum.
- The Recommendations Subcommittee shall meet quarterly and shall be responsible for making decisions related to adoption of draft recommendations that result form CFR and IMR Team meetings.
- Multi-agency fatality reviews (IMR and CFR Teams) shall occur no later than six (6) months from the CFRC receiving notification of a child's death. All efforts shall be made to limit review meetings to twice monthly. However, in the event that this is not possible due to the high volume of cases that need to be reviewed, additional reviews shall be scheduled by the CFRC Coordinator.

In situations where the death is a homicide, a preliminary review shall be conducted within six (6) months of notification. However, in the event that prosecution is pending, discussion during the preliminary review will be limited to past history with service agencies, circumstances surrounding the death and the services provided by those individuals, autopsy results and cause/manner of death. A final review may be scheduled after the conclusion of the prosecution phase to discuss issues specific to the investigation and criminal justice system and determine if additional recommendations are required. The CFRC Coordinator shall be responsible for identifying the cases, determining the composition of the Team and coordinating the review.

Cluster Review Team meetings shall be on held on an as needed basis. The CFRC Coordinator shall be responsible for determining the frequency, identifying the cases, determining the composition of the Team and coordinating the review.

VII. REVIEW TEAM ROLES AND RESPONSIBILITIES:

The primary roles and responsibilities of all the Review Teams shall be as follows:

- To review the deaths of all identified children within the designated timeframes;
- To identify systemic problems, issues or concerns within the District public/private agencies/organizations serving children and their families; and
- To develop recommendations to address such systemic problems, issues and concerns within or among District government agencies.

CFRC Coordinator Role/Responsibilities

The CFRC Coordinator shall serve as the focal point for child fatality case identification and notification. Some of the responsibilities shall include:

- Determine the type of review required;
- Ensure that reviews are held in a timely manner;

- Designate chairs of Cluster and Multi-agency Child Fatality Review Teams;
- Gather, review and analyze data/information to plan reviews;
- Develop case summary for the Chair;
- Determine the composition of Review Teams for each case;
- Develop and manage case identification system which ensures confidentiality and anonymity of cases except as required by protocols;
- Collect and distribute case data while preserving confidentiality;
- Schedule Cluster and Multi-agency review and general meetings;
- Notify appropriate committee members, team chair, and non-CFRC members in a timely manner of fatality cases;
- Attend Internal Review meetings on all cases of children committed to the District or known to the child welfare, juvenile justice, mental retardation/developmental disabilities systems;
- At the conclusion of each review retrieve materials and file necessary data in designated secured location;
- Develop final report for each Multi-agency and Cluster case reviewed and manage report the dissemination of reports; and
- Facilitate communication among participating agencies

Role of Agency Liaisons

Each agency shall designate a CFRC Liaison to work directly with the Coordinator. This person shall serve as the primary point of contact and shall be responsible for facilitating the process of planning/coordinating reviews and implementing recommendations. Some of the duties of the Agency Liaison will include the following:

- Assisting with and monitoring the records search process;
- Ensuring that proper notification is provided to CFRC of known fatalities, in a timely manner,
- Assisting with the data gathering,
- Coordinating the internal fatality review, when necessary, including preparing a summary of all services and interventions provided that documents the child/youth's history with the agency and/or contract programs;
- Determining the appropriate representatives for each case and ensuring that selected representatives attend the reviews and are prepared to provide a brief summary of agency's involvement with the family/child;
- Disseminating information/notification and planning the case reviews;
- Provide information during the CFRC review on issues raised and recommendations made during the internal review;
- Facilitating the appropriate dissemination of recommendations that result from reviews; and
- Providing CFRC follow-up information on the implementation of recommendations.

VIII. FATALITY REVIEW PROCEDURES

The notification process shall begin immediately upon learning of a child's death. The process shall begin with those CFRC member agencies identified above as notification sources contacting the FRU, either verbally or in writing, to report the death. Upon notification, the Coordinator shall immediately complete the CFRC Death Notification Form based on the information provided. All cases shall be assigned a number, which shall include the year of death and the order in which the case was received by CFRC (i.e., CFRC # 98-001). Cases will be assigned and tracked based on the CFRC number.

Agency Record Search **-** The CFRC Coordinator and FRU Staff Assistant shall be responsible for gathering the information necessary to determine the type of case and review required. The first step is to determine whether the case meets the mandated case review categories as a child welfare, juvenile justice and mental retardation fatality. This step requires specific agencies to complete a record search to determine whether they had prior involvement with the family and whether this involvement meets the criteria for inclusion into one of the three (3) mandated case type categories (child welfare, juvenile justice and mental retardation/developmental disabilities). The FRU Staff Assistant is responsible for maintaining a computerized log of potential CFRC fatalities that were gathered through the various notification processes. Minimally on a quarterly basis, a list of these deaths shall be complied and provided to the agencies with a request to search relevant program records to determine whether the child and/or his/her family is/was known to their agency. The agencies involved in the record search process shall include CFSA, DYRS and DOH. Additionally, agencies may include the DMH, and MPD. The type of information that must be provided to the agencies to complete the record search shall include, the decedent's name, date of birth, date of death and mother's name and date of birth. Additional information may be required based on request from the agencies.

Designation of Type of Case and Case Assignment **-** Once it has been determined whether the case is or has been active with the mandated and non-mandated agencies, the next step is to designate the case type and assign the case to the appropriate Fatality Review Team. Case type will be based on the age of the child, the cause and manner of death and agency involvement.. Determining the case type and assignment to one of the three (3) Review Teams must occur no more than 60 days of CFRC receiving notification of a fatality.

Once the case is assigned to the CFRC Review Teams, critical steps must be taken to ensure that the fatality review occurs within the established timeframes (six months after notification). This requires the case to be assigned to a Fatality Review Specialist, necessary records to be obtained and reviewed, case summary and other critical documents to be prepared, Review Team members/participants to be notified and the Chair to be selected. Within 15 working days after the review has been completed, the Review Specialist shall forward the case by CFRC number back to the CFRC Coordinator. The Information that must be forwarded to the Coordinator shall include the completed data instrument and a brief summary of the review, including findings and recommendations.

The CFRC Cluster Fatality Review Team, reviews any combination of case types, based on the specific topic that is being addressed. As indicated previously, these reviews are planned, at the discretion of CFRC, to include groupings of fatalities, based on common data elements, trends and/or characteristics or behavior patterns of the decedents and/or family members. The types of cases to be reviewed by the Cluster Fatality Review Team will be determined quarterly. While statistical data will be maintained on each individual case, the review material, findings and recommendations will be based on common trends based on cluster topics.

Internal Fatality Reviews

Several District government agencies have established internal fatality review processes. The purpose of these reviews is to comprehensively examine and assess the services, interventions and communication, compliance with and adequacy of policies and procedures, adequacy of resources for families and staff and adequacy of legislation. Internal reviews are organized and coordinated by the specific agency, which had primary responsibility for the case and must be held prior to the CFRC review for this decedent. These review results in program specific recommendations, which are incorporated into the CFRC case summary and become a critical component of the city-wide case review process.

