GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER
401 E St, SW, Sixth Floor
Washington, D.C. 20024

Roger A. Mitchell, Jr., M.D., FASCP
Chief Medical Examiner

202-698-9001 (Office)
202-698-9101 (Fax)

January 12, 2018

The Honorable Charles Allen
Chairman, Committee on the Judiciary and Public Safety
Council of the District of Columbia
The John A. Wilson Building
1350 Pennsylvania Avenue, N.W.
Suite 110
Washington, D.C. 20004

Dear Chairman Allen:

Please find below the Office of the Chief Medical Examiner (OCME) responses to questions forwarded by the Committee on the Judiciary and Public Safety in preparation for the upcoming performance oversight hearing. Should you have any questions or need additional information, please do not hesitate to contact us.

General Questions

1. Please provide a current organizational chart for the agency, including the number of vacant, frozen, and filled positions in each division or subdivision. Include the names and titles of all senior personnel, and note the date that the information was collected on the chart.

   See Attachment A for a copy of the current organization chart for the agency.

   a. Please provide an explanation of the roles and responsibilities of each division and subdivision.

   Offices of the Chief & Administration Division
   The Office of the Chief is responsible for oversight of the operational and programmatic functions of the OCME including establishing the vision and mission for the organization. The Office of Administration provides administrative services and support to the staff of the OCME. These services include personnel management (timekeeping, training and educational development, and labor relations); contracting and procurement; risk, fleet, property and financial management; information technology and legal services; communications; and agency performance management.

Death Investigation Division

The Death Investigation Division includes: a) forensic pathology; b) forensic investigation; c) anthropology and identification; d) a histology laboratory; e) mortuary services and the medical examiner transport team. Forensic pathology involves conducting decedent examination, certifying the cause and manner of death and providing that information to next of kin and law enforcement, as well as designated government entities and interested parties. Forensic investigation includes evidence gathering, medical interpretation and provision of information to aid in the determination of the cause and manner of death. The Anthropology and Identification Unit administers the agency's Decedent Identification Program ensuring that identifications are made in an accurate and efficient manner. The histology laboratory processes samples of tissue in support of cause and manner of death findings. The purpose of mortuary services is to provide body disposition and autopsy support to forensic pathology staff and the funeral industry. Lastly, the medical examiner transport team ensures timely response and removal of decedents for scenes, homes, and hospitals for examination and disposition by the OCME.

Forensic Toxicology Laboratory Division

The OCME Forensic Toxicology Laboratory maintains standards of practice for the detection, identification and quantitation of alcohol, drugs and other toxins in biological specimens. The Laboratory provides scientific support services to OCME in order that the agency may provide accurate death investigation and certification information in a timely manner to next of kin, law enforcement agencies, legal counsel and the community when required. The Forensic Toxicology Laboratory Division also administers the District's Breathe Program.

Fatality Review Program Division

The Fatality Review program reviews the circumstances of the deaths of individuals within certain populations, including their interaction with District government services. The purpose of the 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. The Fatality Review Division supports two Fatality Review Committees: the Child Fatality Review Committee (CFRC) and the Developmental Disabilities Fatality Review Committee.

b. Please provide a narrative explanation of any changes to the organizational chart made during the previous year.

Mortuary Unit

While not considered a change within the organizational chart, the Mortuary Unit has been impacted by a modification in its overall team. As discussed during last year's performance responses, the agency continued plans to augment its Medical Examiner Transport Team (METT), within the Mortuary Unit, which consists of a team of agency staff to perform body transport (livery) services. The implementation of the METT concept provided the District the ability to become self-sufficient in body transport without the wholesale dependency on any one vendor. In addition to the current services provided by the existing vendor, which only include body transport, the significant

advantage to a METT includes the ability to perform: fleet maintenance; decedent intake and release; fatality management response logistics; post-mortem radiology and identification; supply inventory and tracking; and mortuary qa/qc processes. Further, the formation of the METT fulfills the standards established by National Association of Medical Examiner (NAME) Accreditation Guidelines for proper body handling during day to day case response, as well as in a mass fatality. During FY17, the METT was expanded from a team of four to twelve. First, four staff were hired as part of a FY17 enhancement. Second, the agency requested and received approval to hire four additional staff (for METT) during FY17 that were slated as FY18 FTE enhancements. These actions resulted in a team of twelve, as required for full implementation.

2. Please provide a current Schedule A for the agency which identifies each position by program and activity, with the employee's title/position, salary, fringe benefits, and length of time with the agency. Please note the date that the information was collected. The Schedule A should also indicate if the position is continuing/term/temporary/contract or if it is vacant or frozen. Please separate salary and fringe and indicate whether the position must be filled to comply with federal or local law.

   See Attachment B.

3. Please list all employees detailed to or from your agency. For each employee identified, please provide the name of the agency the employee is detailed to or from, the reason for the detail, the date of the detail, and the employee's projected date of return.

Name	Date of Detail	Date of Return
Vivene Philip	7/05/16	9/30/18
Fimiya Gray	7/03/17	7/02/18
Michele Hawkins	7/03/17	7/02/18
Jada Hinnant	7/03/17	7/02/18
Karen Parker	7/03/17	7/02/18
Tia Watson	7/03/17	7/02/18
Thura Zaki	7/03/17	7/02/18

The agency has one employee detailed to the agency through the District's Return to Work Program administered by the Office of Risk Management (ORM). The Return to Work Program helps employees get back to work as soon as possible after a job-related injury or illness and the employee has been detailed to the agency in a job consistent with modified duty restrictions. Ms. Philip is detailed to the IT Unit where she is tasked with managing the customer support system which entails service ticket issuance to other IT staff members and interfacing with end users. She also serves as the primary point of contact for the fixed asset tracking and inventory system and the liaison with agency IT and service vendors.

The agency also has six employees detailed to the agency through the District's Learn, Earn, Advance, Prosper (L.E.A.P.) Program, administered by the DC Office of Employee

Services. L.E.A.P. is a network of interconnected partners utilizing the "earn-and-learn" approach that links the city's unemployed residents with employment, education, and training opportunities. The six employees are working within various divisions/units of the agency where a need for assistance was identified to include: Record/Quality Assurance Unit; Administrative Unit; Mortuary Unit; Fatality Review Division; and the Histology Laboratory.

4. Please provide the Committee with:

    a. A list of all employees who received or retained cellphones, personal digital assistants, or similar communications devices at agency expense in FY17 and FY18, to date;

Mitchell, Roger Dr. *
Diaz, Francisco Dr. *
DeVillier, Mikelle *
Fields, Beverly *
Cheryle Adams *
Fripp, Savern
Leak, Chikarlo Dr.
Dixon, Leautry *
Nolan, James*
Coleman, Michael*
Contee, Kenneth*
Shelton, Esther
Rouse, Benita
Love, Jennifer Dr.*
Tabron, Lisa
Betts, Elizabeth*
Brown, Matthew
Bryant, Stephon
Clingerman, Chelsea
Garner, LaTishia
Landrie, Rachael
Lassiter, Kimberly*
Waters, Lawrence
Watson Tia
Bell, Dennis
Hinkle, Jamal
Hough, Bonnie
Johnson, Keith
Kelly, Derrick
Kidwell, Robert
Mills, Robert
Prince, Johnathan

Pyos, Raymona
Robinson-Porter, Latisha
Rooney, Sofia
Snowden, Brian
Williams, Markeshia
Breland, Sasha, MD*
Giese, Kristinza W, MD
Golden, Kimberly MD
Njiwaji Chantel MD
Davenport, Terencia
Diaz, Carolina
Fields, Leigh
Jamison, Latoya
Johnson, Breen John
Johnson, Stephanie
Kim, Katherine
Kurash, Lalynn
Lyles, Denise*
Morgan, Daniel*
Petrasek, Marybeth
Ware-Murell, Tiffany
Wolf, Julie
Wood, Rebecca
Wright, Jerel
Harvin, Donnell*
Diggs, Keon
Mason, Nikia
Tolliver, Samantha*
Zarwell, Lucas*
Francis, Anna*
Beebe-Aryee, Jenna*

**The asterisk denotes the issuance of both a mobile phone and a tablet*

b. A list of all vehicles owned, leased, or otherwise used by the agency and to whom the vehicle is assigned, as well as a description of all vehicle accidents involving the agency's vehicles in FY17 and FY18, to date;

UNIT ASSIGNED	TAG NUMBER	MAKE	MODEL	YEAR	Accidents
ADMIN	DC 3866	FORD	EXPLORER Sport Trac	2005	NONE
ADMIN	DC 6320	DODGE	GRAND CARAVAN	2007	NONE

ADMIN	DC 6270	CHEV	UPLANDER	2007	NONE
MORTUARY	DC 3882	CHEV	VAN XPRES	2005	NONE
MORTUARY	DC 3883	CHEV	VAN XPRES	2005	July 18th, 2016: 1 (minor, no injuries, no other vehicle involved)
MORTUARY	DC 7323	CHEV	VAN XPRES	2009	NONE
MORTUARY	DC 7324	CHEV	VAN XPRES	2009	NONE
INVESTIGATIONS	DC 1338	FORD	EXPLORER	2002	NONE
MEDICAL RECORDS	DC3616	DODGE	GRD CARAVAN	2005	NONE
INVESTIGATIONS	DC10929	FORD	EXPLORER	2017	NONE
INVESTIGATIONS	DC10930	FORD	EXPLORER	2017	6-14-2017 (minor, no injuries, no other vehicle involved); 8-3-2017 (minor, no injuries, no other vehicle involved)
Emerg. Management	DC10917	FORD	F-350	2017	NONE
Emerg. Management	DC11347	Freightliner	Mobile Command	2013	NONE
Emerg. Management	DC11632	FORD	EXPLORER	2017	NONE
INVESTIGATIONS	DC12879	FORD	EXPLORER	2017	9-11-2017 (minor, no injuries)
MORTUARY	DC12822	Chevy	Express	2017	NONE
Emerg. Management	DC11006	Box Trailer 1	trailerlogic	2017	NONE
Emerg. Management	DC11007	Box Trailer 2	trailerlogic	2017	NONE
Emerg. Management	DC11008	Box Trailer 3	trailerlogic	2017	NONE
Emerg. Management	DC11009	Box Trailer 4	trailerlogic	2017	NONE
Emerg. Management	DC11782	logistics trailer 1	trailerlogic	2017	NONE
Emerg. Management	DC11781	logistics trailer 2	trailerlogic	2017	NONE

c. A list of travel expenses, arranged by employee for FY17 and FY18, to date, including the justification for travel; and

PUBLIC SAFETY AND JUSTICE AGENCY
FY 2017 TRAVEL EXPENSES BY EMPLOYEE
Office of the Chief Medical Examiner (FX0)

Agency Code	Fiscal Year	Employee	Position Title	Description	Justification	Expense Amount
FX0	2017	Francis,Anna D	Supervisory Quality Control	ARMROrlando_OrlandoFL_10.15-10.17.17	Professional Training	1,563.52
FX0	2017	Francis,Anna D	Supervisory Quality Control	QualtraxConference_BlacksburgVA_09.19-09.21.17	Professional Training	2,030.52
FX0	2017	Mullings, Andre	Outreach Program Specialist	NCKISSConference_PittsburghPA_4.25-4.28.17	Professional Training	1,441.60
FX0	2017	Ruggery,Bryan A.	Forensic Toxicologist	BrokensteinCourse_BloomingtonIN_12.04-12.09.16	Professional Training	1,423.58
FX0	2017	Ruggery,Bryan A.	Forensic Toxicologist	PIT-Training_PhiladelphiaPA_6.12-6.15.17	Professional Training	2,534.60
FX0	2017	Bayard,Ciena N	Forensic Toxicologist	2017SOFT_BocaRatonFL_1.7-1.11.18	Professional Association	949.00
FX0	2017	Decobecq,Christian	DVI Commander, Brussels	OCMEMFSymposium_WasingtonDC_9.10-9.14.17	OCME Mass Fatality	3,362.66
FX0	2017	Wynn,Charis	Forensic Toxicologist	IntoximerMaintenanceSchool_StLouisMO_8.14-	Professional Training	1,943.38
FX0	2017	Kightlinger,Danylle	Forensic Toxicologist	IntoximerMaintenanceSchool_StLouisMO_8.14-	Professional Training	1,943.38
FX0	2017	Morgan,Daniel	SUPVY MEDICO LEGAL	AAFSAnnualMeeting_NewOrleansLA_2.13-2.17.17	Professional Association	2,259.85
FX0	2017	Corbin-	Fatality Review Program	AMCHAnnualConference_KansalCityMO_3.4-3.7.17	Professional Association	2,016.93
FX0	2017	Hill,Jeffrey	Fatality Review Program	HNHVIPAnnConference_MilwaukeeWI_09.24-	Professional Association	1,321.87
FX0	2017	Love,Jennifer	Forensic Anthropologist	AAFSAnnualMeeting_NewOrleansLA_2.11-2.18.17	Professional Association	3,448.62
FX0	2017	Benzio,Katharine	Forensic Toxicologist	2017SOFT_BocaRatonFL_1.7-1.11.18	Professional Association	1,208.20
FX0	2017	Chopra,Kiran	Forensic Toxicologist	IACTAnnualMeeting_ColoradoSpringsCO_4.23-	Professional Association	2,146.10
FX0	2017	Giese,Kristinza W.	Medical Officer (Medical	44thANEFSeminar_WatervilleME_7.30-8.3.17	Professional Training	1,719.71
FX0	2017	Kim,Katherine	FORENSIC INVESTIGATOR	M17ADIConference_StLouisMO_7.17-7.20.17	Professional Association	2,006.64
FX0	2017	Zarwell,Lucas W	Chief Toxicologist	SOFT_DallasTX_10.17-	Professional Association	1,592.45
FX0	2017	King,Michael	Deputy Inspector, NYC	OCMEMFSymposium_WashingtonDEC_9.10-9.14.17	OCME Mass Fatality	184.40
FX0	2017	Kuhn,Michael	Forensic Toxicologist	PIT-Training_PhiladelphiaPA_6.12-6.15.17	Professional Training	2,541.90
FX0	2017	Landrie,Rachael A.	Forensic Photographer	IFPConference_MiamiFL_10.31-11.04.16	Professional Association	1,399.45
FX0	2017	Mitchell,Roger A	Chief Medical Examiner	AAFS AnnualMeeting_NewOrleans,LA_2.13-2.17.17	Professional Association	1,662.60
FX0	2017	Mitchell,Roger A	Chief Medical Examiner	AMA Conference_Orlando,FL_11.11-11.12.16	Professional Association	519.30
FX0	2017	Mitchell,Roger A	Chief Medical Examiner	APHA Annual Meeting_Denver,CO_11.1-11.2.16	Professional Association	2,303.54
FX0	2017	Mitchell,Roger A	Chief Medical Examiner	IAFSTriennialMeeting_OntarioCanada_8.22-8.25.17	Professional Association	16.00
FX0	2017	Mitchell,Roger A	Chief Medical Examiner	MBK-WeDC_AustinTX_3.11-3.13.17	Professional Association	3,278.60
FX0	2017	Mitchell,Roger A	Chief Medical Examiner	NAMEAnnMeeting_ScottsdaleAZ_10.13-10.17.17	Professional Association	1,472.41
FX0	2017	Mitchell,Roger A	Chief Medical Examiner	NMAConvention_PhiladelphiaPA_7.28-8.2.17	Professional Association	1,911.00
FX0	2017	Mitchell,Roger A	Chief Medical Examiner	NMAHealthPolicyColloquium_BeverlyHillsCA_3.23-	Professional Association	565.15
FX0	2017	Brathwaite,Sophia	Forensic Toxicologist	2017SOFT_BocaRatonFL_1.7-1.11.18	Professional Association	1,349.00
FX0	2017	Tolliver	Dep Chief Toxicologist	SOFTTraining_DallasTX_10.17-10.21.16	Professional Association	333.24
FX0	2017	Nwachukwu,Vivian	Forensic Toxicologist	2017SOFT_BocaRatonFL_1.7-1.11.18	Professional Association	1,074.00
FX0	2017	Develter,Wim	Royal Belgian Society of Legal Medicine &	OCMEMFSymposium_WasingtonDC_9.10-9.14.17	OCME Mass Fatality	924.00
AGENCY GRAND TOTAL						**$54,447.20**

PUBLIC SAFETY AND JUSTICE AGENCY
FY 2018 TRAVEL EXPENSES BY EMPLOYEE
Office of the Chief Medical Examiner (FX0)

Agency Code	Fiscal Year	Employee	Position	Description	Justification	Expense Amount
FX0	2018	Leak,Chikarlo	Epidemiologist	APHAAnnualMeeting_AtlantaGA_11.4-11.8.17	Professional	1,809.70
FX0	2018	Harvin,Donell	Emergency Response and	ClarkCoMedicalExaminerVisit_LosVegasNV_12.11-	Los Vegas Medical	731.15
FX0	2018	Coleman	Chief Information Officer	ClarkCoMedicalExaminerVisit_LosVegasNV_12.11-	Los Vegas Medical	731.15
FX0	2018	Mitchell,Roger	Chief Medical Examiner	ClarkCoMedicalExaminerVisit_LosVegasNV_12.11-	Los Vegas Medical	734.14
FX0	2018	Mitchell,Roger	Chief Medical Examiner	NAMEAnnMeeting_ScottsdaleAZ_10.13-10.17.17	Professional	1,150.26
AGENCY GRAND TOTAL						**$5,156.40**

d. A list of the total workers' compensation payments paid in FY17 and FY18, to date, including the number of employees who received workers' compensation payments, in what amounts, and for what reasons.

Payment Amount	**Class Code**		
Fiscal Year	**Indemnity**	**Medical**	**Grand Total**
2017	$ 24,360.97	$ 2,285.20	$ 26,646.17
2018		$ 697.25	$ 697.25
Grand Total	**$ 24,360.97**	**$ 2,982.45**	**$ 27,343.42**

Date Issued	Date of Injury	Payment Amount	Finance Detail Level 3	Fiscal Year Issued
12/08/2016	01/29/2013	$24,360.97	(7) Temporary Total Disability	2017
11/17/2016	03/04/2016	$302.99	(123) Medical Diagnostics	2017
12/15/2016	03/04/2016	$119.76	(25) Physical Therapy	2017
12/15/2016	03/04/2016	$148.44	(25) Physical Therapy	2017
02/01/2017	03/04/2016	$119.29	(25) Physical Therapy	2017
02/01/2017	03/04/2016	$119.29	(25) Physical Therapy	2017
02/01/2017	03/04/2016	$243.33	(25) Physical Therapy	2017
02/09/2017	03/04/2016	$118.41	(25) Physical Therapy	2017
02/09/2017	03/04/2016	$88.85	(25) Physical Therapy	2017
04/27/2017	03/04/2016	$118.41	(25) Physical Therapy	2017
10/27/2017	03/04/2016	$161.46	(25) Physical Therapy	2018
10/27/2017	03/04/2016	$149.86	(25) Physical Therapy	2018
11/17/2016	03/04/2016	$158.37	(9) Medical Payment - Doctor	2017
11/23/2016	03/04/2016	$123.64	(9) Medical Payment - Doctor	2017
12/15/2016	03/04/2016	$122.75	(9) Medical Payment - Doctor	2017

02/01/2017	03/04/2016	$88.85	(9) Medical Payment - Doctor	2017
02/01/2017	03/04/2016	$122.75	(9) Medical Payment - Doctor	2017
02/01/2017	03/04/2016	$119.29	(9) Medical Payment - Doctor	2017
02/16/2017	03/04/2016	$81.93	(9) Medical Payment - Doctor	2017
03/30/2017	03/04/2016	$88.85	(9) Medical Payment - Doctor	2017
10/13/2017	03/04/2016	$252.64	(9) Medical Payment - Doctor	2018
11/30/2017	03/04/2016	$133.29	(9) Medical Payment - Doctor	2018

The above table represents workers compensation payments for a total of two employees.

5. For FY17 and FY18, to date, what was the total cost for mobile communications and devices, including equipment and service plans?

   The total for wireless service plans (to include voice and data) for FY17 was $61,926.61 with a monthly burn rate of $5,160.55. The FCMS system does not yet reflect FY18 invoice charges for Quarter 1, however, the estimated expenditure to date is $15,481.65.

6. For FY17 and FY18, to date, please list all intra-District transfers to or from the agency.

PUBLIC SAFETY AND JUSTICE AGENCY
OFFICE OF THE CHIEF MEDICAL EXAMINER (FX0)
FY 2017 Intra-District Transfers

FY 2017 Intra-District Summary - BUYER

SELLING	DESCRIPTION OF SERVICES	FUNDING SENT	FUNDING DUE
Office of the Chief Technology	Request for Telecommunications	$14,500	
The Office of Contracting and	Purchase Cards	$30,000	
Office of Unified Communications	Access to City-Wide radio System	$1,930	
Department of Public Works (KT0)	Fleet Management Administration	$65,222	
TOTAL		**$111,652**	**$0**

FY 2017 Intra-District Summary - SELLER

BUYING	DESCRIPTION OF SERVICES	FUNDING RECEIVED	FUNDING OWED
Office of Victim Services and	Coverdale - Continuing Education for	$35,073	
Department of Health (HC0)	Public Health Responders Personal Protective Equipment (PPE) to handle	$60,000	
Homeland Security & EMA (BN0)	Fatality Mgmt Logistics & Equipment	$70,000	
Office of Victim Services and	Infant Fatality Review Board Support	$72,156	
Office of Victim Services and	Male Survivors Advisory Board Support	$66,929	
Office of Victim Services and	Drug Facilitated Sexual Assaults	$200,000	
District Department of	Drug Impaired Driving Toxicology	$804,180	
TOTAL		**$1,308,338**	**$0**

7. For FY17 and FY18, to date, please identify any special purpose revenue funds maintained by, used by, or available for use by the agency. For each fund identified, provide:

   a. The revenue source name and code;

   b. The source of funding;

   c. A description of the program that generates the funds;

d. The amount of funds generated by each source or program;

e. Expenditures of funds, including the purpose of each expenditure; and

f. The current fund balance.

There is no special purpose revenue in FY17 and FY18, to date, maintained by, used by, or available for use by the agency.

8. For FY17 and FY18, to date, please list any purchase card spending by the agency, the employee making each expenditure, and the general purpose for each expenditure.

PUBLIC SAFETY AND JUSTICE AGENCY
FY 2017 SMART PAY CARD PURCHASES BY EMPLOYEE
Office of The Chief Medical Examiner (FX0)

Agency Code	Fiscal Year	Card Holder Name	Purchase Limits			General Purpose	Expense
			Daily	Single Item	Monthly		
FX0	2017	COLEMAN, MICHAEL	5,000.00	2,500.00	20,000.00	Maintenance - Software	$995.00
FX0	2017	COLEMAN, MICHAEL	5,000.00	2,500.00	20,000.00	Pro Services - Other	$8,911.53
FX0	2017	COLEMAN, MICHAEL	5,000.00	2,500.00	20,000.00	Supplies - Educational	$6,039.70
FX0	2017	COLEMAN, MICHAEL	5,000.00	2,500.00	20,000.00	Supplies - Laboratory	$2,345.00
FX0	2017	COLEMAN, MICHAEL	5,000.00	2,500.00	20,000.00	Supplies - Office	$758.00
FX0	2017	COLEMAN, MICHAEL	5,000.00	2,500.00	20,000.00	Upgrades - Facilities	$1,887.01
FX0	2017	FRIPP, SAVERN	5,000.00	2,500.00	20,000.00	Clothing & Uniforms - New	$1,685.50
FX0	2017	FRIPP, SAVERN	5,000.00	2,500.00	20,000.00	Training - Registration	$17,674.50
FX0	2017	FRIPP, SAVERN	5,000.00	2,500.00	20,000.00	Training&Travel - Local	$1,500.00
FX0	2017	FRIPP, SAVERN	5,000.00	2,500.00	20,000.00	Training&Travel - Out of Town	$48,368.08
FX0	2017	HARVIN, DONELL	5,000.00	2,500.00	20,000.00	Food	$475.49
FX0	2017	HARVIN, DONELL	5,000.00	2,500.00	20,000.00	Maintenance - Equipment	$636.24
FX0	2017	HARVIN, DONELL	5,000.00	2,500.00	20,000.00	Pro Services - Hauling&Moving	$4,370.00
FX0	2017	HARVIN, DONELL	5,000.00	2,500.00	20,000.00	Pro Services - Other	$5,398.48
FX0	2017	HARVIN, DONELL	5,000.00	2,500.00	20,000.00	Supplies - Office	$420.00
FX0	2017	HARVIN, DONELL	5,000.00	2,500.00	20,000.00	Training&Travel - Local	$101.00
FX0	2017	HIERS, VIOLA	5,000.00	2,500.00	20,000.00	Food	$2,608.62
FX0	2017	HIERS, VIOLA	5,000.00	2,500.00	20,000.00	Office Support (PCard)	$5,370.10
FX0	2017	HIERS, VIOLA	5,000.00	2,500.00	20,000.00	Pro Services - Hauling&Moving	$442.00
FX0	2017	HIERS, VIOLA	5,000.00	2,500.00	20,000.00	Pro Services - Other	$1,248.00
FX0	2017	HIERS, VIOLA	5,000.00	2,500.00	20,000.00	Pro Services - Recruitment	$100.00
FX0	2017	HIERS, VIOLA	5,000.00	2,500.00	20,000.00	Supplies - Office	$326.83
FX0	2017	ZARWELL, LUCAS	5,000.00	2,500.00	20,000.00	Accreditations & Certifications	$1,179.96
FX0	2017	ZARWELL, LUCAS	5,000.00	2,500.00	20,000.00	Acquisitions - Hardware	$1,275.36
FX0	2017	ZARWELL, LUCAS	5,000.00	2,500.00	20,000.00	Acquisitions - Software	$259.04
FX0	2017	ZARWELL, LUCAS	5,000.00	2,500.00	20,000.00	Maintenance - Equipment	$851.85
FX0	2017	ZARWELL, LUCAS	5,000.00	2,500.00	20,000.00	Pro Services - Legal	$542.06
FX0	2017	ZARWELL, LUCAS	5,000.00	2,500.00	20,000.00	Pro Services - Other	$2,812.30
FX0	2017	ZARWELL, LUCAS	5,000.00	2,500.00	20,000.00	Small & Emergency Purchases	$3,650.00
FX0	2017	ZARWELL, LUCAS	5,000.00	2,500.00	20,000.00	Supplies - Laboratory	$3,692.02
FX0	2017	ZARWELL, LUCAS	5,000.00	2,500.00	20,000.00	Supplies - Office	$313.95
FX0	2017	ZARWELL, LUCAS	5,000.00	2,500.00	20,000.00	Training&Travel - Out of Town	$400.00
FX0 Grand Total							**$126,637.62**

PUBLIC SAFETY AND JUSTICE AGENCY FY 2018 SMART PAY CARD PURCHASES BY EMPLOYEE Office of The Chief Medical Examiner (FX0)							
Agency Code	Fiscal Year	Card Holder Name	Purchase Limits			General Purpose	Expense Amount
			Daily	Single	Monthly		
FX0	2018	COLEMAN,	5,000.00	2,500.00	20,000.00	Food	$1,570.00
FX0	2018	COLEMAN,	5,000.00	2,500.00	20,000.00	Pro Services - Other	$495.00
FX0	2018	COLEMAN,	5,000.00	2,500.00	20,000.00	Supplies - Office	$1,545.88
FX0	2018	DAVENPORT,	5,000.00	2,500.00	20,000.00	Maintenance -	$1,430.00
FX0	2018	DAVENPORT,	5,000.00	2,500.00	20,000.00	Supplies - Laboratory	$1,260.00
FX0	2018	FRIPP, SAVERN	5,000.00	2,500.00	20,000.00	Training - Registration	$5,000.00
FX0	2018	FRIPP, SAVERN	5,000.00	2,500.00	20,000.00	Training&Travel - Local	$40.00
FX0	2018	FRIPP, SAVERN	5,000.00	2,500.00	20,000.00	Training&Travel - Out of	$8,667.44
FX0	2018	HARVIN, DONELL	5,000.00	2,500.00	20,000.00	Maintenance -	$2,178.93
FX0	2018	ROUSE, BENITA	5,000.00	2,500.00	20,000.00	Supplies - Office	$334.61
FX0	2018	ZARWELL, LUCAS	5,000.00	2,500.00	20,000.00	Supplies - Laboratory	$625.00
FX0	2018	ZARWELL, LUCAS	5,000.00	2,500.00	20,000.00	Training - Registration	$750.00
FX0 Grand Total							**$23,896.86**

9. Please list all memoranda of understanding ("MOU") entered into by your agency during FY17 and FY18, to date, as well as any MOU currently in force. For each, indicate the date on which the MOU was entered and the termination date.

Fiscal Year	Agency	Subject	Start and End Duration
FY18	DCHR – OCME	MOU for suitability related services	Oct. 1, 2017 to Sept. 30, 2018
FY18	GW-OCME	Internship Agreement	July 1, 2017 to June 30, 2022
FY17	HUH Clinical Education - OCME	Clinical Education Affiliation Agreement	Aug 30, 2017 to Aug 30, 2020
FY17	HUH PLA- OCME	Program Letter of Agreement	Sept 1, 2017 to Sept 30, 2017

FY17	AMU-OCME	Internship Agreement	Aug 22, 2017 to Aug 22, 2018
FY17	DDOT-OCME	Impaired Driving Program	Oct. 1, 2017 to Sept. 30, 2018
FY17	OVSJG-OCME	Sexual Assault Testing	Oct. 1, 2017 to Sept. 30, 2018
FY16	NMHM-OCME	Unidentified Skeletal Remains	5.-16.2016 to 9.30.2025
FY16	NMHM-OCME	Review & Consultation Services - Anthropology	5.-16.2016 to 9.30.2025
FY16	OCME-OVS-MultiAgency	Homicide Review	9.30.2018
FY16	DFS-OCME	Parking at PHL Annex	4.25.2016 until terminated
FY16	GW-OCME	Faculty/Education	4.5.2016 to June 3, 2020
FY16	DDOT-Tox	Traffic Safety Information System (TSIS) Participant	Oct. 2015 to Oct. 2020
FY15	CIA-OCME(Tox)	Toxicology Testing	Aug. 2015 to Aug. 2020
FY14	DOH-OCME	IRB Review	4.28.2014 to April 28, 2019
FY14	DOJ-ICITAP and OCME	Training and Teaching	7.3.2014 to 7.3.2019
FY14	HIDTA-MPD-OCME	Data Fusion	Dec. 2, 2017 to Dec. 3, 2019

10. Please list the ways, other than MOU, in which the agency collaborated with analogous agencies in other jurisdictions, with federal agencies, or with non-governmental organizations in FY17 and FY18, to date.

Fatality Management

With regard to fatality management, the agency has formed stakeholder partnerships with several District and regional agencies. For example, through its participation in the MCOG, the agency has worked to coordinate fatality management planning, resource utilization and training and exercises for the agency and first responders and other critical entities involved in emergency response and incident management. Of note, during FY17, the agency held its second annual Fatality Management Symposium and Full Scale Exercise which involved participation from national and international medical examiner

offices including New York, Brussels, Egypt, San Bernardino and Bangladesh. The Symposium also included District Public Safety and Justice Cluster agencies, the Department of Health, as well as federal entities, such as the Federal Bureau of Investigation (FBI).

The Chief Medical Examiner, Emergency & Safety Administrator and Chief Information Officer also visited the Las Vegas Coroner's Office between December 12-14, 2017. The purpose of the visit following the recent mass fatality incident was "knowledge exchange" in the areas of procedures and protocols, resources utilized and staffing matters in the areas of death investigation, victim identification, and information technology. The focus was on overall emergency preparedness as related to the mass fatality plans of the District, OCME and its stakeholders (i.e., public safety and justice cluster agencies, hospitals and other entities).

Public Surveillance
The agency's Data Fusion Analysis Center has been instrumental in forging partnerships surrounding the agency's mission in public health and safety surveillance. The agency has provided mortality statistical data toward prevention and deterrence to various entities within and external to the District government. Moreover, studies on specified topics (i.e., opioids, in-custody deaths, homelessness, hypothermia, public dispositions, infant mortality, and traffic mortalities) have been published and are available on the agency's website for general public review.

Fingerprint
The agency is engaging in external partnering with other medical examiner offices (i.e., San Diego Medical Examiner) and research institutions (i.e., Boston University) on innovative technologies being developed to obtain fingerprints on decedents. The benefit of this technology will allow the agency to obtain fingerprints in cases where we are currently unable to do so. By participating in this research project, the agency also obtains access to top leaders in the field of decedent fingerprinting. Fingerprinting is one of the more expedient ways to obtain identifications scientifically and allows the agency to meet best practices in the field. This effort is grant funded through the National Institutes of Justice (NIJ). The agency lead on this project is the agency's Supervisory Forensic Anthropologist.

Knowledge Exchange
The agency has provided tours of its facility to analogous agencies, such as the Hennepin County Medical Examiner's Office, Minneapolis, MN. The Hennepin County ME is building a new facility and stated that it was reviewing premier facilities throughout the country for design, work process flow, standard operating procedure, autopsy and laboratory setup best practices and ideas, as well as challenges in building construction and design experienced by end users. In attendance on the tour where the Hennepin County ME's Chief Medical Examiner; office administrators, as well as project architects and representatives from the design firm. The OCME was able to not only provide a facility tour but have managers and line staff discuss with the tour group best practices

and challenges with certain build-outs of the facility and those modifications that were made after construction to enhance process flow and operations.

The US Department of Defense Intelligence Agency (DIA), located out of JBAB in DC, also toured and discussed with the agency a collaboration between the two agencies on fatality management planning, training, and exercises.

The agency partnered with the Egyptian Ministry of Justice's Forensic Medicine Authority to conduct training and a needs assessment with Egyptian forensic officials in Cairo, Egypt. A videoconference workshop was facilitated between the agency and the Egyptian Ministry's FMA to collaborate with the Fatality Management staff, IT staff, and Administrative staff. The focus was to provide a presentation on the OCME's 2016 Fatality Management Symposium and Full Scale Exercise with lessons learned.

The Chief Medical Examiner worked through the Egyptian Ministry of Justice's Forensic Medicine Authority to conduct training and a needs assessment with Egyptian forensic officials in Cairo, Egypt. The training and needs assessment will be used to support OCME through improved awareness of death investigations in other cultures, thereby providing the necessary exposure and education to be equipped and prepared to serve families from immigrant communities in the District. Participating in US DOJ's International Criminal Investigative Assistance Program (ICITAP) allowed the agency the opportunity to teach and learn. The trip was fully funded by ICITAP via an in-kind and monetary donation.

Academic Partnerships
The agency has also formed academic partnerships with universities and hospitals within the District. Residents from George Washington and Georgetown are trained at the agency in their rotations in forensic pathology and Howard University is currently on-board to begin such training. The forensic pathologists of the agency also serve as faculty at George Washington and serve on mortality and morbidity review education committees at several hospitals.

11. Please list all capital projects in the financial plan and provide an update on all capital projects under the agency's purview in FY17 and FY18, to date, including the amount budgeted, actual dollars spent, and any remaining balances. In addition, please provide:

    a. An update on all capital projects begun, in progress, or concluded in FY16, FY17, and FY18, to date, including the amount budgeted, actual dollars spent, and any remaining balances.

    b. An update on all capital projects planned for FY18, FY19, FY20, FY21, FY22, and FY23.

    c. A description of whether the capital projects begun, in progress, or concluded in FY16, FY17, or FY18, to date, had an impact on the operating budget of the agency. If so, please provide an accounting of such impact.

Note that capital projects have had and are anticipated to have a positive impact on the operating budget of the agency. The FY18 capital funding for vehicle replacement reduces the need to spend operating funds and, thus, enables the agency to utilize such local funding on other critical needs. The capital funding also establishes a capital vehicle replacement program. Secondly, given the agency growth in staff over the past three years, facility renovation for additional workspace is required. A capital budget, as opposed to an operating budget, is more appropriate for a renovation project which can span over a length of time crossing over fiscal years.

PUBLIC SAFTEY AND JUSTICE AGENCY
FY2017 through FY 2022 Capital Improvements Plan
Office of The Chief Medical Examiner (FX0)

Project No	Project Title	Brief Project Status: [With in Budget, Delayed, Funding Needed, Completed]	Implementing Agency	Approp Fund	Agy Fund	Lifetime Budget	LTD Expenditures	Encumbrances	Pre Encumbrances	ID Advances	LifeTime Balance	Amount to be Re-Directed	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	6-yr Total
AA416C	RENOVATION OF HVAC SYSTEM	Completed - will request that remaining allotment be reprogrammed to FXOFRC for FY2018	AM0	0300	0300	618,491	613,265	5,225	0	0	5,225	(5,225)	0	0	0	0	0	0	0
AA517C	RENOVATION OF MORTUARY, PHOTOGRAPHIC AND HISTOLOGY LAB	Completed - will request that remaining allotment be reprogrammed to FXOFRC for FY2018	AM0	0300	0300	1,267,849	1,267,674	175	0	0	175	(175)	0	0		0	0	0	0
FX0FRC	OCME FACILITY RENOVATION AT THE CFL	Awaiting start of construction	AM0	0300	0300	100,000	0	0	0	0	100,000	5,400	0	105,400	0	0	0	0	105,400
FX0VRC	OCME VEHICLE REPLACEMENT PROGRAM	Awaiting receipt & fit-up of second vehicle	KT0	0300	0300	115,000	38,726	40,000	0	0	36,274	0	0	36,274	0	0	0	0	36,274
Grand Total - CURRENT						**2,101,340**	**1,919,666**	**45,400**	**0**	**0**	**141,674**	**0**	**0**	**141,674**	**0**	**0**	**0**	**0**	**141,674**

12. Please provide a list of all budget enhancement requests (including capital improvement needs) for FY17 and FY18, to date. For each, include a description of the need and the amount of funding requested.

    In FY17 and FY18, agency needs have been met by the Mayor's Budget. Moving forward, we are working with the Mayor's Budget Office and the Deputy City Administrator/Deputy Mayor for Public Safety on agency needs.

13. Please list, in chronological order, each reprogramming in FY17 and FY18, to date, that impacted the agency, including those that moved funds into the agency, out of the agency, and within the agency. Include the revised, final budget for your agency after the reprogrammings for FY17 and FY18, to date. For each reprogramming, list the date, amount, rationale, and reprogramming number.

PUBLIC SAFETY AND JUSTICE
AGENCY
OFFICE OF THE CHIEF

FISCAL YEAR	FUND	DATE	SOAR DOC	DESCRIPTION	AMOUNT
LOCAL				**Starting Budget**	**$11,422,664**
2017	0100	1/13/2017	BJRTWDO0	Budget Increase - Funds for the Return to Work Program	$71,240
2017	0100	1/23/2017	BJRPFXFX	Net Zero internal local reprogramming moving $433,076 from PS vacancy savings to NPS to cover costs associated with supplies, information technology and infrastructure upgrades, service contracts, and	$0
2017	0100	1/30/2017	BJRTW130	Budget Increase - Funds for the Return to Work Program	$34,751
2017	0100	4/11/2017	BJRTWFX0	Budget Increase - Funds for the Return to Work Program	$56,760
2017	0100	6/29/2017	BJRTWPAR	Budget Increase - Funds for the Return to Work Program	$48,652
2017	0100	7/6/2017	BJRPFXCA	Internal local reprogramming moving $400,000 from PS vacancy savings to NPS and $100,000 to OCME Facilities Renovation Program to cover costs associated with supplies, information technology and infrastructure upgrades, service contracts, equipment maintenance, and Facilities Renovations.	($100,000)
				Final Budget	**$11,534,067**
INTRA-DISTRICT				**Starting Budget**	**$512,155**
2017	0700	11/17/2016	BJFXKA33	Budget Increase - DIDMVF additional funds awarded to purchase Breath Equipment.	$194,210
2017	0700	11/17/2016	BJFXKA34	Budget Increase - DIDMVF additional funds awarded to purchase Tox Lab Equipment.	$350,000
2017	0700	12/1/2016	BJFXKA60	Budget Increase - to match the awarded amount for DIDMVF Base Award	$59,970
2017	0700	12/21/2016	BLFX0212	Establish Budget for FY 2017 HSEMA Mass Fatality Equipment Support (2FXUA6) MOU.	$70,000
2017	0700	12/21/2016	BLFX0212	Establish Budget for FY 2017 OVS Male Survivors Advisory Board Support (FRMSAB) MOU.	$100,231
2017	0700	1/9/2017	BLFX0123	Budget Increase - to match the awarded amount for FY17 OVS Fatality Review Infant Board support (FRS17N)	$19,091
2017	0700	3/20/2017	BIFX0100	Budget Increase - to match the awarded amount for FY17 OVS Drug Facilitated Sexual Assualts support	$19,360
2017	0700	3/20/2017	BIFX0100	Budget Increase - for award from DoH for FY17 PPE support for agencies handling infectious patients	$60,000
2017	0700	7/19/2017	BLFX0106	Budget Increase - to match the awarded amount for FY17 OVS Coverdale Training Support (CVD17) MOU	$3,558
2017	0700	8/15/2017	BLFX0202	Budget decrease for FY 2017 OVS Male Survivors Advisory Board Support (FRMSAB) MOU revised forecast.	($33,302)
2017	0700	8/15/2017	BLFX0202	Budget decrease - for FY17 OVS Fatality Review Infant Board support (FRS17N) MOU revised forecast.	($46,935)
				Final Budget	**$1,308,338**

14. Please list each grant or sub-grant received by your agency in FY17 and FY18, to date. List the date, amount, source, purpose of the grant or sub-grant received, and amount expended.

