

Policy: The Office of the Chief Medical Examiner (OCME) reviews the circumstances of the deaths of individuals within certain populations, including their interaction with District government services.

Purpose: To outline the statutory mandates, Mayoral orders and other requirements of the OCME's fatality review program.

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

1. General

- 1.1. The Fatality Review program reviews the circumstances of the deaths of individuals within certain populations, including their interaction with District government services.
- 1.2. The purpose of the fatality reviews is to provide analysis and recommendations to the public and District entities serving defined populations, so they can address systemic problems, provide better services and be held accountable.
- 1.3. The purpose of the fatality reviews is also 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 residents.

2. Protocol for Fatality Reviews

2.1. The Fatality Review deaths are investigated based on national protocols.

2.1.1. Child deaths are reviewed according to protocols provided by national organizations such as the National Center for Child Death Review (Center) and Inter-agency Council on Child Abuse. Such protocols include: *A Program Manual for Child Death Review* (2003); *Multi-Agency Identification and Investigation of Severe and Fatal Child Injury* (2009); *Curriculum and Training Manual* (2006); *ICAN Youth Suicide Coroner/Medical Examiner Investigation Procedural Guide*. Additionally, reviews are investigated based on guidelines published by the Centers for Disease Control and Prevention (CDC) regarding certain types of child deaths, such as *Guidelines for Death Scene Investigation of Sudden, Unexplained Infant Deaths: Recommendations of the Interagency Panel on Sudden Infant Death Syndrome* (1996).

- 2.1.2. Deaths of developmentally disabled community are reviewed per Mayor's Order 2009-225, December 22, 2009, as amended by Mayor's Order 2013-154, August 26, 2013.

3. Fatality Review Program

- 3.1. The OCME's fatality review program includes: the Child Fatality Review Committee (CFRC), which includes the Infant Fatality Review Committee and Developmental Disabilities Fatality Review Committee (DDFRC).
- 3.2. Child Fatality Reviews
 - 3.2.1. The authority to operate the Child Fatality Review Committee (CFRC) is based on: "Child Fatality Review Committee Establishment Act of 2001", (D.C. Official Code § 4-1371 et. seq.).
 - 3.2.2. The CFRC reviews deaths of children based on the above authorities and protocols provided in Appendix A. (See Appendix A)

4. Developmental Disabilities Fatality Review Committee

- 4.1. The authority to operate the Developmental Disabilities Fatality Review Committee (DDFRC) is based on:
 - 4.1.1. Mayor's Order 2009-225, December 22, 2009, as amended by Mayor's Order 2013-154, August 26, 2013.
 - 4.1.2. The DDFRC reviews deaths of disabled based on the above authorities and protocols provided in Appendix A. (See Appendix B)

APPENDIX A

APPENDIX B