Currently the agencies which are routinely conducting internal reviews include the Child and Family Services Agency, Department of Youth and Rehabilitation Services and the Department of Health. These agencies are reviewing fatalities of children/families that were determined to be known to any agency related program. The agencies are responsible for taking the lead in conducting internal reviews and as such, they are responsible for the full coordination, chairing the meetings, preparation of a report that thoroughly summaries all services, interventions provided to the child/youth and completing the finalization and follow-up necessary. The report should document the child/youth's history with any internal as well as contract program provided by District agency conducting the review.

A representative of CFRC is a required participant in all internal fatality reviews. At the conclusion of the meeting, a report shall be provided to CFRC Coordinator that summarizes the internal review, highlighting the major service issues and recommendations that were made. This report shall become part of the decedent's CFRC record and the summary/discussion during the CFRC review of the case. .

Meeting Notification

Written notification shall be provided to all review participants at a minimum least two (2) weeks prior to the review. For all member agencies/participants who were involved with the family/child, either prior to, at the time of the death or subsequent to the death, 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 upon information shall be provided to the CFRC Coordinator immediately or no later that one (1) week prior to the meeting.

Written notification shall also be provided to all independent and/or community individuals invited to the review meeting. This may include experts from various relevant disciplines or service areas. Follow-up may be provided to all persons invited, at least three (3) days prior to the review.

Case Record Reviews
Prior to scheduling the review meetings, the CFRC Coordinator shall review the records of critical primary District government service agencies and/or related contractors. This includes but is not limited to CFSA, DYRA, DHS, DOH, DMH, DCPS, OCME, FEMSD, MPD and DCSC. The Coordinator shall also review the records of other critical private service providers, including but not limited to local hospitals, clinics and other medical/mental health providers; and community-based organizations. The purpose of the record reviews is to gather complete information to be incorporated into the "Case Summary" that highlights and summarizes the services provided to the decedent and his/her family through the public and private service delivery systems within the District; the health, social and economic status of the child/family members and any related observations/findings. Record reviews also assist in fully identifying all involved programs/agencies and assist in determining the case specific individuals/programs to be invited to the review.

Case Summary
The Coordinator shall also ensure that a summary is prepared for distribution to Review Team members. The summary minimally highlights the pertinent facts and information on the decedent, parents and siblings; and the history of the various service agencies involved. The case summary should be developed based on the established format (see Attachment 2).

CFRC Data Instrument
Completion of the CFRC Data Instrument (see Attachment 3) begins at the point that the fatality is determined to be an eligible CFRC case. The initial data entry includes demographic data on the decedent, parents and siblings. The Instrument is then updated to included additional information gathered during the case preparation and finalization process. The Data Instrument shall be submitted to the CFRC Coordinator with the all other documents related to finalizing the case after the review meeting.

Selecting a Review Team Chair
A Chairperson shall be designated two (2) weeks prior to the review meeting. The chairperson must be a member of the CFRC, however, cannot have any current or prior association with the family and/or decedent. The Coordinator shall select and notify the

Chair. The Chairperson shall be briefed at least one day in advance of the meeting and shall have access to the fatality record for review.

Case Review Proceeding

An agenda shall be prepared for distribution during the review. Review participants shall also be required to review and sign a Confidentiality Statement, which must be maintained in office files, separate from the fatality record. The review proceeding shall consist of a brief period to review the case summary, for discussion and analysis, and identification of issues and recommendations for systemic change. Agencies/programs will be given an opportunity to make verbal corrects and/or additions to the summary for the record. Additionally, critical agencies will be requested to clarify information or answer questions posed by the Review Team. The agencies that should be available to share service related information includes, but is not be limited to the following:

- Medical Examiner,
- Hospital Where Child Died/Emergency Services,
- Pediatrician/Other Physician Knowledgeable About the Child,
- MPD/VCD/SVU,
- Fire Department,
- Child Welfare System,
- Juvenile Justice System,
- Office of Corporation Counsel,
- US Attorney's Office,
- D.C. Public Schools

After the presentation of facts surrounding the case, the Review Team shall use the following major questions to guide its discussion:

- Was the investigation complete? If not, what are the problems areas that need to be addressed?
- Is the autopsy/death certificate complete and are there areas of concern that should be considered?
- Are there services that should have been provided?
- Were there efforts to collaborate among public/private agencies and were they successful?
- What were the major risk factors?
- What agency policies and practices need improvement?
- What can be done to change behavior, practices, policies, or laws?
- Are there specific prevention strategies that can be implemented?

Case Finalization and Recommendations Process

Based on the issues raised, the Review Committee shall make recommendations for systemic, parental, community and legislative change. Recommendations may be made verbally or in

writing. Written recommendations shall be recorded by Team members on "Recording of CFRC Review Team Findings and Recommendations" form. When making verbally recommendations, members must be clear, specifically indicating their intent to make a recommendation.

Within 15 days of any final review the appropriate CFRC staff shall complete a final report for each case, including the Data Instrument, Final Summary and Findings and Recommendations. Recommendations are considered to be draft until they are presented to the Recommendations Subcommittee for final adoptions. However, in an effort to include input from the majority of CFRC members, draft recommendations are issued during case review meetings for review and comment. Draft recommendations are issued for initial review and comment within 30 days of the case review meeting. Comments are immediately incorporated when possible. In situations where incorporation of comments is not possible, comments are held and are submitted to the Recommendations Subcommitte along with the recommendations for review and consideration.
The Recommendations Subcommittee meets quarterly and considers recommendations for a three (3) month period. Prior to the meeting, the CFRC Coordinator is responsible for distributing copies of all recommendations to be considered for the quarter. During the Subcommittee meetings, case specific findings and recommendations are discussed, along with any comments received prior to the meeting. Subcommittee members may make the following decisions related to recommendations presented:

- Fully adopt the recommendations as written,
- Adopt the recommendations with revisions, considering comments received prior to or during the meeting,
- Place the recommendation on hold pending additional information/clarification, and/or
- Delete the recommendation based on information shared during the meeting that indicates that the recommendation is not needed to address a specific finding or due to clarity concerns.

Within one (1) month after the Subcommittee meeting, final adopted recommendations are formally issued to the appropriate District government Department heads, Deputy Mayors and Council for Public Safety and Human Resources. Responses to recommendations are required within 60 days of receipt. When responses are not received, the CFRC Coordinator shall sent written follow-up letters. Agency responses to recommendations are held by the CFRC Coordinator for review by the Recommendations Subcommittee during the quarterly meetings. When responses are not received from agencies, this information is also recorded and reported to the Recommendations Subcommittee.