    As listed below, the agency is in receipt of sub-grant funding for the purpose of hiring FTEs and purchasing of supplies.

    a. How many FTEs are dependent on grant funding? What are the terms of this funding? If it is set to expire, what plans, if any, are in place to continue funding the FTEs?

    There are six (6) FTEs dependent on subgrant funding as outlined below. The agency will reapply for all subgrants.

- Office of Victims Services and Justice Grants – Drug Facilitated Sexual Assault – One Year Term (FY18 funding)

  Two FTEs and supplies

- Office of Victims Services and Justice Grants – Male Survivor Advisory Board – One Year Term (FY18)

  One FTE and supplies

- Department of Transportation, Driving Under the Influence – One Year Term (FY18)

  Two FTEs and supplies

- UASI: Fatality Management Logistics and Equipment Cache – One Year Term (FY17-18)

  One FTE

15. Please list each contract, procurement, and lease, entered into, extended, and option years exercised by your agency during FY17 and FY18, to date. For each contract, please provide the following information, where applicable:

    a. The name of the contracting party;
    b. The nature of the contract, including the end product or service;
    c. The dollar amount of the contract, including amount budgeted and amount actually spent;
    d. The term of the contract;
    e. Whether the contract was competitively bid;
    f. The name of the agency's contract monitor and the results of any monitoring activity; and
    g. The funding source.

Attachment II	**FY 2017**						
Contracts							
Vendor Name	**Contract Purpose - Description of Services**	**Contract Amount**	**Contract Term Begin**	**Contract Term End**	**Option Year in FY17**	**Funding Source (local, federal, private, special revenue)**	**Competitive or Sole Source**
Wendt Center	Grief Counseling for decedent's family or friends	$77,561.62	10/1/2016	9/30/2017	Opt Yr 2 Extended	Local	Sole Source
Orasure (DSX)	Drug Screening Instrument (DSX #1) Maintenance and Repair	$17,000	10/1/2016	9/30/2017	Base	Local	Sole Source
Nova Biomedical	Electrolyte Instrument Maintenance	$4,462.00	10/1/2016	9/30/2017	Base	Local	Sole Source
ThermoFisher	Centrifuges, Scales, & TurboVap Maintenance	$5,908.00	10/1/2016	9/30/2017	Base	Local	Sole Source
Agilent Technologies	GC/MS, GC/MS/MS, LC/MS Instrument Maintenance and Repair	$122,760.00	10/1/2016	9/30/2017	Opt Yr 4	Local	Sole Source
WATERS, INC.	LC/MS/MS Instrument Maintenance and Repair (Aquity TQDs and QTOF)	$113,732.99	10/1/2016	9/30/2017	Opt Yr 3	Local	Sole Source
Parker Hannifin	Nitrogen Generation system	$8,588.00	10/1/2016	9/30/2017	Base	Local	Sole Source

Attachment II	**FY 2018**						
Contracts							
Vendor Name	**Contract Purpose - Description of Services**	**Contract Amount**	**Contract Term Begin**	**Contract Term End**	**Option Year in FY18**	**Funding Source (local, federal, private, special revenue)**	**Competitive or Sole Source**
Wendt Center	Grief Counseling for decedent's family or friends	$79,035.2	10/1/2017	9/30/2018	Final Option	Local	Sole Source
Orasure (DSX)	Drug Screening Instrument (DSX #1) Maintenance and Repair	$17,000.00	10/1/2017	9/30/2018	Base	Local	Sole Source
Nova Biomedical	Electrolyte Instrument Maintenance	$6,299.00	10/1/2017	9/30/2018	Base	Local	Sole Source
Static Power	Universal Supply System	$3,359.00	10/1/2017	9/30/2018	Base	Local	Sole Source
ThermoFisher	Centrifuges, Scales, & TurboVap Maintenance	$5,303.00	10/1/2017	9/30/2018	Base	Local	Sole Source
Agilent Technologies	GC/MS, GC/MS/MS, LC/MS Instrument Maintenance and Repair	$105,170.64	10/1/2017	9/30/2018	Opt Yr. 3	Local	Sole Source
WATERS, INC.	LC/MS/MS Instrument Maintenance and Repair (Aquity TQDs and QTOF)	$115,751.08	10/1/2017	9/30/2018	Opt Yr. 3	Local	Sole Source
Parker Hannifin	Nitrogen Generation system	$8,850.00	10/1/2017	9/30/2018	Base	Local	Sole Source

16. Please list all pending lawsuits that name the agency as a party. Identify which cases on the list are lawsuits that potentially expose the District to significant financial liability or will result in a change in agency practices, and describe the current status of the litigation. Please provide the extent of each claim, regardless of its likelihood of success. For those identified, please include an explanation about the issues involved in each case.

The agency has one lawsuit wherein the agency is named as a party – Mike Eckel v. Office of the Chief Medical Examiner. It is currently pending and the Office of the Attorney General is representing the agency on behalf of the District. The agency does not anticipate financial liability or a change in agency practices. The case is based upon utilizing an exemption to the District's Freedom of Information Act (FOIA) to withhold decedent information from release to the public.

17. Please list all settlements entered into by the agency or by the District on behalf of the agency in FY17 or FY18, to date, and provide the parties' names, the amount of the settlement, and if related to litigation, the case name and a brief description of the case. If unrelated to litigation, please describe the underlying issue or reason for the settlement (e.g. administrative complaint, etc.).

    The agency entered into one (1) administrative settlement in FY17 of which the details are confidential.

18. Please list the administrative complaints or grievances that the agency received in FY17 and FY18, to date, broken down by source. Please describe the process utilized to respond to any complaints and grievances received and any changes to agency policies or procedures that have resulted from complaints or grievances received. For any complaints or grievances that were resolved in FY17 or FY18, to date, describe the resolution.

    There have been no administrative complaints or grievances filed in FY17 and FY18, to date.

19. Please describe the agency's procedures for investigating allegations of sexual harassment or misconduct committed by or against its employees. List and describe any allegations received by the agency in FY17 and FY18, to date, whether or not those allegations were resolved.

    The agency follows the local and federal human rights laws, including Mayor's Order 2004-171. It has a certified Equal Employment Opportunity (EEO) counselor on staff and has obligated all agency employees, including managers, to take the online training "Sexual Harassment Prevention for Employees" before February 28, 2018. The agency's policy will be updated to ensure consistency with the new Mayor's Order 2017-313.

    The OCME received one (1) complaint of sexual harassment in FY17 that was resolved in FY17.

20. Please list and describe any ongoing investigations, audits, or reports on the agency or any employee of the agency, or any investigations, studies, audits, or reports on the agency or any employee of the agency that were completed during FY17 and FY18, to date.

    On September 15, 2016, the Office of the D.C. Auditor (ODCA) initiated a study of child fatalities in the District. The purpose of the study is to address the trends in child

fatalities over time with regard to the number of fatalities, demographics of child decedents, and the cause and manner of death; how the Child Fatality Review Committee (CFRC) recommendations align with the trends in child fatalities and service delivery issues identified by the CFRC in its annual reports; and how selected CFRC recommendations have been implemented. The final report, entitled "Critical Work of the Child Fatality Review Committee Should Build on Recent Reforms," was published on July 21, 2017.

On October 4, 2017, ODCA initiated a discretionary audit of the Domestic Violence Fatality Review Board covering fiscal years 2003 through 2017. The audit concern is whether D.C. Code Section 16-1052 and requirements therein have been complied with, including whether:
- the board has collected data that identifies trends and patterns surrounding domestic violence fatalities in DC;
- the annual reports were timely; and
- recommendations proposed by the board have been implemented.

ODCA will request related documents and interviews with the OCME that describes the agency's involvement with the board until the transfer of responsibilities to the Office of Victim Services and Justice Grants (OVSJG) on December 31, 2015. The ODCA will request similar information from OVSJG, which took over management of the review board in January 2016. This audit is ongoing.

21. Please describe any spending pressures the agency experienced in FY17 and any anticipated spending pressures for the remainder of FY18. Include a description of the pressure and the estimated amount. If the spending pressure was in FY17, describe how it was resolved, and if the spending pressure is in FY18, describe any proposed solutions.

    The agency had no spending pressures in FY17 and none anticipated for FY18.

22. Please provide a copy of the agency's FY17 performance plan. Please explain which performance plan objectives were completed in FY17 and whether they were completed on time and within budget. If they were not, please provide an explanation.

    The agency's FY17 performance plan is provided as Attachment C. The plan is presented in the Performance Accountability View which provides a detailed accounting of which performance plan key performance objectives (i.e., initiatives and key performance measures) were completed and whether or not they were completed on time with full explanation. Items completed on time were done so within budget.

23. Please provide a copy of your agency's FY18 performance plan as submitted to the Office of the City Administrator.

    The agency's FY18 performance plan is provided as Attachment D.

24. Please describe any regulations promulgated by the agency in FY17 or FY18, to date, and the status of each.

    The agency did not promulgate any regulations in FY17 or in FY18, to date.

25. Please provide the number of FOIA requests for FY17 and FY18, to date, that were submitted to your agency. Include the number granted, partially granted, denied, and pending. In addition, please provide the average response time, the estimated number of FTEs required to process requests, the estimated number of hours spent responding to these requests, and the cost of compliance.

    In FY17, the agency had 56 FOIA requests, with the following dispositions: 37 denied; 7 granted in whole; 6 granted in part and denied in part; and 6 other disposition. Note that the agency experienced an approximately 240% increase in the number of FOIA requests processed from FY16 to FY17. The increase was likely due to several high-profile deaths in the District and requests for opioid data.

    To date in FY18, the agency has had five (5) FOIA requests with the following dispositions: 1 denied; 2 granted; 1 no responsive records/other; and 1 pending.

    The estimated number of FTEs required to process requests is one and the median estimated number of days spent responding to these requests was one in FY17. The cost of compliance is integrated into the one FTE salary.

26. Please provide a list of all studies, research papers, reports, and analyses that the agency prepared or contracted for during FY17 and FY18, to date. Please state the status and purpose of each. Please submit a hard copy to the Committee if the study, research paper, report, or analysis is complete.

    Forensic Pathology
    - The Violence Epidemic in the African American Community: A Call by the National Medical Association for Comprehensive Reform, Roger A. Mitchell, Jr., M.D., LaQuandra S. Nesbitt, M.D., M.P.H., et. al., Journal of the National Medical Association, 2017, Academic Forensic Pathology: The Official Publicatoin of the National Association of Medical Examiners, 2017
    - National Association of Medical Examiners Position Paper: Recommendations for the Definition, Investigation, Postmortem Examination, and Reporting of Deaths in Custody, Roger A. Mitchell, Jr., M.D., Francisco Diaz, M.D. et. al., 2017

    Mortuary
    - National Institute of Justice Digital Fingerprint Project, which entails methods development/technique study that includes the data collection for 3D digital fingerprint capturing for comparison analysis. Data (fingerprints) collection has not been completed.
    - Georgetown University IRB Brain Bank Donation study which entails tissue collection for CNS tissue research. Tissue collection has not yet been initiated.

    Anthropology
    The purpose of the items is to further the field of forensic anthropology and to meet the recertification requirements of American Board of Forensic Anthropology.

    - A Life History of Skeletal Trauma: Cases from a Medical Examiner's Office. In eds Tegtmeyer and Martin *Broken Bones, Broken Bodies: Bioarchaeological and Forensic*

Approaches for Accumulative Trauma and Violence. Lexington Books: 183-200. Love JC, Derrick SM (Published Manuscript, 2017)

- The Evolution of Forensic Anthropology and the Influence of Court Rulings, Legislative Actions, and Social Trends. Proceedings American Academy of Forensic Sciences, New Orleans; Feb 13-18; 280. Love JC, Fulginiti L (Published Abstract, 2017)

- Application of Bone Fractography to a Medical Examiner Sample: A Case Series. In preparation for submission to Forensic Anthropology Journal. Love JC, Christensen AM (Ongoing)

-Theoretical Foundation of Child Abuse. In Eds. C. Clifford Boyd and Donna C. Boyd editors. Forensic Anthropology: Theoretical Framework and Scientific Basis. John Wiley & Sons Ltd. Love JC, Soto Martinex ME (Ongoing)

Medicolegal Death Investigation

- Medicolegal Death Investigation of Sudden Unexpected Infant Deaths. Mitchell, RA, DiAngelo, C., Morgan D. Pediatric Annals. 2017 August; 46 (8): 297-302.

- Opioid Drug Death Investigations. Acad Forensic Pathol. Morgan, D. 2017 Mar; 7(1): 50-59.

Records Management/Quality Assurance

- OQCRM provided a statement of work for ISO 17020 consulting services, which required an in-depth analysis of requirements to include a market analysis for the establishment of a requisition for services, FY18

- Collaborated with the ANAB training administrators to develop an unofficial comprehensive checklist in preparation for international accreditation. May 30-June 6, 2017.

27. Please separately list each employee whose salary was $100,000 or more in FY17 and FY18, to date. Provide the name, position number, position title, program, activity, salary, and fringe. In addition, state the amount of any overtime or bonus pay received by each employee on the list.

PUBLIC SAFETY AND JUSTICE AGENCY
FY 2017 LIST OF EMPLOYEE(S) SALARY OF $100,000 OR MORE
Office of The Chief Medical Examiner (FX0)

Agency Code	Fiscal Year	Program Number	Activity Number	Employee Name	Position Number	Position Title	Salary	Fringe	Overtime Pay	Bonus Pay
FX0	2017	1000	1090	Mitchell,Roger A	00082137	Chief Medical Examiner	$268,407.70	$58,512.88	$0.00	
FX0	2017	1000	1090	Diaz,Francisco J.	00034821	Deputy Chief Medical	$235,000.00	$51,230.00	$0.00	
FX0	2017	2000	2100	Giese,Kristinza	00013140	Medical Officer	$186,026.00	$40,553.67	$3,788.26	
FX0	2017	2000	2100	Breland,Sasha-	00003341	Medical Officer	$181,815.00	$39,635.67	$1,841.46	$9,090.75
FX0	2017	2000	2100	Njiwaji,Chantel	00075174	Medical Officer	$181,814.00	$39,635.45	$11,581.03	
FX0	2017	2000	2100	Golden,Kimberl	00012132	MEDICAL OFFICER	$176,748.00	$38,531.06	$0.00	
FX0	2017	1000	1090	Fields,Beverly A	00032724	Chief of Staff	$160,079.20	$34,897.27	$0.00	$8,003.95
FX0	2017	4000	4100	Zarwell,Lucas W	00013643	Chief Toxicologist	$147,299.85	$32,111.37	$0.00	$7,364.95
FX0	2017	1000	1060	DeVillier,Mikelle	00041749	SUPERVISORY	$142,751.91	$31,119.92	$0.00	$7,137.55
FX0	2017	2000	2200	Lyles,Denise A	00045537	Lead Medicolegal	$141,187.20	$30,778.81	$0.00	
FX0	2017	1000	1020	Fogg,Peggy J	00010178	MGMT SRVS OFFICER	$140,295.81	$30,584.49	$0.00	
FX0	2017	2000	2200	Petrasek,Mary	00002927	MEDICAL LEGAL	$134,590.00	$29,340.62	$3,689.14	
FX0	2017	1000	110F	Dixon,Leautry	00045538	AGENCY FISCAL	$133,480.00	$29,098.64	$0.00	
FX0	2017	2000	2202	Love,Jennifer	00073619	Forensic	$133,008.92	$28,995.94	$0.00	
FX0	2017	2000	2200	Fields,Leigh S	00035031	MEDICAL LEGAL	$131,051.00	$28,569.12	$7,367.17	
FX0	2017	1000	1056	Harvin,Donell	00050899	Emergency Response	$128,941.79	$28,109.31	$0.00	$6,447.05
FX0	2017	2000	2200	Morgan,Daniel	00002522	SUPVY MEDICO LEG AL	$122,750.25	$26,759.55	$0.00	
FX0	2017	1000	1040	Coleman	00039151	Chief Information	$119,966.16	$26,152.62	$0.00	
FX0	2017	4000	4100	Tolliver	00074664	Dep Chief Toxicologist	$118,178.08	$25,762.82	$0.00	
FX0	2017	2000	2200	Díaz,Carolina	00075184	Medicolegal	$116,881.00	$25,480.06	$3,379.98	
FX0	2017	3000	3100	Beebe-	00051331	Fatality Review	$116,699.00	$25,440.38	$0.00	
FX0	2017	3000	3100	Martin,Tracie	00045527	Senior Fatality Review	$114,199.00	$24,895.38	$0.00	
FX0	2017	1000	1086	Francis,Anna D	00071570	Supervisory Quality	$113,499.33	$24,742.85	$0.00	
FX0	2017	1000	1041	Leak,Chikarlo	00041327	Epidemiologist	$101,927.00	$22,220.09	$0.00	
AGENCY GRAND TOTAL							**$3,546,59**	**$773,157.**	**$31,647.04**	**$38,044**

28. Please list in descending order the top 25 overtime earners in your agency in FY17 and FY18, to date, if applicable. For each, state the employee's name, position number, position title, program, activity, salary, fringe, and the aggregate amount of overtime pay earned.

Agency Code	Fiscal Year	Program Number	Activity Number	Employee Name	Position Number	Position Title	Salary	Fringe	Overtime Pay
FX0	2017	2000	2300	Lassiter,Kimberly A	00047550	Lead Forensic	77,292.00	16,849.66	16,022.97
FX0	2017	2000	2300	Bryant,Stephon M	00001881	Forensic	55,262.00	12,047.12	13,494.63
FX0	2017	2000	2100	Diangelo,Constance	00075174	Medical	181,814.00	39,635.45	11,581.03
FX0	2017	2000	2300	Kidwell Jr.,Robert J.	00091361	Forensic	52,308.00	11,403.14	10,196.86
FX0	2017	2000	2300	Waters,Lawrence K	00071713	Autopsy	64,092.00	13,972.06	9,699.12
FX0	2017	2000	2300	Betts,Elizabeth S	00075679	Supvy Foren	95,325.47	20,780.95	9,183.65
FX0	2017	2000	2200	Fields,Leigh S	00035031	MEDICAL	131,051.00	28,569.12	9,022.37
FX0	2017	2000	2300	Brown,Matthew B	00046876	Forensic	74,711.00	16,287.00	8,934.77
FX0	2017	2000	2300	Garner,LaTishia	00075161	Forensic	74,711.00	16,287.00	8,832.77
FX0	2017	2000	2300	Snowden,Brian	00035145	Forensic	55,262.00	12,047.12	8,346.72
FX0	2017	2000	2300	Hinkle,Jamal	00091364	Forensic	52,308.00	11,403.14	7,963.55
FX0	2017	2000	2200	Jamison,Latoya R	00045530	FORENSIC	87,892.00	19,160.46	7,197.14
FX0	2017	1000	1020	Nolan,James	00071359	Program	85,530.00	18,645.54	6,599.77
FX0	2017	2000	2200	Kim,Katherine	00077462	FORENSIC	85,530.00	18,645.54	6,480.80
FX0	2017	4000	4100	Kuhn,Michael	00075528	Forensic	91,438.00	19,933.48	6,469.07
FX0	2017	2000	2200	Johnson,Stephanie	00073738	FORENSIC	83,168.00	18,130.62	5,740.33
FX0	2017	2000	2300	Kelly,Derrick	00091365	Forensic	52,308.00	11,403.14	5,716.62
FX0	2017	2000	2300	Robinson-	00091363	Forensic	52,308.00	11,403.14	5,449.65
FX0	2017	2000	2200	Petrasek,Mary Beth	00002927	MEDICAL	134,590.00	29,340.62	4,853.86
FX0	2017	2000	2300	Bell,Dennis	00071575	Autopsy	64,092.00	13,972.06	4,677.47
FX0	2017	2000	2200	Ware	00044663	FORENSIC	90,254.00	19,675.37	4,582.55
FX0	2017	2000	2300	Johnson,Keith E	00047548	Forensic	53,785.00	11,725.13	4,304.35
FX0	2017	2000	2200	Wood,Rebecca	00045531	Wood,Rebecca	76,082.00	16,585.88	4,163.92
FX0	2017	2000	2100	Giese,Kristinza W.	00013140	Medical	186,026.00	40,553.67	3,788.26
FX0	2017	4000	4100	Bayard,Ciena N	00075529	Forensic	91,438.00	19,933.48	3,406.94
AGENCY GRAND TOTAL							**$2,148,577.47**	**$468,389.89**	**$186,709.17**

29. For FY17 and FY18, to date, please provide a list of employee bonuses or special pay granted that identifies the employee receiving the bonus or special pay, the amount received, and the reason for the bonus or special pay.

PUBLIC SAFETY AND JUSTICE AGENCY
FY 2017 BONUS PAY OR SPECIAL AWARDS BY EMPLOYEE
Office of The Chief Medical Examiner (FX0)

Agency Code	Fiscal Year	Employee Name	Position Title	Bonus Pay	Special Awar	Reason
FX0	2017	Harvin,Donell	Emergency Response and Safety	6,447.05	0.00	Outstanding Performance
FX0	2017	DeVillier,Mikelle L	SUPERVISORY ATTORNEY ADVISOR	7,137.55	0.00	Outstanding Performance
FX0	2017	Fields,Beverly A	Chief of Staff	8,003.95	0.00	Outstanding Performance
FX0	2017	Breland,Sasha-Gay I	Medical Officer (Medical Examiner)	9,090.75	0.00	Outstanding Performance
FX0	2017	Landrie,Rachael A.	Forensic Photographer	3,844.70	0.00	Outstanding Performance
FX0	2017	Zarwell,Lucas W	Chief Toxicologist	7,364.95	0.00	Outstanding Performance
AGENCY GRAND TOTAL				**$41,888.95**	**$0.00**	

30. Please provide each collective bargaining agreement that is currently in effect for agency employees. Please include the bargaining unit and the duration of each agreement. Please note if the agency is currently in bargaining and its anticipated completion.

The following collective bargaining agreements are in effect with the agency:

Doctors Council of Washington DC:

- Compensation Collective Bargaining Agreement Between The Government of the District of Columbia Representing Compensation Unit 19 Effective Through September 30, 2016
- Non-Compensation Collective Bargaining Agreement Between The Government of District of Columbia and The Doctors Council of the District of Columbia Effective Through September 30, 2009

National Union of Hospital and Health Care Employees:

- Compensation Collective Bargaining Agreement Between The District of Columbia Government and Compensation Units 1 and 2 Effective April 1, 2013 through September 30, 2017 (The District government has reached a tentative agreement with Compensation Units 1 & 2 on this collective bargaining agreement. The Union will vote to ratify the contract on Thursday, January 18, 2018)
- Noncompensation Collective Bargaining Agreement Between the District of Columbia and 1199 Metro District DC, NUHHCE

Alliance of Independent Workers (AIW):

- Compensation Collective Bargaining Agreement Between The District of Columbia Government and Compensation Units 1 and 2 Effective April 1, 2013 through September 30, 2017

See Attachment E.

31. If there are any boards or commissions associated with your agency, please provide a chart listing the names, confirmation dates, terms, wards of residence, and attendance of each member. Include any vacancies. Please also attach agendas and minutes of each board or commission meeting in FY17 or FY18, to date, if minutes were prepared. Please inform the Committee if the board or commission did not convene during any month.

The Office of the Chief Medical Examiner has administrative oversight of the Child Fatality Review Committee (CFRC), Infant Mortality Review Team (CFRC Sub-Committee) and the Developmental Disabilities Fatality Review Committee (DDFRC).

All records related to the appointments, names, terms, vacancies and wards of residence of the committee members of the CFRC and DDFRC are maintained by the Mayor's Office of Talent and Appointments (MOTA).

CFRC: The CFRC Convened on the 3rd Thursday of each month between February 2017 and November 2017 for a total of 10 meetings. Meetings were not held in January 2017

due to the Presidential Inauguration or December 2017 due to the holidays. Meetings are currently scheduled to reconvene on January 18, 2018.

IMR: The IMR Team convened on the 1st Thursday of each month between February 2017 and December 2017 for a total of 11 meetings. No meeting was held in January 2017 due to the holidays. The team is scheduled to reconvene on January 9, 2017.

DDFRC: The DDFRC convened during the months of February, March, May, August, September, October and November of 2017. The DD FRC is scheduled to reconvene on January 19, 2017.

Please note that meeting materials (i.e., minutes and agenda) are strictly confidential as meeting materials (i.e., minutes and agenda) contain decedent information.

32. Please list all reports or reporting currently required of the agency in the District of Columbia Code or Municipal Regulations. Provide a description of whether the agency is in compliance with these requirements, and if not, why not (e.g. the purpose behind the requirement is moot, etc.).

- 2016 Agency Annual Report. Published November 30, 2017. Per D.C. Code the report is to be published by the end of 2017. This publication was in compliance with the law.

33. Please provide a list of any additional training or continuing education opportunities made available to agency employees. For each additional training or continuing education program, please provide the subject of the training, the names of the trainers, and the number of agency employees that were trained.

Trainings or continuing education opportunities are outlined in Question 45 below. In addition to these opportunities, the Department of Human Resources (DCHR) provides in-person and online courses in a myriad of subjects that relate to interpersonal skills; knowledge in the workplace; managerial and supervisory skills; ethics and workplace conduct; and personal growth and development.

34. Does the agency conduct annual performance evaluations of all its employees? Who conducts such evaluations? What steps are taken to ensure that all agency employees are meeting individual job requirements?

The agency conducts annual performance evaluations. The evaluations are conducted by employees' supervisors per the District's Performance Management Program as outlined in the District Personnel Manual (DPM). The program includes performance planning, mid-year discussions, and annual performance evaluations. Supervisors are provided annual performance management training regarding implementation of the three phases. The performance planning process ensures that the supervisor and employee work together to determine the performance expectations based on job requirements. The expectations are outlined as competencies, goals, and individual development plans. All agency employees undergo periodic discussions throughout the evaluation period, a mid-year discussion and an end-of-year review process with their supervisors. Such reviews

and discussions provide the supervisor and employee an opportunity to determine whether individual job requirements are met and, if not, an opportunity to identify mechanisms and resources toward improvement.

The agency also ensures that all managers receive the requisite training on performance management and that the Chief of Staff and Management Liaison Specialist (responsible for employee performance management) are available to respond to process and system inquiries and problems for resolution.

The agency is pleased to report that 100% of its employee performance plans and evaluations were completed within the District's performance plan deadlines.

Agency Operations

35. Please describe any initiatives that the agency implemented in FY17 or FY18, to date, to improve the internal operations of the agency or the interaction of the agency with outside parties. Please describe the results, or expected results, of each initiative.

The agency has implemented the following initiatives in FY17 or FY18, to date, to improve internal operations or interactions with outside parties:

a) ISO Employee Training

During FY17, the OCME facilitated ISO (International Organization for Standardization) 17020 training to 10 staff persons, including managers. The agency provided the training as part of its continued efforts to maintain accreditation standards set by the National Association of Medical Examiners (NAME). ISO training is part of new standards and guidelines now required for medical examiner offices as part of accreditation. As agency staff is trained and becomes proficient in the standards and guidelines set forth as industry best practices, they are able to work to incorporate such guidelines and standards into agency internal operations and/or ensure that such guidelines and standards are maintained.

b) Fatality Management Training & Exercises

The agency's initiative on fatality management for FY17 included its Second Annual Fatality Management Symposium and Full-Scale Exercise held September 11-13, 2017. Guests included representatives of medical examiner offices internationally, as well as nationally and within the region (i.e., Brussels, Egypt, New York, San Bernardino, and Bangladesh). Moreover, event registrants included stakeholder agencies and private entities on the local, state and federal level that have a function in emergency and incident planning and response. OCME, along with sister agencies and federal agencies such as the FBI successfully completed tabletop and full exercises based on active shooter and explosion incidents.

c) Medical Examiner Office Knowledge Exchange

Forensic Pathology, death investigation, and fatality management knowledge exchange has been a key focus of the agency. To this end, during FY17 and FY18 to date, there have been several instances wherein the agency invited representatives of medical examiner offices to participate in facility activities/exercises/workshops and the Chief Medical Examiner and/or staff members visited other medical examiner offices.

In March 2017, The Chief Medical Examiner visited the Egyptian Ministry of Justice's Forensic Medicine Authority (FMA) to conduct training and a needs assessment with Egyptian forensic officials in Cairo, Egypt is an example of knowledge exchange between medical examiner offices on an international level. During the visit, a videoconference workshop was conducted with the Egyptian Ministry's FMA and the agency to collaborate with the Fatality Management staff, IT staff and Administrative staff. The focus was to provide a presentation on the agency's 2016 Fatality Management Symposium and Full-Scale Exercise with lessons learned. There was discussion on how to improve fatality management in Egypt, particularly in the decedent identification arena.

Another example of knowledge exchange is the agency's Second Annual Fatality Management Symposium and Full-Scale Exercise. Guests included representatives of medical examiner offices internationally, as well as nationally and within the region (i.e., Brussels, Egypt, New York, San Bernardino, and Bangladesh). Moreover, event registrants included stakeholder agencies and private entities on the local, state and federal level that have a function in emergency and incident planning and response.

On August 16, 2017, the OCME provided a tour of its facility to the Hennepin County Medical Examiner's Office, Minneapolis, MN. The Hennepin County ME is building a new facility and is reviewing premier facilities throughout the country for design, work process flow, standard operating procedure, autopsy, and laboratory setup best practices and ideas as well as challenges in building construction, and design experienced by end users. In attendance on the tour were the Hennepin County ME's Chief Medical Examiner and office administrators, as well as project architects and representatives from the design firm. The agency was able to provide a facility tour as well as have managers and line staff discuss with the tour group best practices and challenges with certain build-outs of the facility and those modifications that were made after construction to enhance process flow and operations.

d) Partnership with DOES L.E.A.P. and ORM Return to Work

The agency recognized gaps in various work processes and tasks in specific Divisions/Units wherein there were insufficient human resources to ensure management and completion in an efficient, timely, and accurate manner. As part of its strategic planning, the agency pursued a partnership with the Department of Employee Services' (DOES) L.E.A.P. **(**Learn, Earn, Advance, Prosper**)** and continued to work also with the Office of Risk Management's Return to Work Program. As a result, the agency has six employees detailed to the agency through L.E.A.P. and one through Return to Work. These employees have been working to meet identified needs within the following

divisions/units of the agency: Record/Quality Assurance Unit; Administrative Unit; Mortuary Unit; Fatality Review Division; IT Unit; and the Histology Laboratory.

e) Howard University School of Medicine Partnership

OCME and Howard University's School of Medicine have signed an agreement for Howard residents to rotate at the agency as part of their residency program. This introduces residents to the practice of forensic pathology and is critical in light of efforts to encourage physicians to enter into the field, which is currently experiencing a shortage. Such an agreement also enhances the overall partnership between the agency and Howard in overall forensic pathology, death investigation, and academic initiatives.

f) Management Leadership Training Series

In FY17, the agency implemented a Management Training Series for the purpose of enhancing the skills in operating their Divisions and Units, as well as supervision of employees. The purpose of the series was to empower managers to fully understand District and OCME procedures and protocols. Workshops included: Managing in a Union Environment; Ethics in the District; Understanding the Family & Medical Leave Act (FMLA) and Americans with Disabilities Act (ADA); and Navigating the District Personnel and OCME Employee Manuals. During FY18, the series will continue with a focus on the concept of lean operations (Six Sigma training). The series of courses was taught in FY17 by the Chief of Staff and General Counsel. During FY18, the Chief of Staff will continue with the lean concepts. The General Counsel and other managers will also participate.

g) "Going from Good to Great Initiative"

During FY18, the agency will focus on the theme: "Going from Good to Great." This initiative was implemented during the first quarter at the agency's internal all staff annual meeting with a workshop conducted by the Chief Medical Examiner. This theme incorporates the concepts of "disciplined people"; "disciplined thought"; and "disciplined action." The focus will be on moving to a workplace culture wherein these concepts serve as the foundation for effective and efficient operations and, ultimately, fulfilling the mission of the agency.

36. What are the agency's top five priorities? Please explain how the agency expects to address these priorities in FY18. How did the agency address its top priorities listed for this question last year?

The agency's top priorities are the same as in FY17, with the exception of Case Management System Implementation, which has replaced Death Pronouncement. The Rulemaking providing for remote Death Pronouncements by DC FMS EMTs is now in effect. See 29 DCMR §526, EMS Providers: Scope of Practice, Amendment to provide for remote death pronouncement (Final Rulemaking published at 64 DCR 1111 (February

3, 2017)). FEMS took over performing Death Pronouncements in the field for unattended home deaths, per their termination of resuscitation protocols in June 2017.

a) Quality

An agency top priority is to provide efficient and effective service through a quality management system supported by continuous process improvement, quality control measures, adherence to accrediting body guidelines, training, and best practices. The agency has several initiatives that fall within this priority to include: case and inventory management; document management; and professional development and career development. Moreover, there is an overall focus on the achievement of agency ISO Accreditation.

During FY17, the agency provided ISO 17020 and 17025 training for all managers. The agency hired a manager to revamp its records management unit to one of Quality Management/Records Management. In keeping with the vision to obtain ISO Accreditation, managers and toxicology laboratory staff have completed ISO 17020 and 17025 training (as noted in Question 31) and the International ISO requirements are currently being reviewed for compliance. Moreover, QA/QC operating procedures for all agency programs are being established and reviewed through the agency's QA/QC committee and the agency is developing a robust audit methodology.

With regard to document management, in FY16, the agency invested in a software document control system that provides electronic document management for the purposes of standardization and streamlining which ultimately enhances quality. During FY17, the agency focused on customizing the system to its needs; uploading all Standard Operating Procedures, Memoranda of Understandings/Agreements, Legal Documents, and other pertinent operational documents; training managers on the use of the system; and, lastly, actually using the system for document revision and review.

In FY18, the agency has contracted with a vendor to assist with developing an ISO compliant quality management system that integrates with the existing national program requirements as well as with District of Columbia law and the agency's policies and procedures. This includes the development of an ISO 17020 compliant Quality Manual; ISO pre-inspection report; and ISO accreditation application that is submission ready.

Lastly, the agency's mandate includes an academic component which provides the quality management component via human resources. This includes: 1) ensuring employees are afforded training and educational opportunities to maintain required licensures/certificates and to keep in compliance with industry standards; and 2) providing academic and fatality management training opportunities and internships to external stakeholders, residents, medical students and forensic students.

The agency will continue to enhance its quality efforts through technology, academic, and professional training and other innovative methodologies.

b) Accreditation

Agency Accreditation

The agency has been granted full accreditation by NAME effective February 16, 2016 through February 16, 2021. Each year, the agency must be accredited. In FY17, the agency received its reaccreditation, which is a review of the annual status of the agency operations, facility and standard operating procedures and a fee payment.

The agency is currently preparing for the annual reaccreditation inspection to be held in February 2018. Such preparation includes an update of Standard Operating Procedures and training of staff regarding new procedures; evaluation of the facility; and review of physical and human resources per the NAME guidelines.

Accreditation brings national recognition and status to the agency and establishes it as a national model with standard operating procedures, a physical facility, and well-trained, professional personnel that are in compliance with industry standards. This represents the highest quality of death investigation systems and provides an endorsement to District residents that the agency provides an adequate environment in which a medical examiner may practice the profession and provide s reasonable assurance that the office well serves the jurisdiction with a high caliber of medicolegal death investigation.

Forensic Toxicology Laboratory

The OCME's Forensic Toxicology Laboratory received American Board of Forensic Toxicology Laboratory (ABFT) Accreditation for the period November 1, 2015 to October 31, 2017. During the course of the accreditation, which included FY17, the laboratory provided evidence of satisfactory participation in recognized alcohol and drug-based proficiency test programs. During the first quarter of FY18, the laboratory underwent a re-inspection and was recently approved in January 2018, by ABFT, for reaccreditation from November 1, 2017 through October 31, 2019.

c) Fatality Management

Fatality and Incident planning is critical in order to ensure the safety of the residents of DC and the surrounding areas. It is important not only that gaps in emergency response and planning be recognized, but that continuous exercising of plans be conducted to ensure that emergency responders are well-trained. In this current climate of natural and man-made threats, incident planning is a priority.

Given the critical nature of fatality management and the fact that OCME is the fatality management arm of the District, the agency launched an effort during FY2016 to ensure that District agencies were equipped and prepared for emergent situations -- a city-wide Fatality Management Symposium and Exercise. The second annual Symposium and Exercise was held during FY17 from September 11-13, 2017, and again involved public safety cluster agencies (HSEMA, MPD, FEMS, OUC, DFS, OVSJG etc.), as well as other stakeholders such as DOH, OCTO and other regional

agencies that would have a role in a mass fatality incident. The symposium portion included a national and international knowledge exchange with the Belgium and Egyptian Chief Medical office, as well as specialized sessions to assess District gaps in emergency management in regard to personnel, resources, and training. The exercise provided the agencies an opportunity to utilize the OCME FMOC situational room which provided interagency communication awareness, as well as, the ability to exercise in real-time and full-scale.

Of note during FY17, the agency hired two staff persons through a UASI subgrant through the Homeland Security and Emergency Management Administration (HSEMA); one focusing on regional level incident planning and another focusing on city-wide fatality management plans, exercises, and training. First, the agency worked with local hospitals to develop their mass fatality plans and conducted tabletop fatality management exercises with the majority of hospitals.

Second, OCME staff members, including the Chief Medical Examiner, continued to participate during FY17 in the National Capital Region's Mass Fatality Working Group meeting, facilitated by DC OCME, regarding development of an Interstate Compact of regional stakeholders. Such a compact would define roles and responsibilities, and sharing of resources during a mass fatality incident. Led by the OCME's Emergency Preparedness Administrator, the stakeholders discussed the mission/goals, the concepts to be included in a possible agreement, timelines, funding, training and exercises, legal/liabilities, and next steps.

The OCME also participated in District-wide emergency response full-scale exercises and hot washes. This included the agency's forensic pathology, death investigation, mortuary, identification, anthropology, and records units; as well as agency appointed emergency liaison officers and METT team. These exercises provided the agency an opportunity to exercise its newly procured Mobile Command Unit and other emergency response vehicles/resources.

During FY18, the OCME will continue its evaluation of mass fatality and continuity of operations planning; emergency response standard operating procedures; local and regional planning and cooperation; and training and exercising. This will involve coordination with regional entities, such as other medical examiners, funeral homes, universities and hospitals, federal partners, and other stakeholders. The agency will host an internal mass fatality exercise for the purposes of continuing staff training.

d) Data Fusion Analysis Center

The agency will focus on data collection, surveillance, and analysis resulting in the promotion of public safety and health. This involves establishing scientific and technical methods and practices to identify and evaluate data in order to determine outcomes and trends in mortality statistics to improve the quality of life of District residents. This is done via the agency's Data Analysis Fusion Center ("Center") concept, which is a collaborative effort between agencies to provide and/or share data with the goal of "prevention," "detection," 'law enforcement" or other types of evaluation or analysis, particularly in the areas of public safety or health. The Center

is led by the agency's Epidemiologist who is tasked with data collection and statistical reporting of trends toward such public surveillance.

For example, the agency's mortality data is critical data that can be formatted in a manner which can provide key information to the Department of Health (DOH) for use in various "prevention" messages. Thus far, published public surveillance reports include topics such as: Opioids, Homicides, Myocarditis, Accidental Drownings, In-custody Deaths, Homelessness/Hypothermia, Public Dispositions, Infant Mortality, and Traffic Mortalities. Further, the agency IT staff has been trained in GIS mapping wherein mortality data can be utilized by public safety cluster partners. Such data analysis used in a collaborative effort within a fusion center can play a vital role in providing enhanced support services to District residents and visitors.

During FY17, the Center Director, the agency's resident Epidemiologist, worked with DOH to secure a National Violent Death Reporting System (NVDRS) five-year grant focused on violent deaths occurring in the District. Staff was hired under the grant to perform data entry for the project in order to meet grant criteria. The agency also obtained another grant – "State Unintentional Overdose Reporting System." The Center will continue its focus in FY18 on the NVDRS grant and work on the implementation of processes for the second grant.

e) Case Management System Implementation

The OCME worked during FY17 to establish a new case management system via enhancements to the existing system, which was named the Forensic Analytic Case Tracking System (FACTS). Note that the agency's case management system is the foundation to its work, as it integrates the death notification information and demographics; death investigation reports; autopsy findings (to include toxicology findings); x-rays and photographs; decedent transport; intake and release information; medical or case records disposition; and case and death certificate status. The new system is designed to address several gaps that currently exist to include: mass fatality, toxicology, and fatality review, and will improve functionality for the end user. Further, there will be improved efficiency with integrated reporting for various units and additional forms for required recordkeeping. All divisions/units of the agency have provided input to work processes. During FY18, the enhanced system will "go live."

37. Please list each new program implemented by the agency during FY17 and FY18, to date. For each initiative, please provide:

    a. A description of the initiative;
    b. The funding required to implement to the initiative; and
    c. Any documented results of the initiative.

The agency has added no new programs during FY17 and FY18, to date. Initiatives are discussed in Question 1 under this Agency Operations Sections.

38. How does the agency measure programmatic success? Please discuss any changes to outcomes measurement in FY17 and FY18, to date.

The agency measures programmatic success via comparison of performance against industry standards and guidelines; evaluation of metrics determined within its performance plan; and review of financial management against programmatic performance. The agency is able to obtain the minimum standards and guidelines of operation for medicolegal death investigation, forensic pathology, histology, forensic toxicology, anthropology, and other services performed from those professional and peer-review organizations that provide accreditation, professional training, and oversight of these particular disciplines and industries. These include the National Association of Medical Examiners (NAME), American Board of Forensic Toxicologists (ABFT), American Board of Medicolegal Death Investigators (ABMDI), and the American Board of Forensic Anthropologists (ABFA), amongst others.

As stated above, the agency is fully accredited by NAME and the forensic toxicology laboratory is accredited by ABFT. Further, the agency forensic pathologists are members of NAME and are board-certified, the Chief Toxicologist is certified by ABFT, and the medicolegal death investigation staff and our forensic anthropologist are certified by ABMDI and ABFA. These accreditations and certifications are ongoing and must be renewed, which demonstrates not only programmatic success but the expertise of the staff members that must operate such programs in order to maintain and operate them.

Further, the agency measures programmatic success via the agency's performance management schematic, which uses evidence from measurement to support governmental planning, funding, and operations. The purpose of the program is to allow managers to recognize success, identify problem areas, and respond with appropriate actions in order to better serve the public. The Performance Management framework focuses on collecting, analyzing, and reporting on strategic objectives, initiatives, and key performance indicators set forth in an agency performance plan. Managers report quarterly on the status of initiatives and whether they are meeting their targets on key performance indicators. Year-end results are recorded in the form of Public Accountability Reports (PARs). The PARs provide an overview of the agency's top accomplishments and programmatic success.

Significantly, benchmarking is a process that is also vital to measuring the agency's performance. Within the death investigation, forensic pathology, and forensic toxicology arenas, this is done via conference attendance, referral to industry and academic journals, forming partnerships with agencies internationally and nationally for knowledge exchange, as well as personal academic relationships. Agency practitioners are charged with ensuring that they individually are trained in up-to-date industry standards and best practices and ensure that their staffs are also on the same track. Performance success is measured by evaluating benchmark statistical measures between analogous agencies utilizing best practices.

Financial management plays a vital role in evaluating programmatic success. The agency has developed budgetary standard operating procedures that include manager meetings on a routine basis with the executive team, which includes the agency fiscal officer. The

purpose of the meetings is to evaluate day to day programmatic operations with the status of budget and procurement line items, as well as needs and/or challenges. The executive team then conducts meetings to evaluate operations, the budget, procurements, and any issues in order to ensure continuity of operations and, ultimately, programmatic success. In essence, programmatic success is being measured on a consistent basis throughout the fiscal year via such operational and fiscal management meetings.

Lastly, the agency Executive Team plans and evaluates the performance of employees, including managers, to gauge programmatic success, in that agency operations are only efficient and effective if employees are meeting their individual performance goals. Such goals are aligned with the agency strategic plan and performance plan. As such, employee performance management and agency performance management are looked at simultaneously and provide a guide to the success of the overall agency program.

39. What are the top metrics regularly used by the agency to evaluate its operations? Please be specific about which data points are monitored by the agency.

As discussed in Question 38, to evaluate its operations, the agency utilizes the District's performance management schematic, which uses evidence from measurement to support governmental planning, funding, and operations. The purpose of the program is to allow managers to recognize success, identify problem areas, and respond with appropriate actions in order to better serve the public. The Performance Management framework focuses on collecting, analyzing, and reporting on strategic objectives, initiatives and key performance indicators set forth in an agency performance plan. Managers report quarterly on status of initiatives and whether they are meeting their targets on key performance indicators and year-end results are recorded in the form of Public Accountability Reports (PARs). The PARs provide an overview of the agency's top accomplishments and programmatic success in meeting objectives and key performance indicators and completing initiatives and rationales.

Within the performance management schematic, the agency has identified key performance measures which are based on NAME accreditation guidelines, District protocols, and agency policies and procedures. Standard measures are as follows:

- Percent of all reports of postmortem examinations completed within 90 calendar days from the time of autopsy in all cases;

- Percent of mortuary/transport service scene response within one hour of transport notification by an investigator or medical examiner of an accepted case;

- Percent of toxicology examinations completed within 90 calendar days of case submission;

- Percent of toxicology examinations completed within 60 calendar days of case submission;

- Percent of forensic pathologists (medical examiners) that are board certified or board eligible;

- Percent of public dispositions ready for release within 45 days;

- Percent of decedent cases identified in 5 days;

- Percentage of preliminary investigative reports presented at the morning meeting containing sufficient detail for the Medical Examiners to determine the type of postmortem examination;

- Percent of Child Fatality Review Committee (CFRC) fatality reviews held within six months of notification of the death;

- Percent of Developmental Disabilities Fatality Review Committee (DDS) fatality reviews held within three months of receipt of the investigative report from the Department of Human Services (DHS)/DDS and determination of the cause and manner of death; and

- Percent of agency employees completing a mass fatality training annually;

The metrics are monitored and reported upon on a quarterly basis and the year-end result included in the PAR. The quarterly monitoring provides the agency an opportunity to make improvements in operations when the measure is not met and to memorialize procedures and standards when the measure is met.

40. Please list the task forces and organizations of which the agency is a member.

- National Association of Medical Examiners (accredited)
- American Board of Forensic Toxicologists (accredited)
- International Association for Identification – Forensic Photography Certification
- International Association for Identification - Membership
- American Academy of Forensic Science
- Society of Forensic Anthropologists
- National Institute of Standards and Technology - The Organization of Scientific Area Committees for Forensic Science Anthropology Subcommittee
- Adjunct Graduate Faculty, Department of Anthropology, Texas State University, San Marcos Clinical Assistant Professor, George Washington University, School of Medicine and Health Sciences
- District of Columbia Sexual Assault Response Team (DC SART)
- ARMA International's (formerly known as Association of Records Managers and Administrators); Greater Washington DC Association of Records Managers and Administrators (GWDC ARMA
- Volunteer Faculty – George Washington Department of Pathology
- Volunteer Faculty – Howard University Department of Surgery

41. Please explain the impact on your agency of any legislation passed at the federal level during FY17 and FY18, to date, which significantly affected agency operations.

There is no impact on the agency of any legislation passed at the federal level during FY17 and FY18, to date, which significantly affected agency operations.

42. Please describe any steps the agency took in FY17 and FY18, to date, to improve the transparency of agency operations.

The OCME participates in the Administration's Performance Management Program which uses evidence from measurement to support governmental planning, funding and operations and provides transparency in agency operations. The purpose of the program is to allow managers to recognize success, identify problem areas, and respond with appropriate actions in order to better serve the public. The Performance Management framework focuses on collecting, analyzing, and reporting on strategic objectives, initiatives, and key performance indicators set forth in an agency performance plan. Not only are the performance plans placed on the District government website for public review but agencies provide quarterly reporting on status of initiatives and whether they are meeting their targets on key performance indicators. Further, year-end results on the performance plans in the form of Public Accountability Reports (PARs) are also published. The PARs provide an overview of the agency's top accomplishments based on performance in meeting objectives and key performance indicators and completing initiatives and rationales.

The agency has also improved transparency of its operations through the utilization of a modernized website. In FY16, the agency revamped its website to ensure that all agency and fatality review committee annual reports were uploaded; to include a public surveillance report section; and to provide a more enhanced OCME informational section. In FY17, the agency utilized the informational section to upload all Data Fusion Center reports for public/media review. Agency and fatality review annual reports are also available on the website for public review. The agency also responds to all public inquiries that are forwarded through the website within 24 hours, which requires efficiency and knowledge of agency operations.

The agency also participates in any audit and or study requested or conducted by the Office of the Inspector General and/or Office of the D.C. Auditor (ODCA). Note, as discussed above, that the agency has in the past requested OIG to conduct an evaluation in order to prepare for its accreditation. During FY17, the agency participated in a study of the Child Fatality Review Committee by the Office of the Auditor and in FY18, will work with the Auditor's Office to complete an audit of the Domestic Violence Fatality Review Board. Both of these projects are discussed in Question 20.

Lastly, the agency conducts operational tours for D.C. Councilmembers, law enforcement, judges, and prominent figures. This mandates that the agency managers ensure that their divisions and units remain in an acceptable state for review at any given moment.

43. Please identify all electronic databases maintained by your agency, including the following:

a. A detailed description of the information tracked within each system;
b. The age of the system and any discussion of substantial upgrades that have been made or are planned to the system; and
c. Whether the public can be granted access to all or part of each system.

FACTS/Case Management System

a. The CMS is used to track each OCME case, from initiation through decedent release, capturing all elements of death investigation and determination of cause and manner of death.
b. The system has been online for more than a decade and has undergone several upgrades and new iterations. The latest iteration is currently in acceptance testing for immediate deployment.
c. Given the sensitive nature of the data gathered and stored in this system, it is not available for public access.

PACS (Picture Archiving & Communication System)

a. The PACS is a digital radiology platform which stores digitally capture radiographs from the various modalities at the OCME. It allows complex analysis of radiographs and includes OCME case numbers and decedent demographics for each image.
b. The system has been online for more than a decade and has undergone several upgrades. The latest upgrade is the most current vendor offering with no plans for further upgrade.
c. Given the sensitive nature of the data gathered and stored in this system, it is not available for public access.

Toxicology Database

a. Similar to the OCME case management system, the toxicology database houses toxicology case data for all toxicology cases (OCME and external). It is an MS Access database, designed in-house, and is used to assign, track, and manage all toxicology processes performed in the laboratory.
b. In lieu of having a comprehensive LIMS (Laboratory Information Management System), the database has been online for more than a decade, designed and managed by the Chief Toxicologist.
c. Given the sensitive nature of the data gathered and stored in this system, it is not available for public access.

GigaTrak Asset Tracking System

a. GigaTrak is used to track OCME fixed assets, including (but not limited to) all computer hardware (desktop & server), mobile devices (tablets and cellphones),

equipment, and vehicles. Information such as procurement details, maintenance schedules, item location, and property disposition are all stored in this system.

b. The system has been online for two years. The version in production is current with no plans for upgrade.
c. Although not directly accessible to the public due to network security and firewall considerations, the information within this data set has and can be made available to the public through an official FOIA request.

SurgiCare Inventory Management System

a. SurgiCare is used to track and manage OCME's consumable and perishable inventories, such as copier toner, body bags, and laboratory supplies & chemicals. It is heavily populated with corresponding information from the PASS procurement system, allowing easier management of vendors and purchase orders, while also providing robust reporting and usage analytics.
b. The system has been online for four years and has undergone several updates and custom enhancements. The current version is not scheduled for upgrade.
c. Although not directly accessible to the public due to network security and firewall considerations, the information within this data set can be made available to the public through an official FOIA request.

Qualtrax

a. Qualtrax is a quality control and compliance management system used to track and manage many of OCME's processes, policies, and workflows. It is directly related to the agency's accreditation efforts and is managed by the Quality Assurance Officer.
b. The system has been online for three years and has undergone several vendor updates. The current version is not scheduled for upgrade.
c. Although not directly accessible to the public due to network security and firewall considerations, the information within this data set can be made available to the public through an official FOIA request.

44. Please provide a detailed description of any new technology acquired in FY17 and FY18, to date, including the cost, where it is used, and what it does. Please explain if there have there been any issues with implementation.

A description of new technology acquired in FY17 and FY18 is as follows:

Cisco VTC Enhancements:

The agency acquired and implemented one additional Cisco Video TelePresence unit, while upgrading two others.

The first upgraded Cisco codec (Cisco SX20) was deployed as a replacement for the unsupported component in the autopsy viewing theater with a cost of $9,800 (not including labor and accessories), which allows the recording and/or video transmission of procedures conducted in the theater. A new Cisco SX20 was deployed in the autopsy documentation suite at the cost of $9,800 (not including labor and accessories). This upgrade addressed the need to have full visibility in this area, as it acts as the OCME disaster morgue and is an integral part of the emergency response plan. The total cost, including installation, licensing, accessories, and electrical work for both Cisco units was $35,368.33.

The second upgraded Cisco codec (Cisco SX80) was deployed in the main conference room with a cost of $17,500 (not including labor and accessories). Additionally, this conference room underwent extensive modifications, included the removal of the existing projector and projector screen, as well as the addition of several monitors and interactive displays, custom controllers, and other peripherals. As a total solution, it transforms the space into an interactive media center with enhanced video teleconferencing capabilities while capitalizing on the District's existing Cisco infrastructure. The total cost of these enhancements was $74,000.

Sharp Interactive Display – Autopsy Suite:

The agency acquired two new Sharp Interactive Aquos Displays as replacements for antiquated SmartBoard technology. This solution provides optimum visibility for examining radiographs during autopsy, while also affording touchscreen capabilities and remote display control through mobile devices. It works seamlessly with WebEx for content sharing & collaboration and features built-in dual-core Windows client software. The total cost of this enhancement was $20,300 and includes unlimited service and end-user training for the life of the warranty.

45. How many in-person training programs took place in FY17 and FY18, to date?

- American Society of Crime Laboratory Directors Laboratory Accreditation Board- The Corrective Action Process: Root Cause Analysis Basics. November 29- December 2, 2016. 8 hours, Web-based, 2016

- ISO/IEC 17020 and Audit Preparation for Forensic Agencies. Provided by ANAB. August 17-18, 2017. 16-hour course, 2017

- Communication Strategies to Mitigate Bias and Strengthen Scientific Foundations in Forensic Sciences at the 69th Annual Scientific Meeting of the American Academy of Forensic Sciences, 2017.

- Forensic Sciences at the 69th Annual Scientific Meeting of the American Academy of Forensic Sciences – approximately 20 hours of presentations, 2017

- "Sudden Unexpected Infant Death: What's My Role?" Conference, October 25-26, 2016. The course was attended by over 50 participants from the following agencies: MPD, DC OCME, DC CFSA, Wendt Center for Loss and Healing, CNMC, USAO, PG County Detectives, and Safe Shores (Program attached).

- OCME "Homicide School" conducted on November 9-10, 2016. Attended by 22 detectives from the Metropolitan Police Department Homicide Branch. (Program Schedule attached).

- American Academy of Forensic Sciences Annual Meeting, New Orleans, LA, February 2017.

- Certification & Recertification Exam Review, Physician Assistant Review Panel, Arlington, VA, March 2017
- Masters 17 Advanced Death Investigators Conference, St. Louis, MO, July 2017

- NARA Records Management Certification Training, May 2-3, 2017; May 8-5, 2017; May 15-17, 2017

- Knowledge Area's 1-6: Overview of Records Management; Creating and Maintaining Agency Business; Records Scheduling; Asset and Risk Management; Records Mgmt. Development, July 10-14, 2017; July 18-19, 2017; July 24-26, 2017

- ARMA LIVE 2017 Conference, October 2017

- Qualtrax User Conference, September 21, 2017

- Toxicology
Cross Training Program combining lectures, hands-on demonstrations, and proficiency testing in order to authorize team members to handle and perform chemical tests on forensic casework. The program is governed by a training manual which guides the process.

Digital Equipment:
- In-House Digital Fingerprint Training/Pilot, March 2017
- PACS Digital Media Archiving/Annotation System Training, April 2017

Mass Fatality Management:
- In-House Mass Fatality Fixed Disaster Morgue Training/Symposium, September 2017
- In-House Mass Fatality Mobile Disaster Morgue Training, July 2017
- DC-OCME Fatality Management Symposium and Training, 2017

Forensic Photography:
- Miami Dade International Forensic Photography Workshop, October 2016

- In-House Forensic Photography Training, September 2017

Quality:
- ISO 17020 Training, August/September 2017
- Root Cause Analysis Training, December 2016

Safety:
- In-House CFL Safety Trainings (Level I, II, III)

- Department of Human Resources (DCHR) Online and In-Person Trainings

46. What training deficiencies, if any, did the agency identify during FY17 and FY18, to date?

The agency did not identify any training deficiencies during FY17, nor during FY18, to date.

47. Please describe the major activities of the fatality review committees in FY17 and FY18, to date.

During the 2017 review year, the CFRC continued the hard work of cultivating and socializing robust recommendations, building upon external collaborations with District Government agencies, and developing an annual report that can be used as a tool to address public health issues that impact outcomes for the District's most vulnerable populations. The combined expertise of the OCME FRU staff, CFRC members, and participants paved the way for several outreach initiatives originally planned in 2016 and launched in 2017. Some of these achievements are as follows:

- The CFRC members participated in a series of live and web-based trainings to learn more about the social and mental health implications associated with youth homicides. As a result of multiple cases reviewed in 2017, the Committee agreed to continue its focus on school attendance and truancy, which is a national leading risk factor associated with youth homicides. OCME FRU Staff also collaborated with OSSE to improve its process of data extraction as well as consulting with OSSE administrative staff on the purpose of the CFRC and its recommendations. Looking forward to 2018, the OCME and the CFRC will continue its collaborative efforts with government agencies and community based providers to address the needs of District residents.

a. Please ask the Mayor's Office of Talent and Appointments to provide information about the appointments, names, terms, vacancies, and wards of residence of the committee members who are currently serving.

To be provided by MOTA. Please provide data on attendance for all committee meetings in FY17 and FY18, to date.

b. Please provide information on committee staffing, including a description of the job responsibilities of that staff member.

The Fatality Review Division, which provides support to the fatality review committees, consists of the following staff and duties:

Supervisory Fatality Review Program Manager: Jenna Beebe-Ayre
The purpose of this position is to provide overall management, oversight, and full execution of all services and responsibilities associated with all mandated Fatality Review (FR) functions established within the District of Columbia. As the Administrator, the incumbent is responsible for providing leadership and direction in the execution of all fatality review functions, including planning, coordinating, and implementing fatality review activities in accordance with appropriate legislation, policies, and procedures.

Senior Fatality Review Specialist: Tracie Martin
This position plans and coordinates special project and presentations; conducts national and local research, gathers, analyzes, and correlates data; and prepares summaries of findings for review. The incumbent assists with development and implementation of plans, policies and procedures and other operational modules for fatality review. The incumbent plans and coordinates case review meetings to meet the criteria as mandated by statute and Mayor's order toward the purpose of reviewing history, cause and manner of death and involvement of service organizations with specified populations. The incumbent works with supervisor in the development of annual reports.

Fatality Review Program Specialist: Jacqueline Corbin Armstrong
The incumbent coordinates and plans case reviews for specified populations; organizes and provides timely notification of meetings; and ensures adequate meeting preparation. The incumbent reviews and analyzes complex medical records from various public and private programs that were involved with decedents and their families prior to or at the time of death. The incumbent compiles information from records based on in-depth knowledge of and familiarity with medical terminology, diagnosis and treatment. The incumbent develops final reports from review meetings to include findings, statistics and recommendations and compiles data from all reviews conducted for future analysis in annual reports.

Staff Assistant: Toya Byrd
The incumbent gathers relevant information, including confidential law enforcement, hospital, and other documents, to assist in determining the case/review type. The Incumbent maintains a log of cases, including, at a minimum, the case number, date of death, cause of death, type of review, and date the review is required. The Incumbent works with their District vital records counterparts to ensure access to pertinent birth/death certificates

services information and the effective coordination of other FRD related services and program requirements.

c. Please provide metrics on the progress of committee goals detailed in annual reports, including information about times that the agency incorporated committee recommendations into its operations.

This question is not wholly applicable as there have not been "committee goals" detailed in annual reports. However, during FY16, the agency implemented a 2015 annual report initiative to conduct community outreach to discuss recommendations related to sudden unrelated infant deaths and youth violence. The agency hired an Outreach Specialist via a subgrant from the Office of Victim Services and Justice Grants. Through grant funding, the OCME FRU Outreach Specialist convened multiple community based group meetings to address the needs of victims of violence in Ward 8.

d. Please provide information on when OCME declined to incorporate suggestions of the annual reports, and why.

OCME FRU Staff continued to work diligently and collaboratively with CFRC members to complete annual reports that presented a full picture of the data compiled. This applied to 2016 case review meetings and adopted recommendations. Most importantly, the Committee discussions provided in the 2016 annual report represent information taken directly from meeting minutes approved by the Committee. Draft versions of the report were reviewed by members of the Committee, who were provided with an opportunity to make suggestions for edits. These edits were incorporated, and the Committee voted to approve the final version of the 2016 CFRC Annual Report on September 28, 2017.

e. Does OCME work with other District agencies to help incorporate Committee recommendations? If so, please describe how.

Collaborations with OCME, USAO, NIH, DOH, CFSA and Medicaid Managed Care Organizations led to the facilitation of the October 19, 2017 Safe Sleep Symposium. Held at the Malcolm X Recreation Center, residents learned about preventing Sudden Unexplained Infant Deaths (SUID). This was the first time the Committee focused its outreach to residents of Ward 8, a community with the highest rate of SUID in the District of Columbia.

48. Please describe OCME's involvement in the Domestic Violence Fatality Review Board now that the Board has moved to the Office of Victim Services and Justice Grants.

The agency has a position on the Domestic Violence Fatality Review Board but oversight of the Board is under the purview of the Office of Victim Services and Justice Grants.

49. How many cases were reported to OCME in FY17 and FY18, to date?

Reported to OCME	# of Cases
FY 2017	6,722
FY 2018 (YTD)	1,783

a. Of those cases, in how many did OCME accept jurisdiction? How many of those cases accepted were autopsied?

Accepted Cases FY17: 1418
Accepted Cases FY18 (YTD): 332

b. Of those cases, how many were declined? How many of those cases declined became storage requests?

Declined Cases FY17: 1916
Declined Cases FY18 (YTD): 536

Please see answer to 49(c) for information on storage requests.

c. How many cremation requests were received in FY17 and FY18, to date?

Cremation Cases FY17: 3206
Cremation Cases FY18 (YTD): 755

Case Decision	# of Cases in FY2017	# of Cases in FY2018
Accepted	1418	332
Declined	1916	536
Storage, previously declined	59	22
Cremation requests	3206	755

50. How did the creation of the Medical Examiner Transport Team ("METT") change or improve upon the agency's operations in FY17 and FY18, to date?

As discussed above, the agency continued plans to augment its Medical Examiner Transport Team (METT), within the Mortuary Unit, which consists of a team of agency staff to perform body transport (livery) services. The implementation of the METT

concept provided the District the ability to become self-sufficient in body transport without the wholesale dependency on any one vendor. In addition to the current services provided by the existing vendor, which only include body transport, the significant advantage to a METT includes the ability to perform: fleet maintenance; decedent intake and release; fatality management response logistics; post-mortem radiology and identification; supply inventory and tracking; and mortuary qa/qc processes. Further, the formation of the METT fulfills the standards established by National Association of Medical Examiner (NAME) Accreditation Guidelines for proper body handling during day to day case response, as well as in a mass fatality.

During FY17, the METT was expanded from a team of four to twelve. First, four staff were hired as part of a FY17 enhancement. Second, the agency requested and received approval to hire four additional staff (for METT) during FY17 that were slated as FY18 FTE enhancements. These actions resulted in a team of twelve, as required for full implementation. With 12 staff, the agency noted a change in the number of in-house versus vendor transports with over 80% completed by METT. The agency's response to death scenes with the use of METT averaged about 40 minutes versus approximately 67 minutes with the vendor. The agency's Key Performance Indicator (KPI) is to respond to 90% of scenes within an hour.

The agency has also been able to expand hours and increase the number of decedent releases to funeral homes per hour. This has increased the number of cases released per day from an average of four to an ability to release twelve per day. This results in shorter wait times for families to receive their loved ones.

a. Is the METT now fully staffed?

   The METT is staffed sufficiently to allow for operations 24 hours, 7 days a week. The agency continually evaluates the effectiveness and efficiency of the body transport function and will seek adjustments as necessary.

51. How many scenes did OCME visit in FY17 and FY18, to date?

    In FY17, the OCME visited 955 scenes and in FY18 has visited 182, to date.

52. How many organ donation requests were received during FY17 and FY18, to date?

    In FY17, the OCME received 8 organ donor requests and has received 23 in FY18, to date.

53. How many post-mortem examinations did OCME perform in FY17 and FY18, to date?

    See the Table in Question 54 below.

54. Please list all medical examiner cases in FY17 and FY18, to date, by manner of death and type of case.

Manner	Exam Type	# of Cases in FY2017	# of Cases in FY2018
Accident	Autopsy	473	44
	Autopsy (at hospital)	1	0
	External Exam	131	24
	Review of Med. Rec.	16	6
Homicide	Autopsy	128	32
	External Exam	0	0
Natural	Autopsy	298	43
	External Exam	245	66
	Review of Med. Rec.	3	0
Suicide	Autopsy	59	7
	External Exam	2	0
Undetermined	Autopsy	37	1
	External Exam	0	0
Pending		19	102
TOTAL		**1412**	**325**

55. Please describe the agency's activities relating to mass fatality incidents in FY17 and FY18, to date.

The agency's activities relating to mass fatality incidents for FY17 included its Second Annual Fatality Management Symposium and Full-Scale Exercise held September 11-13, 2017. Guests included representatives of medical examiner offices internationally, as well as nationally and within the region (i.e., Brussels, Egypt, New York, San Bernardino, and Bangladesh). Moreover, event registrants included stakeholder agencies and private entities on the local, state, and federal level which have a function in emergency and incident planning and response. OCME, along with sister agencies and federal agencies such as the FBI successfully completed tabletop and full exercises based on active shooter and explosion incidents.

The agency has formed stakeholder partnerships with several District and regional agencies. For example, through its participation in the MCOG, the agency has worked to

coordinate fatality management planning, resource utilization and training; and exercises for the agency, first responders, and other critical entities involved in emergency response and incident management. Overall, the agency conducted twelve mass fatality exercises in FY17 to include eight exercises with DC area hospitals to prepare them for a large influx of fatalities. The agency conducted a mass fatality incident exercise in and for the sates of Maryland and Virginia as part of a greater National Capital Region (NCR) preparedness effort.

The Chief Medical Examiner, Emergency & Safety Administrator, and Chief Information Officer also visited the Las Vegas Coroner's Office between December 12-14, 2017. The purpose of the visit, following the recent mass fatality incident was "knowledge exchange" in the areas of procedures and protocols, resources utilized and staffing matters related to death investigation, victim identification, and information technology. The focus of the visit was overall emergency preparedness as related to the mass fatality plans of the District, OCME and its stakeholders (i.e., public safety and justice cluster agencies, hospitals and other entities).

The US Department of Defense Intelligence Agency (DIA), located out of JBAB in DC, also toured and discussed with the agency a collaboration between the two agencies on fatality management planning, training, and exercises.

The agency also partnered with the Egyptian Ministry of Justice's Forensic Medicine Authority to conduct training and a needs assessment with Egyptian forensic officials in Cairo, Egypt. A videoconference workshop was facilitated between the agency and the Egyptian Ministry's FMA to collaborate with the Fatality Management staff, IT staff, and Administrative staff. The focus was to provide a presentation on the OCME's 2016 Fatality Management Symposium and Full-Scale Exercise with lessons learned.

The activities during FY17 provided the experience and knowledge base, as memorialized in "after action reports," to enable the agency to update the District-wide Mass Fatality Management Plan. The agency is currently in the process of drafting an NCR Regional Mass Fatality Management Playbook with regional and federal partners.

a. Were there any procedural changes that took place in response to the "Chief Medical Examiner Amendment Act of 2017" that was passed in the FY18 Budget Support Act?

The Chief Medical Examiner Amendment Act of 2017 was effective December 17, 2017. The agency is currently undergoing the annual standard operating procedures review process. Changes to procedures or policies based upon this new statutory requirement will be incorporated as appropriate.

56. How many cases did the Forensic Toxicology lab test in FY17 and FY18, to date?

The Forensic Toxicology laboratory tested 1,941 cases in FY2017 and 462 cases in FY2018, to date.

a. Please provide a chart broken down by types of cases tested in the lab.

Type of Case	FY2017	FY2018
Postmortem	1375	324
DUI	439	109
DFSA	127	29

b. Please provide information about OCME's role in the Synthetic Drug Surveillance Initiative, and report on any findings.

The OCME did not have any role in the Synthetic Drug Surveillance Initiative in FY17. However, the laboratory continues to test for both synthetic cannabinoids and fentanyl analogs in its routine casework.

57. Please report on the findings of the Data Fusion Center in FY17 and FY18, to date.

The Data Fusion Center has continued to be asset to the agency in the identification and monitoring of mortality trends. This includes developing several special reports highlighting concerns to District residents. One example is the Opioid-related Fatal Overdoses special report, which is still one of the agencies most sought after data sources. The Opioid-related Fatal Overdoses special report has highlighted the continual increase in opioid overdoses since 2014.

In addition, the Data Fusion Center has been instrumental in overseeing the agency's grant related projects. This includes the National Violent Death Reporting System and the Enhanced State Surveillance of Opioid-Involved Morbidity and Mortality (ESOOS) grants. Both of these grants are funded by the Centers for Disease Control and Prevention and involve a comprehensive and systematic collection of violent death and opioid overdose data.

58. What was the agency's involvement in Safer, Stronger DC initiative in FY17 and FY18, to date?

The agency's Chief Medical Examiner provided consultation and guidance to the Safer Stronger DC Initiative in FY 17 and FY 18, to date. This included regularly attending meetings with the Mayor and EOM. The Chief Medical Examiner also served on the application panel and helped identify the Executive Director for the newly created Office of Neighborhood Safety and Engagement.

59. How does the agency envision its role in violence prevention, intervention, and response?

The agency routinely performs an independent examination of all deaths of a violent or suspicious nature. Given the agency's role in the city, we envision we will continue to

identify trends in violent death and disseminate the information to key stakeholders in the public health and safety cluster that can develop effective prevention and intervention strategies. This will include a focus on all forms of violence, including homicide, suicide, intimate partner violence, etc. As an example of our dedication to these efforts, the agency was a primary contributor to the legislation submitted to Council for the creation of the Violence Fatality Review Committee. See "Violence Fatality Review Board Act of 2017" (B22-0266, Title II, Section. 101 of the "Victim Services Omnibus Amendment Act of 2017" (introduced April 28, 2017)).

In addition, we envision continuing to provide trainings and other collaborative efforts with the Metropolitan Police Department and the Office of Neighborhood Safety and Engagement. The agency's Homicide School is an example of one training the agency has provided in the past to MPD and other public safety partners.

60. How does the agency conduct multi-agency reviews of homicides? Please describe any relevant MOUs.

The agency is statutorily mandated to investigate all violent deaths occurring in the District for the determination of cause and manner of death, including homicides. There is no multi-agency review that occurs to meet this mandate.

61. Please describe the agency's contract with the Wendt Center and the services provided under the contract.

The Wendt Center's RECOVER program continued to work collaboratively with the Office of the Chief Medical Examiner to support the community through the process of decedent identification by providing crisis and early intervention bereavement support, education, and resources to all individuals who come to the office to complete decedent identification. The RECOVER staff works closely with the OCME staff as policies change and to best meet the needs of families in the community. Ensuring a positive identification and the emotional well-being of surviving family members are both of critical importance. Recognizing the impact of vicarious trauma, monthly stress release workshops and the option to schedule 1:1 support sessions continued to be offered to all OCME staff members.

The RECOVER team is comprised of counselors, social workers and masters graduate interns who are trained in grief, trauma, loss and crisis intervention. Staff counselors are present at the OCME 7 days a week, 365 days a year to provide support, education and resources to individuals and families as they navigate the decedent identification process. The RECOVER staff believes in empowering survivors through education, normalization, and compassionate emotional support. All individuals completing decedent identifications are treated with respect and dignity. Staff counselors work closely with OCME investigators, Identification Unit staff, and medical examiners to provide families with appropriate and helpful information in an effort to decrease the anxiety and stress that can often accompany sudden death and the identification process. Staff assists families in thinking about next steps, preparing children for funerals, and recognizing acute reactions to crisis and trauma. It is within the identification suite that

RECOVER staff will often teach individuals grounding and stabilizing techniques to manage the overwhelming feelings experienced during an ID.

RECOVER Staff provided informational packets and support to family members who present to complete identifications on site. The informational packets provide families with a better understanding of the policies and procedures of the OCME, how to talk to children and teens about trauma, understanding grief and loss, preparing for a funeral or memorial service, accessing a community based vigil program, identifying common reactions to death, identifying concrete recommendations for taking care of oneself after a death and identify resources to help deal with crisis, burial assistance and social services. Informational handouts have been made available in both English and Spanish. Follow up letters and phone calls are made to the majority of families for continuity of care and to increase awareness of the continued impact of trauma and grief beyond the identification.

Each month, a RECOVER staff counselor facilitates a staff stress relief session to OCME staff. Sessions provide educational material on issues including vicarious trauma, loss, self - care, stress, mindfulness and grief. Utilizing art, music, food and talk, staff members are invited to explore the impact on their body, mind and spirit of working in a high stress environment and learn healthy ways of taking care of themselves. Outreach is made to staff members whose schedules do not allow attendance at the support sessions in an effort to make certain support is given to all individuals who work within the agency. Outside of the group support, staff has the opportunity to request 1:1 sessions to debrief about difficult situations and emotional experiences.

62. Please describe the agency's process for handling unclaimed bodies, including where the remains are subsequently buried.

The OCME arranges a public disposition (cremation and subsequent burial of cremains) for all unclaimed decedents (D.C. Official Code § 5-1411(c) and 28 DCMR §§ 5007.1(j) and 5004.2). The cremains of several individuals are buried in a single casket. The most recent burial of cremains was April 16, 2016 in Bethel Cemetery, Alexandria, VA. The cremains of 91 individuals were buried. Also, a single decedent (unclaimed 14-year old) was buried in Bethel Cemetery, Alexandria, VA on October 31, 2017.

a. Please provide information about how many unclaimed bodies the agency has dealt with in FY17 and FY18, to date.

In FY17, 191 unclaimed decedents were released for public disposition. In FY18, no decedents to date have been released for public disposition. Note that 59 decedents were eligible for public disposition as of December 26, 2017.

63. Please provide digital copies of all Developmental Disabilities Fatality Review Committee reports to date and make these reports accessible to the public on the agency's website.

Copies of the Developmental Disabilities Fatality Review Committee from calendar years 2001-2011 are available on the agency's website at https://ocme.dc.gov. There are no reports after 2011. Digital copies of reports are provided as Attachment F.

64. Is the agency compliant with Section 211 of the Sexual Assault Victims' Rights Act of 2014, effective November 20, 2014 (D.C. Law 20-139; D.C. Official Code § 4-561.11)?

    The agency is compliant with Section 211 of the Sexual Assault Victims' Rights Act of 2014. In FY2017, the agency completed 95.7 % of DFSA casework within 90 days of submission (Section 202 of § 4-561.11) and continues to publish the time it took each sample to be processed in the OCME annual report (Section 211 of § 4-561-11).