Finalization of Homicide and Pending Fatalities
When the manner of death is a homicide or remains pending, the initial review shall be considered the preliminary review. These cases may require a second review to examine the information from the MPD/CID related to the full investigation and U.S. Attorney's Office

related to prosecution and sentencing. While some issues may be discussed during the preliminary review, the Review Team may feel free to hold the analysis and recommendations for the final review.

In homicides, the decision to conduct a second review shall be initiated by the USAO at the conclusion of prosecution. The final review on pending cases will occur at a minimum within 60 days after the final cause and manner of death have been determined. The Coordinator may routinely requests statuses on these cases from the U.S. Attorney's Office and the Office of the Chief Medical Examiner. During the final review, the Chair shall summarize the information provided during the preliminary review and then allow the MPD/CID, U.S. Attorney's Office and/or the OCME an opportunity to provide the Team with additional information related to the investigation/prosecution of homicides and the final diagnoses related to cause and manner of death. At the final review full discussion related to the issues and recommendations shall occur.

IX. MAINTENANCE OF RECORDS

All records shall be maintained in a secured area with locked file cabinets. When cases are assigned to CFRC staff, records must be officially sign-out by completing the "Records Request" form. When records are sign-out, responsible CFRC staff shall maintain case files in locked file cabinets within their offices. Records must be returned to the main office file within 10 working days following a fatality review meeting.

One year after the Annual Report has been developed, all supporting documentation in each fatality record shall be destroyed. The only material that will be maintained in a fatality will include the following:

- Initial Data Form,
- CFRC Case Summary,
- Final Summary,
- Findings and Recommendations,
- Unusual Incident/Critical Events Reports from member agencies,
- Internal Review Summaries and Final Reports,
- Death Certificates and Birth Certificates for infant deaths.

X. ANNUAL REPORT

By December 31st of each year, an annual report for the preceding year shall be forwarded to the Chair of the Child Fatality Review Committee. This report shall include the findings and recommendations that resulted from the fatality reviews conducted, progress made towards achieving the recommendations and description of general activities of the Committee.

PART III: SPECIFIC PROTOCOLS FOR THE DVFRB

I. DEFINITIONS

Domestic Violence Fatality includes the following:

- A homicide under any of the following circumstances:
    - The alleged perpetrator and victim resided together at any time;
    - The alleged perpetrator and victim were married, divorced, separated, or had a romantic relationship, not necessarily including a sexual relationship;
    - The alleged perpetrator is or was married to, divorced, or separated from, or in a romantic relationship, not necessarily including a sexual relationship with the victim;
    - The alleged perpetrator had been stalking the victim;
    - The victim filed a petition for a protective order against the alleged perpetrator at any time;
    - The victim resided in the same household, was present at the workplace of, was in proximity of, or was related by blood or affinity to a person who experienced or was threatened with domestic violence by the alleged perpetrator; or
    - The victim or the perpetrator was or is a child, parent, sibling, grandparent, aunt, uncle, or cousin of a person in a relationship that is described within this subsection.

- A suicide of an individual where there were implications that the individual was the victim of domestic violence prior to his or her suicide, including the following circumstances:
    - The victim had applied for or received a protection order within the 2-year period preceding the suicide;
    - The victim had undergone counseling or treatment as a result of being the victim of domestic violence within the 2-year period preceding the suicide; or
    - The victim had reported to the police that he or she had been the victim of domestic violence within the two-year period preceding the suicide.

Protection Order-is an injunction or other order, whether temporary or final, issued by a tribunal for the purpose of preventing violent or threatening acts or harassment against, contact or communication with, or physical proximity to, another individual.

Preventable Death is one in which, with retrospective analysis, it is determined that a reasonable intervention (e.g., medical, educational, social, legal, psychological) might have prevented the death.

II. ORGANIZATION OF THE DVFRB

The DVFR Board membership shall consist of representatives from the following:

- Metropolitan Police Department;
- Office of the Chief Medical Examiner;
- Office of the Attorney General;
- Department of Corrections;
- Fire and Emergency Medical Services Department;
- Department of Health, Addiction Prevention and Recovery Administration;
- Department of Health, Medical Assistance Administration

- Child and Family and Services Agency;
- Mayor's Commission on Violence Against Women;
- Superior Court of the District of Columbia;
- Office of the United States Attorney for the District of Columbia;
- District of Columbia hospitals;
- University legal clinics;
- Department of Human Services, Adult Protective Services,
- Domestic violence shelters;
- Domestic violence advocacy organizations, and
- An expert or representative from a local organization/program that works with perpetrators. (After full development of the process (by 9/30/06), the Board shall routinely make efforts to include a family member of a victim of domestic violence death, prior victims, and/or perpetrators who have received therapeutic intervention in the case review meetings.)

Quorum - A minimum of two-thirds of the members shall be present to constitute a quorum.

III. ROLES AND RESPONSIBILITIES OF DV COORDINATOR

The DVFRB Coordinator shall serve as the focal point for fatality case identification, notification and case preparation. Key responsibilities shall include:

- Receive and log in all fatalities from notification sources;
- Identify cases through reviewing the OCME Log and OIS Print-out;
- Determine eligible domestic violence fatality cases;
- Have primary responsibility for the pre-review process that shall include a review of all agency records, relevant reports from the court, police, and the Office of the Chief Medical Examiner to assess the victim's history with social and protection systems;
- Determine the type of case and review required;
- Ensure that reviews are held in a timely manner;
- Designate chairs for case review meeting;
- Gather, review and analyze data/information to plan reviews;
- Develop case summaries;
- Determine the composition of Review Teams for each case;
- Develop and manage the case identification system, which ensures confidentiality and anonymity of cases except as required by protocols;
- Collect and distribute case data while preserving confidentiality;
- Schedule case review and general meetings;
- Notify appropriate committee members, team chair, and non-DVFRB members in a timely manner of fatality cases;
- At the conclusion of each review retrieve materials and file necessary data in a designated secured location;
- Manage information system (data collection, entry, and analysis under supervision);

- Develop final report for cases reviewed and manage the dissemination of reports; and
- Interact with agency directors and staff liaison on behalf of the Board and facilitate communication among participating agencies.

Role of DVFRB Chair/Co-Chairs

- Assist with convening and presiding over case review and other Board meetings, ensuring the members are respected and given ample opportunity to participate;
- Assist the Coordinator in planning activities associated with all Board meetings;
- Assist the Coordinator in maintaining a record or minutes of meetings;
- Participate in the development and finalization of the Annual Report and other statistical and special reports issued by the Board;
- Interact with agency directors and staff liaison on behalf of the Board;
- Serve with fairness and impartiality;
- Serves as the Chief spokesperson of the Board for Board actions;
- Ensures that all individuals appearing before a board proceeding shall be treated with respect, dignity, fairness and impartiality;
- Assist with development of policy/practice and other documents generated by the Board;
- Sign letters, memorandums transmitting adopted recommendations and other Board related business on behalf of the Board;
- Provide written testimony, if required, before the Council of the District of Columbia on proposed legislation, proposed rules, or the annual fiscal year budget, on behalf of the Board;
- Works with the Coordinator/Program Manager in identifying and advocating for needed Board resources through grant, private and/or public funding sources.