Sincerely,

/s/

Roger A. Mitchell
Chief Medical Examiner

CC: Office of the Deputy Mayor for Public Safety and Justice
Office of Policy and Legislative Affairs

ATTACHMENT A

OCME Organizational Chart

as of 1/10/18

D.C. OFFICE OF THE CHIEF MEDICAL EXAMINER

Chief Medical Examiner, Roger A. Mitchell, Jr., MD
Agency Fiscal Officer, Leautry Dixon
General Counsel, Mikelle DeVillier, Esq.
Emergency Response & Safety Admin, Donell Harvin
Epidemiologist, Chikarlo Leak, PhD
Special Assistant

FORENSIC TOXICOLOGY DIVISION

Chief Toxicologist, Lucas Zarwell
Deputy Chief Toxicologist, Samantha Tolliver, PhD
Program Analyst

Forensic Toxicologist (Breath Program Mgr)
Forensic Toxicologists (QA/QC Mgr)

Forensic Toxicologists (7)
Laboratory Support Specialist
Program Analyst

Grant Funded Positions:
- DDOT/DUI (2)
- OVS/DFSA (2)

DEATH INVESTIGATION & CERTIFICATION DIVISION

Deputy Chief Medical Examiner, Francisco Diaz, MD
Pathology Coordinator

Forensic Pathology Unit
Medical Examiners (6) – Vacant

Anthropology Unit
Forensic Anthropologist, Jennifer Love, PhD
Customer Service Representative
Intake Assistants (5)

Histology Laboratory
Medical Technologist

Death Investigation Unit
Sup. Medicolegal Investigator, Daniel Morgan
Lead Medicolegal Investigator, Denise Lyles
Medicolegal Investigators (3)
Forensic Investigators (8)

Mortuary Unit
Supervisory Pathologists' Assistant, Elizabeth Betts
Lead Forensic Autopsy Assistant
Pathologists' Assistants (2)
Autopsy Assistants (4)
Lead Forensic Photographer
Forensic Photographers (2)
Mortuary Technicians (12), Vacant

ADMINISTRATION DIVISION

Chief of Staff. Beverly Fields, Esq.
Executive Assistant

Human Resources Unit
Management Liaison Specialist

IT Unit
Chief Information Officer, Michael Coleman
IT Specialist (Customer Service)
ORM Return to Work Position

Contracts & Procurement Unit
Management Services Officer, Vacant
Program Analyst
Support Services Specialist

Records Management Unit
Sup. Quality Control/Records Manager, Anna Francis
Quality Control & Records Management Specialist, Vacant
Records Management Specialists (2)
Quality Control Specialist

FATALITY REVIEW DIVISION

Supervisory Fatality Review Program Manager, Jenna Bebbe

Child Fatality Review Committee
Developmental Disabilities Fatality Review Cmt

Sr. Fatality Review Specialist
Fatality Review Specialist
Staff Assistant

Grant Funded Position:
OVS/MSAB

LEGEND

Senior Personnel	Names Included
Total # of FTEs	93
Filled FTEs	89
Vacant FTEs	4 *Death Investigation & Certification Division: - Medical Examiner - Mortuary Technician +Administration Division - Management Services Officer - Quality Control & Records Management Specialist
Frozen	0

PUBLIC SAFETY AND JUSTICE AGENCY
FY 2018 SCHEDULE A
Office of The Chief Medical Examiner
As of December 31, 2017

Vacancy Status	FTE
Filled	90.40
Vacant	5.00
Frozen	4.00
Total Authorized FTEs	**99.40**

Agy Code	Fiscal Year	Program Code	Activity Code	Filled, Vacant or Frozen	Position Title	Employee Name	Hire Date	Grade	Step	Reg/ Temp/ Term	Hiring Status	Filled by Law Y/N	Salary	Fringe	FTE
FX0	18	1000	1010	Filled	Management Liaison Specialist	Rouse,Benita R	11/1/2004	13	6	Reg	On-Board	N	94,035	20,500	1.0
FX0	18	1000	1020	Vacant	MGMT SRVS OFFICER	0	2/4/2018	15	0	Reg	PD being Updated	N	132,745	28,938	1.0
FX0	18	1000	1020	Filled	Program Analyst	Nolan,James	3/10/1991	12	7	Reg	On-Board	N	90,254	19,675	1.0
FX0	18	1000	1020	Filled	Support Services Specialist	Shelton,Esther	1/28/1990	11	5	Reg	On-Board	N	69,395	15,128	1.0
FX0	18	1000	1040	Filled	Chief Information Officer	Coleman Jr.,Michael A	2/5/2007	15	5	Reg	On-Board	N	119,966	26,153	1.0
FX0	18	1000	1040	Frozen	IT Spec. (Applic. Software)	0	9/30/2018	12	1	Reg	Frozen	N	76,082	16,586	1.0
FX0	18	1000	1040	Filled	IT Spec (Customer Support)	Contee,Kenneth D	12/22/2008	11	4	Reg	On-Board	N	67,419	14,697	1.0
FX0	18	1000	1040	Filled	RTW Support Services Specialist	Philp,Vevene A	6/7/2015	11	2	Term	On-Board	N	58,679	12,792	1.0
FX0	18	1000	1041	Filled	Epidemiologist	Leak,Chikarlo	9/21/2015	14	3	Reg	On-Board	N	101,927	22,220	1.0
FX0	18	1000	1056	Filled	Emergency Response and Safety	Harvin,Donell	8/12/2014	15	7	Reg	On-Board	N	128,942	28,109	1.0
FX0	18	1000	1056	Filled	Supply Technician	Diggs,Keon E	5/18/2015	7	6	Term	On-Board	N	45,848	9,995	1.0
FX0	18	1000	1060	Filled	SUPERVISORY ATTORNEY ADVISOR	DeVillier,Mikelle L	1/24/2011	2	0	Reg	On-Board	N	142,752	31,120	1.0
FX0	18	1000	1086	Filled	Supervisory Quality Control &	Francis,Anna D	2/10/2003	14	0	Reg	On-Board	N	113,499	24,743	1.0
FX0	18	1000	1086	Vacant	Records Management Specialist	0	9/30/2018	12	1	Reg	On-hold	N	70,345	15,335	1.0
FX0	18	1000	1086	Filled	Quality Assurance Specialist	Wright,Patricia E	6/24/1985	11	7	Reg	On-Board	N	67,814	14,783	1.0
FX0	18	1000	1086	Filled	RECORDS MANAGEMENT SPECIALIST	Greene,Adrine	11/30/2015	9	1	Reg	On-Board	N	51,039	11,127	1.0
FX0	18	1000	1086	Filled	RECORDS MANAGEMENT SPECIALIST	McArdle,Andrew T	6/26/2017	9	1	Reg	On-Board	N	51,039	11,127	1.0
FX0	18	1000	1090	Filled	Chief Medical Examiner	Mitchell,Roger A	2/14/2014	PS3	0	Term	On-Board	Y	268,408	58,513	1.0
FX0	18	1000	1090	Filled	Deputy Chief Medical Examiner	Diaz,Franciso J.	6/26/2017	MD6	1	Reg	On-Board	N	235,000	51,230	1.0
FX0	18	1000	1090	Filled	Chief of Staff	Fields,Beverly A	8/23/2004	16	0	Reg	On-Board	N	160,079	34,897	1.0
FX0	18	1000	1090	Filled	Executive Assistant	Fripp,Savern M	1/23/2006	12	4	Reg	On-Board	N	76,894	16,763	1.0
FX0	18	1000	1090	Vacant	Special Assistant	0	1/8/2018	12	1	Reg	Offer Issued	N	70,345	15,335	1.0
FX0	18	1000	1090	Frozen	RTW Administrative Specialist	0	9/30/2018	11	1	Reg	Frozen	N	56,852	12,394	1.0
FX0	18	1000	110F	Filled	AGENCY FISCAL OFFICER	Dixon,Leautry	12/16/2013	14	10	Reg	On-Board	N	133,480	29,099	1.0
FX0	18	2000	2100	Filled	Medical Officer (Medical Exami	Giese,Kristinza W.	12/27/2016	6C	3	Reg	On-Board	N	190,346	41,495	1.0
FX0	18	2000	2100	Filled	Medical Officer (Medical Exami	Njiwaji,Chantel Y	9/18/2017	6C	3	Reg	On-Board	N	190,346	41,495	1.0
FX0	18	2000	2100	Filled	Medical Officer (Medical Exami	Breland,Sasha-Gay I	7/15/2015	6C	1	Reg	On-Board	N	181,815	39,636	1.0
FX0	18	2000	2100	Filled	Medical Officer (Medical Exami	Weedn,Victor	4/18/2017	6C	1	Temp	On-Board	N	181,815	39,636	0.4
FX0	18	2000	2100	Filled	Medical Officer (Medical Exami	Golden,Kimberly	7/10/2017	6C	1	Reg	On-Board	N	181,815	39,636	1.0
FX0	18	2000	2100	Vacant	Medical Officer (Medical Exami	0	9/30/2018	6C	1	Reg	On-hold	N	181,815	39,636	1.0
FX0	18	2000	2200	Filled	Lead Medicolegal Investigator	Lyles,Denise A	9/25/2000	15	10	Reg	On-Board	N	141,187	30,779	1.0
FX0	18	2000	2200	Filled	MEDICAL LEGAL INVESTIGATOR	Petrasek,Mary Beth	1/18/2000	14	9	Reg	On-Board	N	134,590	29,341	1.0
FX0	18	2000	2200	Filled	MEDICAL LEGAL INVESTIGATOR	Fields,Leigh S	2/21/2006	14	8	Reg	On-Board	N	131,051	28,569	1.0
FX0	18	2000	2200	Filled	SUPVY MEDICO LEG AL INVEST	Morgan,Daniel	11/2/2015	16	0	Reg	On-Board	N	122,750	26,760	1.0
FX0	18	2000	2200	Filled	Medicolegal Investigator	Díaz,Carolina	7/29/2013	14	5	Reg	On-Board	N	116,881	25,480	1.0
FX0	18	2000	2200	Filled	FORENSIC INVESTIGATOR	Kurash,Lalynn G	2/19/2008	12	8	Reg	On-Board	N	92,616	20,190	1.0
FX0	18	2000	2200	Filled	FORENSIC INVESTIGATOR	Ware Murrell,Tiffany N	12/1/2003	12	7	Reg	On-Board	N	90,254	19,675	1.0
FX0	18	2000	2200	Filled	Lead Forensic Investigator	Wood,Rebecca	1/13/2014	13	4	Reg	On-Board	N	88,841	19,367	1.0
FX0	18	2000	2200	Filled	FORENSIC INVESTIGATOR	Jamison,Latoya R	12/21/2009	12	6	Reg	On-Board	N	87,892	19,160	1.0
FX0	18	2000	2200	Filled	FORENSIC INVESTIGATOR	Wright,Jerel K	10/24/2011	12	6	Reg	On-Board	N	87,892	19,160	1.0
FX0	18	2000	2200	Filled	FORENSIC INVESTIGATOR	Kim,Katherine	5/20/2013	12	5	Reg	On-Board	N	85,530	18,646	1.0
FX0	18	2000	2200	Filled	FORENSIC INVESTIGATOR	Johnson,Stephanie M.	12/30/2013	12	4	Reg	On-Board	N	83,168	18,131	1.0
FX0	18	2000	2200	Filled	FORENSIC INVESTIGATOR	Wolf,Julie	1/23/2017	12	1	Reg	On-Board	N	76,082	16,586	1.0
FX0	18	2000	2200	Filled	FORENSIC INVESTIGATOR	Johnson,John Breen	8/7/2017	12	1	Reg	On-Board	N	76,082	16,586	1.0
FX0	18	2000	2202	Filled	Forensic Anthropologist	Love,Jennifer	9/8/2014	14	0	Reg	On-Board	N	133,009	28,996	1.0

PUBLIC SAFETY AND JUSTICE AGENCY
FY 2018 SCHEDULE A
Office of The Chief Medical Examiner
As of December 31, 2017

Vacancy Status	FTE
Filled	90.40
Vacant	5.00
Frozen	4.00
Total Authorized FTEs	**99.40**

Agy Code	Fiscal Year	Program Code	Activity Code	Filled, Vacant or Frozen	Position Title	Employee Name	Hire Date	Grade	Step	Reg/ Temp/ Term	Hiring Status	Filled by Law Y/N	Salary	Fringe	FTE
FX0	18	2000	2202	Filled	Customer Support Specialist	Tabron,Lisa M	5/21/2001	9	7	Reg	On-Board	N	60,819	13,259	1.0
FX0	18	2000	2202	Filled	INTAKE ASSISTANT	Belle,Jeannette G	2/22/1998	7	8	Reg	On-Board	N	52,526	11,451	1.0
FX0	18	2000	2202	Filled	INTAKE ASSISTANT	Hall,Kimberli	6/11/2007	7	7	Reg	On-Board	N	51,058	11,131	1.0
FX0	18	2000	2202	Filled	INTAKE ASSISTANT	Smith,Melinda Delois	2/6/2006	7	7	Reg	On-Board	N	51,058	11,131	1.0
FX0	18	2000	2202	Filled	INTAKE ASSISTANT	Gales,Perlieshia	3/3/2008	7	6	Reg	On-Board	N	49,590	10,811	1.0
FX0	18	2000	2202	Filled	INTAKE ASSISTANT	Jewell,Azalie S	5/15/2006	7	6	Reg	On-Board	N	49,590	10,811	1.0
FX0	18	2000	2300	Filled	Supvy Foren Pathologist's Asst	Betts,Elizabeth S	1/6/2008	13	0	Reg	On-Board	N	95,325	20,781	1.0
FX0	18	2000	2300	Filled	Lead Forensic Photographer	Brown,Matthew B	11/24/2008	13	2	Reg	On-Board	N	83,647	18,235	1.0
FX0	18	2000	2300	Filled	Forensic Pathologists Assistan	Clingerman,Chelsea Nicolle	2/1/2010	12	6	Reg	On-Board	N	81,260	17,715	1.0
FX0	18	2000	2300	Filled	Lead Forensic Autopsy Assistan	Lassiter,Kimberly A	9/28/1998	11	6	Reg	On-Board	N	79,265	17,280	1.0
FX0	18	2000	2300	Filled	Forensic Photographer	Landrie,Rachael A.	6/16/2014	12	4	Reg	On-Board	N	76,894	16,763	1.0
FX0	18	2000	2300	Filled	Pathology Coordinator	Davenport,Terencia E	2/21/2017	11	1	Reg	On-Board	N	76,894	16,763	1.0
FX0	18	2000	2300	Filled	Forensic Pathologists Assistan	Garner,LaTishia	8/10/2015	12	3	Reg	On-Board	N	74,711	16,287	1.0
FX0	18	2000	2300	Filled	Forensic Photographer	Burnett,Jamie	5/1/2017	12	1	Reg	On-Board	N	70,345	15,335	1.0
FX0	18	2000	2300	Filled	Autopsy Assistant (Mortuary)	Bell,Dennis	9/24/1990	9	5	Reg	On-Board	N	64,092	13,972	1.0
FX0	18	2000	2300	Filled	Autopsy Assistant (Mortuary)	Waters,Lawrence K	2/10/2003	9	5	Reg	On-Board	N	64,092	13,972	1.0
FX0	18	2000	2300	Filled	AUTOPSY ASSISTANT (MORTUARY)	Rooney,Sofia	3/20/2017	9	1	Reg	On-Board	N	57,556	12,547	1.0
FX0	18	2000	2300	Vacant	AUTOPSY ASSISTANT (MORTUARY)	0	2/4/2018	9	0	Reg	Position Advertized	N	57,556	12,547	1.0
FX0	18	2000	2300	Filled	AUTOPSY ASSISTANT (MORTUARY)	Mills,Robert	3/20/2017	0	0	Reg	On-Board	N	57,556	12,547	1.0
FX0	18	2000	2300	Filled	Forensic Autopsy Assistant	Bryant,Stephon M	4/9/2012	8	3	Reg	On-Board	N	55,262	12,047	1.0
FX0	18	2000	2300	Filled	Forensic Autopsy Assistant	Johnson,Keith E	11/16/2015	8	3	Reg	On-Board	N	55,262	12,047	1.0
FX0	18	2000	2300	Filled	Forensic Autopsy Assistant	Snowden,Brian	12/28/2015	8	3	Reg	On-Board	N	55,262	12,047	1.0
FX0	18	2000	2300	Filled	Forensic Autopsy Assistant	Hinkle,Jamal	1/9/2017	8	1	Reg	On-Board	N	52,308	11,403	1.0
FX0	18	2000	2300	Filled	Forensic Autopsy Assistant	Kelly,Derrick	1/9/2017	8	1	Reg	On-Board	N	52,308	11,403	1.0
FX0	18	2000	2300	Filled	Forensic Autopsy Assistant	Kidwell Jr.,Robert J.	1/9/2017	8	1	Reg	On-Board	N	52,308	11,403	1.0
FX0	18	2000	2300	Filled	Forensic Autopsy Assistant	Robinson-Porter,Latisha L	1/9/2017	8	1	Reg	On-Board	N	52,308	11,403	1.0
FX0	18	2000	2300	Filled	Forensic Autopsy Assistant	Pyos,Raymona	10/3/2016	8	1	Reg	On-Board	N	52,308	11,403	1.0
FX0	18	2000	2300	Filled	Forensic Autopsy Assistant	Williams,Markeshia	7/24/2017	8	1	Reg	On-Board	N	52,308	11,403	1.0
FX0	18	2000	2300	Filled	Forensic Autopsy Assistant	Prince,Johnathan	7/24/2017	8	1	Reg	On-Board	N	52,308	11,403	1.0
FX0	18	2000	2300	Filled	Forensic Autopsy Assistant	Hough,Bonnie T.	7/24/2017	8	1	Reg	On-Board	N	52,308	11,403	1.0
FX0	18	2000	2302	Filled	Medical Technologist	Darby,James	4/2/2013	12	5	Reg	On-Board	N	78,111	17,028	1.0
FX0	18	3000	3100	Filled	Fatality Review Program Manage	Beebe-Aryee,Jenna Leigh	5/2/2005	15	0	Reg	On-Board	N	116,699	25,440	1.0
FX0	18	3000	3100	Filled	Senior Fatality Review Prog Sp	Martin,Tracie	2/7/2005	14	7	Reg	On-Board	N	114,199	24,895	1.0
FX0	18	3000	3100	Filled	Fatality Review Program Specia	Corbin-Armstrong,Jacqueline	12/14/2015	12	5	Reg	On-Board	N	79,077	17,239	1.0
FX0	18	3000	3100	Frozen	Outreach Program Specialist	0	9/30/2018	12	1	Term	Sub-Grant not renewed	N	70,345	15,335	1.0
FX0	18	3000	3100	Filled	Staff Assistant	Byrd,Toya M	9/21/2015	9	10	Reg	On-Board	N	65,709	14,325	1.0
FX0	18	3000	3100	Filled	Fatality Review Program Specia	Hill,Jeffrey	12/27/2016	10	2	Term	On-Board	N	51,768	10,871	1.0
FX0	18	3000	3100	Frozen	RTW Staff Assistant	0	9/30/2018	9	1	Reg	Frozen	N	51,039	11,127	1.0
FX0	18	4000	4100	Filled	Chief Toxicologist	Zarwell,Lucas W	7/1/2002	16	0	Reg	On-Board	N	147,300	32,111	1.0
FX0	18	4000	4100	Filled	Dep Chief Toxicologist	Tolliver Ph.D,Samantha S.	1/27/2014	14	0	Reg	On-Board	N	118,178	25,763	1.0
FX0	18	4000	4100	Filled	Forensic Toxicologist	Bayard,Ciena N	9/19/2005	13	6	Reg	On-Board	N	94,035	20,500	1.0
FX0	18	4000	4100	Filled	Forensic Toxicologist	Chopra,Kiran	11/4/2002	13	5	Reg	On-Board	N	91,438	19,933	1.0
FX0	18	4000	4100	Filled	Forensic Toxicologist	Kuhn,Michael	5/6/2013	13	5	Reg	On-Board	N	91,438	19,933	1.0
FX0	18	4000	4100	Filled	Forensic Toxicologist	Kightlinger,Danylle	2/8/2016	12	2	Term	On-Board	N	72,528	15,811	1.0
FX0	18	4000	4100	Filled	Forensic Toxicologist	Ruggery,Bryan A.	3/10/2014	12	2	Reg	On-Board	N	72,528	15,811	1.0

PUBLIC SAFETY AND JUSTICE AGENCY
FY 2018 SCHEDULE A
Office of The Chief Medical Examiner
As of December 31, 2017

Vacancy Status	FTE
Filled	90.40
Vacant	5.00
Frozen	4.00
Total Authorized FTEs	**99.40**

Agy Code	Fiscal Year	Program Code	Activity Code	Filled, Vacant or Frozen	Position Title	Employee Name	Hire Date	Grade	Step	Reg/ Temp/ Term	Hiring Status	Filled by Law Y/N	Salary	Fringe	FTE
FX0	18	4000	4100	Filled	Forensic Toxicologist	Wynn,Charis	1/25/2016	12	2	Term	On-Board	N	72,528	15,811	1.0
FX0	18	4000	4100	Filled	Forensic Toxicologist	Brathwaite,Sophia K.V	9/8/2014	12	1	Reg	On-Board	N	70,345	15,335	1.0
FX0	18	4000	4100	Filled	Forensic Toxicologist	Benzio,Katharine	3/21/2016	12	1	Reg	On-Board	N	70,345	15,335	1.0
FX0	18	4000	4100	Filled	Laboratory Support Specialist	Mason,Nikia	5/20/2002	11	3	Reg	On-Board	N	65,443	14,267	1.0
FX0	18	4000	4100	Filled	Staff Assistant	Pugh,Andrea	12/7/1998	11	1	Reg	On-Board	N	65,443	14,267	1.0
FX0	18	4000	4100	Filled	Forensic Toxicologist	Nwachukwu,Vivian	9/19/2016	11	3	Reg	On-Board	N	60,506	13,190	1.0
FX0	18	4000	4100	Filled	FORENSIC TOXICOLOGIST	Ross,Margaret J.	1/9/2017	11	1	Reg	On-Board	N	56,852	12,394	1.0
FX0	18	4000	4100	Filled	FORENSIC TOXICOLOGIST	Levitas,Matthew	3/20/2017	11	1	Term	On-Board	N	56,852	12,394	1.0
FX0	18	4000	4100	Filled	Forensic Toxicologist	Wiseman,James R	10/2/2017	11	1	Term	On-Board	N	56,852	12,394	1.0
FX0	18	4000	4100	Filled	Forensic Toxicologist (Accessi	Hobbs,Alexia	12/28/2015	9	5	Reg	On-Board	N	53,217	11,601	1.0
AGENCY GRAND TOTAL													**$8,919,475**	**$1,944,031**	**99.40**

PUBLIC SAFETY AND JUSTICE AGENCY
FY 2018 - 1st Qtr Vacancy List and Hiring Plan Schedule for Local Postions
OFFICE OF THE CHIEF MEDICAL EXAMINER (FX0)

FUND	VAC	PROG	ORG	POSN NBR	POSITION TITLE	FTE	FY 2018 SALARY AMOUNT	FY 2018 BUDGETED SALARY AMOUNT	FY 2018 PLANNED HIRING DATES			NBR OF PAY PERIODS	VACANT PAY PERIOD % [3.846%]	FY 2018 ESTIMATED PS COST
									1/8/2018	2/4/2018	9/30/2018			
0100	V	1000	1020	00010178	MGMT SRVS OFFICER	1.00	$132,745	$70,148		1.00		17.00	0.03846	$86,791
0100	V	1000	1086	00091371	Records Management Specialist	1.00	$70,345	$54,299			1.00	0.00	0.03846	$0
0100	V	1000	1090	00035033	Special Assistant	1.00	$70,345	$81,260	1.00			18.93	0.03846	$51,211
0100	V	2000	2100	00008299	Medical Officer (Medical Exami	1.00	$181,815	$181,815			1.00	0.00	0.03846	$0
0100	V	2000	2300	00047551	AUTOPSY ASSISTANT (MORTUARY)	1.00	$57,556	$65,099		1.00		17.00	0.03846	$37,631
0100 - Grand Total						**5.00**	**$512,806**	**$452,621**	**1.00**	**2.00**	**2.00**			**$175,633**

Office of the Chief Medical Examiner FY2017

FY2017 Performance Accountability Report

The Performance Accountability Report (PAR) measures each agency's performance for the fiscal year against the agency's performance plan and includes major accomplishments, updates on initiatives, and key performance indicators (KPIs).

Mission

The mission of the Office of Chief Medical Examiner (OCME) is to ensure that justice is served and that the health and safety of the public is improved by conducting quality death investigations and certification, and providing forensic services for government agencies, health care entities and grieving families.

Summary of Services

OCME provides forensic services to local and federal government agencies, health care providers, institutions of higher learning and citizens in the District and metropolitan area. Forensic services include: forensic investigation and certification of certain deaths (i.e., deaths occurring as a result of violence (injury) as well as those that occur unexpectedly, without medical attention, in custody, or pose a threat to public health); review of deaths of specific populations; grief counseling; performance of a full range of toxicological examinations; cremation approvals; and public dispositions of unclaimed remains.

FY17 Top Accomplishments

Accomplishment	Impact on Agency	Impact on Residents
While the OCME has been granted full accreditation by NAME effective February 16, 2016 through February 16, 2021, each year the agency must be reaccredited. The agency has received its reccreditation which is a review of the annual status of the agency operations, facility and standard operating procedures and a fee payment. The initial inspection, which is a rigorous process involving the physical facility and review of office practices and policies and procedures, only revealed six (6) Phase I and zero (0) Phase II deficiencies out of 351 accreditation checklist items.	This impacts the agency in that it provides national visibility as an accredited office, thus, attracting professional talent and also ensuring that it is a premier medical examiner's office with best practices for medicolegal investigation.	The residents of DC can be assured that the agency is run by industry standard and that death investigation is sound and medicolegally efficient.
In FY16, the agency implemented a Mortuary Examiner Transport Team (METT) Pilot Program. This METT fulfills the standards established by NAME which requires proper body handling on a daily basis and during a mass fatality. In FY17, the agency's goal was to phase in additional staff and gradually phase out the vendor.	This accomplishment is significant in light of the fact that the vendor not only had performance challenges but, ultimately, lost clean hands/licensing. As such, the development of the METT enabled the continuity of the critical decedent transport function with the use of in-house staff resources. The initiative also reduced costs via phase out of the vendor, improved efficiency in reporting to death scenes for transport and provided additional opportunity for staff to perform other duties,	With 12 staff, the agency noted a change in the number of in-house versus vendor transports with over 80% completed by METT. The agency's response to death scenes with the use of METT averaged about 40 minutes versus approximately 67 minutes with the vendor. The agency's KPI is to respons to 90% of scenes within an hour. The METT are also performing decedent releases to funeral homes, inventory work, mortuary room setup and cleaning, periodic autopsy work, fleet maintenance and other duties.

Fiscal Accountability: The agency was able to spend more than 99% of its FY17 local budget (below $100,000) and keep a small vacancy rate throughout the fiscal year, including to below 5 FTEs during Q3 and Q4. This was achieved while fulfilling the agency mission of death investigation. This was accomplished utilizing standard operating procedures established in-house on budget/procurement and human resources; managerial oversight; and strategic and performance planning.	This impacts the agency in maintaining accreditation status for the agency as a whole and for the Toxicology Laboratory and ensuring that the agency operates efficiently and effectively/	Fiscal Accountability demonstrates to District residents good governance and use of their tax dollars.
The OCME sponsored a Fatality Management Symposium and Full-Scale Exercise from September 11-13, 2017. The event was held at the Consolidated Forensic Laboratory, Hyatt Place and at designated District sites for the exercise located at 401 E Street and across the street respectively. The "international" event focused on District-wide mass fatality plans and training for all District and regional stakeholders. International guests include representatives from Belgium and Egypt to discuss experiences from mass fatality incidents in those jurisdictions. Emergency response local and regional stakeholders participated in workshops and fatality management exercises over the 4 day period. The Mayor provided remarks during the first two days of the Symposium portion of the event.	This initiative provided training to staff agency wide in emergency response and also gives the agency regional and even nationwide visibility as a lead in emergency response and fatality management.	This initiative was designed to prepared the agency, pubic safety cluster agencies, regional and federal partners and other stakeholders for emergency incidents, in particular mass fatalities. District residents benefit from the training that their public servants receive in emergency preparedness.

2017 Strategic Objectives

Objective Number	Strategic Objective
1	Provide efficient and quality forensic services related to: a) the medicolegal investigation and certification of the cause and manner of death; b) toxicological analyses and interpretations; c) family assistance in understanding the cause and manner of death; d) expert testimony; and e) education and training of law enforcement, health care providers, academic institutions and other stakeholders.
2	Provide efficient and effective service through a quality management system supported by continuous process improvement, quality control measures, adherence to accrediting body guidelines, training and best practices.
3	Serve as a public health and safety surveillance organization providing statistical data to law enforcement, health care entities and social service entities tasked with prevention, detection and deterrence and ultimately preventing deaths.
4	Provide sound expertise as the District's fatality management authority maintaining a comprehensive District-wide plan to respond to all types of fatality incidents and ensure decedent disposition, family assistance, and continuity of operations.
5	Create and maintain a highly efficient, transparent and responsive District government.**

2017 Key Performance Indicators

Measure	Freq	Target	Q1	Q2	Q3	Q4	FY 2017	KPI Status	Explanation
1 - Provide efficient and quality forensic services related to: a) the medicolegal investigation and certification of the cause and manner of death; b) toxicological analyses and interpretations; c) family assistance in understanding the cause and manner of death; d) expert testimony; and e) education and training of law enforcement, health care providers, academic institutions and other stakeholders. (6 Measures)									

Percent of all reports of postmortem examinations completed within 90 calendar days from the time of autopsy in all cases.	Quarterly	90%	72.8%	66.1%	68.3%	83.1%	72.6%	Unmet	The agency experienced a shortage of medical examiners for the majority of the reporting period. Of six medical examiner positions, only two were filled until the 3rd quarter when a part-time medical examiner was hired. Subsequently, during the 4th quarter, two additional medical examiners were hired. Note also that the agency's Deputy Chief Medical Examiner position was also vacant throughout the fiscal year until 4th quarter. Not only did the agency experience a staff shortage during the year, but the caseload increased. During FY18, the agency will fill the remaining medical examiner position. Having a full forensic pathologist staff will assist the agency in addressing the increased workload and it is anticipated that this target will be met.

Percent of public dispositions ready for release within 45 days	Quarterly	90%	28.4%	81.7%	64.3%	72.7%	58.3%	Unmet	This target is impacted by the agency's work with next of kin who are attempting to claim their family members. Often there are delays due to the inability to finance a funeral/cremation; claim disputes; or other legal matters. There are times when after delay the next of kin does not ultimately claim the decedent and the public disposition process moves forward but beyond the time period slated. The agency however is cognizant of its role in working with next of kin to assist them as much as possible in claiming their loved ones.
Percentage of preliminary investigative reports presented at the morning meeting contain sufficient detail for the Medical Examiners to determine the type of postmortem examination.	Quarterly	95%	98.9%	99.5%	100%	99.1%	99.4%	Met	
Percent of mortuary/transport service scene response within one hour of transport notification by an investigator or medical examiner of an accepted case	Quarterly	95%	79.2%	100%	96.1%	100%	97.1%	Met	
Percent of toxicology examinations completed within 90 calendar days of case submission	Quarterly	75%	97%	77.6%	97.3%	94.4%	91.4%	Met	
Percent of toxicology examinations completed within 60 calendar days of case submission	Quarterly	40%	81.2%	55.8%	74.9%	78.8%	72.5%	Met	

2 - Provide efficient and effective service through a quality management system supported by continuous process improvement, quality control measures, adherence to accrediting body guidelines, training and best practices. (4 Measures)

Percent of employees completing and maintaining licensure, certification, industry-specific, web-based, internal agency training	Quarterly	90%	68.1%	79.1%	88.9%	92.9%	82.6%	Nearly Met	This target was actually met as noted during the 4th quarter with 92 of 99 employees obtaining or maintaining licensure, certifications and/or requisite trainings.
Percent of forensic pathologists (medical examiners) that are board certified or board eligible.	Quarterly	90%	100%	100%	100%	100%	100%	Met	
Percentage of all death certificate amendments processed wthin 3 business days of completion/signature.	Quarterly	90%	52%	66.3%	100%	98.4%	87.1%	Nearly Met	This target was impacted by the first two quarters when a new process was being established.
Percent of external autopsy requests responded to within 2 business days of receipt.	Quarterly	90%	98.6%	80.1%	100%	100%	92.1%	Met	
3 - Serve as a public health and safety surveillance organization providing statistical data to law enforcement, health care entities and social service entities tasked with prevention, detection and deterrence and ultimately preventing deaths. (3 Measures)									
Percent of FOIA requests responded to within fiften (15) days.	Quarterly	90%	100%	75%	98%	90%	95.5%	Met	
Percent of Child Fatality Review Committee (CFRC) fatality reviews held within six months of notification of the death	Quarterly	70%	100%	100%	83.3%	100%	96.5%	Met	
Percent of Developmental Disabilities Fatality Review Committee (DDS FRC) fatality reviews held within three months of receipt of the investigative report from DHS/DDS and determination of the cause and manner of death	Quarterly	100%	100%	100%	100%	100%	100%	Met	
4 - Provide sound expertise as the District's fatality management authority maintaining a comprehensive District-wide plan to respond to all types of fatality incidents and ensure decedent disposition, family assistance, and continuity of operations. (1 Measure)									
Percent of agency employees completing a mass fatality training annually.	Annually	95%	Annual Measure	Annual Measure	Annual Measure	Annual Measure	100%	Met	
5 - Create and maintain a highly efficient, transparent and responsive District government. (3 Measures)**									

Percent of positions posted and filled within 30 days	Quarterly	80%	85.7%	83.3%	100%	100%	88%	Met
Percent of requisitions submitted by the timeframe as prescribed by the District's contracting authority's acquisition planning.	Annually	98%	Annual Measure	Annual Measure	Annual Measure	Annual Measure	100%	Met
Percent of decedent cases identified in 5 days	Quarterly	80%	94.4%	93.6%	96.2%	96%	95.2%	Met

We've revisited a project to standardize District wide measures for the Objective "Create and maintain a highly efficient, transparent and responsive District government." New measures will be tracked in FY18 and FY19 and published starting in the FY19 Performance Plan.

2017 Workload Measures

Measure	Freq	Q1	Q2	Q3	Q4	FY 2017
1 - Forensic Pathology Services (9 Measures)						
Number of Postmortem Examinations performed: Full/Partial (Not including External Exams)	Quarterly	363	366	356	321	1406
Number of Deaths Due to Traffic Accidents (i.e., cars, Metro, motorcycles, pedestrian, bicycle)	Quarterly	20	16	18	12	66
Number of drug deaths (illicit/rxn) diagnosed	Quarterly	98	100	105	180	483
Number of deaths due to hypertensive cardiovascular disease/obesity	Quarterly	104	96	83	84	367
Number of Infant deaths (1 year and under)	Quarterly	10	10	16	11	47
Number of child deaths due to inappropriate bedding/SUID (with or without crib in the dwelling)	Quarterly	0	3	0	0	3
Number of elder deaths due to falls (age 65 and over)	Quarterly	17	17	26	11	71
Number of youth (ages 10-19) homicides where gun violence is a factor	Quarterly	3	3	1	7	14
Number of Anthropologic Analyses Performed	Quarterly	31	25	36	31	123
1 - Toxicology Analysis (1 Measure)						
Number of DUI cases performed	Quarterly	112	136	94	97	439

2017 Strategic Initiatives

Title	Description	Complete to Date	Status Update	Explanation
CONTRACTS AND PROCUREMENT (1 Strategic Initiative)				

Develop SOPs for In-house Agency Budget & Procurement Process	The agency will develop Standard Operating Procedures for its internal budget and contracts & procurement process. The SOPs will focus on the agency internal budget review meetings and analysis, as well as the procedures to be followed by managers internally with regard to purchasing good and services for operational purposes in line with Office of Contracting & Procurement regulations and policies.	Complete	The SOPs for the Budget and Contracts & Procurement Process were developed and reviewed. They include an overview of the District Process and an outline of the internal agency process such as internal BRT meetings, expectations of agency managers with regard to quarterly budget meetings to review budgetary needs and purchase orders within their jurisdictions; reprogrammings; budget hearings; the agency MARC and District BRT preparations; the FRP; and procurement of resources, goods and services to support the agency's mission.
CUSTOMER SERVICE (1 Strategic Initiative)			
Implementation of Digitization Methodology	The agency Records Management Unit will begin an initiative focused on digitization of agency records. The purpose is to streamline the management of medical examiner case files and other documents generated, utilized and stored by the agency (particularly in light of hard copy storage limitations internally and at District external sites.) This initiative involves staff training, development of Standard Operating Procedures, procurement of associated equipment and development of a phased in approach to the digitization effort.Digitization of documents will enable the agency to provide more timely response to records requests in that they are more easily assessable and, thus, can be more efficiently forwarded or provided in a timely manner.	Complete	As with Q3, during Q4 homicide cases, currently "Accepted" Medical Examiner cases were continued to be converted from paper to a digital format. In addition, all faxes received by Investigations and Records Management are obtained electronically via Right fax, and those documents that are related to an "Accepted" case are saved directly into the applicable case file.The case file folders are established on a dedicated server with a specified naming convention. Staff continue training in the use of various scanning equipment.
FATALITY MANAGEMENT (2 Strategic initiatives)			

Build-Out of Agency Fatality Management Operations Center (FMOC)	The agency must have a centralized location for disaster operations and coordination. As such, the agency plans to construct a fatality management operations center to include "emergency communications and office infrastructure." The Fatality Management Operations Center (FMOC) would provide the agency with initial and ongoing situational awareness for pre-planned or emergency incidents; the ability to centralize operations, assess the situation and provide rapid response; provide appropriate staff preparedness on an ongoing basis; allow communication with other stakeholders (i.e., jurisdictional law enforcement, fire and rescue, emergency agencies and hospitals); and provide a training center for staff and stakeholder partners for emergency preparedness. The center will also be utilized on a day-to-day basis for operational assessment meetings of medical examiner caseload. Build-out of an FMOC also supports the agency's accreditation efforts as related to accreditation standards requiring a sound mass disaster plan and resources. This initiative ensures that the agency has the appropriate resources and infrastructure to fulfill its role in emergency preparedness situations.	0-24%	The agency submitted a FY17/FY18 Capital Requests in the amount of for $700,000 to build-out the FMOC. The agency used local funds to construct a small portion of the project -- the Executive Operations Room -- wherein situational awareness is monitored. The room is currently used for videoconferencing, web-based seminars and trainings. It has also been used for in-house and City-wide emergency incident planning drills and trainings in partnership with District and external public safety and health stakeholders.	The agency was not awarded a capital budget to complete the project as anticipated.
Disaster Plan Evaluation & Training/Exercises	The OCME will continue its evaluation of mass fatality and continuity of operations planning; emergency response standard operating procedures; local and regional planning and cooperation; and training and exercising. This will involve coordination with regional entities, such as other local Medical Examiners, District agency stakeholders, funeral homes, universities and hospital, federal partners and other community stakeholders. The OCME will continue its evaluation of mass fatality and continuity of operations planning; emergency response standard operating procedures; local and regional planning and cooperation; and training and exercising. This will involve coordination with regional entities, such as other local Medical Examiners, District agency stakeholders, funeral homes, universities and hospital, federal partners and other community stakeholders. The agency will participate in an emergency responce exercise. This initiative focuses on agency preparation and collaborative partnerships with stakeholders to ensure the safety and security of the District during natural disasters, public health emergencies and terrorist and criminal threats..	Complete	In addition to the activities in the other quarters, during Q4, the agency hosted the Fatality Management Symposium – September 11th – 13th. The OCME's Second Annual Fatality Management Symposium will be held September 11th – 13th, 2017 and will consist of a symposium to be held at the CFL and an exercise held at the Stadium Armory lot – similar to last year. The Public Safety Cluster agencies will receive invitations and more information in the next week or so.	

Fatality Review (1 Strategic Initiative)

Expansion of Fatality Review Programmatic Populations	The Fatality Review Unit will evaluation the expansion of the programmatic thrust of the review committees to include a maternal review committee as well as one focused on violence prevention. In FY16, the agency has submitted regulations to expand the District's fatality review program to include a Maternal Mortality Fatality Review. During that fiscal year, the agency began discussions with the Administration through the Mayoral Safer Stronger Iniative regarding a Violence Prevention Review.	Complete	In August 2017, the OCME grant application to the OVSJG for continued support for the Male Survivor's project was awarded. . The OCME continues to partner with the DOH to secure funding and develop a Maternal Interview Program. The legislation for the establishment of a Violence Fatality Review Board (VFRB) and a Maternal Mortality Review Committee was submitted and the status remains pending awaiting approval.
FLEET MANAGEMENT (1 Strategic Initiative)			
Fleet Replacement Plan	In FY17, the agency will continue its Fleet Replacement Initiative. The agency will work to replace vehicles utilized by mortuary, investigations or administrative units via grant opportunities or will look to procure additional vehicles for the purpose of mass fatality usage. The agency's fleet is aging and the cost of consistent repairs is not effective nor are the vehicles as reliable as required for day to day usage or mass fatality purposes. As such, as part of it's strategic plan, the agency has developed a Fleet Replacement Plan utilizing grant funding.	Complete	The agency was successful in securing 2 vehicles for its Death Investigations Division -- one for its Investigations Unit for death scene response and one for the Mortuary Unit for body transport. This was above expectation and, thus, this initiative is considered fully met. The agency actually submitted a Capital Request for 6 vehicles which it is currently pending. The agency is looking to FY18 to FY19 for capital support.
FORENSIC INVESTIGATIONS (1 Strategic Initiative)			

Medicolegal Death Investigations Field Guide Revision	The Medicolegal Death Investigations Unit will augment its Standard Operating Procedures with a revised Field Operations Guide. The Field Operatons Guide provides procedures and guidance to the investigative team on a step by step process to death scene investigations, as well as interactions with stakeholders at the scene. The Guide is to be exhaustive and include full details of the procedures.	Complete	The Medicolegal Death Investigations Unit completed its work toward augmenting its SOPs for a revision of its Field Operations Guide. This includes determining current industry standards and guidelines and memorializing any new or modified agency procedures or protocols. The guide includes a number of scene types that are typically investigated during medicolegal death investigation. Sixteen scene types are identified and outlined within the guide.	
FORENSIC PATHOLOGY (1 Strategic Initiative)				
Meet National Association of Medical Examiners (NAME) industry standards for postmortem examination reporting – 90% of reports postmortem examinations completed within 90 days from the time of autopsy in all cases.	The OCME's Medicolegal Death Investigation Division will focus efforts on meeting NAME standards for postmortem examinations – 90% of reports of postmortem examinations completed within 90 days from the time of autopsy in all cases. The agency has implemented a myriad of initiatives to enhance the reporting autopsy reporting time periods to include: improved management modules and work processes, dictation services, staffing models and scheduling.	50-74%	The agency continues to make strides in meeting this initiative. An additional medical examiner began their tenure during Q4. With 6 MEs including the Chief and Deputy, there is consistent coverage within the autopsy suite and autopsy completion rates have improved. However, there has been an increased caseload in FY17 and as such, the agency is recruiting for an additional permanent medical examiner.	The agency's efforts to increase staffing were completed during Q4. The forensic pathology industry has a shortage of medical examiner and it is a hard to fill position. Given the fact that the team now has 6 staff, the autopsy report completion rates are anticipated to improve. However, given the increased workload, the agency is currently recruiting for one more medical examiner.
FORENSIC TOXICOLOGY LAB (2 Strategic initiatives)				

Implementation of DUI Testing Enhancement	The Forensic Toxicology Laboratory will implement a new rapid drug testing methodology that will increase the scope and performance of DUI testing. The Laboratory will monitor turnaround times for DUI casework and tests for an increased number of "impairings" drugs in addition to alcohol. The turnaround times should decrease based on the new methodology.	Complete	The turnaround times are currently being measured for DUI casework and a substantial decrease in turnaround times has been noted based on the new methodology. A graph with supporting data is attached hereto.
Contributions to Forensic Toxicology Scientific Community	As part of its function to contribute to the scientific community specifically, the forensic toxicology laboratory will assess toxicological findings, conduct trend analyses and present research papers, publications or presentations to key stakeholders (i.e, scientific community, health care entities, law enforcement and academic community). The goals are to: 1) highlight data findings and trends relevant to stakeholders; 2) provide training for staff in analyzing findings and trends and presenting such information in an academic setting; and 3) provide visibility to the District's forensic tociology laboratory.	Complete	During Q4, the Toxicology Division hosted a two day national forensic toxicology method development workshop at the Consolidated Forensic Laboratory where the agency is located with over fifty (50) attendees.
INFORMATION TECHNOLOGY (3 Strategic initiatives)			
Qualtrax and Surgicare Implementation	The agency will implement two web-based systems to ensure inventory and document control -- Qualtrax and Surgicare. These systems are managed by the Information Technology and Quality Control/Records Management Units. In FY16, agency staff underwent extensive training and built-out the foundation of these systems and uploaded the requisite documents and items to each.	Complete	The agency has fully implemented both Qualtrax and Surgicare. Qualtrax, as managed by the Records Management Unit, is being utilized for document control and all agency SOPs, MOUs and other critical documents have been uploaded. It is currently being utilized for document modification and review by all managers and for quality control. Surgicare is utilized for inventory control and is managed by IT. It is fully utilized by the Toxicology Division and Administration and Mortuary/Investigation are at the initiation stages of utilization.

Enhancement of FACTS and Implementation of FACTS	The agency will implement consultation on the implemenation of Lab Information System (LIMS) and work toward enhancement of its current Forensic Analytic Case Tracking System.	Complete	During Q4, data from departmental focus groups yielded a list of dashboard and application requirements that were provided to the software vendor for finalizing the newest iteration of the FACTS application – now known as CMS (Case Management System). The entire application has been migrated from its legacy Microsoft operating system to Microsoft Windows Server 2012 on new Dell server hardware. The final component was the enhanced application dashboard overlay and robust reporting features, including electronic signatures.
Establishment of Data Analysis Fusion Center Grant	The Data Analysis Fusion Center is a collaborative effort established by the agency to provide and/or share data with stakeholders toward "prevention," "detection," "law enforcement" or other types of evaluation or analysis, particularly in the areas of public safety or health. Mortality data is critical data that can be formatted in a manner that can provide key information to other agencies in the form of trends, GIS mapping and statistical studies. This data can be utilized within the District in providing enhanced services to residents and visitors. In FY17, the Center Director will focus efforts on obtaining a grant(s) to support such public surveillance work in the form of resources and/or staffing.	Complete	The Data Analysis Fusion Center worked with DOH to secure a National Violent Death Reporting System (NVDRS) grant focused on violent deaths occuring in the District, such as homicides, suicides, unintentional firearm related deaths. During Q4, the staff hired under the grant performed data entry for the project (about 142 cases year that meet the grant criteria.) A second grant was obtained, entitled "State Unintentional Overdose Reporting System".
MORTUARY (1 Strategic Initiative)			
METT	In FY16, the agency implemented a Mortuary Examiner Transport Team (METT) Pilot program. This METT fulfills the standards established by NAME which requires proper body handling on daily basis and during mass fatality. Body transport has been performed by a vendor but during the pilot and in FY17 will be performed by METT. In FY17, the agency's goal is to phase in additional staff with the existing pilot staff and phase out the vendor. This initiative will be evaluated with regard to the staffing model, overtime, emergency availability of the vendor, annual/sick leave and the use of the METT team for other duties to determine the cost, resource, time savings, as well as whether there will be maintenance of improved death scene response times as compared to the vendor (a KPI).	Complete	The 4 new METT staff hired during Q3 were trained during Q4 and were able to be integrated into the full schedule by October 1st for the start of FY18. The addition of this staff will assist the agency in meeting its 24 hours/7 days per week obligation to provide medical examiner transport services the District.

PERSONNEL (1 Strategic Initiative)			
Ensure Efficient Recruitment Process for Qualified Candidates	The agency will implement an Efficient and Effective Recruitment Initiative in line with DCHR's goal to ensure that the recruitment process is within a 45 day timeline and that the best qualified candidates are hired.	Complete	The Chief of Staff and Management Liaison Specialist (HR Advisor) have worked to establish agency procedures surrounding timelines for in-house management review of candidate applications, the interview process and preparation of candidate selection packet. This timeline also includes the time the candidate may need to accept the offer and the hire/on-boarding date. The 45 day turnaround time is the goal. The last portion of the SOP includes training of management in the interview and selection process.
TRAINING (1 Strategic Initiative)			
Establish a Formal Internal and External Academic & Training Program	The agency's mandate includes an academic component. This includes: 1) ensuring that staff obtains requisite training to maintain required licensures and certificates and to implement agency standards within work processes and procedures (i.e. attendance at professional toxicology, forensic pathology, death investigations, mass fatality, human resources, quality assurance, records management, IT, anthropology, histology, epidemiology, fatality review and social services, legal, business processing, fatality management and emergency preparedness and other conferences associated with the industries in the fields of work of the staff);; 2) providing academic training opportunities for external stakeholders to learn about the agency and its procedures; internships and other educational opportunities for students (i.e., residents, medical students, forensic students); and 3) training opportunities for stakeholders.	Complete	During the fourth quarter, staff continued to attend trainings throughout the agency to include Forensic Toxicology, Anthropolgoy, Medicolegal Death Investigation, Administration and Fatality Management. Throughout the summer and last quarter, Management staff also participated in a several workshops given by the Chief of Staff and General Counsel geared towards supervisory skills.

Office of the Chief Medical Examiner FY2018

Agency Office of the Chief Medical Examiner **Agency Code** FX0 **Fiscal Year** 2018

Mission The mission of the Office of Chief Medical Examiner (OCME) is to ensure that justice is served and that the health and safety of the public is improved by conducting quality death investigations and certification, and providing forensic services for government agencies, health care entities and grieving families.

2018 Strategic Objectives

Objective Number	Strategic Objective	# of Measures	# of Operations
1	Provide efficient and quality forensic services related to: a) the medicolegal investigation and certification of the cause and manner of death; b) toxicological analyses and interpretations; c) family assistance in understanding the cause and manner of death; d) expert testimony; and e) education and training of law enforcement, health care providers, academic institutions and other stakeholders.	7	5
2	Provide efficient and effective service through a quality management system supported by continuous process improvement, quality control measures, adherence to accrediting body guidelines, training and best practices.	4	4
3	Serve as a public health and safety surveillance organization providing statistical data to law enforcement, health care entities and social service entities tasked with prevention, detection and deterrence and ultimately preventing deaths.	4	2
4	Provide sound expertise as the District's fatality management authority maintaining a comprehensive District-wide plan to respond to all types of fatality incidents and ensure decedent disposition, family assistance, and continuity of operations.	1	3
5	Create and maintain a highly efficient, transparent and responsive District government.**	11	4
TOT		**27**	**18**

2018 Key Performance Indicators

Measure	New Measure/ Benchmark Year	FY 2014 Actual	FY 2015 Target	FY 2015 Actual	FY 2016 Target	FY 2016 Actual	FY 2017 Target	FY 2017 Actual	FY 2018 Target
1 - Provide efficient and quality forensic services related to: a) the medicolegal investigation and certification of the cause and manner of death; b) toxicological analyses and interpretations; c) family assistance in understanding the cause and manner of death; d) expert testimony; and e) education and training of law enforcement, health care providers, academic institutions and other stakeholders. (7 Measures)									
Percent of public dispositions ready for release within 45 days of the date of decedent receipt		Not available	Not available	Not available	90%	24.3%	90%	58.3%	75%
Percent of toxicology examinations completed within 90 calendar days of case submission		29.9%	75%	51.9%	75%	Not Available	75%	91.4%	75%
Percent of all reports of postmortem examinations completed within 90 calendar days from the time of autopsy in all cases		Not available	50%	66.5%	90%	89.1%	90%	72.6%	90%
Percent of toxicology examinations completed within 60 calendar days of case submission		Not available	Not available	Not available	Not available	Not Available	40%	72.5%	40%

Percent of mortuary/transport service scene response within one hour of transport notification by an investigator or medical examiner of an accepted case		84%	90%	90.2%	95%	89.9%	95%	97.1%	95%
Percent of preliminary investigative reports presented at the morning meeting contain sufficient detail for the Medical Examiners to determine the type of postmortem examination		89.8%	90%	80.8%	95%	95.2%	95%	99.4%	95%
Percent of decedent cases scientifically identified within five days	✔	Not available	Not available	Not available	Not available	New Measure	New Measure	New Measure	30%
2 - Provide efficient and effective service through a quality management system supported by continuous process improvement, quality control measures, adherence to accrediting body guidelines, training and best practices. (4 Measures)									
Percent of employees completing and maintaining licensure, certification, industry-specific, web-based, internal agency training		Not available	Not available	Not available	Not available	Not Available	90%	82.6%	90%
Percent of forensic pathologists (medical examiners) that are board certified or board eligible		Not available	Not available	Not available	Not available	Not Available	90%	100%	90%
Percent of external autopsy requests responded to within 2 business days of receipt		Not available	Not available	Not available	Not available	Not Available	90%	92.1%	90%
Percent of all death certificate amendments processed wthin 3 business days of completion/signature		Not available	Not available	Not available	Not available	Not Available	90%	87.1%	90%
3 - Serve as a public health and safety surveillance organization providing statistical data to law enforcement, health care entities and social service entities tasked with prevention, detection and deterrence and ultimately preventing deaths. (4 Measures)									

Percent of Child Fatality Review Committee (CFRC) fatality reviews held within six months of notification of the death		90%	70%	93%	70%	97.1%	70%	96.5%	70%
Percent of Developmental Disabilities Fatality Review Committee (DDS FRC) fatality reviews held within three months of receipt of the investigative report from DHS/DDS and determination of the cause and manner of death		100%	80%	100%	80%	100%	80%	80.5%	90%
Percent of FOIA requests responded to within fifteen (15) days		Not available	Not available	Not available	Not available	Not Available	90%	95.5%	90%
Percent of CFRC case summary reports that will be uploaded to the web portal three days prior to the scheduled case review meetings	✔	Not available	Not available	Not available	Not available	New Measure	New Measure	New Measure	80
4 - Provide sound expertise as the District's fatality management authority maintaining a comprehensive District-wide plan to respond to all types of fatality incidents and ensure decedent disposition, family assistance, and continuity of operations. (1 Measure)									
Percent of agency employees completing a mass fatality training annually		Not available	Not available	Not available	Not available	Not Available	95%	100%	95%
5 - Create and maintain a highly efficient, transparent and responsive District government. (2 Measures)**									
Percent of positions posted and filled within 30 days		Not available	Not available	Not available	80%	Not Available	80%	88%	80%
Percent of requisitions submitted by the timeframe as prescribed by the District's contracting authority's acquisition planning.		Not available	Not available	Not available	90%	Not Available	98%	100%	98%

We've revisited a project to standardize District wide measures for the Objective "Create and maintain a highly efficient, transparent and responsive District government." New measures will be tracked in FY18 and FY19 and published starting in the FY19 Performance Plan.

2018 Operations

Operations Header	Operations Title	Operations Description	Type of Operations	# of Measures	# of Strategic Initiatives
1 - Provide efficient and quality forensic services related to: a) the medicolegal investigation and certification of the cause and manner of death; b) toxicological analyses and interpretations; c) family assistance in understanding the cause and manner of death; d) expert testimony; and e) education and training of law enforcement, health care providers, academic institutions and other stakeholders. (5 Activities)					
FORENSIC TOXICOLOGY LAB	Toxicology Analysis	Provides toxicological analyses, interpretive services and expert testimony. Provides toxicological testing on postmortem cases, as well as testing on a variety of drug and alcohol related matters for law enforcement entities, other District agencies and federal entities, as well as administers the District's District's Breath Alcohol Testing Program.	Daily Service	2	2
FORENSIC SUPPORT SERVICES	Forensic Analytic Testing	Provide scientific support services in the form of analytic testing for OCME and law enforcement agencies. Support toward the timely determination of cause and manner of death determinations via testing of specimens at forensic laboratories.	Daily Service	0	0
MORTUARY	Decedent Handling/Postmortem Examination	Provide body transport, body release and postmortem examination support services. Support forensic pathologists in postmortem examination toward determination of the cause and manner of death; release of bodies to the funeral industry in a timely manner; and transport of bodies from public spaces, homes, hospitals and other facilities.	Daily Service	0	1
FORENSIC PATHOLOGY	Forensic Pathology Services	Provide timely decedent examination and cause and manner of death determination. Investigation and analysis services performed by forensic pathologists resulting in certification of cause and manner of death provided to next of kin, law enforcement, government agencies and other interested parties.	Daily Service	9	2
FORENSIC INVESTIGATIONS	Medicolegal Death Investigations	Gather information and collect evidence and perform medical interpretation services for agency forensic pathologists, law enforcement agencies and legal counsel. Utilize information obtained from investigations toward identification of decedents and to aid in the determination of the cause and manner of death by forensic pathologists.	Daily Service	0	1
TOT				11	6
2 - Provide efficient and effective service through a quality management system supported by continuous process improvement, quality control measures, adherence to accrediting body guidelines, training and best practices. (4 Activities)					

INFORMATION TECHNOLOGY	Standard Operating Procedures	Manage agency operational documents providing effective and detailed tracking, auditing and reporting. Maintain and update standard operating procedures, work processes and instructions and other related documentation utilizing document management and control systems and process automations to ensure compliance with industry standards.	Daily Service	0	0
INFORMATION TECHNOLOGY	Case Management System	Utilize to manage death investigation and toxicology documents and data, as well as for decedent tracking. Maintain and continue development of case management databases utilized to track: a) all relevant case types from case initiation through disposition; b) testing and analysis toxicology data; c) inventory; d) decedents; and e) other key documents and resources.	Daily Service	0	1
CUSTOMER SERVICE	Records Management	Serve as the custodian of agency records providing premier customer service to all parties requesting records the agency is entrusted to secure. Process, maintain and secure error-free quality records for the District to include autopsy reports, photographs and other documents as requested by next of kin, the legal community, insurance companies, courts and other entities.	Daily Service	0	1
TRAINING	Professional Training/Career Development	Provide training and career development services to agency staff so they can maintain licensure and certifications, meet accrediting guidelines and adhere to best practices. Establish innovate ways to obtain training opportunities for staff through District, university, industry-specific, web-based and internal programs.	Daily Service	0	2
TOT				0	4

3 - Serve as a public health and safety surveillance organization providing statistical data to law enforcement, health care entities and social service entities tasked with prevention, detection and deterrence and ultimately preventing deaths. (2 Activities)

INFORMATION TECHNOLOGY	Data Analysis Fusion Center	Provide data collection, surveillance, and analysis resulting in the promotion of public safety and health. Establish scientific and technical methods and practices to identify and evaluate data in order to determine outcomes and trends in mortality statistics to improve the quality of life of District residents.	Daily Service	0	0
Fatality Review	Committee Recommendations	Review circumstances of the deaths of individuals within certain populations, including their interaction with District government services. Conduct fatality reviews to provide recommendations to District entities serving defined populations, so they can address systemic problems, provide better services and be held accountable.	Daily Service	0	0
TOT				0	0

4 - Provide sound expertise as the District's fatality management authority maintaining a comprehensive District-wide plan to respond to all types of fatality incidents and ensure decedent disposition, family assistance, and continuity of operations. (3 Activities)

FATALITY MANAGEMENT	Mass Fatality Training and Education	Provide training and education to agency staff and District stakeholders in order to ensure preparedness for mass fatality incident. Develop and coordinates emergency response/incident training and exercise programs amongst District, regional and federal stakeholders to ensure the appropriate implementation of incident plans and standard operating procedures, availability and use of equipment and resources and interoperability.	Daily Service	0	1
HEALTH AND SAFETY	Medical Surveillance Program	Provide a safe and healthy workplace for all employees and visitors. Implement a employee medical surveillance program involving and a formal safety program that involves management, supervisors and employees in identifying and eliminating hazards and that exist or may develop during work processes and testing.	Daily Service	0	0
FLEET MANAGEMENT	Vehicle Operations & Accountability	Implement and maintain a system for managing the use of agency vehicles and accountability for agency drivers. Work throughout the year to manage, maintain and purchase new vehicles utilized for death scene investigation, transport of decedents, emergency incident management, and administrative functions.	Daily Service	0	0
TOT				0	1

5 - Create and maintain a highly efficient, transparent and responsive District government. (4 Activities)**

PERSONNEL	Human Resources	Recruitment and retention of a highly skilled, professional and diverse workforce. Focus on staff development, hiring candidates with requisite qualifications, licenses and certifications, maintaining a low vacancy rate and an efficient onboarding time.	Daily Service	0	1
CONTRACTS AND PROCUREMENT	Procurement Process Management	Support the District's contracts and procurements process through adherence to the District's rules and regulations, particularly percentage of budget spent on CBEs. Provision of contracts management, purchasing, and technical assistance to agency staff to obtain products and services within budget, in a timely manner, and according to customer specifications.	Daily Service	0	1

CUSTOMER SERVICE	Customer Service	Provide service information and responses to internal and external customers to have their needs met in a courteous, reliable, and timely manner. Engage next of kin, the funeral industry, law enforcement, health care providers, legal entities, educational institutions, emergency response entities, the public health entities, elected officials, other agencies and residents in the: a) dissemination of requested information; and b) the awareness of agency programs, issues and challenges.	Daily Service	0	1
PERFORMANCE MANAGEMENT	Performance Management	Provide support to overall organizational performance via agency leadership; administrative support services; and employee performance management. Develop short and long term strategic plan for the agency; manage agency and employee performance planning, reporting and evaluating; and provide the administrative support necessary to operate.	Daily Service	0	1
TOT				0	4
TOT				**11**	**15**

2018 Workload Measures

Measure	New Measure/ Benchmark Year	FY 2014 Actual	FY 2015 Actual	FY2016 Actual	FY 2017 Actual
1 - Forensic Pathology Services (9 Measures)					
Number of Postmortem Examinations performed: Full/Partial (Not including External Exams)		Not available	Not available	1185	1406
Number of Deaths Due to Traffic Accidents (i.e., cars, Metro, motorcycles, pedestrian, bicycle)		Not available	Not available	Not Available	64
Number of drug deaths (illicit/rxn) diagnosed		Not available	Not available	170	153
Number of deaths due to hypertensive cardiovascular disease/obesity		Not available	Not available	290	288
Number of Infant deaths (1 year and under)		Not available	Not available	31	47
Number of child deaths due to inappropriate bedding/SUID (with or without crib in the dwelling)		Not available	Not available	7	0
Number of elder deaths due to falls (age 65 and over)		Not available	Not available	88	68
Number of youth (ages 10-19) homicides where gun violence is a factor		Not available	Not available	2	11
Number of Anthropologic Analyses Performed		Not available	Not available	107	123
1 - Toxicology Analysis (2 Measures)					
Number of DUI cases performed		Not available	Not available	122	439

Number of Synthetic Drug Samples Tested		Not available	Not available	259	Data Forthcoming

Initiatives

Strategic Initiative Title	Strategic Initiative Description	Proposed Completion Date	Add Initiative Update	# of Initiative Updates	Needs Initiative Update Notification
Case Management System (1 Strategic Initiative)					
Full Revision of Case Management System	The OCME will work with vendor to establish a new case management system, currently named Forensic Analytic Case Tracking System (FACTS). The new system will address several gaps that currently exist to include: mass fatality, toxicology and fatality review and will improve functionality for the end user. Further, there will be improved efficiency with integrated reporting for various units and additional forms for required recordkeeping. All units will be involved with providing input to work processes that serve as the foundation for the system and how it will integrate with the hard copy medical examiner case files and daily end user utilization.	09-30-2018	Add Initiative Update	0	Needs Update
TOT				0	
Customer Service (1 Strategic Initiative)					
Implementation of Automated Call Center Solution	The agency will implement an Automated Call Center Service Pilot wherein the main line will be automated and provide details on what number to press to direct the caller to the appropriate person or Division/Unit depending on the matter they are calling about. This will be tested during the first and then implemented throughout the year with feedback and improvements. Note that given the nature of the work of the agency, only certain individuals and Divisoins/Units will be included in the automated system. The purpose of the automated system is to ensure that all calls are captured and transferred in an efficient and timely manner, particularly those that may not deal directly with a death investigation matter and can be automatically transferred to the appropriate individuals for administrative resolution.	09-30-2018	Add Initiative Update	0	Needs Update
TOT				0	
Decedent Handling/Postmortem Examination (1 Strategic Initiative)					

Full Implementation of METT Body Release & Transport Project	The agency established a Mortuary Examiner Transport Team consisting of Forensic Mortuary Technicians (METT) to fulfill NAME proper body handling during Mass Fatality and day to day case response. The METT also operates to fill gaps identified in: fleet maintenance; decedent intake and release; mass fatality response logistics; post-mortem radiology and identification; supply inventory and tracking; and mortuary quality assurance and control processes. In FY17, the METT was fully staffed with 12 employees, with the last four hired during 4th quarter. During FY18, the full METT transport project will be implemented given completion of training of the additional 4 staff during the 4th quarter such that there will be 12 fully-trained personnel. In FY18, the agency will also fully implement a body release project wherein the METT will have responsibility to coordinate body release to funeral homes.	03-31-2018	Add Initiative Update	0	Needs Update
TOT				0	

Forensic Pathology Services (2 Strategic initiatives)

Meet National Association of Medical Examiners (NAME) industry standards for postmortem examination reporting - 90% of report completed within 90 days from the time of autopsy in all cases	The OCME's Medicolegal Death Investigation Division will focus efforts on meeting NAME standards for postmortem examinations 90% of reports of postmortem examinations completed within 90 days from the time of autopsy in all cases. The agency has implemented a myriad of initiatives to enhance the staffing models and scheduling.	09-30-2018	Add Initiative Update	0	Needs Update
Establishment of OCME Forensic Library and Training Center	The OCME will develop a forensic library for use of staff specifically to encourage continued certification and licensure and staff ability to maintain knowledge of industry standards for positions such as: medical examiners, toxicologists, investigators, pathologists' assistants, social workers, human resource specialists, attorneys and information technology specialists. The library will also be used as a training facility for all staff and as a resource for work-related matters. Library resources will hard copy and electronic.	09-30-2018	Add Initiative Update	0	Needs Update
TOT				0	

Human Resources (1 Strategic Initiative)

Coordination of Staff Training on DPM and OCME Employee Manual	The OCME staff has increased from about 75 to approximately 100 over the past 3 years. With the number of new staff due to the increase and a number of backfills, it is recognized that enhanced training must be conducted on the District Personnel Manual and OCME Employee Manual above and beyond the annual trainings that have been provided. As such, the agency will provide a series of trainings focused on key elements of the DPM and OCME Employee Manual to ensure that employees are knowledgeable about the procedures and protocol of the District and OCME and are able to ask question. The trainings will occur throughout the year. The agency's orientation process will also be enhanced to ensure that critical training items and issues are addressed during the on-boarding process.	09-30-2018	Add Initiative Update	0	Needs Update
TOT				0	

Mass Fatality Training and Education (1 Strategic Initiative)

District-wide Fatality Management Evaluation and Training	The OCME will continue its evaluation of mass fatality and continuity of operations planning; emergency response standard operating procedures; local and regional planning and cooperation; and training and exercising. This will involve coordination with regional entities, such as other local Medical Examiners, District agency stakeholders, funeral homes, universities and hospital, federal partners and other community stakeholders. The OCME will continue its evaluation of mass fatality and continuity of operations planning; emergency response standard operating procedures; local and regional planning and cooperation; and training and exercising. This will involve coordination with regional entities, such as other local Medical Examiners, District agency stakeholders, funeral homes, universities and hospital, federal partners and other community stakeholders. The agency will host an internal mass fatality exercise. This initiative focuses on agency preparation and collaborative partnerships with stakeholders to ensure the safety and security of the District during natural disasters, public health emergencies and terrorist and criminal threats.	09-30-2018	Add Initiative Update	0	Needs Update
TOT				0	

Medicolegal Death Investigations (1 Strategic Initiative)

Implement a Pilot Investigations Fatality Review Project	The Investigations Unit will engage the District's Fatality Review Committee, Boards and Commissions to provide guidance on the most beneficial information collected from scene investigators for improved interaction with individuals on a scene. This will provide for a more wholistic understanding of the multipurpose uses of information that investigators collect and provide in the District and may provide insight on more effective interactions with individuals at the scene.	09-30-2018	Add Initiative Update	0	Needs Update
TOT				0	

Performance Management (1 Strategic Initiative)

Coordination of Performance Management/Leadership Training Series for Managers	The OCME HR Unit will coordinate a performance management training series for managers to focus on enhancing their resources and skills to ensure improved effectiveness and efficiency in the operations of their Divisions and Units, as well as supervision of employees. The purpose of the series is to empower managers to have an understanding of District and OCME procedures and protocols and a concept of lean operations (Six Sigma) in order to improve the overall operations of the agency toward fulfilling its mission. The series of courses will be taught by the HR Advisor, General Counsel, Chief of Staff and Agency Fiscal Officer, as well as external invited speakers on specialized topics.	09-30-2018	Add Initiative Update	0	Needs Update
TOT				0	

Procurement Process Management (1 Strategic Initiative)

Improve Efficiency of Consultation-Testing Services Funding	The agency will work with its OCP Contracting Officer to evaluate its consultation and maintenance services to develop a short-term and long-term plan for obtaining such services. Part of such plan includes development of a justification to use non-expiring local fund type to fund the consultation testing contracts or some other method to address the issue described herein. The agency's consultation services include for example such as toxicology specimens. There is a challenge in estimating the number of specimens to be tested during the fourth quarter due to the business of the inability to forecast death and the number of tests required. As such, while purchase orders are established, it is difficult to predict the amounts needed on the PO. The agency has in the past set up a significant amount of "reserve" funding to account for the unanticipated spending, however, this is not believed to be an efficient method as money may not be utllized by by year's end. The purpose of this initiative is to prevent the agency from going into ratification if there are insufficient funds and not have a surplus of unused funds by keeping a reserve.	09-30-2018	Add Initiative Update	0	Needs Update
TOT				0	

Professional Training/Career Development (2 Strategic initiatives)

Implementation of Internal and External Professional & Academic Training	The agency's mandate includes an academic component. During FY18, the Deputy Chief Medical Examiner will coordinate this academic program which include:1) ensuring that staff obtains requisite training to maintain required licensures and certificates and to implement agency standards within work processes and procedures; 2) providing academic training opportunities for external stakeholders to learn about the agency and its procedures; internships and other educational opportunities for students (i.e., residents, medical students, forensic students); and 3) training opportunities for stakeholders.	09-30-2018	Add Initiative Update	0	Needs Update

Training on Standard Operating Procedures Toward NAME Re-Accreditation	The agency will focus on Standard Operating Procedures and continued preparation for ISO accreditation. First, the agency will provide training on all Standard Operating Procedures (SOPs) per Division/Unit in preparation for National Association of Medical Examiner's re-accreditation which occurs every 2 years. Per the guidelines, the SOPs will be updated and then socialized with the staff to ensure that any new procedures/protocols and revisions are recognized and effectuated appropriately. Re-accrediation inspection or review occurs in February/March of 2018. Secondly, the agency will begin a first phase of planning toward ISO accreditation. This includes staff ISO training (some of which has been conducted over the past two years, as recently as 4th quarter FY17). The agency will also work to gain additional expertise through consultation which will augment work done by the agency's Records Management/Quality Control Supervisor and ISO Coordinator. This is being implemented as part of the agency's continued efforts to maintain accreditation standards set by the National Association of Medical Examiners (NAME). ISO will be incorporated into the new NAME standards and guidelines now required for medical examiner offices as part of accreditation.	03-30-2018	Add Initiative Update	0	Needs Update
TOT				0	

Records Management (1 Strategic Initiative)

Enhancement of Digitization Methodology	The agency Records Management Unit will begin an initiative focused on digitization of agency records. The purpose is to streamline the management of medical examiner case files and other documents generated, utilized and stored by the agency (particularly in light of hard copy storage limitations internally and at District external sites.) This initiative involves staff training, development of Standard Operating Procedures, procurement of associated equipment and development of a phased in approach to the digitization effort. Digitization of documents will enable the agency to provide more timely response to records requests in that they are more easily assessible and, thus, can be more efficiently forwarded or provided in a timely manner.	09-30-2018	Add Initiative Update	0	Needs Update
TOT				0	

Toxicology Analysis (2 Strategic initiatives)

Contribute to the Forensic Toxicology Scientific Community	As part of its function to contribute to the scientific community specifically, the forensic toxicology laboratory will assess toxicological findings, conduct trend analyses and present research papers, publications and presentations to key stakeholders (i.e., scientific community, health care entities, law enforcement and academic community). The goals are to: 1) highlight data findings and trends relevant to stakeholders; 2) provide training for staff in analyzing findings and trends and presenting such information in an academic setting: and 3) provide visibility to the District's forensic toxicology laboratory.	09-30-2018	Add Initiative Update	0	Needs Update
Incorporate ISO 17025 requirements into Forensic Toxicology Laboratory	The forensic toxicology laboratory will be adding forms, policies, and practices which will prepare it for future 17020 and 17025 accreditation across the division. Upgrading and streamlining processes associated with ISO 17020 and 17025 will lead to further improvement in the overall quality of the laboratory and bring OCME in line with future national and international standards"	09-30-2018	Add Initiative Update	0	Needs Update
TOT				0	
TOT				**0**	

Created on Dec. 15, 2016 at 3:17 PM (EST). Last updated by Katz, Lia (EOM) on June 6, 2017 5:49 PM at 5:49 PM (EDT). Owned by Katz, Lia (EOM).

COMPENSATION COLLECTIVE BARGAINING AGREEMENT

BETWEEN

THE DISTRICT OF COLUMBIA GOVERNMENT

AND

COMPENSATION UNITS 1 AND 2

EFFECTIVE APRIL 1, 2013 – SEPTEMBER 30, 2017

TABLE OF CONTENTS

PREAMBLE

This Compensation Agreement is entered into between the Government of the District of Columbia and the undersigned labor organizations representing units of employees comprising Compensation Units 1 and 2, as certified by the Public Employee Relations Board (PERB).

The Agreement was reached after negotiations during which the parties were able to negotiate on any and all negotiable compensation issues, and contains the full agreement of the parties as to all such compensation issues. The Agreement shall not be reconsidered during its life nor shall either party make any changes in compensation for the duration of the Agreement unless by mutual consent or as required by law.

ARTICLE 1
WAGES

SECTION A: FISCAL YEAR 2013:

Effective the first day of the first full pay period beginning on or after April 1, 2013, the FY 2013 salary schedules of employees employed in bargaining units as certified and assigned to Compensation Units 1 and 2 by the Public Employees Relations Board shall be adjusted by 3%.

SECTION B: FISCAL YEAR 2014:

The Parties agree that the District shall set aside the amount equivalent to 1.5% of the total salaries for Compensation Units 1 and 2, as of November 19, 2012, to be used to implement any compensation adjustment required by the Classification and Compensation and Reform Project.

SECTION C: FISCAL YEAR 2015:

Effective the first day of the first full pay period beginning on or after October 1, 2014, the FY 2015 salary schedules of employees employed in bargaining units as certified and assigned to Compensation Units 1 and 2 by the Public Employees Relations Board shall be adjusted by 3%.

SECTION D: FISCAL YEAR 2016:

Effective the first day of the first full pay period beginning on or after October 1, 2015, the FY 2016 salary schedules of employees employed in bargaining units as certified and assigned to Compensation Units 1 & 2 by the Public Employees Relations Board shall be adjusted by 3%.

SECTION E: FISCAL YEAR 2017:

Effective the first day of the first full pay period beginning on or after October 1, 2016, the FY 2017 salary schedules of employees employed in bargaining units as certified and assigned to Compensation Units 1 & 2 by the Public Employees Relations Board shall be adjusted by 3%.

ARTICLE 2
METRO PASS

The District of Columbia Government shall subsidize the cost of monthly transit passes for personal use by employees by not less than twenty five ($25.00) per month for employees who purchase and use such passes to commute to and from work.

ARTICLE 3
PRE-PAID LEGAL PLAN

SECTION A:

The Employer shall make a monthly contribution of ten dollars ($10.00) for each bargaining unit member toward a pre-paid legal services plan. The Employer shall make monthly contributions directly to the designated provider of the legal services program.

SECTION B:

The plan shall be contracted for by the Union subject to a competitive bidding process where bidders are evaluated and selected by the Union. The District may present a proposed contract which shall be evaluated on the same basis as other bidders. The contract shall provide that the Employer will be held harmless from any liability arising out of the implementation and administration of the plan by the benefit provider, that the benefit provider will supply utilization statistics to the Employer and the Union upon request for each year of the contract, and that the benefit provider shall bear all administrative costs.

SECTION C:

The parties shall meet to develop procedures to implement the legal plan which shall be binding upon the benefit provider. The procedures shall include an enrollment process.

SECTION D:

To be selected for a contract under this Article, the benefit provider must maintain an office in the District of Columbia; be incorporated in the District and pay a franchise tax and other applicable taxes; have service providers in the District; and maintain a District bank account.

SECTION E:

The Employer's responsibility under the terms of this Article shall be as outlined in Section C of this Article and to make premium payments as is required under Section A of this Article. To the extent that any disputes or inquiries are made by the legal services provider chosen by the Union, those inquiries shall be made exclusively to the Union. The Employer shall only be required to communicate with the Union to resolve any disputes that may arise in the administration of this Article.

ARTICLE 4
DISTRICT OF COLUMBIA
NEGOTIATED EMPLOYEE ASSISTANCE HOME PURCHASE PROGRAM

SECTION A:

The Parties shall continue the Joint Labor-Management Taskforce on Employee Housing.

SECTION B:

Pursuant to the DPM, Part 1, Chapter 3 §301, the District provides a preference for District residents in employment. In order to encourage employees to live and work in the District of Columbia, a joint Labor-Management Task Force on Employee Housing was established during previous negotiations with Compensation Units 1 & 2. The Taskforce strives to inform employees of the programs currently available for home ownership in the District of Columbia. Additionally, the Taskforce collaborates with other government agencies including the Department of Housing and Community Development and the District's Housing Finance Agency to further affordable housing opportunities for bargaining unit employees, who have been employed by the District Government for at least one year.

SECTION C:

The parties agree that $500,000.00 will be set aside to be used toward Negotiated employee Assistance Home Purchase Program (NEAHP) for the duration of the Agreement. If at any time, the funds set aside have been depleted, the Parties will promptly convene negotiations to provide additional funds for the program.

SECTION D:

Any funds set aside in Fiscal Years 2014, 2015, 2016 and 2017 shall be available for expenditure in that fiscal year or any other fiscal year covered by the Compensation Units 1 and 2 Agreement. All funds set aside for housing incentives shall be expended or obligated prior to the expiration of the Compensation Units 1 and 2 Agreement for FY 2014 – FY 2017.

ARTICLE 5
BENEFITS COMMITTEE

SECTION A:

The parties agree to continue their participation on the District's Joint Labor-Management Benefits Committee for the purpose of addressing the benefits of employees in Compensation Units 1 and 2. The Benefits Committee shall meet quarterly, in January, April, July and October of each year.

SECTION B: RESPONSIBILITIES:

The Parties shall be authorized to consider all matters that concern the benefits of employees in Compensation Units 1 and 2 that are subject to mandatory bargaining between the parties. The Parties shall be empowered to address such matters only to the extent granted by the Unions in Compensation Units 1 and 2 and the District of Columbia Government. The parties agree to apply a system of expedited arbitration if necessary to resolve issues that are subject to mandatory bargaining. The Committee may, by consensus, discuss and consider other benefit issues that are not mandatory bargaining subjects.

SECTION C:

The Committee shall:

1. Monitor the quality and level of services provided to covered employees under existing Health, Optical and Dental Insurance Plans for employees in Compensation Units 1 and 2.

2. Recommend changes and enhancements in Health, Optical and Dental benefits for employees in Compensation Units 1 and 2 consistent with Chapter 6, Subchapter XXI of the D.C. Official Code (2001 ed.).

3. With the assistance of the Office of Contracting and Procurement, evaluate criteria for bids, make recommendations concerning the preparation of solicitation of bids and make recommendations to the contracting officer concerning the selection of providers following the receipt of bids, consistent with Chapter 4 of the D.C. Official Code (2001 ed.).

4. Following the receipt of bids to select health, dental, optical, life and disability insurance providers, the Union's Chief Negotiator shall be notified to identify no more than two individuals to participate in the RFP selection process.

5. Explore issues concerning the workers' compensation system that affect employees in Compensation Units 1 and 2 consistent with Chapter 6, Subchapter XXIII of the D.C. Official Code (2001 ed.).

6. The Union shall be notified of proposed benefit programs to determine the extent to which they impact employees in Compensation Units 1 and 2. Upon notification, the Union shall inform the Office of Labor Relations and Collective Bargaining within ten (10) calendar days to discuss any concerns it has regarding the impact on employees in Compensation Units 1 and 2.

ARTICLE 6
BENEFITS

SECTION A: LIFE INSURANCE:

1. Life insurance is provided to covered employees in accordance with §1-622.01, *et seq.* of the District of Columbia Official Code (2001 Edition) and Chapter 87 of Title 5 of the United States Code.

(a) District of Columbia Official Code §1-622.03 (2001 Edition) requires that benefits shall be provided as set forth in §1-622.07 to all employees of the District first employed after September 30, 1987, except those specifically excluded by law or by rule.

(b) District of Columbia Official Code §1-622.01 (2001 Edition) requires that benefits shall be provided as set forth in Chapter 87 of Title 5 of the United States Code for all employees of the District government first employed before October 1, 1987, except those specifically excluded by law or rule and regulation.

2. The current life insurance benefits for employees hired on or after October 1, 1987 are: The District of Columbia provides life insurance in an amount equal to the employee's annual salary rounded to the next thousand, plus an additional $2,000. Employees are required to pay two-thirds (2/3) of the total cost of the monthly premium. The District Government shall pay one-third (1/3) of the total cost of the premium. Employees may choose to purchase additional life insurance coverage through the District Government. These additions to the basic coverage are set-forth in the schedule below:

Option A – Standard	Provides $10,000 additional coverage	Cost determined by age
Option B – Additional	Provides coverage up to five times the employee's annual salary	Cost determined by age and employee's salary
Option C – Family	Provides $5,000 coverage for the eligible spouse and $2,500 for each eligible child.	Cost determined by age.