Role of the Agency Liaison

Each agency involved with domestic violence fatalities and that provide domestic violence and other related services shall designate a Liaison to work directly with the DVFRB Coordinator. This person shall serve as the primary point of contact and shall be responsible for facilitating the process of planning/coordinating reviews and implementing recommendations. Some of the duties of the Liaisons shall include the following:

- Assisting with and monitoring the records search process;
- Ensuring that proper notification is provided to the DVFRB of known fatalities, in a timely manner;
- Providing the DVFRB Coordinator with access to agency records and other information and assisting with the data gathering process; and
- Determining the appropriate representatives for each case and ensuring that selected representatives attend the reviews and are prepared to provide a brief summary of agency's involvement with the decedent/family;

Role of the Case Review Meeting Chairperson

The Chairperson shall ensure that fatality review meetings are conducted in an effective and

efficient manner and in a manner that is respectful of the rights of victims and agencies and protects the confidentiality of information being discussed/shared.

IV. Case Review Criteria

The DVFR Board is responsible for conducting reviews of all domestic violence related homicides and suicides of victims of all ages and involved in all types of intimate/familiar relationships, who are determined to be residents of the District of Columbia and non residents where the death occurs in the District. The cases shall be selected based on the definition of DV fatality included above (see page 2). Cases shall be reviewed within the following timeframes:

- ***Homicides*** shall be reviewed within six months after closure of criminal cases (including sentencing, dismissals and decisions to not prosecute but excluding the appeals process); and
- ***Suicides*** shall be reviewed within six months of notification of the death.

The case review process shall be initiated with deaths that occurred during the 2004 calendar years.

Overlapping Fatality Review Populations

In situations where there are domestic violence related deaths that overlap with other established fatality review populations, i.e., Child Fatality Review, the following procedures shall be followed:

- DVFRB shall statistically include all domestic violence related fatalities regardless of age;
- DVFRB shall take the lead on all fatalities of victims 19 years of age or older;
- Child Fatality Review Committee shall take the lead in conducting reviews of victims under the age of 19 years; and
- DVFRB shall take the lead in conducting reviews of deaths that involve the deaths of a parent and child(ren).

Additionally, in cases of overlapping populations, the Committee/Board that has leadership responsibility shall ensure that a limited number (no more than 5) of members/experts from the other involved fatality review group(s) participate in the case review meeting in order to include the expertise of these groups in the discussion, as well as the determination of findings and recommendations.

V. Case Identification/Notification Process

The notification process shall begin immediately upon learning of a domestic violence death. Direct notification may be initiated from a variety of sources. Appropriate FRU stall shall complete the Death Notification Form (Attachment 1) to document notices received by telephone. The primary notification sources are as follows:

- ***Medical Examiners Office*** shall provide the DVFRB verbal or written notification of all domestic violence related deaths within 24 hours of notification of the death. These reports shall be provided by the medical/legal investigators and shall include but not be limited to

the decedent's name, OCME number, date of birth, date of death, address, cause/manner of death, death circumstances, and place of death. The Medical Examiner's Office shall also provide the Board access to relevant OCME records for review and collection of information.

- Additionally, at a minimum, once weekly, the Fatality Review Unit (FRU) Staff Assistant and/or DVFRB Coordinator shall review the OCME Communications Log, FACTS reports, and OCME records to identify any new deaths that may meet the DVFRB case review criteria.

- ***MPD/Violent Crimes Division*** shall provide the DVFRB Coordinator with verbal or written notification of all domestic violence related deaths within 24 hours of completion of the preliminary investigation. Notification shall include copies of all death reports that shall be provided within five (5) days after the death.

- ***Other Agency Notification*** may also be received from additional District agencies, hospitals or community-based organizations. These notices may be provided to the DVFRB Coordinator. When the call is received the staff person taking the call shall complete a "Death Notification Form". (See Attachment 1) This completed form should be immediately provided to the FRU Staff Assistant in order for the notification process to be complete. The form shall be provided to the Staff Assistant immediately or within 24 hours of receiving the notification.

Additionally, notification of a DV death may occur through the ***Media*** (television, radio and newspaper). Any FRU staff person who obtains information on a death through the media should provide this information to the FRU Staff Assistant and DVFRB Coordinator. This can be achieved by providing a copy of the article/obituary or by completing a "Death Notification Form" documenting the information obtained from the television news.

Process for Case Selection

In order to determine whether cases identified meet the case review criteria as outlined in DC Law 14-296 and the type of review required, all death notifications received must be researched through several District government systems. The case selection process shall include the following steps:

- Monthly report shall be obtained from the OCME FACTS system of all suicides and homicides.
- A list of cases identified shall be created by the FRU Staff Assistant that includes all cases identified monthly, including deaths identified through the monthly FACTS report. The case listing shall include the following information:
    - Name of victim
    - Date of birth,
    - Date of death,
    - Address of victim, and

- Address of incident.

- The list shall be provided to the DC Superior Court, Domestic Violence Division and the Metropolitan Police Department with specific requests for the following information:

  Suicides

  - The victim requested a protective order within a two year period preceding the death?
  - Number of protective orders requested and number issued.
  - Date last protective order was issues.
  - The victim filed a complaint with the MPD related to being a victim of domestic within a two year period preceding the suicide.

  Homicides

  - The victim filed for a protective order against the alleged perpetrator at any time,
  - The relationship of the victim and alleged perpetrator,
  - Members of the household of the victim,
  - Number of children in common between victim and alleged perpetrator,

- Based on responses, cases will be selected as meeting the domestic violence fatality review criteria.
- Once it has been determined that a case meets the criteria for review, a record shall be created and the record shall be maintained in a separate, secured file cabinet designated for domestic violence fatalities.
- Reviews of homicide cases shall not be initiated until notification is received from the USAO representative regarding the completion of the criminal case. The DVFRB Coordinator shall obtain quarterly updates from MPD and/or USAO on all cases identified and accepted as domestic violence. Once the criminal process has been completed the Coordinator shall immediately initiate the data/information gathering process in order to complete the case review within the designated timeframes.
- Once suicide deaths have been accepted as a domestic violence fatality, the case review process can begin immediately.
- Any case that does not meet the definition as a domestic violence fatality shall be maintained in the record search database with information that documents the results of the record search process, i.e., reason case selected out. All data/information gathered to make this determination shall be immediately shredded.

Based on a decision made during the May 2006 DVFRB meeting, deaths selected for review will be temporarily limited to those cases referred by the MPD/VCD and the US Attorney's Office.

VI CASE REVIEW MEETING PROCESS

Selecting a Review Team Chair

Any member of the DVFRB may chair multi-agency case review meetings. However, the chair may not be from an agency/organization that had prior involvement/association with the decedent or family. The DVFRB Coordinator shall select meeting chairs based on a rotation

process. Each member shall be expected to chair at least one meeting per year. The DVFRB Coordinator shall notify the member designated as Chair two weeks prior to the date of the meeting. The Chairperson shall be briefed at least one day in advance of the meeting and shall have access to the full fatality record for review**.**

Frequency of Meetings
The DVFR Board shall meet monthly. The primary purpose of monthly DVFRF meetings is to conduct reviews of the population defined above (see Case Review Criteria, page 6). Other purposes of the meeting may include:

- Updating previously reviewed cases by providing new information or data;
- Adopting recommendations and discussion statuses of responses for recommendations;
- Developing and finalizing the annual report; and
- Discussing other general business necessary to fulfill the overall goals and responsibilities of the Board.

The DVFRB Coordinator and Chair may also schedule separate general DVFR Board meetings. This shall occur in situations when the case review meetings are consumed with the review of cases leaving no opportunities to address general business issues. Cluster Review Team meetings shall be held on an as needed basis and shall cover cases that address themes and/or trends agreed upon by the DVFRB. The DVFRB Coordinator is responsible for planning and coordinating all meetings of the Board with input from the Chair/Co-chairs.

Methodology
The methodology for the fatality case review involves a thorough – examination of the cause/manner of death, circumstances surrounding the death, the death investigation, the prosecution process and the services/interventions provided prior to, at the time of and subsequent to the death. The case review process shall involve an independent review of the following documentation and records:

- The Medical Examiner's autopsy report;
- Death certificate;
- Hospital and medical care providers records that document the full medical history, needs, treatment and medications of the decedent;
- Police investigation records;
- DC Superior Court records;
- United States Attorney records; and
- Records of a range of public and private service providers, including mental health social services, public assistance, legal assistance, etc.

Meeting Notification
The DVRVB Coordinator shall notify appropriate committee members and non-committee members in a timely manner of fatality case review meetings. An annual calendar of meetings for each calendar year shall be provided to DVRVB members. Additionally, written notification

shall be provided to all review participants at least two (2) weeks prior to the review.

For all member agencies/participants who were involved with the victim, either prior to, at the time of the death or subsequent to the death, notification shall include sufficient information for the case to be researched, the record identified and reviewed; and to provide adequate information related to the nature of the agency's involvement for presentation during the review meeting. Any agreed upon information shall be provided to the DVFRB Coordinator immediately, or no later that one (1) week prior to the meeting.

Written notification shall also be provided to all independent and/or community individuals invited to the review meeting. This may include experts from various relevant disciplines or service areas.

Meeting attendance shall be monitored by the DVRVB Coordinator via an attendance sheet. Each participant is required to sign the attendance document at each fatality review meeting. In situations where members are unable to attend monthly case review meetings, a replacement may be designated, however, designees shall be non-voting participants. The Coordinator is responsible for sending a written notice to any DVFRB member who misses three (3) consecutive monthly case review meetings, regarding the problem of non-participation and to request that participation be improved. If the problem of non-participation persists, the Coordinator with the Chairpersons approval shall inform the Office of Boards and Commissions and request that the member be replaced.

VII. Method of Accessing and Sharing Information

Not withstanding any provision of law, immediately upon the request of the DVRVB and as necessary to carry out the Board's purpose and duties, the Board shall be provided, without cost and without authorization of the persons to whom the information or records relate, access to:

- All information and records of any District of Columbia agency, or their contractors, including but not limited to, birth and death certificates, law enforcement investigation data, unexpurgated juvenile and adult criminal records, mental retardation and developmental disabilities records, autopsy reports, parole and probation information and records, and information records of social services, housing, and health agencies that provided services to the victim's family, or an alleged perpetrator of domestic violence which led to the death of the victim.
- All information and records of any private health-care providers located in the District of Columbia who provided services to the victim, the victim's immediate family, or the alleged perpetrator of domestic violence which led to the death of the victim.
- All information and records of any private child welfare agency, educational facility or institution, or child care provider doing business in the District of Columbia who provided services to the victim, the victim's immediate family, or the alleged perpetrator of domestic violence which led to the death of the victim.

The Board shall have the authority to seek information from entities and agencies outside of the District of Columbia by any legal means.

- Information and records concerning a current investigation may be withheld, at the discretion of the investigating authority, if disclosure of the information would compromise a criminal investigation or prosecution.
- If information is withheld under the above item above, a report on the status of the investigation shall be submitted to the Board by the investigating authority every three months until the earliest of the following events occurs:
  - The investigation is concluded;
  - The investigating authority determines that providing the information shall no longer compromise the investigation; or
  - The information or records are provided to the Board.

All records and information obtained by the Board from an ongoing criminal investigation of the deceased victim or other individual shall be destroyed immediately following the preparation of the Board's annual report. The Board shall destroy all additional information concerning a review except statistical data, one year after publication of the Board's annual report.

Record Reviews of Involved Agencies

The record review shall be conducted by the DVFRB Coordinator with the assistance of the Liaison of the involved agency(ies). Prior to scheduling the review meetings, the DVFRB Coordinator shall review the records of critical primary District government service agencies and/or related contractors. This includes but is not limited to MPD, OCME, USAO, DCSC, CFSA, DHS, DOH, DMH, DCPS, and DOC. The Coordinator may also review the records of other critical private service providers, including but not limited to local hospitals, clinics and other medical providers; battered women shelters, and community-based organizations. The purpose of the record reviews is to gather complete information to be incorporated into the "Case Summary" that highlights and summarizes the services provided to the decedent and his/her family through the public and private service delivery systems within the District of Columbia; the health, social and economic status of the child/family members and any related observations/findings. Record reviews also assist in fully identifying all involved programs/agencies and assist in determining the case specific individuals/programs to be invited to the review.

The case record review shall include the following:

- Review agency policies, protocols, trainings and records regarding domestic violence deaths;
- Note if the agency has written policies in place;
- Note what risks indicators were present for the victim, perpetrator, and other family members; See Attachment 4)
- Note if current policies are adequate or how could they be improved;
- Note if policies were followed;
- Note any best practice procedures;

- Note if relevant statutes regarding family abuse, protective orders, stalking, firearms, etc. were enforced;
- Note services offered/provided/declined;
- Note when services and interventions occurred;
- Note the timeline of service intervention;
- Note missing services that could have been utilized.