Employees must contact their respective personnel offices to enroll or make changes in their life insurance coverage.

SECTION B: HEALTH INSURANCE:

1. Pursuant to D.C. Official Code §1-621.02 (2001 Edition), all employees covered by this agreement and hired after September 30, 1987, shall be entitled to enroll in group health insurance coverage provided by the District of Columbia.

(a) Health insurance coverage shall provide a level of benefits comparable to the plan(s) provided on the effective date of this agreement. Benefit levels shall not be reduced during the term of this agreement except by mutual agreement of the District, representatives of Compensation Units 1 and 2 and the insurance carrier(s). District employees are required to execute an enrollment form in order to participate in this program.

(b) The District may elect to provide additional health care providers for employees employed after September 30, 1987, provided that such addition of providers does not reduce the current level of benefits provided to employees. Should the District Government decide to expand the list of eligible providers, the District shall give Compensation Units 1 & 2 representatives notice of the proposed additions.

(c) Employees are required to contribute 25% of the total premium cost of the employee's selected plan. The District of Columbia Government shall contribute 75% of the premium cost of the employee's selected plan.

2. Pursuant to D.C. Official Code §1-621.01 (2001 Edition), all District employees covered by this agreement and hired before October 1, 1987, shall be eligible to participate in group health insurance coverage provided through the Federal Employees Health Benefits Program (FEHB) as provided in Chapter 89 of Title 5 of the United States Code. This program is administered by United States Office of Personnel Management.

3. The plan descriptions shall provide the terms of coverage and administration of the respective plans. Employees and union representatives are entitled to receive a copy of the summary plan description upon request. Additionally, employees

and union representatives are entitled to review copies of the actual plan description upon advance request.

SECTION C: OPTICAL AND DENTAL:

1. The District shall provide Optical and Dental Plan coverage at a level of benefits comparable to the plan(s) provided on the effective date of this agreement. Benefit levels shall not be reduced during the term of this agreement except by mutual agreement of the District, the Union and the insurance carrier(s). District employees are required to execute an enrollment form in order to participate in the Optical and Dental program.

2. The District may elect to provide additional Optical and/or Dental providers, provided that such addition of providers does not reduce the current level of benefits provided to employees. Should the District Government decide to expand the list of eligible providers, the District shall give Compensation Units 1 & 2 representatives notice of the proposed additions.

SECTION D: SHORT-TERM DISABILITY INSURANCE PROGRAM

Employees covered by this Agreement shall be eligible to enroll, at their own expense, in the District's Short-Term Disability Insurance Program, which provides for partial income replacement when employees are required to be absent from duty due to a non-work-related qualifying medical condition. Employees may use income replacement benefits under the program in conjunction with annual or sick leave benefits provided for in this Agreement.

SECTION E: ANNUAL LEAVE:

1. In accordance with D.C. Official Code §1-612.03 (2001 Edition), full-time employees covered by the terms of this agreement are entitled to:

(a) one-half (1/2) day (4 hours) for each full biweekly pay period for an employee with less than three years of service (accruing a total of thirteen (13) annual leave days per annum);

(b) three-fourths (3/4) day (6 hours) for each full biweekly pay period, except that the accrual for the last full biweekly pay period in the year is one and one-fourth days (10 hours), for an employee with more than three (3) but less than fifteen (15) years of service (accruing a total of twenty (20) annual leave days per annum); and,

(c) one (1) day (8 hours) for each full biweekly pay period for an employee with fifteen (15) or more years of service (accruing a total of twenty-six (26) annual leave days per annum).

2. Part-time employees who work at least 40 hours per pay period earn annual leave at one-half the rate of full-time employees.

3. Employees shall be eligible to use annual leave in accordance with the District of Columbia laws.

SECTION F: SICK LEAVE:

1. In accordance with District of Columbia Official Code §1-612.03 (2001 Edition), a full-time employee covered by the terms of this agreement may accumulate up to thirteen (13) sick days in a calendar year.

2. Part-time employees for whom there has been established in advance a regular tour of duty of a definite day or hour of any day during each administrative workweek of the biweekly pay period shall earn sick leave at the rate of one (1) hour for each twenty (20) hours of duty. Credit may not exceed four (4) hours of sick leave for 80 hours of duty in any pay period. There is no credit of leave for fractional parts of a biweekly pay period either at the beginning or end of an employee's period of service.

SECTION G: OTHER FORMS OF LEAVE:

1. **Military Leave**: An employee is entitled to leave, without loss of pay, leave, or credit for time of service as reserve members of the armed forces or as members of the National Guard to the extent provided in D.C. Official Code §1-612.03(m) (2001 Edition).

2. **Court Leave:** An employee is entitled to leave, without loss of pay, leave, or service credit during a period of absence in which he or she is required to report for jury duty or to appear as a witness on behalf of the District of Columbia Government, or the Federal or a state or local government to the extent provided in D.C. Official Code §1-612.03(l) (2001 Edition).

3. **Funeral Leave:**

a. An employee is entitled to two (2) days of leave, without loss of pay, leave, or service credit to make arrangements for or to attend the funeral or memorial service for an immediate relative. In addition, the Employer shall grant an employee's request for annual or compensatory time up to three (3) days upon the death of an immediate relative. Approval of additional time shall be at the Employer's discretion. However, requests for leave shall be granted unless the Agency's ability to accomplish its work would be seriously impaired.

b. For the purpose of this section "immediate relative" means the following relatives of the employee: spouse (including a person identified by an employee as his/her "domestic partner" (as defined in D.C. Official Code §32-701 (2001 edition), and related laws), and parents thereof, children (including adopted and foster children and children of whom the employee is legal guardian and spouses thereof, parents, grandparents, grandchildren, brothers, sisters, and spouses thereof. For the purposes of certification of leave, employees shall provide a copy of the obituary or death notice, a note from clergy or funeral professional or a death certificate upon the Employer's request.

c. An employee is entitled to not more than three (3) days of leave, without loss of pay, leave, or service credit to make arrangements for or to attend the funeral or memorial service for a family member who died as a result of a wound, disease or injury incurred while serving as a member of the armed forces in a combat zone to the extent provided in D.C. Official Code §1-612.03(n) (2001 Edition).

SECTION H: PRE-TAX BENEFITS:

1. Employee contributions to benefits programs established pursuant to D.C. Official Code §1-611.19 (2001 ed.), including the District of Columbia Employees Health Benefits Program, may be made on a pre-tax basis in accordance with the requirements of the Internal Revenue Code and, to the extent permitted by the Intemal Revenue Code, such pre-tax contributions shall not effect a reduction of the amount of any other retirement, pension, or other benefits provided by law.

2. To the extent permitted by the Internal Revenue Code, any amount of contributions made on a pre-tax basis shall be included in the employee's contributions to existing life insurance, retirement system, and for any other District government program keyed to the employee's scheduled rate of pay, but shall not be included for the purpose of computing Federal or District income tax withholdings, including F.I.C.A., on behalf of any such employee.

SECTION I: RETIREMENT:

1. **CIVIL SERVICE RETIREMENT SYSTEM (CSRS):** As prescribed by 5 U.S.C. §8401 and related chapters, employees first hired by the District of Columbia Govemment before October 1, 1987, are subject to the provisions of the CSRS, which is administered by the U.S. Office of Personnel Management. Under Optional Retirement the aforementioned employee may choose to retire when he/she reaches:

(a) Age 55 and 30 years of service;
(b) Age 60 and 20 years of service;
(c) Age 62 and 5 years of service.

Under Voluntary Early Retirement, which must be authorized by the U.S. Office of Personnel Management, an employee may choose to retire when he/she reaches:

(a) Age 50 and 20 years of service;
(b) Any age and 25 years of service.

The pension of an employee who chooses Voluntary Early Retirement will be reduced by 2% for each year under age 55.

2. CIVIL SERVICE RETIREMENT SYSTEM: SPECIAL RETIREMENT PROVISIONS FOR LAW ENFORCEMENT OFFICERS:

Employees first hired by the District of Columbia Government before October 1, 1987, who are subject to the provisions of the CSRS and determined to be:

(a) a "law enforcement officer" within the meaning of 5 U.S.C. §8331(20)(D); and

(b) eligible for benefits under the special retirement provision for law enforcement officers;

shall continue to have their retirement benefits administered by the U. S. Office of Personnel Management in accordance with applicable law and regulation.

3. DEFINED CONTRIBUTION PENSION PLAN:

Section A:

The District of Columbia shall continue the Defined Contribution Pension Plan currently in effect which includes:

(1) All eligible employees hired by the District on or after October 1, 1987, are enrolled into the defined contribution pension plan.

(2) As prescribed by §1-626.09(c) of the D.C. Official Code (2001 Edition) after the completion of one year of service, the District shall contribute an amount not less than 5% of their base salary to an employee's Defined Contribution Pension Plan account. The District government funds this plan; there is no employee contribution to the Defined Contribution Pension Plan.

(3) As prescribed by §1-626.09(d) of the D.C. Official Code (2001 Edition) the District shall contribute an amount not less than an additional .5% of a detention officer's base salary to the same plan.

(4) Compensation Units 1 and 2 Joint Labor Management Technical Advisory Pension Reform Committee

(a) Establishment of the Joint Labor-Management Technical Advisory Pension Reform Committee (JLMTAPRC or Committee)

(1) The Parties agree that employees should have the security of a predictable level of income for their retirement after a career in public service. In order to support the objective of providing retirement income for employees hired on or after October 1, 1987, the District shall plan and implement an enhanced retirement program effective October 1, 2008. The enhanced program will consist of a

deferred compensation component and a defined benefit component.

(2) Accordingly, the Parties agree that the JLMTAPRC is hereby established for the purpose of developing an enhanced retirement program for employees covered by the Compensation Units 1 and 2 Agreement.

(b) Composition of the JLMTAPRC

The Joint Labor-Management Technical Advisory Pension Reform Committee will be composed of six (6) members, three (3) appointed by labor and three (3) appointed by management, and the Chief Negotiators (or his/her designee) of Compensation Units 1 and 2. Appointed representatives must possess a pension plan background including but not limited to consulting, financial or actuarial services. In addition, an independent consulting firm with demonstrated experience in pension plans design and actuarial analysis will support the Committee.

(c) Responsibilities of the JLMTAPRC

The Committee shall be responsible to:

- Plan and design an enhanced retirement program for employees hired on or after October 1, 1987 with equitable sharing of costs and risks between employee and employer;
- Establish a formula cap for employee and employer contributions;
- Establish the final compensation calculation using the highest three-year consecutive average employee wages;
- Include retirement provisions such as disability, survivor and death benefits, health and life insurance benefits;
- Design a plan sustainable within the allocated budget;
- Draft and support legislation to amend the D.C. Code in furtherance of the "Enhanced Retirement Program."

(d) Duration of the Committee

The Committee shall complete and submit a report with its recommendations to the City Administrator for the District of Columbia within one hundred and twenty (120) days after the effective date of the Compensation Units 1 and 2 Agreement.

4. TIAA-CREF PLAN:

For eligible education service employees at the University of the District of Columbia hired by the University or a predecessor institution, the University will contribute an amount not less than seven percent (7%) of their base salary to the Teachers Insurance and Annuity Association College Retirement Equities Fund (TIAA-CREF).

SECTION J: HOLIDAYS:

1. As prescribed by D.C. Official Code §1-612.02 (2001 Edition) the following legal public holidays are provided to all employees covered by this agreement:

(a) New Year's Day, January 1st of each year;
(b) Dr. Martin Luther King, Jr.'s Birthday, the 3rd Monday in January of each year;
(c) Washington's Birthday, the 3rd Monday in February of each year;
(d) Emancipation Day, April 16th;
(e) Memorial Day, the last Monday in May of each year;
(f) Independence Day, July 4th of each year;
(g) Labor Day, the 1st Monday in September of each year;
(h) Columbus Day, the 2nd Monday in October of each year;
(i) Veterans Day, November 11th of each year;
(j) Thanksgiving Day, the 4th Thursday in November of each year; and
(k) Christmas Day, December 25th of each year.

2. When an employee, having a regularly scheduled tour of duty is relieved or prevented from working on a day District agencies are closed by order of the Mayor, he or she is entitled to the same pay for that day as for a day on which an ordinary day's work is performed.

ARTICLE 7
OVERTIME

SECTION A: Overtime Work:

Hours of work authorized in excess of eight (8) hours in a pay status in a day or forty (40) hours in a pay status in a work week shall be overtime work for which an employee shall receive either overtime pay or compensatory time unless the employee has used unscheduled leave during the eight (8) hours shift or the forty (40) hour work week. The unscheduled leave rule will not apply when an employee has worked a sixteen (16) hour shift (back-to-back) and takes unscheduled leave for an eight (8) hour period following the back-to-back shift or where an employee has indicated his/her preference not to work overtime and the Employer has no other option but to order the employee to work overtime. Scheduled leave is leave requested and approved prior to the close of the preceding shift.

SECTION B: Compressed, Alternate and Flexible Schedules:

1. Compressed, Alternate and Flexible schedules may be jointly determined within a specific work area that modifies this overtime provision (as outlined in Section A of this Article) but must be submitted to the parties to this contract prior to implementation. This Agreement to jointly determine compressed schedules does not impact on the setting of the tour of duty.

2. When an employee works a Compressed, Alternate, and Flexible schedule, which generally means (1) in the case of a full-time employee, an 80-hour biweekly basic work requirement which is scheduled for less than 10 workdays, and (2) in the case of a part-time employee, a biweekly basic work requirement of less than 80 hours which is scheduled for less than 10 workdays, the employee would receive overtime pay or compensatory time for all hours in a pay status in excess of his/her assigned tour of duty, consistent with the 2004 District of Columbia Omnibus Authorization Act, 118 Stat. 2230, Pub. L. 108-386 Section (October 30, 2004).

3. The purpose of this Section is to allow for authorized Compressed, Alternate, and Flexible time schedules which exceed eight (8) hours in a day or 40 hours in a week to be deemed the employee's regular tour of duty, and not be considered and not be considered overtime within the confines of the specific compressed work schedule and this Article. Bargaining unit members so affected would receive overtime or compensatory time for all hours in pay status in excess of their assigned tour of duty.

SECTION C:

Subject to the provisions of Section D of this Article, an employee who performs overtime work shall receive either pay or compensatory time at a rate of time and one-half (1-1/2) for each hour of work for which overtime is payable.

SECTION D:

Bargaining Unit employees shall receive overtime pay unless the employee and the supervisor mutually agree to compensatory time in lieu of pay for overtime work. Such mutual agreement shall be made prior to the overtime work being performed.

SECTION E:

Paramedics and Emergency Medical Services Technicians employed by the Fire and Emergency Medical Services Department and represented by the American Federation of Government Employees, Local 3721 shall earn overtime after they have worked 40 hours in a week.

ARTICLE 8
INCENTIVE PROGRAMS

PART I - SICK LEAVE INCENTIVE PROGRAM:

In order to recognize an employee's productivity through his/her responsible use of accrued sick leave, the Employer agrees to provide time-off in accordance with the following:

SECTION A:

A full time employee who is in a pay status for the leave year shall accrue annually:

1. Three (3) days off for utilizing a total of no more than two (2) days of accrued sick leave.

2. Two (2) days off for utilizing a total of more than two (2) but not more than four (4) days of accrued sick leave.

3. One (1) day off for utilizing a total of more than four (4) but no more than five (5) days of accrued sick leave.

SECTION B:

Employees in a non-pay status for no more than two (2) pay periods for the leave year shall remain eligible for incentive days under this Article. Sick leave usage for maternity or catastrophic illness/injury, not to exceed two (2) consecutive pay periods, shall not be counted against sick leave for calculating eligibility for incentive leave under this Article.

SECTION C:

Time off pursuant to a sick leave incentive award shall be selected by the employee and requested at least three (3) full workdays in advance of the leave date. Requests for time off pursuant to an incentive award shall be given priority consideration and the employee's supervisor shall approve such requests for time off unless staffing needs or workload considerations dictate otherwise. If the request is denied, the employee shall request and be granted a different day off within one month of the date the employee initially requested. Requests for time off shall be made on the standard "Application for Leave" form.

SECTION D:

All incentive days must be used in full-day increments following the leave year in which they were earned. Incentive days may not be substituted for any other type of absence from duty. There shall be no carryover or payment for any unused incentive days.

SECTION E:

Part-time employees are not eligible for the sick leave incentive as provided in this Article.

SECTION F:

This program shall be in effect in Fiscal Years 2014, 2015, 2016 and 2017.

PART II – PERFORMANCE INCENTIVE PILOT PROGRAM:

In order to recognize employees' productivity through their accomplishment of established goals and objectives, special acts toward the accomplishment of agency initiatives, demonstrated leadership in meeting agency program and/or project goals and/or the District's Strategic Plan initiatives, the Employer, in accordance with criteria established by the High Performance Workplace Committee agrees to establish pilot incentive programs within agencies, including time off without loss of pay or charge to leave as an incentive award. The District of Columbia Government Office of Labor Management Partnerships and the District of Columbia Incentive Awards Committee may serve as resources at the request of the parties in the implementation of the pilot incentive programs within agencies.

ARTICLE 9
CALL-BACK/CALL-IN/ON-CALL AND PREMIUM PAY

SECTION A: CALL-BACK

A minimum of four (4) hours of overtime, shall be credited to any employee who is called back to perform unscheduled overtime work on a regular workday after he/she completes the regular work schedule and has left his/her place of employment.

SECTION B: CALL-IN

1. When an employee is called in before his/her regular tour of duty to perform unscheduled overtime and there is no break before the regular tour is to begin, a minimum of two (2) hours of overtime shall be credited to the employee.

2. A minimum of four (4) hours of overtime work shall be credited to any employee who is called in when not scheduled and informed in advance, on one of the days when he/she is off duty.

SECTION C: ON-CALL

1. An employee may be required to be on call after having completed his/her regular tour of duty. The employer shall specify the hours during which the employee is on call; and shall compensate the employee at a rate of twenty-five percent (25%) of his/her basic rate of pay for each hour the employee is on call.

2. The employee's schedule must specify the hours during which he/she will be required to remain on-call. On call designation will be made on the form attached as Appendix 1.

SECTION D: HOLIDAY PAY

An employee who is required to work on a legal holiday falling within his or her regular basic workweek, shall be paid at the rate of twice his or her regular basic rate of pay for not more than eight (8) hours of such work.

SECTION E: NIGHT DIFFERENTIAL

An employee shall receive night differential pay at a rate of ten percent (10%) in excess of their basic day rate of compensation when they perform night work on a regularly scheduled tour of duty falling between 6:00 p.m. and 6:00 a.m. Employees shall receive night differential in lieu of shift differential.

SECTION F: PAY FOR SUNDAY WORK

A full-time employee assigned to a regularly scheduled tour of duty, any part of which includes hours that fall between midnight Saturday and midnight Sunday, is entitled to Sunday premium pay for each hour of work performed which is not overtime work and which is not in excess of eight (8) hours for each tour of duty which begins or ends on Sunday. Sunday premium pay is computed as an additional twenty-five percent (25%) of the employee's basic rate of compensation.

SECTION G: ADDITIONAL INCOME ALLOWANCE FOR CHILD AND FAMILY SERVICES

1. The Additional Income Allowance (AIA) program within the Child and Family Services Agency (CFSA) which was established pursuant to the "Personnel Recruitment and Retention Incentives for Child and Family Services Agency Compensation System Changes Emergency Approval Resolution of 2001", Council Resolution 14-53 (March 23, 2001) and as contained in Chapter 11, Section 1154 of the District Personnel Manual, "Recruitment and Retention Incentives – Child and Family Services Agency," shall remain in full force and effect during the term of this Agreement.

2. The Administration of the AIA within CFSA shall be governed by the implementing regulations established in Child and Family Services Agency, Human Resources Administration Issuance System, HRA Instruction No. IV.11-3.

3. **OTHER SUBORDINATE AGENCIES WITH SIGNIFICANT RECRUITMENT AND RETENTION PROBLEMS**

Subordinate agencies covered by this Agreement may provide additional income allowances for positions that have significant recruitment and retention problems consistent with Chapter 11, Part B, Section 1143 of the District Personnel Manual.

ARTICLE 10
MILEAGE ALLOWANCE

SECTION A:

The parties agree that the mileage allowance established for the employees of the Federal Government who are authorized to use their personal vehicles in the performance of their official duties shall be the rate for Compensation Units 1 and 2 employees, who are also authorized in advance, by Management to use their personal vehicles in the performance of their official duties.

SECTION B:

To receive such allowance, authorization by Management must be issued prior to the use of the employee's vehicle in the performance of duty. Employees shall use the appropriate District Form to document mileage and request reimbursement of the allowance.

SECTION C:

1. Employees required to use their personal vehicle for official business if a government vehicle is not available, who are reimbursed by the District on a mileage basis for such use, are within the scope of the District of Columbia Non-Liability Act (D.C. Official Code §§2-411 through 2-416 (2001 Edition)). The Non-Liability Act generally provides that a District Employee is not subject to personal liability in a civil suit for property damage or for personal injury arising out of a motor vehicle accident during the discharge of the employee's official duties, so long as the employee was acting within the scope of his or her employment.

2. Claims by employees for personal property damage or loss incident to the use of their personal vehicle for official business if a government vehicle is not available may be made under the Military Personnel and Civilian Employees Claim Act of 1964 (31 U.S.C. §3701 *et seq.*).

SECTION D:

No employee within Compensation 1 and 2 shall be required to use his/her personal vehicle unless the position vacancy announcement, position description or other pre-hire

documentation informs the employee that the use of his/her personal vehicle is a requirement of the job.

SECTION E:

Employees required as a condition of employment to use their personal vehicle in the performance of their official duties may be provided a parking space or shall be reimbursed for non-commuter parking expenses, which are incurred in the performance of their official duties.

ARTICLE 11
ANNUAL LEAVE/COMPENSATORY TIME BUY-OUT

SECTION A:

An employee who is separated or is otherwise entitled to a lump-sum payment under personnel regulations for the District of Columbia Government shall receive such payment for each hour of unused annual leave or compensatory time in the employee's official leave record.

SECTION B:

The lump-sum payment shall be computed on the basis of the employee's rate at the time of separation in accordance with such personnel regulations.

ARTICLE 12
BACK PAY

Arbitration awards or settlement agreements in cases involving an individual employee shall be paid within sixty (60) days of receipt from the employee of relevant documentation, including documentation of interim earnings and other potential offsets. The responsible Agency shall submit the SF-52 and all other required documentation to the Department of Human Resources within thirty (30) days upon receipt from the employee of relevant documentation.

ARTICLE 13
DUTY STATION COVERAGE

The Fire and Emergency Medical Services employees and the correctional officers at the Department of Corrections and the Department of Youth Rehabilitative Services who are covered under Section 7(k) of the Fair Labor Standards Act shall be compensated a minimum of one hour pay if required to remain at his/her duty station beyond the normal tour of duty.

ARTICLE 14
GRIEVANCES

SECTION A:

This Compensation Agreement shall be incorporated by reference into local working conditions agreements in order to utilize the grievance/arbitration procedure in those Agreements to consider alleged violations of this Agreement.

SECTION B:

Grievances concerning compensation shall be filed with the appropriate agency and the Office of Labor Relations and Collective Bargaining under the applicable working conditions agreement.

ARTICLE 15
LOCAL ENVIRONMENT PAY

SECTION A:

Each department or agency shall eliminate or reduce to the lowest level possible all hazards, physical hardships, and working conditions of an unusual nature. When such action does not overcome the hazard, physical hardship, or unusual nature of the working condition, additional pay is warranted. Even though additional pay for exposure to a hazard, physical hardship, or unusual working condition is authorized, there is a responsibility on the part of a department or agency to initiate continuing positive action to eliminate danger and risk which contribute to or cause the hazard, physical hardship, or unusual working condition. The existence of pay for exposure to hazardous working conditions or hardships in a local environment is not intended to condone work practices that circumvent safety laws, rules and regulations.

SECTION B:

Local environment pay is paid for exposure to (1) a hazard of an unusual nature which could result in significant injury, illness, or death, such as on a high structure when the hazard is not practically eliminated by protective facilities or an open structure when adverse conditions exist, e.g., darkness, lightning, steady rain, snow, sleet, ice, or high wind velocity; (2) a physical hardship of an unusual nature under circumstances which cause significant physical discomfort in the form of nausea, or skin, eye, ear or nose irritation, or conditions which cause abnormal soil of body and clothing, etc., and where such distress or discomfort is not practically eliminated.

SECTION C:

Wage Grade (WG) employees as listed in Chapter 11B, Appendix C of the DPM and any other employee including District Service (DS) employees as determined pursuant to Section 4 of this Article and Chapter 11B, Subpart 10.6 of the DPM are eligible for environmental differentials.

SECTION D:

The determination as to whether additional pay is warranted for workplace exposure to environmental hazards, hardships or unusual working conditions may be initiated by an agency or labor organization in accordance with the provisions of Chapter 11B, Subpart 10.6 of the DPM.

SECTION E:

Employees eligible for local environment pay under the terms of this Agreement shall be compensated as follows:

1. **Severe Exposure.** Employees subject to "Severe" exposure shall receive local environment pay equal to twenty seven percent (27%) of *the rate for RW 10, step 2 on the Compensation Unit 2 pay schedule.* The following categories of work are currently paid the rate for "severe" exposure:

- High Work

2. **Moderate Exposure.** Employees subject to "Moderate" exposure shall receive local environment pay equal to ten percent (10%) of *the rate for RW 10, step 2 on the Compensation Unit 2 pay schedule.* The following categories of work are currently paid the rate for "moderate" exposure:

- Explosives and Incendiary Materials – High Degree Hazard
- Poison (Toxic Chemicals) – High Degree Hazard
- Micro Organisms – High Degree Hazard

3. **Low Exposure.** Employees subject to "Low" exposure shall receive local environment pay equal to five percent (5%) of *the rate for RW 10, step 2 on the Compensation Unit 2 pay schedule.* The following categories of work are currently paid the rate for "low" exposure:

- Dirty Work
- Cold Work
- Hot Work
- Welding Preheated metals

- Explosives and Incendiary Materials
  – Low Degree Hazard
- Poison (Toxic Chemicals)
  – Low Degree Hazard
- Micro Organisms
  – Low Degree Hazard

SECTION F:

These changes to local environment pay shall not take effect until the payroll modules of PeopleSoft are implemented by the District of Columbia.

ARTICLE 16
NEWLY CERTIFIED BARGAINING UNITS

For units placed into a new compensation unit, working conditions or non-compensatory matters shall be negotiated simultaneous with negotiations concerning compensation. Where the agreement is for a newly certified collective bargaining unit assigned to an existing compensation unit, the parties shall proceed promptly to negotiate simultaneously any working conditions, other non-compensatory matters, and coverage of the compensation agreement. There should not be read into the new language any intent that an existing compensation agreement shall become negotiable when there is a newly certified collective bargaining unit. Rather, the intent is to require prompt negotiations of non-compensatory matters as well as application of compensation (e.g., when pay scale shall apply to the newly certified unit).

ARTICLE 17
TERM AND TEMPORARY EMPLOYEES

The District of Columbia recognizes that many temporary and term employees have had their terms extended to perform permanent services. To address the interests of current term and temporary employees whose appointments have been so extended over time and who perform permanent services, the District of Columbia and the Union representing the employees in Compensation Units 1 and 2 agree to the following:

SECTION A:

Joint labor-management committees established in each agency/program in the Compensation Units 1 and 2 collective bargaining agreement which was effective through September 30, 2010, shall continue and will identify temporary and term employees whose current term and or temporary appointments extend to September 30, 2006, and who perform permanent services in District agency programs.

SECTION B:

Each Agency and Local Union shall review all term appointments within the respective agencies to determine whether such appointments are made and maintained consistent with applicable law. The Union shall identify individual appointments it believes to be contrary to applicable law and notify the Agency. The Agency shall provide the Union reason(s) for the term or temporary nature of the appointment(s), where said appointments appear to be contrary to law. If an employee has been inappropriately appointed to or maintained in a temporary or term appointment, the Agency and the Union shall meet to resolve the matter.

SECTION C:

The agency shall convert bargaining unit temporary and term employees identified by the joint labor-management committees, who perform permanent services, who are in a pay status as of September 30, 2010, and are paid from appropriated funding to the career service prior to the end of the FY 2013 – FY 2017 Compensation Agreement.

SECTION D:

Prior to the end of the FY 2013 – FY 2017 Compensation Agreement, to the extent not inconsistent with District or Federal law and regulation, the District shall make reasonable efforts to convert to the career service temporary and term bargaining unit employees identified by the joint labor-management committees who perform permanent services, are in a pay status as of September 30, 2017, are full-time permanent positions, and are paid through intra-district funding or federal grant funding.

SECTION E:

Employees in term or temporary appointments shall be converted to permanent appointments, consistent with the D.C. Official Code.

SECTION F:

District agencies retain the authority to make term and temporary appointments as appropriate for seasonal and temporary work needs.

SECTION G:

A Joint-Labor Management Committee shall consist of one (1) representative from each national union comprising Compensation Units 1 and 2. The District shall appoint an equal number of representatives. The Committee will facilitate the implementation of this Article should difficulties arise in the Joint-Labor Management Committees set forth in Section A.

ARTICLE 18
SAVINGS CLAUSE

SECTION A:

Should any provisions of this Agreement be rendered or declared invalid by reason of any existing or subsequently enacted law or by decree of a court or administrative agency of competent jurisdiction, such invalidation shall not affect any other part or provision hereof. Where appropriate, the parties shall meet within 120 days to negotiate any substitute provision(s).

SECTION B:

The terms of this contract supersede any subsequently enacted D.C. laws, District Personnel Manual (DPM) regulations, or departmental rules concerning compensation covered herein.

ARTICLE 19
DURATION

This Agreement shall remain in full force and effect through September 30, 2017. On this _____ day of _____ 2013, and as witness the parties hereto have set their signature.

Compensation Units One and Two Collective Bargaining Agreement
Signed: July 2, 2013

FOR THE DISTRICT OF COLUMBIA GOVERNMENT

Natasha Campbell, Director
Office of Labor Relations and
Collective Bargaining

Dean Aqui,
Supervisory Attorney Advisor
Office of Labor Relations and
Collective Bargaining

Joxel Garcia, MD, MBA, Acting Director
Department of Health

Earl Murphy, Labor Liaison
Department of Health

William Howland, Director
Department of Public Works

Kwelli Sneed, Labor Liaison
Department of Public Works

Cathy Lanier, Chief
Metropolitan Police Department

FOR THE UNIONS

Geo T. Johnson, Chief Negotiator
Compensation Units 1 and 2

James Ivey, President
AFSCME Local 2091

Miranda Gillis, President
AFGE Local 2725

John Rosser, Chairman
Fraternal Order of Police/Department of
Corrections Labor Committee

Lee Blackmon, President
National Association of Government
Employees, R3-07

Ben Butler, President
AFGE Local 2741

Cynthia Perry, Staff Representative
1199 NUCHHE

Compensation Units One and Two Collective Bargaining Agreement
Signed: July, 2013

Mark Viehmeyer, Labor Liaison
Metropolitan Police Department

Lisa Wallace, Vice President
SEIU 1199E-DC

Kenneth Ellerbe, Chief
DC Fire and Emergency Medical Services

Clifford Lowrey, President
AFGE Local 1975

Brian Lee
DC Fire and Emergency Medical Services

Sabrina Brown, President
AFSCME Local 2401

Jesús Aguirre, Director
Department of Parks and Recreation

Reginald Walker, President
AFSCME Local 1200

Jamarj Johnson, Labor Liaison
Department of Park and Recreation

Cliff Dedrick, President
AFSCME Local 2743

Lucinda Babers, Director
Department of Motor Vehicles

Kenneth Lyons, President
AFGE Local 3721

Odessa Nance, Labor Liaison
Department of Motor Vehicles

Robert Hollingsworth, President
AFSCME Local 2776

Terry Bellamy, Director
Department of Transportation

Antoinette White-Richardson, President
AFSCME Local 1808

Compensation Units One and Two Collective Bargaining Agreement
Signed: July, 2013

Melissa Williams, Labor Liaison
Department of Transportation

Robert Mayfield, President
AFGE Local 2978

Thomas Faust, Director
Department of Corrections

Timothy Traylor, President
AFGE Local 383

Paulette Johnson-Hutchings,
Labor Liaison
Department of Corrections

~~Richard Campbell~~, President Alletta Samuels
AFGE Local 1000

Marie Lydie Pierre-Louis
Chief Medical Examiner
Office of the Chief Medical Examiner

Walter Jones, President
AFSCME Local 2087

Beverly Fields, Labor Liaison
Office of the Chief Medical Examiner

Barbara Milton, President
AFGE Local 631

Brian Hanlon, Director
Department of General Services

Antonio Reed, President
NAGE R3-05

Cecelia Bankins, Labor Liaison
Department of General Services

Cedric Crawley
FOP-DYRSLC

Phillip A. Lattimore, III, Director
Office of Risk Management

Darren Roach, President
AFSCME Local 877

Compensation Units One and Two Collective Bargaining Agreement
Signed: July, 2012

Amy Mauro, Labor Liaison
Office of Risk Management

Sheila Bailey-Wilson, President
AFSCME Local 709

Emily Duso, Interim State
Superintendent of Education
Office of the State Superintendent
Of Education

Johnnie Walker, Representative
AFGE Local 3444

RaeShawn Crosson, Labor Liaison
Office of the State Superintendent
Of Education

Keith Washington, President
AFSCME Local 2092

Dr. Natwar Gandhi,
Chief Financial Officer
Office of the Chief Financial Officer

Mary Horne, President
AFSCME Local 2095

Paul Lundquist, Labor Liaison
Office of the Chief Financial Officer

Phillip A. Lattimore, III, Director
Office of Risk Management

Wayne M. Turnage, Director
Department of Health Care Finance

Compensation Units One and Two Collective Bargaining Agreement
Signed: July, 2012

Portia Shorter, Labor Liaison
Department of Health Care Finance

David Berns, Director
Department of Human Services

Jaki Buckley, Labor Liaison
Department of Human Services

Ginnie Cooper, Executive Director
DC Public Libraries

Barbara Kirven, Labor Liaison
DC Public Libraries

Jennifer Green, Director
Office of Unified Communications

Arnita Bonner-Evans, Labor Liaison
Office of Unified Communications

Compensation Units One and Two Collective Bargaining Agreement
Signed: July, 2012

Gustavo F. Velasquez, Director
Office of Human Rights

Ayanna Lee, Labor Liaison
Office of Human Rights

Lisa Maria Mallory, Director
Department of Employment Services

Rahsaan J. Coefield, Labor Liaison
Department of Employment Services

William P. White, Commissioner
Department of Insurance, Securities
And Banking

Margaret Schruender, Labor Liaison
Department of Insurance, Securities
And Banking

Nicholas A. Majett, Director
Department of Consumer and
Regulatory Affairs

Donald Tatum, Labor Liaison
Department of Consumer and
Regulatory Affairs

Compensation Units One and Two Collective Bargaining Agreement
Signed: July, 2012

Keith Anderson, Director
Department of the Environment

Denise Rivera-Portis, Labor Liaison
Department of the Environment

Michael Kelly, Director
Department of Housing and
Community Development

Angela Nottingham, Labor Liaison
Department of Housing and
Community Development

Dr. James E. Lyons, Sr., Interim President
University of the District of Columbia

_____, Labor Liaison
University of the District of Columbia

Neil Stanley, Director
Department of Youth Rehabilitation
Services

Tania Mortensen, Labor Liaison
Department of Youth Rehabilitation
Services

Vikkie Garay, Labor Liaison
Department of General Services

Compensation Units One and Two Collective Bargaining Agreement
Signed: July, 2012

Ron M. Linton, Commissioner
DC Taxicab Commission

Patty Mason, Labor Liaison
DC Taxicab Commission

Harriet Tregoning, Director
Office of Planning

Sandra Harp, Labor Liaison
Office of Planning

Eric E. Richardson, Executive Director
Office of Cable Television

Angela Harper, Labor Liaison
Office of Cable Television

Robert Mancini, Chief Technology Officer
Office of the Chief Technology Officer

Christina Fleps, Labor Liaison
Office of the Chief Technology Officer

Compensation Units One and Two Collective Bargaining Agreement
Signed: July, 2012

Laura L. Nuss, Director
Department of Disability Services

Kehinde Asuelimen, Labor Liaison
Department of Disability Services

James Staton, Jr., Chief Procurement Officer
Office of Contracting and Procurement

Shirley Lanier, Labor Liaison
Office of Contracting and Procurement

Stephen Baron, Director
Department of Mental Health

Frankie T. Wheeler, Director,
Human Resources
Department of Mental Health

Brendolyn McCarty-Jones, Labor Liaison
Department of Mental Health

APPROVAL

This collective bargaining agreement between the District of Columbia and Compensation Units 1 and 2, dated April 12, 2012, has been reviewed in accordance with Section 1-617.15 of the District of Columbia Official Code (2001 Ed.) and is hereby approved on this 10th day of July, 2013.

Vincent C. Gray

Vincent Gray
Mayor

APPENDIX A

Memorandum of Understanding

Between
Compensation Units 1 & 2
and
The District of Columbia
Concerning Classification and Compensation Collaborative Review

"The Parties hereby agree that in order to support the objective of rewarding a high performance workforce, a training program for all bargaining committee members shall be developed by a joint labor-management committee. The Committee will be composed of sixteen members, eight appointed by labor and eight appointed by management, and the Chief and Co-Chief negotiators of Compensation Units 1 & 2. This training program shall enhance the understanding of compensation and classification concepts and explore the appropriateness and application of high performance rewards to the District's workforce.

Furthermore, the Parties hereby agree that the District and the Unions shall commence a joint labor-management classification and compensation collaborative review of District jobs. This project shall examine the current classification and compensation systems in order to ensure that job classifications fairly represent actual work performed by District employees as well as the appropriateness of the District's current classification and compensation systems.

In order to support the training, classification and compensation joint labor-management initiatives, it is understood that the District shall retain the services of The Segal Company to assume the role of the lead consultant with these projects."

For Labor

For Management

January 30, 2001

APPENDIX B

MEMORANDUM OF AGREEMENT
BETWEEN THE
DISTRICT OF COLUMBIA
AND
COMPENSATION UNITS 1 AND 2
CLASSIFICATION AND COMPENSATION REFORM TASK FORCE INITIATIVES

Pursuant to the terms of the "Memorandum of Understanding Between Compensation - Units 1 and 2 and the District of Columbia Concerning Classification and Compensation Collaborative Review," which was incorporated as part of the Compensation Agreement between the District of Columbia Government and Compensation Units I and 2, FY 2001-FY 2003 ("Compensation Agreement"), the District of Columbia Government and the Unions in Compensation Units I and 2, established the Joint Labor-Management Classification and Compensation Reform Task Force (Joint Task Force). In addition, under the terms of the Compensation Agreement, the District Government agreed to set aside certain funding in fiscal years 2002 and 2003, which would be used by the Joint Task Force to implement initiatives designed to reform the District's compensation and classification systems.

The Compensation Agreement provides that in FY 2003 the District shall invest the equivalent of a minimum of one percent (1 %) increase in the aggregate salaries of Compensation Units 1 and 2 ("1 % Set-aside") toward classification and compensation reform. The District expended a portion of the 1 % Set-aside to implement the first significant change to the compensation system in the District by changing the pay progression of Compensation Units 1 and 2 employees, or how employees move between steps within a grade. The Joint Task Force has also agreed to begin the first classification reform project by reviewing the position classifications in each of the 9 occupational pay groups and where appropriate reclassify positions and adjust the grades and rates of pay for the reclassified positions.