VIII. CONDUCTING THE DVFRB REVIEW

Case Review Proceeding

The Chair shall welcome members and review the mission, goals and objectives of the review. An agenda shall be prepared for distribution during the review. Review participants shall also be required to review and sign a Confidentiality Statement, which must be maintained in office files, separate from the fatality record. The review proceeding shall consist of a brief period to review the case summary, for discussion and analysis, and identification of issues and recommendations for systemic change. Agencies/programs shall be given an opportunity to make verbal corrects and/or additions to the summary of the review for the record. Additionally, critical agencies shall be requested to clarify information or answer questions posed by the Review Team. The information that shall be shared by each major service entity shall include, but not be limited to the following:

- Medical Examiner;
- Hospital where victim died/emergency services;
- Physician knowledgeable about the victim's medical needs and treatment,
- MPD/VCD
- Fire Department;
- US Attorney's Office;
- DC Superior Courts, Domestic Violence Division; and
- Battered Women Shelters and other service providers.

Case Summary

The Coordinator shall also ensure that a case summary is prepared for distribution to Review Team members. The summary minimally highlights the pertinent facts and information on the decedent, immediately family members; circumstances surrounding the death and the history of the various service agencies involved, including prior history of services related to domestic /family violence. The case summary shall be developed based on the established format.

- Basic Demographics;
- Circumstances surrounding the death of the victim;
- Personal histories of the parties including: biographical information on the victim and perpetrator, medical, mental health, financial, legal (civil and criminal complaints, specifically the existence of past or present protective orders);
- Substance abuse history on the victim and perpetrator;

- Services obtained by the victim, perpetrator and family prior to the fatal incident and services rendered after the fatality to family members an/or other affected persons; and
- Timeline of the events that lead to the death of the victim.

The case summary shall be distributed to all Board members in attendance at the meeting and the case may be verbally presented by the DVFRB Coordinator/Chair. Following the presentation of the case Board members will have the opportunity to ask questions and obtain clarification from any service provider or agency/program who was involved with the victim. The process will be concluded with the presentation of findings and suggested recommendations.

DVFRB Data Instrument

Completion of the Domestic Violence Fatality Review Data Instrument (see Attachment 4) begins at the point that the death is determined to be an eligible domestic violence fatality case. The initial data entry includes demographic data on the victim(s) and perpetrator and shall be completed by the Statistical Assistant. The Instrument shall be maintained in the record and shall be updated by the DVFR Board Coordinator or Program Specialist with information/data gathered throughout the process of preparing the case for review and finalizing the case subsequent to the review.

IX. REPORTS AND RECOMMENDATIONS

Case Report Finalization and Recommendations Process

Based on the issues raised, the DVFR Board shall make recommendations for systemic, community and/or legislative change. Recommendations may be made through two mechanisms, the monthly case review meeting and/or six month trend analysis meeting. These processes are described below:

Monthly Case Review Meetings

During the case review meeting, recommendations may be made verbally or in writing. Written recommendations shall be recorded by DVFR Board members on "Recording of DVFRB Review Team Findings and Recommendations" form. (See Attachment) When making recommendations verbally, members must be clear, specifically indicating their intent to make a recommendation.

Within seven (7) working days of any final review, the DVFRB Coordinator shall complete a final report for each case, including the Data Instrument, Final Summary and Findings and Recommendations (See Attachment). Recommendations are considered to be draft until they are presented to the DVFRB members in a subsequent case review meeting where draft recommendations will be discussed. Members shall be responsible for making final comments for revisions and voting to adopt recommendations either as originally written or with the revisions discussed. Comments shall be immediately incorporated and the recommendations finalized by the DVFRB Coordinator.

Six Month Trend Analysis Meeting

On a six month basis, the DVFRB Coordinator shall prepare a report, documenting information that resulted from cases reviewed during the six month period. The report shall include at a minimum cumulative data on perpetrators/victims demographics, risk indicators and trends as documented by the Board members. This report shall be presented for discussion during the six month trend analysis DVFR Board meeting. Based on agreement related to findings, systemic trends, gaps and determination of need, the DVFRB may make additional recommendations. These recommendations must be clearly presented verbally or noted by individual Board members in writing. The DVFRB Coordinator shall draft the recommendations for presentation in the next DVFR Board meeting for review, comment and finalization. Recommendations shall be finalized for distribution within 30 days of finalizations.

Distribution of DVFRB Recommendations

Recommendations shall be formally transmitted within 30 days of adoption to appropriate District government agency heads and other appropriate private organizations within the District by the DVFRB Coordinator and Chair. Copies of adopted recommendations shall also be provided to appropriate Deputy Mayors and members of the Council of the District of Columbia. Agencies/programs shall submit written responses to final adopted DVFRB recommendations to the Coordinator within 30 days of receipt.

X. RECORD MAINTENANCE

All records shall be maintained in a secured area with locked file cabinets specifically designated for domestic violence fatalities. The DVFRB Coordinator is responsible for following FRU policies and protocols related to signing records in and out for use. Records must be officially signed-out by completing the "Records Request" form. (See Attachment 6) When records are signed-out, the DVFRB Coordinator or other appropriate FRU staff shall maintain case files in locked file cabinets within their offices. Records must be returned to the main office file within 10 working days following a fatality review meeting.

One year after the Annual Report has been developed all supporting documentation in each fatality record shall be destroyed. The only material that shall be maintained shall include the following:

- Data Instrument,
- DVFRB Case Summary,
- Final Report,
- Findings and Recommendations, and
- Death Certificates of Victims

XI. ANNUAL REPORT

By July 31 of each year, an annual report for the preceding year shall be completed for distri bution to the Mayor, Council, public agencies and the general public. This report shall include the findings and recommendations that resulted from the fatality reviews conducted, progress made towards achieving the recommendations and description of general activities of the DVFRB.

PART III: SPECIFIC PROTOCOLS FOR MRDD FRC

I. METHODOLOGY

The methodology for the fatality case review involves a thorough – examination of the cause/manner of death and the services and interventions provided prior to and at the time of the death. The case review process shall involve an independent review of the following documentation and records:

- The Medical Examiner's autopsy report;
- Death certificate, when applicable;
- Hospital and medical care providers records that document the full medical history, needs, treatment and medications of the decedent;
- Fatality investigation report, conducted by MRDDA or their contractors, that include interviews with all service providers and/or caregivers to determine the full spectrum of services provided, the appropriateness of these services and whether there were any occurrences, incidents or circumstances that would raise questions and/or concern;
- MRDDA case management records that document the level and quality of care required and received by the decedent with special emphasis on care provided during the preceding 30 days and particularly within the last week of care; and Contractor's records, including group homes, nursing homes, ICF/MR, etc.

II. MRDD FATALITY REVIEW COMMITTEE MEMBERSHIP

The Mayor maintains an open policy for seeking candidates interested in appointment to boards and commissions. The Office of Boards and Commissions distributes a booklet of profiles on the boards and inventories of vacancies as part of an outreach program to the community.