The Joint Task Force classification review will begin in August 2003, with a review of positions in the clerical/administrative occupational group and specific classification series and/or positions, which the Joint Task Force has determined, requires immediate review. The Joint Task Force has agreed that the District shall expend the unencumbered FY 2003 1% Set-aside fund balance under the terms of the Compensation Agreement, to fund increases in salaries or make other pay adjustments for employees in Compensation Units 1 and 2 who occupy positions the grade and/or the rate of pay of which is changed because of reclassification, re-grading, rate adjustment or changes in the District's classification and/or compensation policy as part of the classification reform project initiated by the Joint Task Force in FY 2003.

The Joint Task Force has agreed to apply any rate adjustment retroactively to a date in FY 2003. The retroactive date of implementation will be determined based on the number of employees affected and the unexpended balance of the 1% set-aside. That is pay adjustments will be made in affected employees' pay retroactive to the date permitted by the fund balance. Payment to employees should be made by March 31, 2004.

Further, the contracting parties agree that amounts hereafter designated through collective bargaining for classification and compensation collaborative review under the terms of the FY 2004 to FY2006 Compensation Units 1 and 2 Agreement, shall be accorded similar treatment for purposes of implementation. Specifically, any funds set aside in the Fiscal Years 2004, 2005 or 2006 shall be available for expenditure in that fiscal year or any other fiscal year covered by the Compensation Unit 1 and 2 agreement. Provided however, that all funds set aside for compensation and classification reform shall be expended or obligated prior to the expiration of the Compensation Units 1 and 2 Agreement for FY2004 – FY2006.

AGREED, this 26th day of August, 2003.

FOR THE DISTRICT OF COLUMBIA GOVERNMENT

Mary E. Leary, Director
Office of Labor Relations
and Collective Bargaining

FOR COMPENSATION UNITS 1 & 2

Geo T. Johnson, Chief Negotiator
Compensation Units 1 and 2

Union Proposal 2/1/06

Memorandum of Understanding
Between
Compensation Units 1 and 2 and the District of Columbia

The "Memorandum of Understanding between Compensation Units 1 and 2 and the District of Columbia Concerning Classification and Compensation Collaborative Review" was initially incorporated as part of the Compensation Agreement between the District of Columbia Government and Compensation Units 1 and 2 covering fiscal years 2001 through 2003.

Pursuant to the terms of this MOU, the joint Labor Management Classification and Compensation Reform Task Force (LMCCRTF) shall:

1. Effective March 1, 2006, this joint labor management committee established pursuant to the terms of the Compensation Units 1 and 2 collective bargaining agreements (the LMCCRTF) shall be administered under the District's Office of Labor Relations and Collective Bargaining (OLRCB);

2. The LMCCRTF shall have eight (8) voting representatives from labor including representatives from each national labor union comprising Compensation Units 1 and 2 and the District's OLRCB shall appoint an equal number of management representatives;

3. Outside consultants and other subject matter experts are not members of the LMCCRTF and shall not have voting rights in the LMCCRTF. However, such persons may be invited to attend said meetings only when they are presenting information relevant to the task;

4. The funds from the LMCCRTF for fiscal years FY 2004 through FY 2006 shall be used to implement the new pay schedules the last pay period of September 2006, which are attached as Appendices A(1) through A(8) to management's proposals for base wage increases for the contract beginning October 1, 2006.

mel 2/1/06

G.T.S. 2/1/06

NON-COMPENSATION

COLLECTIVE BARGAINING AGREEMENT

BETWEEN

THE GOVERNMENT OF THE DISTRICT OF COLUMBIA

AND

THE DOCTORS COUNCIL OF THE DISTRICT OF COLUMBIA

EFFECTIVE THROUGH

SEPTEMBER 30, 2009

TABLE OF CONTENTS

NON-COMPENSATION ARTICLES

NON-COMPENSATION ARTICLES

ARTICLE 1 PREAMBLE

This Non-Compensation Agreement is entered into between the Government of the District of Columbia and the Doctors Council of the District of Columbia, NUHHCE, AFSCME, AFL-CIO, representing a unit of employees comprising Compensation Unit 19 (Physicians, Dentists and Podiatrists) previously certified by the Public Employee Relations Board ("PERB") in PERB Case No. 88-R-12, dated January 5, 1989, PERB Case No. 92-R-01, dated January 10, 1992, and PERB Case No. 96-AC-01 (1966).

ARTICLE 2 RECOGNITION

The Employer recognizes the Doctors Council of the District of Columbia as the sole and exclusive representative of the following bargaining unit described in the certification as:

> All dentists, physicians and podiatrists employed by the District of Columbia Departments of Corrections, the District of Columbia Department of Public Works, and the District of Columbia Department of Motor Vehicles, Human Services, and Health including all dentists, physicians and podiatrists who, prior to October 1, 1987, were employed by St. Elizabeth's Hospital, U.S. Department of Health and Human Services and pursuant to Public Law 98 621, as of October 1, 1987 became employed by the District of Columbia Department of Human Services, excluding management officials, supervisors, confidential employees, employees engaged in personnel work in other than purely clerical capacities, employees who are regularly scheduled for less than forty (40) hours per pay period and employees engaged in the administration of the provisions of Title XVII of the District of Columbia Comprehensive Merit Personnel Act of 1978.

It is understood that a joint petition to modify the above-quoted certification to accurately reflect the bargaining unit represented by the Union is pending before the Public Employee Relations Board (PERB), PERB Case Nos. 02 UM 02 and 99 UM 02. The parties have agreed in that the unit represented by the Doctors Council proceeding that should be described as:

> All dentists, physicians and podiatrists employed by the District of Columbia Government in agencies under the personnel authority of the Mayor, excluding management officials, supervisors, confidential employees, employees engaged in personnel work in other than purely clerical capacities and employees engaged in the administration of the

provisions of Title XVII of the District of Columbia Comprehensive Merit Personnel Act of 1978.

ARTICLE 3 DEFINITIONS

Section A

The word "doctor(s)" in this Agreement shall mean physicians, dentists and podiatrists.

Section B

Except as otherwise indicated, the phrase "medical" in this Agreement shall include, but not be limited to "mental health," "dentistry" and "podiatry".

ARTICLE 4 UNION SECURITY

Section A Membership

Any employee in the bargaining unit may join or refrain from joining the Union without interference, coercion, restraint, discrimination or reprisal. The terms of the Agreement shall apply to all employees in the unit without regard to membership in the Union.

Any employee who is a member of the Union during the effective date of this Agreement or becomes a member during its term shall remain a member while employed in the bargaining unit provided that such employee may resign from the Union during a period between sixty (60) and thirty (30) days prior to the annual anniversary date of this Agreement. The Employer shall afford the Union with the opportunity to meet with any new bargaining unit members within two (2) weeks of the employee's reporting to their work site.

Section B Information on Bargaining Unit Members

The Employer shall promptly and as soon as feasible notify the Union in writing of the name, title, pay level/step, salary, work location and home address of each new bargaining unit member and in no event later than two (2) weeks after the employee's reporting to their worksite.

Section C Dues Checkoff

Pursuant to D.C. Official Code § 1-617.07, the Employer shall deduct dues from the bi-weekly salaries of those employees who execute an appropriate membership/union dues deduction authorization form. The Union shall transmit any dues deduction authorization forms to the OLRCB together with an appropriate D.C. Government transmittal form when such form becomes available. After receipt of written notification from the Employer of name and home address of bargaining unit employees, the Union shall bear the responsibility of providing any applicable legal notices to new members who authorize withholding.

The amount to be deducted shall be certified to the Office of Labor Relations and Collective Bargaining in writing by the appropriate Union official. The amount deducted shall be forwarded to the Union within ten (10) days after each pay day, with a list of employees from whom membership dues was deducted. It is the responsibility of the employees and the Union to bring errors or changes in status to the attention of the Employer. Corrections or changes will be made at the earliest opportunity after notification is received, but in no case will changes be made retroactively.

Dues deduction may be cancelled upon written notice to the Employer on a form acceptable to the D.C. Government, provided such notice is received in the D.C. Office of Labor Relations and Collective Bargaining during a period between sixty (60) and thirty (30) days prior to the annual anniversary date of this Agreement. Any such notice will become effective on the first pay period after each anniversary date.

Section D Service Fees

In keeping with the principle that employees who benefit by the Agreement should share in the cost of its administration, and as provided by D.C. Official Code § 1-617.07 and 1-617.11(a), upon the Union's request that employees who do not pay Union dues shall pay a service fee amount (not to exceed Union dues), the Employer shall withhold the requested service fee. The amount deducted shall be forwarded to the Union within ten (10) days after each pay day, with a list of employees from whom the service fee was deducted.

The Union retains the sole responsibility to develop and maintain procedural safeguards required by existing applicable law with regard to the administration of the payments of service fees. The Union shall bear the responsibility of providing any applicable legal notices to service fee payors after receipt of the names and home addresses. The Employer shall promptly provide the name and current home address of each bargaining unit employee who is listed as a service fee payor.

Section E Administrative Fee

The Employer shall deduct $.10 per deduction (dues or service fee) per pay period from each employee who has dues or service fees deducted.

Section F Hold Harmless

The Union shall indemnify, defend and hold the Employer harmless against any and all claims, demands and other forms of liability, which may arise from the operation of this Article. In any case in which a judgment is entered against the employer as a result of the deduction of dues, service fees or other assessments, the amount held to be improperly deducted from an employee's pay and actually transferred to the Union by the Employer shall be returned to the Employer or conveyed by the Union to the employee(s) as appropriate.

Section G

When a service fee is not in effect, the Union may require that an employee who does not pay dues or service fees shall pay reasonable costs incurred by the Union in representing such employees in grievances, adverse actions or appeal proceedings within the provisions of the CMPA.

ARTICLE 5 MANAGEMENT RIGHTS

Section A Management Rights in Accordance with CMP

The Comprehensive Merit Personnel Act (§ 1-617.08, D.C. Code 2001 ed.) provides the following regarding management rights:

> "(a) The respective personnel authorities (management) shall retain the sole right, in accordance with applicable laws and rules and regulations:
>
> 1. To direct employees of the agency;
>
> 2. To hire, promote, transfer, assign, and retain employees in positions within the agency and to suspend, demote, discharge or take other disciplinary action against employees for cause;
>
> 3. To relieve employees of duties because of lack of work or other legitimate reasons;
>
> 4. To maintain the efficiency of the District Government operations entrusted to them;
>
> 5. To determine the mission of the agency, its budget, its organization, the number of employees and the number, types and grades of positions of employees assigned to an organizational unit, work project or tour of duty, and the technology of performing its work; or its internal security practices; and
>
> 6. To take whatever actions may be necessary to carry out the mission of the District Government in emergency situations.
>
> (b) All matters shall be deemed negotiable except those that are proscribed by the subchapter. Negotiations concerning compensation are authorized to the extent provided in §1-617.16."

Section B Exercise of Management Rights

The Employer agrees it will not exercise management rights in an arbitrary or capricious manner.

ARTICLE 6 STRIKES AND LOCKOUTS

Section A Unlawful Strikes

Under the provisions of the comprehensive Merit Personnel Act (§1-617.05, D.C, Code 2001 ed.), it is unlawful to participate in, authorize or ratify a strike.

Section B Lockouts

The Employer will not lockout employees from the worksite, except that the Employer retains the right in a strike to close down any facilities to provide for the safety of employees, equipment or the public.

ARTICLE 7 UNION FACILITIES RIGHTS

Section A Meeting Space

The Union shall, upon request to the Management official designated for such purposes, be granted use of meeting space, as available, for Union business. Whenever practicable, requests shall be made at least five (5) working days, but no less than two (2), before the meeting and shall specify the time of the meeting, expected duration, and the space requested. The Union will be responsible for maintaining decorum and restoring the space to its prior condition.

Section B Bulletin Boards

1. The Employer agrees to provide space on existing bulletin boards for the posting of official Union notices. Bulletin board space will be provided at each facility where bargaining unit members are employed. At facilities where bargaining unit members are located in multiple buildings, space on several bulletin boards will be provided. The Union shall limit its postings to the locations provided for that purpose.

2. Materials posted on bulletin boards must be readily identified as representing the Union, and shall not support or oppose candidates for any public elective office.

3. The Employer reserves the right, after notification to the Union, and an opportunity for consultation, to remove posted material that does not comply with this Article.

Section C Employee Lists

Upon a request from the Union, the Employer will furnish the Union with a list of all employees in the bargaining unit, including titles, grades and rate of pay and a list of new and terminated employees, containing the same information.

Section D Copies of Agreement

The cost of photocopying the contract will be divided equally between the Union and Management.

Section E File Cabinet

A locked two (2) drawer file cabinet for Union use shall be made available in one of the agencies covered by this Agreement.

ARTICLE 8 UNION ACTIVITIES ON WORKING TIME

Section A Official Time

1. Pursuant to the statutory right and responsibility of the Union to represent bargaining unit employees, representatives of the Union will be granted reasonable official time (i.e., time during working hours and without loss of pay) to investigate, communicate regarding, prepare for, travel to and conduct representational functions under the terms of this Agreement and District of Columbia law. Examples of activities for which official time will be authorized include, but are not limited to:

a. Labor Negotiations

b. contacts between employee representatives and employees provided for in the negotiated grievance procedure;

c. grievance meetings, administrative hearings and arbitration hearings;

d. disciplinary or adverse action proceedings, if the union is designated as a representative of the employee;

e. attendance at an examination of an employee who reasonably believes he or she may be the subject of disciplinary or adverse action and the employee has requested representation;

f. attendance at board or other committee meetings on which the Union representatives are authorized membership by the Employer or the Agreement;

g. attendance at meetings between the Employer and the Union;

h. attendance at Employer recognized/sponsored activities to which the Union has been invited;

i. Union-sponsored training that benefits both labor and management, as approved by the Office of Labor Relations and Collective Bargaining (OLRCB);

j. attendance at meetings between the Union and bargaining unit employees regarding the terms and conditions of employment and compensation;

k. other joint labor-management activities benefiting both labor and management;

1. to effectuate contacts with officials of government including the Mayor, Council of the District of Columbia, Congress and their staffs;

m. any proceeding in which the Union is representing an employee or the Union pursuant to its obligations under relevant contract provisions, regulations, or law;

n. posting notices of Union meetings dealing with representational functions.

2. Official time shall not include time spent on internal Union business, including, but not limited to:

a. attending Union meetings regarding internal Union business;

b. soliciting members;

c. collecting dues;

d. posting notices of Union meetings that involve internal Union business only;

e. carrying out internal union elections;

f. preparing and distributing internal Union newsletters or other such internal documents;

g. preparing for appeals, administrative hearings or arbitration proceedings, except to the extent that it involves activity for which official time is permitted in Section A, above on internal Union matters;

h. attending Union sponsored training in excess of hours provided for by Section 11 below.

Section B Visits by Council Representatives

Accredited representatives of the Union who are not employees of the District Government shall have access to the premises of the Employer, except in restricted areas, to conduct business on behalf of the Union, after advance notification to and coordination with the designated Management official, so as to minimize the disruption of work.

Section C Designated Union Representatives

The Union shall submit a list to the Employer of unit members who are designated representative(s), not to exceed eight (8), and the Agency each representative is designated to represent. The Union shall notify the Employer promptly of changes in the designated representatives and designated representational areas. In the absence of a designated representative, the Union President or designee will designate an alternate and notify Management. Designated representatives shall have the duties described in Section A above.

Section D Time for Performance of Duties

Designated representatives shall obtain permission from their supervisor or designee prior to leaving their work assignment to properly and expeditiously carry out their duties. A reasonable amount of official time, to be estimated in advance whenever possible will be allowed for such purposes. Official Time Form, attached to this Agreement, will be used for "recording" official time used for the purposes on this form.

When contacting an employee, the designated representative will first obtain permission to see the employee from the employee's supervisor or designee. Such permission will be granted unless the employee cannot be immediately relieved from his/her duties, in which case permission will be granted as soon as possible thereafter.

The same system of obtaining permission, as outlined above, shall apply to employees when visiting Union designated representatives for the purpose of discussing grievances. Requests by designated representatives for permission to meet with employees and/or by employees to meet with designated representatives shall not require prior explanation to the supervisor or designee of the problems involved other than to identify the area to be visited and the general nature of the meeting. A designated representative or employee thus engaged will notify his/her supervisor or designee (if available) upon completion of such duties and return to the job. The Employer agrees that there shall be no restraint, interference, coercion or discrimination against a designated representative in the performance of such duties in accordance with this Article.

Section E Union Leave

Attendance at Union-sponsored conventions, conferences, training or other programs shall be annual leave or leave without pay unless administrative leave has been authorized.

Other leaves of absence for bargaining unit business shall be available upon the discretion of the Employer, in accordance with law and applicable regulations.

ARTICLE 9 LABOR-MANAGEMENT COMMITTEE

Section A Joint Labor-Management Committee

A joint Labor-Management Committee shall be established and maintained during the course of this Agreement and shall meet quarterly or as otherwise mutually agreed. The Committee shall be composed of no more than five (5) members each, broadly representative of all parts of the bargaining unit, representing the Union and Management and shall discuss matters concerning labor-management relations, working conditions, terms and conditions of employment, matters of common interest, or any other matter which either party believes will contribute to improvement in the relations between them within the framework of this Agreement. It is understood that grievances shall not be the subject of discussion at these meetings, nor shall the meetings be for any other purpose, which will modify, add to or detract from the provisions of this Agreement.

Section B Meeting Dates

Meeting dates will be set by mutual agreement sufficiently ahead of time to allow compliance with Section C. Individuals with authority to speak with authority on the issues on the agenda will be in attendance.

Section C Agenda

An agenda, including appropriate items submitted by the Union and the Employer, will be prepared by the Employer seven (7) calendar days prior to such meetings. A brief summary of matters discussed and any understandings reached at all meetings, as well as the positions taken by the parties in a disagreement will be prepared and initialed by both sides, if necessary. Meetings may be cancelled if neither side submits agenda items. Either party may postpone discussion of an agenda item to the next meeting if impracticable to consider or if the complexity of the issue so requires. Recommendations which are agreed upon by both sides will be submitted to appropriate designated officials for consideration. Agency officials to whom recommendations are submitted will provide a written response no later than ten (10) days before the next meeting. Any other officials to whom recommendations are submitted will be requested to provide a written response no later than ten (10) days before the next meeting.

Section D Subcommittee

There shall be a Labor-Management Subcommittee for each Agency, which shall meet at the request of either party. Additional subcommittees may be established as agreed upon by the parties.

Section E Meeting Times

Reasonable efforts will be made to schedule Committee and Subcommittee meetings during the working time of all members. Employee members of the labor side who are scheduled to work at the time of the meeting will receive official time (but not overtime) as necessary to attend each

meeting; provided however, that members who are assigned to shift work at a 24-hour facility shall be rescheduled or receive compensation at the straight time rate, as determined by Management, to attend meetings during any shift in which they are not scheduled to work.

ARTICLE 10 NON-DISCRIMINATION

Section A Non-Discrimination

Neither party will discriminate against any member of the unit on account of race, color, religion, national origin, sex, age, marital status, sexual orientation, physical handicap, or other grounds prohibited by the D.C. Human Rights Act or on account of union affiliation, membership and/or service.

Section B Discrimination Charges

Charges of discrimination shall be subject to the negotiated grievance procedure as provided below:

1. If a charge of discrimination based upon union affiliation, membership, and/or service of an employee is filed as an Unfair Labor Practice charge and as a grievance pursuant to the negotiated grievance procedure, the Public Employee Relations Board will be requested to stay action on the charge pending a determination through the grievance procedure.

2. Any claim of discrimination covered by the D.C. Human Rights Act which does not involve an alleged violation of some other portion of this contract may not be appealed through the contractual grievance procedure.

ARTICLE 11 GRIEVANCE PROCEDURE

Section A Definition

Grievance shall be defined as a dispute involving an alleged violation, misinterpretation or misapplication of this Agreement.

Section B Exclusive Procedure

This procedure shall be the exclusive procedure available for consideration of grievances as defined herein, except as provided elsewhere in this Agreement.

Step 1: The aggrieved employee(s) (or the Union if a grievance involves grievable matters of general applicability or involves more than one employee) shall informally present the grievance to the immediate supervisor or higher level Management official who took, or failed to take, the action which gave rise to the grievance. Grievances must

be presented within twenty (20) working days (Monday through Friday, except holidays) after the date of the act or failure to act, or within twenty (20) working days after the employee (or Union) knew or should have known of the alleged violation. The supervisor or manager will respond within five (5) working days after the grievance is presented to him/her. A Step I grievance does not have to be written; however, a written grievance will be responded to in writing. A written grievance at Step 1 must contain the information required of written grievances at Step 2 and above.

Step 2: If a grievance is un-resolved after consideration at Step 1, a formal written grievance may be filed with the appropriate Senior Deputy or Administrator (Health Administrator in Department of Corrections) within five (5) working days after the Step 1 response was received, or was due. Written grievances filed at Step 2 and above shall contain:

1. The date the grieved action occurred.
2. The date the person obtained knowledge of the grieved action.
3. Name and signature of the Council's representative filing the grievance.
4. The signature of the aggrieved employee.
5. The date the grievance is filed.
6. Name of grievant and worksite.
7. Name of Management official with whom grievance was filed.
8. Nature of grievance, and relief requested.
9. Articles and Sections of contract which were violated.

The Administrator/Senior Deputy shall respond in writing within ten (10) working days.

Step 3: If the grievance has not been satisfactorily resolved at Step 2, the grievance may be submitted in writing, with attachments of documents and/or decisions at each prior step, to the Department Director within five (5) working days after the response was received or due. The Director will have twenty (20) working days to respond.

Step 4: Arbitration: Within twenty (20) working days after the conclusion of Step 3, the Union may invoke arbitration by written notification to the Office of Labor Relations and Collective Bargaining, with a copy of the Department Director. Unless the parties agree otherwise, arbitrators will be selected as follows. If the parties cannot agree within seven (7) working days on the selection of an arbitrator, the Union may request a list of nine (9) labor arbitrators (at least six (6) of whom are on the American Arbitration

Association (AAA) and/or National Academy of Arbitrators (NAA) lists) from the Federal Mediation and Conciliation Service (FMCS) list of arbitrators in the sub-regional area for Washington, D.C. The FMCS shall be provided with the name and address of the Office of Labor Relations and Collective Bargaining as the representative of the Employer. The parties shall use an alternate strike method to select an arbitrator. The parties will alternate the first strike.

The arbitrator shall be requested to render his or her decision within thirty (30) calendar days after the record is closed.

Expenses for the arbitrator's services and the Proceedings shall be borne equally by the Employer and the Doctors Council. However, each party shall be responsible for compensating its own representatives and witnesses. If either party desires a verbatim record of the Proceedings, it may cause such a record to be made and make copies available without charge to the other party and to the arbitrator. If the parties agree on the need for a verbatim record, they shall share the cost.

The arbitrator shall not have the power to add to, subtract from, or modify any provision in this Agreement. The decision of the arbitrator shall not be inconsistent with the terms of this Agreement.

If agreed to by the parties, disputes concerning procedural arbitrability will be a threshold issue to be decided before a hearing on the merits.

Section C General

1. In the presentation of a grievance, representation of aggrieved employees by a Council representative shall be permitted at each step.

2. A grievant and his/her representative may request and receive a reasonable amount of official time to pursue and present a grievance.

3. The settlement of a grievance prior to arbitration shall not constitute a precedent in the consideration of other grievances unless the parties agree otherwise.

4. Working days under this Article shall mean Monday through Friday, except holidays.

5. All time limits shall be strictly observed unless the parties agree to a different time limit. Extensions will be confirmed in writing, upon request. In computing time limits under this Article, the date the answer is received or due in the Preceding step shall not be counted.

6. Grievances involving Corrective Actions (written reprimands and suspensions of less than ten (10) calendar days) may be contested as a disciplinary grievance pursuant to this article within twenty (20) working days of the effective date of the action. The

grievance shall be filed at the step which involves the person who made the final decision to impose the corrective action.

7. Adverse Actions (suspension often (10) or more calendar days, reduction in grade, and removals) may be grieved through the negotiated grievance procedure or appealed with the Office to Employee Appeals (OEA) within thirty (30) calendar days of the effective date of the action, but not both. If a grievance is filed pursuant to this provision it shall be filed in writing at the step which involves the person who made the final decision to impose the adverse action. The Agency will have thirty (30) days to respond to the grievance.

An employee shall be deemed to have elected his or her remedy when he or she files the grievance in writing in accordance with the provision of this Article or files an appeal with the Office of Employee Appeals (OEA). The effective date of the election shall be determined by the date the employee files a grievance in writing or appeals the action to OEA, whichever event occurs first. The filing of a grievance prior to the issuance of a final agency decision or effective date of an action constitutes an election of the negotiated grievance procedure.

8. As an alternative to arbitration, the parties may submit unresolved grievances to mediation upon such terms as they may agree. Grievances not successfully resolved through mediation may be submitted to arbitration in accordance with this procedure within ten (10) working days after receipt of written notification from either party or the mediator that mediation efforts have terminated.

Section D Individual Presentation of Grievances

An employee may bring a grievance to the attention of Management and have the grievance considered without representation by the Council, subject to the following restrictions.

1. The Council is notified and given the opportunity to be present at any meeting between the grievant and Management to consider the grievance.

2. The resolution of a grievance shall not conflict with the provisions of this Agreement.

3. The decision concerning any grievance in which the Council does not represent the grievant shall not be considered precedent.

4. The grievant may represent himself or herself or be represented by a person of his or her choosing, but cannot be represented by any Union other than the Doctors Council.

5. Only the Councilor the Employer may utilize the arbitration provision of this Agreement.

ARTICLE 12 DISCIPLINE

Section A Definition

For the purpose of this Article, the term "corrective action" refers to written reprimands and suspensions of less than ten (10) calendar days. The term "adverse actions" refers to suspensions of ten (10) calendar days or more, reductions in grade and removals under adverse action procedures within the meaning of district personal regulations. Discharge during probation is not a corrective or adverse action and is not covered by this Article. Disciplinary action shall be taken only for just cause.

Section B Procedures

Consistent with the principle of progressive discipline, disciplinary actions shall be taken in a timely manner and shall be appropriate to the circumstances. If the Employer has reason to discipline an employee, it shall be done in a manner that will not embarrass the employee before other employees or the public. The employer shall give ten (10) calendar days advance notice of a proposed corrective action and fifteen (15) calendar days advance notice of a proposed adverse action except in the case of Summary Suspension or Removal. The notice will identify the causes and reasons for the proposed action.

Section C Review of Actions

Employees may grieve all types of disciplinary actions through the negotiated grievance procedure.

With regards to an "adverse action" an employee may appeal through negotiated grievance procedures in Article 11 or appeal to the Office of Employee Appeals under applicable regulations, but not both. If an employee elects to appeal or grieve an adverse action, he/she shall elect either procedure in writing within thirty (30) calendar days of the effective date of the action.

Section D Use of Prior Disciplinary Actions

Written reprimands may be cited by the Employer as a prior offense only within one (1) year of the earlier reprimand; a prior suspension or discharge may be cited as a prior offense only within three (3) years from the effective date of the action.

ARTICLE 13 ORIENTATION

Newly appointed medical officers will receive a general orientation regarding employment matters and a specific orientation, which includes topics such as, but not limited to: medical-legal issues, infection control, medical record requirements and laboratory procedures. The Employer reserves the right to determine the content of the program; however, it will be receptive to recommendations from the collective bargaining unit. During the specific

orientation, the Employer will inform bargaining unit members where applicable policies and procedures may be reviewed in their Service or at their worksite. The Employer will provide appropriate material for the orientation. In addition, the Union will be afforded the opportunity to meet separately with newly appointed medical officers within two weeks of the employees reporting to his/her worksite or during the new employee orientation session, whichever occurs sooner, to conduct an orientation to the Union.

ARTICLE 14 PERFORMANCE EV ALVA TION

Section A

Where bargaining unit members are being evaluated on clinical performance and the official rater is not a professional peer in the field in which the bargaining unit member works, input into the evaluation will be obtained from a professional peer in the member's field and the name of the medical reviewer will appear on the bargaining-unit member's evaluation form or on a paper attached thereto.

When the official rater is not a professional peer in the bargaining unit member's field, at the request of the bargaining unit member, the medical reviewer and rater shall meet with the bargaining unit member prior to the rater signing the evaluation form.

Section B

Before implementing revised performance standards, the Employer shall provide a copy to the employees who would be affected and the Union. The Employer shall consider their comments prior to implementing new standards.

Section C

The Employer agrees to notify the Union and consult concerning appropriate design and procedures, medical protocols, and legal and/or licensing requirements before implementing peer review, peer support or processes affecting bargaining unit members.

ARTICLE 15 WORKING CONDITIONS

Section A Security

Bargaining unit members shall be provided appropriate security when delivering clinical services. The Employer agrees not to reduce the existing security for doctors delivering clinical services and to enhance the security if possible.

Section B Restrooms

The Employer shall provide adequate restrooms that are reasonably accessible to bargaining unit members.

Section C Locked Storage for Medical Instruments and Equipment

The Employer shall provide locked storage facilities in treatment areas where medical and dental instruments and equipment can be kept.

Section D Clothing

The Employer will provide each bargaining unit member with sufficient white coats or disposable gowns and will make available laundry service for unit members.

Section E Reimbursement for Damages to Employees Clothes or Personal Property

Claims for reimbursement for job-related damage to clothing or personal property will be acted on in accordance with 31 U.S.C. Section 3721.

Section F Physical Examinations and Tests

Physical examinations or tests, including tests for alcohol and drugs may be required by the Employer in order to comply with infection control criteria and requirements as set forth by licensure and regulating agencies or D.C. Law. Prior to requiring any new type of examination or test under this paragraph, the Employer will notify the Union of the basis for such examination or tests and provide a copy of proposed rules, regulations and policies sufficiently in advance of implementation to provide an opportunity to bargain consistent with the requirements of law.

Section G Emergency

In case of emergency, such as flood, fire, epidemic, disaster, catastrophe or other unforeseen major contingency, this Agreement shall not be deemed to apply in connection with reasonable measures taken by the Employer for the care and protection of patients, the equipment and buildings, or reasonably necessary to repair and place the same in condition for occupancy.

In the event of an emergency as described above, employees will report to duty (as called) after notification. Failure to report as called may be excused by the responsible Management official for good reason.

Section H Inclement Weather

Those bargaining unit members who are designated as emergency employees are expected to report to work as scheduled in inclement weather or other conditions that make reporting difficult unless individually excused by the responsible Management officials. Call-ins or failure

to report for work will be reviewed on an individual basis by the appropriate Management official in order to determine if leave should be charged.

Section I Reimbursement for Transportation and Parking Expenses

1. Employees authorized to use their personal vehicles in the performance of their official duties shall be reimbursed for non-commuter parking expenses, which are incurred in the performance of their official duties. Employees shall be reimbursed for non-commuter parking expenses when such expenses are authorized in advance and incurred in the performance of their official duties.

2. The Employer will reimburse bargaining unit members for transportation expenses (taxi, metro or mileage at the applicable Federal rate) and for parking when they are requested to travel from one site to another and transportation is not provided.

Section J Availability of Parking for Bargaining Unit Members

The Parties agree that, over the course of the contract, the Employer will assess the adequacy of parking for bargaining unit members, particularly those who are required to drive from site to site during the course of their work, provide the union with the opportunity for input, and consider the Union's recommendations for improving parking.

ARTICLE 16 SUPPLIES, EQUIPMENT AND MEDICATION

Section A

As determined by the responsible Management Officials, the Employer shall provide to bargaining unit members, the equipment, supplies and medication necessary to carry out their duties. Any actual or perceived shortages, defects or deficiencies in equipment or supplies furnished by the Employer shall be brought to the immediate attention of the immediate supervisor. The supervisor will respond as soon as possible, not to exceed five (5) working days, and if the condition is described as an emergency, the supervisor will respond immediately. The Employer will take action to correct a shortage or deficiency in the shortest possible time, or provide another appropriate response.

Section B

The Employer will provide necessary protective equipment such as gloves, masks, and goggles/shields.

Section C

The Employer shall provide one or more medical emergency kits or crash carts at each treating facility. The Employer shall monitor these items on a regular schedule and keep such kits and

carts fully supplied with unexpired drugs, and up-to-date, functional equipment, including, but not limited to, oxygen.

ARTICLE 17 SAFETY

Section A

The Employer shall provide and maintain adequate, safe and sanitary facilities in compliance with D.C. health and safety laws, licensure requirements and requirements of regulatory agencies. The Center for Disease Control guidelines are used to provide a central reference containing recommendations for Preventing and controlling nosocomial infections.

Section B

The Employer will make available essential infection control equipment and supplies, provide education and training as necessary and encourage and require its use.

Section C

Any doctor who detects a hazardous condition shall bring the matter to the attention of his/her supervisor. The supervisor shall take appropriate steps to assure that hazardous conditions are corrected, and shall notify the involved doctor(s) of the steps taken.

Section D

Inspections for health endangering contaminants shall be conducted in accordance with the laws, licensure requirements and requirements of regulatory agencies described in Section A above. The Employer shall notify the Union whenever an inspection under this section is scheduled and shall make available to the Union the portions of the report(s) pertaining to the bargaining unit members' worksites.

Section E

Grievances submitted under this Article may be filed at Step 2 of the grievance procedure.

ARTICLE 18 DESCRIPTION OF TREATMENT/SERVICES

To the extent necessary, the Employer shall prepare a statement of dental services to be provided to patients and update the list or statement as appropriate.

ARTICLE 19 OFFICES, LOCKERS, LOUNGES AND PATIENT CARE AREAS

Section A Offices, Lockers, and Eating Areas

1. The Employer will provide adequate office space for bargaining unit members' use on an individual or shared basis. The Employer agrees it is desirable over the course of the contract to assess the office space available to the bargaining unit members. Such assessment shall be undertaken by the appropriate Labor-Management Committee, who will make recommendations based on its findings.

2. To secure personal belongings the Employer will provide secured lockers or secured areas to bargaining unit members

3. Where on-site eating areas are not otherwise available, the Employer will designate space, separated from treatment areas, suitable for eating lunch.

Section B Lounge Areas

The Employer will provide space equipped with a couch or cot, and with reasonable access to a restroom for bargaining unit members who are required to remain on-site, On-call, or to those held over or called back for extended periods of time in emergency situations.

Section C Condition of Patient Care Areas, Offices and Lounges:

1. The Employer shall ensure that patient care areas are adequately cleaned.

2. The Employer shall provide and repair screens, where required and take appropriate steps for insect and rodent control.

3. The Employer will comply with applicable regulations concerning heating and ventilation. In case of a breakdown or malfunction of heating or air conditioning equipment the Employer will promptly initiate corrective or remedial action.

4. The Employer recognizes the adverse impact of excessively hot or cold conditions on the delivery of patient care and agrees to respond to such conditions and take appropriate action.

Section D Corrective Action

A bargaining unit member who believes that any of the provisions of Section C are not being carried out shall notify his/her supervisor, who shall take prompt corrective action and shall notify the employee involved of the action taken.

Section E Consultation on new Facilities

The Employer will timely notify the Union and consult with the Union upon request concerning the design, layout, and equipment of new or renovated facilities, where bargaining unit employees are or may be assigned.

ARTICLE 20 PROFESSIONAL DEVELOPMENT

Section A Continuing Medical Education

1. The Employer encourages bargaining unit members to participate in continuing medical education programs for the purposes of continuing medical education, training conferences and studying and sitting for board examinations. Full-time bargaining unit members shall be afforded the opportunity to take ten (10) days per year of administrative leave with pay for the purpose of Continuing Medical Education (CME), the timing of which shall be based upon the concurrence of the Agency Directors or their designees. Concurrence shall not be unreasonably denied.

2. Part-time employees will be eligible for Participation in the CME Program as follows:

Tour of Duty:	60-79 hours - 64 hours CME
	48-63 hours - 48 hours CME
	8-47 hours - 40 hours CME

3. Requests for administrative leave in excess of the allotted amounts may be granted upon approval of the Agency Directors or their designees.

4.

a. Based upon the availability of funds beyond the amount in the Compensation Agreement, the Employer may pay for tuition, travel, lodging and meals in order to permit attendance at such conferences.

b. Upon request, the Agency Directors or their designees shall provide the Council with a letter detailing funds available for Continuing Medical Education under paragraph

5. Requests for approval of leave or funds under this Section shall be made as far in advance as practicable through supervisory channels. Management shall process requests under this section expeditiously and shall inform the employee of the action taken as soon as practicable.

Section B Publications and Presentations

When an employee publishes an article in a medical journal and/or presents a paper at a medical meeting, as long as the individual's affiliation with the D.C. Government is indicated in the publication or other presentation, the Employer shall pay/reimburse the costs to publish, if any, and the costs of professional fees, slides and document preparation costs reasonably incurred in conjunction with the Publication/presentation based upon advance approval of the Agency Directors or their designees.

Section C New Skills. Techniques. and Procedures

If the Employer requires that a bargaining unit member obtain new skills, the Employer will pay all reasonable costs associated with obtaining that skill, including providing administrative leave as necessary for that purpose.

ARTICLE 21 MEDICAL MALPRACTICE INDEMNIFICATION AND LEGAL REPRESENTATION

Section A Insurance or Indemnification

Bargaining unit members are covered by the Medical Employee Protection Act of 1975, D.C. Official Code Sec. 2-415 (2001 ed.), and the Employer shall, to the extent a bargaining unit member is not covered by appropriate insurance purchased by the District of Columbia, indemnify any bargaining unit member for a final judgment and order to pay money damages entered against the bargaining unit member on account of damage to or loss of property or on account of personal injury or death caused by the negligent act or omission of the bargaining unit member within the scope of his or her empl oyent and performance of professional responsibilities.

Section B Legal Representation

1. The Office of the Attorney General shall, upon timely request of the employee, appear and defend any bargaining unit member named in any action involving negligent acts or omission within the scope of his or her employment unless the Attorney General declines to represent him or her. If the Attorney General declines to provide representation, the bargaining unit member will be so advised and may retain private counsel, and shall be reimbursed by the Employer for reasonable attorney's fees (as determined by the court) incurred in defense of the action.

2. National Practitioner Data Bank

Prior to submitting a report concerning any bargaining unit member to the D.C. Board of Medicine or the National Practitioner Data Bank, the Department will notify the affected doctor of the Department's intention to submit the report and the intended

contents of the report. The doctor shall be given the opportunity to respond prior to submission of any report.

ARTICLE 22 REVOCATION, SUSPENSION OR NONRENEWAL OF LICENSE

Each employee has the obligation to notify the Agency Director, or designee, in writing, concerning any revocation, suspension, nonrenewal or restriction of his/her license as it occurs.

ARTICLE 23 OUTSIDE ACTIVITIES

No member of the bargaining unit shall engage in outside employment or private business activity that conflicts or would appear to conflict with fair, impartial and objective performance of officially assigned duties and responsibilities.

ARTICLE 24 PERSONNEL FILES

Section A Official personnel File

1. Official personnel files shall be maintained in accordance with District Government regulations concerning records management and privacy of records.

2. An employee and his/her authorized representative shall be permitted to examine his/her official personnel file. The employee or his/her representative shall indicate in writing, to be placed in his/her file, that he/she examined said file.

3. Only those personnel who have an official right and reason for doing so may inspect an employee's file. Such personnel shall indicate in writing, to be placed in the employee's file, that he/she has examined said file and the reason for said examination.

4. Employees may have placed in their files, information of a positive nature indicating competencies, achievements, performance or contributions of an academic, professional or civic nature.

5. No material related to an employee's performance, conduct, character or personality shall be placed in the official personnel folder unless it is signed and dated by the person submitting the information. The employee shall be made aware of information described in this paragraph being placed in the file and may have a copy upon request. The employee shall have the right to answer any material filed and the answer shall be attached to the file copy.

6. Materials used in determining corrective or adverse actions shall be subject to the time limitations as established in Chapter 16 of the District personnel regulations.

Section B Departmental Record

1. Any documents about an employee which are not official personnel records such as attendance or clinical practice reviews, or other material shall be given to employees when prepared.

2. Any document concerning an employee which is retained by supervisory personnel shall be kept in a secure area and will not be available to others except for managerial review, or review by the employee or his/her authorized representative.