Each member shall be appointed by the Mayor based on individual expertise in their relevant disciplines to protect the health and welfare of District residents with mental retardation, developmental disability. In accordance with Mayor's Order 2005-143, MRDD FRC membership composition shall be as follows:

Government Members:

- Metropolitan Police Department,
- Office of the Chief Medical Examiner,
- Office of the Inspector General,
- Mental Retardation and Developmental Disabilities Administration,
- Department of Human Services; and
- Fire/Emergency Medical Services Department

Public Members:

A maximum of eight (8) public/community representatives shall be included as MRDD FRC members. Public/community members may not be employees of the District government. A maximum of three public members shall be clinicians with retardation and developmental

disabilities experience. Public/community members shall include the following:

- Two faculty members from schools of social work from District based universities and colleges,
- Two physicians who practice in the District with experience in the evaluation and treatment of persons with mental retardation or developmental disabilities, and
- One psychiatrist and one 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.

Quorum - A minimum of two-thirds of the members shall be present to constitute a quorum.

III. CASE REVIEW CRITERIA

The MRDD FRC is responsible for conducting reviews of deaths of District wards over the age of 18 years who are mentally retarded or have developmental disabilities. As defined by Mayor's Order 2005-143, a District ward is includes those individuals 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 delivery such care, for reasons of mental retardation or developmental disabilities.

IV. NOTIFICATION SOURCE

Cases identification may be initiated from a variety of sources. This will include, but not be limited to, agencies represented on the MRDD FRC, including MRDDA, Metropolitan Police Department, or Medical Examiners Office.

The primary notification sources are as follows:

- ***Medical Examiners Office*** shall provide to the committee verbal or written information on all MRDD deaths within 24 hours of notification of the death. These reports shall be provided by the medical/legal investigators and shall include but not be limited to the decedent's name, date of birth, date of death, address, cause/manner of death, and place of death. The Medical Examiner's Office shall also provide the Committee access to relevant OCME records for review and collection of information.

  Additionally, at a minimum of once weekly, the Fatality Review Unit Staff Assistant or his/her alternate shall review the OCME Communications Log to identify any new deaths that may meet the MRDD FRC case review criteria.

- ***Mental Retardation and Developmental Disabilities Administration*** shall provide written notification of any death that meets the criteria outlined in the DHS/MRDDA Incident Management System (2003). Initial notification shall be provided within 24 hours of the death and shall consist of a completed Unusual Incident Report.

- ***MPD/SVU*** shall provide the MRDD FRC with copies of all death reports resulting from any investigation that is conducted on MRDD deaths. These reports shall be provided within five (5) days after the death.
- ***Other Agency Notification*** may be received from additional District agencies, hospitals or community-based organizations. These notices may be provided to the MRDD FRC Coordinator. When the call is received the staff person taking the call shall complete a "Death Notification Form". This completed form should be immediately provided to the FRU Staff Assistant in order for the notification process to be complete. The form shall be provided to the Staff Assistant immediately or within 24 hours of receiving the notification.

V. CASE REVIEW MEETING PROCEEDINGS

The MRDD FRC shall conduct regular monthly multi-disciplinary reviews of the population defined by the Order. Meetings of the Committee will be for the following purposes:

- Conducting new case reviews,
- Updating previously reviewed cases by providing new information or data;
- Adopting recommendations and discussion statuses of responses for recommendations;
- Developing and finalizing the annual report; and
- Discussing other general business necessary to fulfill the overall goals and responsibilities of the Committee.

All data/information required for the review shall be gathered by and/or submitted to the MRDD FRC within four (4) months after the death. This shall include, at a minimum, the following:

- MPD Death Report;
- OCME Autopsy Report;
- Death certificate;
- MRDDA fatality investigative reports prepared by the contracted Investigative Vendor.

A summary of data points 1-4, as referenced above, shall be prepared by the Committee Coordinator and copies of case summaries shall be available during the meeting for all participants.

Case reviews shall be scheduled within three months of receiving the above information. If the death is criminal in nature or under active criminal investigation, the review shall be preliminary, pending conclusion of the investigation and prosecution, or release by the prosecutor. Preliminary reviews shall be held for the purpose of assessing specific ongoing services related to ongoing and emergency health care, mental health care, and other care providers. At the conclusion of the prosecution of any homicide death, the Committee shall conduct a final review to assess the circumstances surrounding the death, the investigation and prosecution of the case.

The case review process shall include a presentation of the case summary, followed by presentations of relevant information/facts concerning the death by any agencies or person

involved with the decedent or investigating the event. Following presentation of the facts, the Committee will discuss the case and any systemic issues/concerns, guided by the following questions:

- What factors or circumstances caused or contributed to the death?
- What responses and investigations resulted from the death?
- Were the services, interventions appropriate?
- Were the investigations of the death (MRDDA and MPD) timely and adequate?
- Were the staff involved with the decedent adequately prepared, trained and supported to perform their duties correctly?
- Was there adequate communication and coordination among the various entities involved with the decedent?
- 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?

Meeting Notification and Participation

The MRDD FRC Coordinator shall provide timely notification to Committee members and other approved participants of fatality case review meetings. An annual calendar of meetings for each calendar year shall be provided to MFDD FRC members. Additionally, a minimum of two (2) weeks notice shall be provided of all case review meetings.

In order to insure confidentiality, MRDD FRC meetings shall be closed to the general public. Additionally, only appointed members or his/her designee may regularly participate. However, since training and education are among the primary goals of the Committee, consideration may be given to allow guests to participate in care review meetings. However, prior approval must be granted by both MRDD FRC Co-Chairs. A request to bring a guest to meetings shall be made through the MRDD FRC Coordinator at minimum of two weeks prior to the meeting. The Coordinator shall notify the Co-Chairs of the request and the purpose of the guest's attendance within 24 hours of receiving the requests. A decision shall be provided to the requestor within five working days of the original request. Prior to attending the meeting, the guest shall be contacted by the MRDD FRC Coordinator to brief them about the operating procedures of the Committee, including explaining the procedures to ensure confidentiality of information. All participants, including non-MRDD FRC members shall be required to sign and comply with the provisions of the Confidentiality Statement for each review meeting.

Monitoring Attendance - Meeting attendance shall be monitored by the FRC Coordinator via an attendance sheet. Each participant is required to sign the attendance document at each FRC meeting. Any FRC member that has missed three (3) consecutive meetings may be referred to the Office of Boards and Commissions for appropriate action. A representative may be sent in the member's place however they will be a non-voting participant.

VI. RECOMMENDATIONS PROTOCOLS

- Based on the case presentation and discussion, the Fatality Review Committee shall formulate applicable recommendations as enumerated above in Sections IIID and IV B and C (3), of the Mayor's Order for further consideration.
- The Fatality Review Committee shall disseminate recommendations based on the findings of the reviews to support the development and implementation of new or revised services, practices, policies and procedures of agencies and programs (public and private) to further the protection of the target population.
- Recommendations must be proposed and adopted by the FRC based on case presentations and discussion. The recommendation should be clear and concise in wording before being directed to an identified public or private organization.
- Recommendations shall be mailed via US Postal Service with a copy forwarded by email to the department head/administrative designee using the standardized recommendation letter. Recommendations shall be returned to the FRC Coordinator within 60 calendar days. The 60-day time limit begins with the date the initial letter was mailed. All emailed copies shall contain an alert to ensure the mail was received.
- The initial and follow up letters forwarded to respondents shall include the following:
    - If no response is received within 60 calendar days, a reminder will be forwarded requesting a response within 10 calendar days. If an agency cannot respond within 60-days, they are instructed to contact the FRC Coordinator to request an extension with a return date.
    - In the event a response is not received or an extension has not been requested, all delinquent matters will be forwarded to the Advisory Panel by the Coordinator. The Advisory Panel may forward outstanding concerns/barriers to the Office of the Deputy Mayor for Children, Youth, Families and Elders for intervention on behalf of the FRC. The Deputy Mayor and Advisory Panel Recommendations Subcommittee will inform the FRC of the outcome based on their intervention.
- Each agency head/administrative designee shall be requested to prepare a response to the recommendation(s) to include in-depth information on efforts to meet the recommendation. The recommendation shall include the following:
    - The name of the responsible/contact person within the agency
    - The phone number(s) and email address of the responsible/contact person
    - What actions are planned with timelines (to include date(s) of implementation)
    - Where and when activities are to occur
    - How often recommendation(s) will be monitored
    - Reporting the progress of the recommendation to the FRC.
- Ensuring responses to adopted recommendations are received within the timeframe shall be the responsibility of the FRC Coordinator. The Coordinator, recommendation subcommittee and/or designated members of the FRC shall review each response for quality, clarity, and implementation strategy. If there are concerns or barriers with the response, the FRC Coordinator and Committee members shall forward the concern to the Advisory Panel for review and intervention. The Advisory Panel shall inform the FRC of its activities regarding

the efforts to remove barriers or concerns related to the implementation of the recommendation.

- If an agency rejects a recommendation, the response to the FRC Coordinator shall also be made within the timeframe. The Coordinator and designated members of the Committee will reassess the recommendation for appropriateness. If the recommendation, based on the review, was forwarded to the appropriate agency, the FRC Coordinator will forward the concern to the Advisory Panel.
- It is expected that the entire recommendations response process, e.g., the initial requests and the agency's response regarding the recommendation, shall be completed within a 90-day timeframe. Exceptions may include (1) requests for extension, (2) forwarding a recommendation to an appropriate agency or (3) monitoring the implementation of recommendation procedures.
- The Advisory Panel may request unscheduled quality surveys to ensure agencies are in compliance with both the response and implementation processes
- The Deputy Mayor for Children, Youth, Families and Elders agrees to share this protocol with agency-heads under the jurisdiction of that office during interagency cabinet level meetings to educate agency leaders regarding the protocol.

Monitoring Agency Response/Implementation of Recommendation:

- The MRDD FRC Coordinator shall review the implementation of the recommendation process in accordance with the Mayor's order (section 3, D, E and Section 4 B) to ensure implementation has occurred.
- The FRC staff will review action items within established timeframes. All recommendations will be tracked by the IMIU number and responsible agency. The review intervals shall be established as 30 days, 60 days, 90 days to ensure recommendations are implemented. The recommendations will be categorized by area of concern to streamline trending and tracking of systemic issues.
- During the review process, data validation measures must be documented by the agency to show the methodology of how the implementation of the recommendation was achieved, to include but not limited to, training curriculum, attendance roster, test sores (if competency based), training calendar, etc. These documents must be collected and available for annual reports, trending, and other requests for information.
- The FRC staff will document all findings to note concerns, address implementation issues, additional strategies to completion etc. In the event that a recommendation has not been implemented with (2) monitoring timeframes (up-to 60 days in accordance with the agency's implementation plan), the FRC, along with the respective Deputy Mayor shall be notified for corrective action measures. If the recommendation has not been implemented within three monitoring timeframes, (up to 90 days in accordance with the agency's implementation plan), the Advisory Panel, along with the respective Deputy Mayor, shall be notified with all available data collected and related findings for additional corrective action measures.
- All recommendations must be presented to the FRC body for motion to close. Each

recommendation presented for closure should include language, e.g., this recommendation was implemented by evidence of the following. Validation documents and/or other related data shall be provided for each recommendation as requested by the FRC.

- The FRC staff shall document the quarterly progress of the recommendations and distribute to the Committee as appropriate.

VII. PROCEDURES FOR CASE CLOSURE

At the conclusion of the case presentation, the Committee Co-Chairs have the authority to present the case for closure if the following conditions are satisfied:

- Completed Death Certification (as necessary)
- Completed Autopsy Report
- Completed investigation report
- Interviews with key individuals have been conducted and completed
- Case has been reviewed and there are no referrals for additional investigation or information exists; and sufficient information regarding the decedent's medical/custodial care exists.

The decision to close a case shall be based on a Committee vote. The Committee majority rule. If the majority expresses a "No" vote for closure, the case is then returned to the FRC Coordinator and additional information shall be sought/required for further case presentation at the next MRDD FRC full Committee meeting.

VIII. MAINTENANCE OF RECORDS

All decedent records shall be maintained in a secured area within locked file cabinets. When cases are removed from the file, records must be officially sign-out by completing the "Records Request" form and placing the form in place of the decedent record. When records are signed-out, the Fatality Review staff is responsible for maintaining the case file in locked file cabinet within his/her office. Records must be returned to the main office file within 10 working days following a fatality review meeting.

At least one year after the Annual Report has been developed, all supporting documentation from public and private agencies related to the decedent shall be destroyed. The only material that will be maintained in a fatality record will include the following:

- MRDD FR data instrument,
- Final Report/Summary, and
- Findings and Recommendations.

IX. RECORD MAINTENANCE

All records shall be maintained in a secured area with locked file cabinets specifically designated for MRDD fatalities. The MRDD FRC Coordinator is responsible for following FRU policies and protocols related to signing records in and out for use. Records must be officially signed-out by completing the "Records Request" form. (See Attachment 6). When records are signed-out, the MRDD FRC Coordinator or other appropriate FRU staff shall

maintain case files in locked file cabinets within their offices. Records must be returned to the main office file within 10 working days following a fatality review meeting.

One year after the Annual Report has been developed all supporting documentation in each fatality record shall be destroyed. The only material that shall be maintained shall include the following:

- Data Instrument,
- MRDD FRC Final Report,
- Findings and Recommendations, and
- Death Certificates of Victims

X. ANNUAL REPORT

By December 31 of each year, an annual report for the preceding year shall be completed for distribution to the Mayor, Council, public agencies and the general public. This report shall include the findings and recommendations that resulted from the fatality reviews conducted, progress made towards achieving the recommendations and description of general activities of the MRDD FRC.