3. Upon request, the employee will be given the opportunity to review his file, can respond to the material and can request that material that is outdated be removed.

4. Written material in such departmental files may not be used adverse to the employees' interest unless he/she has been given a copy of the material.

ARTICLE 25 VACANCIES AND PROMOTIONS

Notice of vacancies and promotional opportunities, announcements for physician, dentist and podiatrist positions shall be posted in a timely fashion on the DCOP website. Copies of notices of vacancies and promotional opportunities and announcements for positions in the 602 (Medical Officer), 668 (Podiatrist), and 680 (Dentist) positions shall also be sent bye-mail to the Union President in a timely fashion.

Section B

Any unit member who applies for a vacancy will be considered for that position if he/she meets the minimum qualifications.

Section C

Outside candidates (i.e., those not employed by the D.C. government) competing for advertised unit positions must be better qualified than unit members in order to be selected.

Section D

Where all candidates for unit positions have equal qualifications as determined by the Department, the employee with the most service by Service Computation Date shall be selected. In determining equal qualifications, the Employer shall give consideration to experience at the worksite where the position will be located.

Section E

When a bargaining unit member applies for and is selected for a posted bargaining unit vacancy, he or she will be released from his/her current assignment within a reasonable time after being formally offered and accepting the position.

ARTICLE 26 REASSIGNMENTS AND DETAILS

Details and reassignments shall be in accordance with the DPM and this Article.

Section B

Bargaining unit members may submit requests for reassignments to other bargaining unit positions for which they qualify. Such requests will be handled and considered in accordance with the applicable personnel regulations.

Section C

Employees detailed to a position at a higher specialty practice level for more than sixty (60) consecutive calendar days shall receive pay at the higher level effective the first full pay period beginning on or after the sixty-first day. Employees detailed to a position subject to an Additional Income Allowance for more than sixty (60) consecutive calendar days shall be offered the opportunity for AIA effective the first full pay period beginning on or after the first day.

Section D

Whenever practicable, the Employer will consider requests submitted pursuant to Section B above before any involuntary detail or reassignment of a bargaining unit member is effected.

Section E

Except in emergencies or when necessary to meet unforeseen staffing or patient care needs, the Employer will give at least two (2) weeks notice of a reassignment or detail

ARTICLE 27 HOURS AND DAYS OF WORK

Section A Administrative Work Week

The basic administrative work week for full-time employees shall be five (5) eight (8) hour work periods, excluding an unpaid lunch period where applicable, in a seven (7) day period, totaling forty (40) hours; an employee with a regularly scheduled tour of duty of less than forty (40) hours per week is a part-time employee. For both full-time and part-time employees,

completion of professional responsibilities may make it necessary to perform official duties in excess of their administrative work week.

Section B Alternative Work Schedules

1. If it is determined that to do so will increase efficiency and productivity and will reduce absenteeism with no significant increase in costs, and based on the needs of the department and individual professional responsibilities, alternative work schedules may be established that differ from the traditional tour of duty described above, but shall be related to the forty (40) hour administrative work week or eighty (80) hour pay period. In the event that alternative work schedules are established, any pay for additional hours of work that may be authorized by this Agreement will not begin to accrue until the scheduled work period is completed. An alternative work schedule shall not affect the leave system. Leave will continue to be earned at the same number of hours per pay period as for employees on five (5) day, forty (40) hour schedules and will be charged on an hour-by-hour basis.

2. Assignment of doctors to any alternative work schedules shall take into account individuals' preferences for such schedules to the maximum extent possible.

3. Management agrees to notify and consult with the Union prior to establishing new alternative work schedules. If disagreement remains after consultation, a labor-management committee will be established prior to establishing any new alternative work schedules. The recommendations, if any, or the positions of the parties shall be communicated to the appropriate Agency Director who shall provide a written response prior to implementation of any new alternative work schedules.

ARTICLE 28 SHIFT, WEEKEND AND HOLIDAY SCHEDULING

Section A Shift Scheduling

1. In scheduling employees to work weekend days and shifts, the Employer shall grant employee preferences whenever possible. However, in the event that all employees' choices cannot be accommodated, given the needed skills, equitable distribution and seniority shall be the determining factors.

2. In the event that preferences of employees cannot be accommodated, the work will be rotated among employees with the needed skills. Rotation of involuntary assignments to weekend days and shifts will begin with the least senior employee with the needed skills. The employees involved in the rotation schedule shall be consulted in establishing the schedule. Except in an emergency situation, shift assignments shall be posted at least thirty (30) calendar days in advance of the effective date.

Section B Holiday Scheduling

Holiday work shall be limited according to past practice. In scheduling employees to work holidays, the Employer shall grant employee preferences, whenever possible. However, in the event that all employees' choices cannot be accommodated, given the needed skills, equitable distribution and seniority shall be the determining factors.

ARTICLE 29 REDUCTION IN FORCE

The Employer will notify the Union in writing when a reduction in force or furlough is proposed and prior to the request to the Mayor for approval of the RIF or furlough, including the reasons for the contemplated action, and the scope of the contemplated action, including but not limited to affected positions and the proposed competitive area. The Employer will provide the Union with relevant information as it becomes available.

Section B

The Employer shall give the Union a reasonable opportunity to present alternatives to the contemplated RIF or furlough (e.g., job sharing and reduced hours, reassigning employees to vacant positions determined essential, etc.) prior to its implementation.

Section C

The Employer will comply with rules, regulations and procedures governing reductions in force as currently provided in the District of Columbia Personnel Manual (DPM) and the Comprehensive Merit Personnel Act (CMP A).

Section D

The Employer will bargain with the Union regarding the impact and effect of the proposed furlough or reduction in force.

Section E

The Agency shall provide the Union a copy of the approved Administrative Order or equivalent (and any amendments) identifying the competitive area, the positions to be abolished by position number, title, series, grade and organizational location, and the reasons therefore within 2 working days of its issuance.

Section F

The Agency shall provide the Union a copy of each D.C. Standard Form 52 for each position to be abolished (without indicating the name of the incumbent of the position) within 2 working days of its issuance.

Section G

No later than the date an Administrative Order for a RIF is issued, the Agency shall provide the Union with a list of its bargaining unit members indicating name, grade, step, salary, title, TOD, Date of Birth, Date of Hire and Service Computation Date, DC Residency and shall provide the Union with a list of its bargaining unit members who will, as of the proposed RIF date be eligible for regular retirement under the CSRS and those who will be eligible for discontinued service retirement as of that date.

Section H

In the event the agency head is planning to establish a competitive area less than the entire Agency for either a RIF or furlough, the Agency shall provide the Union written notice of the proposed lesser competitive area and the agency justification for the proposed competitive area

Section I

The Agency shall provide the Union with a copy of the description of the competitive levels for medical officer, dentist and podiatrist positions as soon as it is prepared.

Section J

The Agency shall provide the Union with a copy of each retention register covering medical officer, dentist and podiatrist positions as soon as it is prepared. The Agency shall provide the Union a copy of the final retention register.

Section K

The Agency shall give written notice to each employee in accordance with D.C. Official Code § 1 624.08(e).

Section L

The Employer will notify the Union of any change in the law, regulations or procedures governing reductions in force and furloughs and will, upon request, bargain on the impact and effect on bargaining unit members.

ARTICLE 30 CONTRACTING OUT

Section A

It is mutually agreed that it is desirable for the Employer to employ and retain medical staff as regular full-time or part-time employees for the D.C. Government.

Section B

1. Except as provided in Section C, in the event a bargaining unit member vacates a position, the Employer shall first attempt to fill the position through documented recruitment efforts to employ a person as a regular full-time or part-time employee to perform that work.

2. The Employer shall consult with the Union to improve recruitment efforts, including working through professional organizations to facilitate the staffing of hard to fill positions in the bargaining unit and reduce to the extent possible, the need to contract for medical officer services in agency programs.

Section C

The Employer does not need to attempt first to recruit under Section B if the Employer can demonstrate that recruiting is not practicable for reasons such as the duration of the work too short to justify filling the position with a regular full-time or part-time employee, there is an immediate need requiring filling of the position temporarily or pending completion of a recruitment process of where documented recent recruitment efforts for a particular specialist indicates the futility of attempting further recruitment efforts.

Section D

The Employer will notify the Union at least 30 days in advance when it intends to contract out work previously done by a bargaining unit employee and will consult with the Union on alternate ways of meeting the need(s). The Employer will give written explanation to the Union of the reasons for contracting out and will consult with the Union on measures to reduce any adverse impact on bargaining unit members. The impact and effects of contracting out is a mandatory subject of bargaining.

Section E

The Employer agrees that any contracting out the work performed by a member of the bargaining unit will comply with the D.C. Code and applicable regulations and this agreement.

Section F

Contracting-out for the purposes of this agreement, means the process in which the District government contracts for a good or service that has been provided (prior to contracting out) by

bargaining unit employees. In the event that the Employer intends to contract-out, the Employer shall comply with the requirements of D.C. Official Code §2-301.05b(a)-(e) prior to entering into a contract.

ARTICLE 31 ANNUAL LEAVE AND SICK LEAVE

Section A

Entitlement, scheduling and use of annual, sick or other leave shall be in accordance with the CMPA, applicable DPM provisions and the "Compensation Agreement between the District of Columbia Government and the Doctors Council of the District of Columbia Representing Compensation Unit 19".

Section B

1. An arbitrary maximum limit will not be placed on the amount of annual leave that can be used at one time; but the Employer retains the right to grant or deny annual leave requests based on factors such as staffing needs created by illness, emergency or other unforeseen events, workload requirements and leave requests from other employees. The Employer shall respond promptly to leave requests.

2. Restoration of annual leave shall be in accordance with applicable DPM provisions. Employees are to request and supervisors are to schedule annual leave for employees with "Use or lose" leave as early in the leave year as practicable.

Section C

Sick leave shall be requested and granted in accordance with the CMP A and applicable DPM provisions. Bargaining unit members are eligible to donate a portion of their annual leave to the Annual Leave Bank for use by employees confronted with medical emergencies and to apply to become a leave recipient under the terms of the DPM provision on the Annual Leave Bank.

Section D

Under the Voluntary Leave Transfer Program, a bargaining unit member may transfer accrued annual leave to the account of any eligible Agency employee who is confronted with a serious health condition or has the responsibility to provide personal care to an immediate relative; and a bargaining unit member may apply to become a recipient employee under the Voluntary Leave Transfer Program.

ARTICLE 32 IMPROVED BENEFITS

Section A

Any future legislation, ordinance or order, which improves the benefits which employees covered by this contract now receive, shall automatically be applied to such employees.

ARTICLE 33 FINALITY OF AGREEMENT

Section A

This Agreement represents the complete agreement of the Parties with respect to all matters which were or could have been negotiated. Matters not referred to in the Agreement shall be provided in accordance with law. The parties waive the right to negotiate with respect to any matter referred to or not referred to herein for the duration of this Agreement except upon mutual agreement

Section B

When action by the Employer on a term or condition of employment not covered by this agreement directly impacts on the conditions of employment of unit members such action shall be a proper subject of negotiation, in accordance with D.C. Code, § 1-617.01, et. seq.

ARTICLE 34 SAVINGS CLAUSE

Section A

In the event that a court of competent authority or other competent authority shall at any time declare any provision of this Agreement invalid, such decision shall not invalidate the entire agreement, it being the intent of the parties that all valid provisions shall remain in full force and effect. In the event any provision is invalidated under this Article, such provision shall be renegotiated at the request of either party.

Section B

In the event of action by the President or Congress of the United States that has been determined to render any provision(s) of this Agreement invalid, any affected provision(s) will be subject to immediate renegotiations.

ARTICLE 35 DURATION

This Agreement shall remain in effect to and including September 30, 2009. The Agreement shall be automatically renewed from year to year thereafter until changed by the parties in the following manner: written notice by a party of its desire to renegotiate the agreement: such notice to be given during the period 120 days to 90 days prior to the first date of a fiscal year, for the purposes of negotiating a non-compensation agreement fore the subsequent fiscal year (e.g., for the purpose of negotiating a non-compensation agreement for FY 2010, notice would be served 120 to 90 days prior to the first day of FY 2009).

In the event that a timely notice to modify the provisions of this Agreement has been served, but the parties have not negotiated a successor contract as of September 30, 2009, it is hereby agreed that all of the provisions of this Agreement shall remain in full force and effect until a successor agreement is achieved through collective bargaining or through the appropriate procedures under the Comprehensive Merit Personnel Act.

Signed in Washington, D.C., this _____ day of _____, 2005.

FOR THE EMPLOYER

Mary E. Leary, Director
Office of Labor Relations and
Collective Bargaining

Michael A. Jacobs, Supervisory
Labor Relations Officer
Office of Labor Relations and
Collective Bargaining

Debra Allen-Williams
Labor Relations Officer
Office of Labor Relations and
Collective Bargaining

10/11/05
Gregg Pane, M.D., Director
Department of Health

Bernadine Booker Brown, Labor Liaison
Department of Health

FOR THE UNION

Wendy L. Kahn 9/9/05
Wendy L. Kahn, Esq.
Chief Negotiator

9/12/05
Raymond Brown, President
Doctors Council of D.C.

Brenda M. Lyons, D.D.S.
Bargaining Team Member

Patricia Higgins
Department of Health

Yvonne Gilchrist, Director
Department of Human Services

Barbara Bailey, Labor Liaison
Department of Human Services

Kim Trawick, Labor Advisor
Department of Human Services

Vincent Schiraldi, Director
Department of Youth Rehabilitative Services

Marie Pierre-Louis, M.D., Chief
Office of the Chief Medical Examiner

Beverly Fields, Labor Liaison
Office of the Chief Medical Examiner

APPROVAL

This Collective Bargaining Agreement between the District of Columbia Government and the Doctors Council of the District of Columbia dated September 9th, 2005 has been reviewed in accordance with §1715(a) of the District of Columbia Comprehensive Merit Personnel Act of 1978, as amended, D.C. Official Code § 1-617.15(a) (2001 ed.), and is hereby approved this 27th day of October, 2005.

Anthony A. Williams
Mayor

DOCTORS COUNCIL OFFICIAL TIME REPORT REPORTING PERIOD (each pay period)

OFFICIAL TIME SPENT ON LABOR-MANAGEMENT ACTIVITIES FROM: TO:

Name of Union Representative (Last Name, First, Middle Initial) Name of Supervisor Submitting Report

Organization (Agency, Division, Branch)

Representational Functions of Official Time (Activity) as identified in the Agreement. [See Reverse Side]

DATE	Activity (1-8) Identify all that apply	Actual Time From: am/pm	TO: am/pm	Total Time Used	Union Rep. Initial	Supv. Approving Initials

1	Labor negotiations.
2	Contacts between employee representatives and employees provided for in the negotiated grievance procedure.
3	Grievance meetings and arbitration hearings.
4	Disciplinary or adverse action meetings, if the Union is designated as representative of the employee.
5	Attendance at an examination of an employee who reasonably believe he or she may be the subject of a disciplinary or adverse action and the employee has requested representation.
6	Attendance at board or other committee meetings on which the Union representatives are authorized membership by the Employer or the Agreement.
7	Attendance at meetings between the Employer and the Union.
8	Attendance at agency recognized/sponsored activities to which the Union has been invited.

Distribution: Original to Office of Labor Relations & Collective Bargaining
Copy kept by Supervisor & Union Representative

COMPENSATION COLLECTIVE BARGAINING AGREEMENT

BETWEEN

THE GOVERNMENT OF THE DISTRICT OF COLUMBIA

AND

DOCTORS COUNCIL OF THE DISTRICT OF COLUMBIA

REPRESENTING COMPENSATION UNIT 19

EFFECTIVE THROUGH

SEPTEMBER 30, 2016

TABLE OF CONTENTS

PREAMBLE

This Compensation Agreement is entered into between the Government of the District of Columbia and the Doctors Council of the District of Columbia, NUHHCE, AFSCME, AFL-CIO, representing a unit of employees comprising Compensation Unit 19 (Physicians, Dentists and Podiatrists) previously certified by the Public Employee Relations Board ("PERB") in PERB Case No. 88-R-12, dated January 5, 1989, PERB Case No. 92-R-01, dated January 10, 1992, and PERB Case No. 96-AC-01 (1996).

ARTICLE I WAGES

Section A – FY 2010

Effective the first day of the first full pay period beginning on or after October 1, 2009, the FY 2009 pay schedules in effect for bargaining unit employees since October 2008 shall remain unchanged).

Section B – FY 2011

Effective the first day of the first full pay period beginning on or after October 1, 2010, the FY 2009 pay schedules referenced above will remain unchanged.

Section C – FY 2012

Effective the first day of the first full pay period beginning on or after October 1, 2011, the FY 2009 pay schedules referenced above will remain unchanged.

Section D – FY 2013

Effective the first day of the first full pay period beginning on or after October 1, 2012, the FY 2009 pay schedules referenced above and the salaries of bargaining unit members will remain unchanged until the first full pay period beginning on or after April 1, 2013 at which time the pay schedules and salaries shall increase by 3% in accordance with past methods of increasing base salary schedules.

Section E – FY 2014

1. Effective the first day of the first full pay period beginning on or after October 1, 2013, the FY 2013 pay schedules under Section D and the salaries of bargaining unit members shall be increased by 1.5% in accordance with past methods of increasing base salary schedules.

2. Effective the first day of the first full pay period beginning on or after October 1, 2013, the pay schedules for Level 5 (i.e., 5, 5B and 5C) as adjusted by 1.5% under subsection (1) and the salaries of bargaining unit members shall be modified as follows:

a. The dollar amount of salary on Step 2 of the pay schedule will become the dollar amount of salary on Step 1. Each subsequent step (i.e., Step 2 through Step 8) will be 2.5% higher than the previous step.

Section F – FY 2015

Effective the first day of the first full pay period beginning on or after October 1, 2014, the FY 2014 pay schedules under Section E and the salaries of bargaining unit members shall be increased by 3.0% in accordance with past methods of increasing base salary schedules.

Section G – FY 2016

1. Effective the first day of the first full pay period beginning on or after October 1, 2015, the FY 2015 pay schedules under Section F at Levels 1, 2, 4, 5, and 6 and the salaries of bargaining unit members shall be increased by 3.0% in accordance with past methods of increasing base salary schedules.

2. Effective the first day of the first full pay period beginning on or after October 1, 2015, the FY 2015 pay schedules under Section F at Level 3 (i.e., 3, 3B and 3C) and the salaries of bargaining unit members shall be increased by 3% in accordance with past methods of increasing base salary schedules plus $1,000.

Section H: Definitions

1. As referenced in this document and any attachments, the term "fully trained" shall be defined as follows:

   a. Physicians: Graduated from an approved residency or fellowship training program. Approved residency or fellowship training programs are those American residency or fellowship programs approved by the Accreditation Council for Gradual Medical Education (ACGME), the Residency Review Committee for Pediatrics, the Residency Review Committee for Emergency Medicine, or other appropriate authority or those Canadian training programs approved by the Royal College of Physicians and Surgeons of Canada, the College of Family Practice Physicians and Surgeons of Canada or other appropriate Canadian medical authority; or experience and/or training programs which are generally accepted to be equivalent to an ACGME approved residency or fellowship program and/or specifically approved and accepted by the relevant licensing board.

   b. Dentists: Graduated with a degree in dental surgery (D.D.S.) or dental medicine (D.M.D.) from a U.S. or Canadian school approved by the Council on Dental Education, American Dental Association, or an equivalent degree from another dental school, provided the education and knowledge acquired are substantially equivalent.

c. Podiatrists: Graduated from a school of podiatric medicine approved by the American Podiatry Association in the year in which the degree was granted.

Section I: Classification Collaborative Review

The parties hereby agree that the District and the Union shall commence a joint labor and management classification collaborative review. This project shall examine the current classification system for bargaining unit positions in order to ensure the appropriateness of the District's current classification system for bargaining unit positions. The parties agree that changes agreed upon by the parties shall upon agreement, be implemented consistent with the terms of parties' agreement.

Section J: Additional Income Allowance Relevant Board Certifications, Training and Experience

Bargaining unit employees may be eligible to receive an "Additional Income Allowance" in accordance with Chapter 11, § 1143 of the District Personnel Manual (DPM), and when an agency desires that a member provide additional services based on skills gained through board certifications(s) and/or training or experience which was not previously credited at the time of appointment (or thereafter) or is required for the performance of the duties of the employee's official position of record.

1. An additional income allowance may be provided for additional board certifications and training or experience only when it is determined by the agency that the employee's use of such certifications and training or experience will enhance the accomplishment of the agency's mission and/or allow the agency access to services that would normally or customarily be obtained through non-bargaining unit sources and may include, but is not limited to, services related to clinical leadership/education which are in addition to the duties customarily required or assigned as part of the employee's official position. The additional income allowance may be provided only after it is approved by the personnel authority in accordance with Chapter 11 of the DPM.

2. Consistent with § 1143.17 of Chapter 11 of the DPM, upon approval of an additional income allowance by the personnel authority, each agency head shall notify each employee offered the additional income allowance of his or her obligation to enter into a service agreement as a condition of accepting the allowance. Each service agreement executed for an additional income allowance shall comply with the requirements set forth in § I 143.19 of the DPM.

3. Whenever an agency is contemplating offering an Additional Income Allowance involving a bargaining unit position, the agency shall give written notification to the Union of the reasons supporting the offer and the intended amount. Such notification shall be given prior to any offer being made in sufficient time to

obtain appropriate input from the Union. The agency shall promptly provide the Union with a copy of each request submitted by the agency for authorization to pay an AIA and a copy of each executed service agreement.

ARTICLE 2 SPECIAL PAY

Section A:

Employees will be eligible for Special Pay as described in this Article.

Section B:

1. Employees who are assigned to tours of duty that include evenings or night shifts, Sundays, or Holidays will receive premium pay for such scheduled hours worked, as follows:

   a. Evening and Night: Ten Percent (10%) for regularly scheduled work performed between 6:00pm and 6:00am.

   b. Sundays: Twenty-five percent (25%) for full-time employees for regularly scheduled hours worked on a Sunday.

   c. Holidays: If required-to-work on a legal-holiday falling within the regular work week, in addition to straight time pay for the holiday, the employee will receive premium pay at the scheduled hourly rate for regularly scheduled hours worked.

Section C:

There shall be no pyramiding of premium pay paid pursuant to this Article, nor shall there be pyramiding of premium pay with pay for additional hours of work authorized by this Agreement. Employees receiving Sunday premium pay will not be eligible for shift premium for the same hours. Premium pay shall not constitute an increase in basic pay nor be considered as part of basic pay for any purpose.

ARTICLE 3 OVERTIME

Section A:

Employees shall be eligible to earn overtime pay as follows:

1. Employees required to work in excess of their administrative work week or alternative work schedule, including call-backs, will receive compensation for additional hours actually worked under the following conditions:

   a. Additional hours of work must be authorized or approved by the Employer, who shall certify in writing that the extra work (a) was medically necessary, (b) was directly related to patient care responsibilities, (c) required the personal professional attention of the employee, and (d) could not have been performed during the employee's regularly scheduled hours of work.

   b. Pay for more than twenty (20) hours of overtime in a pay period must be authorized or approved by the Agency Director or his/her designee.

Section B:

Overtime compensation will be paid for all hours actually worked in excess of forty (40) hours in a work week (or eighty (80) hours for employees on an alternative work schedule based on an eighty (80) hour pay period).

Section C: Call-Back Pay

A minimum of four (4) hours overtime work shall be credited to any unit employee who is called back to perform unscheduled overtime work either on a regular workday after he/she had completed his/her regular work schedule and left his/her place of employment, or on one (1) of the days he/she is off duty.

Section D:

Pay for additional hours worked pursuant to the above shall not constitute an increase in basic pay nor be considered part of basic pay for any purpose.

Section E:

Upon mutual agreement, employees may receive compensatory time on an hour-for-hour basis for overtime hours worked in lieu of the overtime payment described above.

ARTICLE 4 ON-CALL PAY

Section A:

Each agency shall designate bargaining unit positions for which on-call pay is authorized. Positions for which on-call pay is authorized, may be designated based on the following conditions:

1. The work involved in the position is vital to:

    a. Continuity of public health and human services;

    b. Public safety and law enforcement;

    c. Emergency management services and emergency medical services; or

    d. Other crucial operations such as transportation, shelter operation, food distribution, and communication; and

2. The work of the position requires the incumbent, when otherwise off duty, to be available to report for work on short notice, within a maximum of one (1) hour or such lesser time as the agency deems warranted by the nature of the position. Provided, however, where an employee has notified the agency in advance of the assignment of the inability to report for duty within an hour, the employee shall report within the time frame established by the Agency.

Section B:

For an employee to be eligible to receive on-call pay, all of the following conditions must be met:

1. He or she must occupy a position for which on-call pay has been authorized;

2. The agency must have placed the on-call time on the employee's official work schedule on a holiday or outside the employee's scheduled tour of duty;

3. The employee must be required to be in a state of readiness to perform work; and,

4. When called in, the employee must be able to report for work within the time frame established by the agency.

Section C:

Except as provided in Section D, while in an on-call status, an employee shall be entitled to pay at a rate equal to twenty-five percent (25%) of his or her rate of basic pay, payable on an hour-

for-hour basis, in increments of one-quarter (¼) of an hour for each fifteen (15) minutes and portion thereof in excess of fifteen (15) minutes.

Section D:

1. A bargaining unit employee on a regularly established on-call schedule shall be compensated at a rate of forty percent (40%) of his/her basic rate of pay for each hour the employee is scheduled for on-call. For the purpose of this Agreement, "regularly established on-call schedule" is defined as the practice of regularly scheduling an employee for on-call duty by placing the employee on an agency on-call schedule which is usually regularly established each pay period. An employee on a regularly established on-call schedule shall be accessible via telephone or other means of communication and/or available to report for work on short notice, within a maximum of one (1) hour or such lesser time as the agency deems warranted by the nature of the position. Provided however, where an employee has notified the agency in advance of the assignment of the inability to report for duty within an hour, the employee shall report within the time frame established by the agency.

2. As of the date of execution of this agreement it is understood that all of the bargaining unit positions in the Office of the Chief Medical Examiner are assigned to be on-call pursuant to a regularly established on-call schedule. Prior to an agency initiating a regularly established on-call schedule affecting any other bargaining unit position(s), the agency shall give written notice to the Union and the employee(s) of the proposed schedule, and a description of the circumstances of on-call.

Section E:

When an employee who is in an on-call status is called in or according to mutually agreed upon criteria performs work, he or she shall be credited with a minimum of two (2) hours of work time.

Section F:

On-call pay may not be provided nor may an employee be placed in an on-call status while on paid leave.

Section G:

On-call pay shall not be considered basic pay for any purpose except for computing overtime under the Fair Labor Standards Act.

Section H:

Upon mutual consent of the Employee and the Agency, time off may be substituted for part or all of the compensation under this paragraph.

ARTICLE 5 BENEFITS

Section A: Life Insurance

1. Life insurance is provided to covered employees in accordance with §1-622.01 et seq. of the District of Columbia Official Code (2001 Edition) and Chapter 87 of Title 5 of the United States Code.

(a) District of Columbia Official Code §1-622.03 (2001 Edition) requires that benefits shall be provided as set forth in §1-622.07 to all employees of the District first employed after September 30, 1987, except those specifically excluded by law or by rule.

(b) District of Columbia Official Code §1-622.01 (2001 Edition) requires that benefits shall be provided as set forth in Chapter 87 of Title 5 of the United States Code for all employees of the District government first employed before October 1, 1987, except those specifically excluded by law or rule and regulation.

2. The current life insurance benefits for employees hired on or after October 1, 1987 are: The District of Columbia provides life insurance in an amount equal to the employee's annual salary rounded to the next thousand, plus an additional $2,000. Employees are required to pay two-thirds (2/3) of the total cost of the monthly premium. The District Government shall pay one-third (1/3) of the total cost of the premium. Employees may choose to purchase additional life insurance coverage through the District Government. These additions to the basic coverage are set-forth in the schedule below:

Optional Plan	Additional Coverage	Premium Amount
Option A – Standard	Provides $10,000 additional coverage	Cost determined by age
Option B – Additional	Provides coverage up to five times the employee's annual salary	Cost determined by age and employee's salary
Option C – Family	Provides $5,000 coverage for the eligible spouse and $2,500 for each eligible child.	Cost determined by age.

Employees must contact their respective personnel office to enroll or make changes in their life insurance coverage.

Section B: Health Insurance:

1. Pursuant to D.C. Official Code §1-621.02 (2001 Edition), all employees covered by this agreement and hired after September 30, 1987, shall be entitled to enroll in group health insurance coverage provided by the District of Columbia.

(a) Health insurance coverage shall provide a level of benefits comparable to the plan(s) provided on the effective date of this agreement. Benefit levels shall not be reduced during the term of this agreement except by mutual agreement of the District, representatives of Compensation Unit 19 and the insurance carrier(s). District employees are required to execute an enrollment form in order to participate in this program.

(b) The District may elect to provide additional health care providers for employees employed after September 30, 1987, provided that such addition of providers does not reduce the current level of benefits provided to employees. Should the District Government decide to expand the list of eligible providers, the District shall give Compensation Unit 19 representatives notice of the proposed additions.

(c) Employees are required to contribute 25% of the total premium cost of the employee's selected plan. The District of Columbia Government shall contribute 75% of the premium cost of the employee's selected plan.

2. Pursuant to D.C. Official Code §1-621.01 (2001 Edition), all District employees covered by this agreement and hired before October 1, 1987, shall be eligible to participate in group health insurance coverage provided through the Federal Employees Health Benefits Program (FEHB) as provided in Chapter 89 of Title 5 of the United States Code. This program is administered by United States Office of Personnel Management.

3. The plan descriptions shall provide the terms of coverage and administration of the respective plans. Employees and union representatives are entitled to receive a copy of the summary plan description upon request. Additionally, employees and union representatives are entitled to review copies of the actual plan description upon advanced request.

4. The District shall provide an employee a health services program that provides treatment, counseling and preventive health programs consistent with its obligations under D.C. Official Code § 1 620.07 (2001 ed.).

Section C: Optical And Dental:

1. Except as provided in paragraph 2, the Employer will continue to pay premiums at the same rate currently paid to the optical and dental plan providers of the Union-approved programs currently applicable to the bargaining unit.

2. a. During the term of this Agreement, the Union may elect coverage under the Optical and/or Dental plans in effect for District employees in Compensation Unit 1 under the personnel authority of the Mayor ("District Plans"). Should the Union elect to participate in the Optical and/or Dental District Plans as offered by the District Government, the Employer will pay the same premiums paid for other unionized District employees covered by the District Plans. Benefit levels of the District Plans shall not be reduced during the term of this agreement except by mutual agreement of the District, the Union and the insurance carriers.

   b. The District may elect to provide additional Optical and/or Dental providers, provided that such addition of providers does not reduce the current level of benefits provided to employees. Should the District Government decide to expand the list of eligible providers, the District shall give Compensation Unit 19 representatives notice of the proposed additions.

3. Bargaining unit employees are required to execute an enrollment form in order to participate in the District Optical and Dental Plans.

4. In the event the Union elects to participate in the District's Optical and/or Dental Plan as described in Paragraph 2, in consultation with the Union, the Employer shall provide information to the bargaining unit employees about the Plans' terms, benefits, and providers and any changes thereto. The Employer shall assist employees in the unit and the Union in making a transition from the current plans to the District Plan(s), including providing assistance in the enrollment process.

Section D: Short-Term Disability Insurance Program:

Employees covered by this Agreement shall be eligible to enroll, at their own expense, in the District's Short-Term Disability Insurance Program, which provides for partial income replacement when employees are required to be absent from duty due to a non-work-related qualifying medical condition. Employees may use income replacement benefits under the program in conjunction with annual or sick leave benefits provided for in this Agreement.

Section E: Annual Leave:

1. In accordance with D.C. Official Code §1-612.03 (2001 Edition), full-time employees covered by the terms of this agreement are entitled to:

a. one-half (1/2) day (4 hours) for each full biweekly pay period for an employee with less than three years of service (accruing a total of thirteen (13) annual leave days per annum);

b. three-fourths (3/4) day (6 hours) for each full biweekly pay period, except that the accrual for the last full biweekly pay period in the year is one and one-fourth days (10 hours), for an employee with more than three (3) but less than fifteen (15) years of service (accruing a total of twenty (20) annual leave days per annum); and,

c. one (1) day (8 hours) for each full biweekly pay period for an employee with fifteen (15) or more years of service (accruing a total of twenty-six (26) annual leave days per annum).

2. Part-time employees who work at least 40 hours per pay period earn annual leave at one-half the rate of full-time employees.

3. Employees shall be eligible to use annual leave in accordance with the District of Columbia Laws.

Section F: Sick Leave:

1. In accordance with District of Columbia Official Code §1-612.03 (2001 Edition), a full-time employee covered by the terms of this agreement may accumulate up to thirteen (13) sick days in a calendar year.

2. Part-time employees for whom there has been established in advance a regular tour of duty of a definite day or hour of any day during each administrative workweek of the biweekly pay period shall earn sick leave at the rate of one (1) hour for each twenty (20) hours of duty. Credit may not exceed four (4) hours of sick leave for 80 hours of duty in any pay period. There is no credit of leave for fractional parts of a biweekly pay period either at the beginning or end of an employee's period of service.

Section G: Other Forms Of Leave:

1. **Military Leave:** An employee is entitled to leave, without loss of pay, leave, or credit for time of service as reserve members of the armed forces or as members of the National Guard to the extent provided in D.C. Official Code §1-612.03(m) (2001 Edition).

2. **Court Leave:** An employee is entitled to leave, without loss of pay, leave, or service credit during a period of absence in which he or she is required to report for jury duty or to appear as a witness on behalf of the District of Columbia

Government, or the Federal or a state or local government to the extent provided in D.C. Official Code §1-612.03(l) (2001 Edition).

3. **Funeral Leave**:

   a. An employee is entitled to one (1) day of leave, without loss of pay, leave, or service credit to make arrangements for or to attend the funeral or memorial service for an immediate relative. In addition, the Employer shall grant an employee's request for annual or compensatory time up to three (3) days upon the death of an immediate relative. Approval of additional time shall be at the Employer's discretion. However, requests for leave shall be granted unless the Agency's ability to accomplish its work would be seriously impaired.

   b. For the purpose of this section "immediate relative" means the following relatives of the employee: spouse (including a person identified by an employee as his/her "domestic partner" (as defined in D.C. Official Code § 32 701 (2001 ed.) and related laws), and parents thereof, children (including adopted and foster children and children of whom the employee is legal guardian and spouses thereof, parents, grandparents, grandchildren, brothers, sisters, and spouses thereof). For the purposes of certification of leave, employees shall provide a copy of the obituary or death notice, a note from clergy or funeral professional or a death certificate upon the Employer's request.

   c. An employee is entitled to not more than three (3) days of leave, without loss of pay, leave, or service credit to make arrangements for or to attend the funeral or memorial service for a family member who died as a result of a wound, disease or injury incurred while serving as a member of the armed forces in a combat zone to the extent provided in D.C. Official Code §1-612.03(n) (2001 Edition).

4. **Family and Medical Leave**

   a. The District of Columbia Family and Medical Leave Act (D.C. FMLA) of 1990, D.C. Official Code § 32-501 et. seq. (2001 ed.) is applicable to any District of Columbia government employee who has been employed for one year without a break in services and has been in pay status for at least 1000 hours during the 12-month period immediately preceding the request for family or medical leave.

   b. The D.C. FMLA entitles eligible employees to 16 weeks unpaid family leave over a 24-month period for the birth of a child or the placement of a child in the employee's care, or to care for a family member with a serious health condition;

c. The D.C. FMLA entitles eligible employees up to 16 weeks of unpaid medical leave over a 24-month period when the employee is unable to perform his or her job because of serious health condition. The request for medical leave must be supported by a certification of the serious health condition issued by the employee's health care provider.

d. An employee may use paid leave during the 16-week period consistent with D.C. Office of Personnel policy.

5. **Other Leaves (Without Pay)**: Leaves of absence without pay for a limited period may be granted by the agency if requested in advance and in writing.

Section H: Pre-Tax Benefits:

1. Employee contributions to benefits programs established pursuant to D.C. Official Code §1 611.19 (2001 ed.), including the District of Columbia Employees Health Benefits Program, may be made on a pre-tax basis in accordance with the requirements of the Internal Revenue Code and, to the extent permitted by the Internal Revenue Code, such pre-tax contributions shall not effect a reduction of the amount of any other retirement, pension, or other benefits provided by law.

2. To the extent permitted by the Internal Revenue Code, any amount of contributions made on a pre-tax basis shall be included in the employee's contributions to existing life insurance, retirement system, and for any other District government program keyed to the employee's scheduled rate of pay, but shall not be included for the purpose of computing Federal or District income tax withholdings, including F.I.C.A., on behalf of any such employee.

Section I: Retirement:

1. **CIVIL SERVICE RETIREMENT SYSTEM (CSRS)**: As prescribed by 5 U.S.C. 8401 and related chapters, employees first hired by the District of Columbia Government before October 1, 1987, are subject to the provisions of the CSRS, which is administered by the U.S. Office of Personnel Management. Under Optional Retirement the aforementioned employee may choose to retire when he/she reaches:

   a. Age 55 and 30 years of service;

   b. Age 60 and 20 years of service;

   c. Age 62 and 5 years of service.

2. Under Voluntary Early Retirement, which must be authorized by the U.S. Office of Personnel Management, an employee may choose to retire when he/she reaches:

   a. Age 50 and 20 years of service;

   b. Any age and 25 years of service.

3. The pension of an employee who chooses Voluntary Early Retirement will be reduced by 2% for each year under age 55.

4. The Employer will notify the Union prior to submitting any request for Early Out Retirement authority in any Department where bargaining unit members are employed. Upon request, the Employer shall meet and bargain concerning the impact of such request, including the exclusion and/or inclusion of Medical Officer, Dental Officer and Podiatrist positions in the request.

5. **DEFINED CONTRIBUTION PENSION PLAN:**

   a. All eligible employees hired by the District on or after October 1, 1987, are enrolled into the defined contribution pension plan.

   b. As prescribed by §1-626.09(c) of the D.C. Official Code (2001 Edition) after the completion of one year of service, the District shall contribute an amount not less than 5% of their base salary to an employee's Defined Contribution Pension Plan account. The District government funds this plan; there is no employee contribution to the Defined Contribution Pension Plan. Employees are fully vested after five years of participation in the plan.

   c. As prescribed by §1-626.09(d) of the D.C. Official Code (2001 Edition) the District shall contribute an amount not less than an additional .5% of a detention officer's base salary to the same plan.

6. **DEFERRED COMPENSATION PROGRAM:**

As prescribed by §1-626.05 and related Chapters of the D.C. Official Code (2001 Edition), all District Government employees covered by this agreement shall be eligible to participate in the District's Deferred Compensation Program. The Deferred Compensation Program is a savings system through pre-tax deductions and allows employees to accumulate funds for long-term goals, including retirement. The portion of salary contributed reduces the amount of taxable income in each paycheck. The Internal Revenue Service determines the annual maximum deferral amount. Under the program, employees can choose from various fixed or variable investment options.

Section J: Holidays:

1. As prescribed by D.C. Official Code §1-612.02 (2001 Edition) the following legal public holidays are provided to all employees covered by this agreement:

   a. New Year's Day, January 1st of each year;

   b. Dr. Martin Luther King, Jr.'s Birthday, the 3rd Monday in January of each year;

   c. Washington's Birthday, the 3rd Monday in February of each year;

   d. Emancipation Day, April 16th of each year;

   e. Memorial Day, the last Monday in May of each year;

   f. Independence Day, July 4th of each year;

   g. Labor Day, the 1st Monday in September of each year;

   h. Columbus Day, the 2nd Monday in October of each year;

   i. Veterans Day, November 11th of each year;

   j. Thanksgiving Day, the 4th Thursday in November of each year;

   k. Christmas Day, December 25th of each year; and

   l. Inauguration Day (January 20th of each 4th year, starting in 1981).

2. When an employee, having a regularly scheduled tour of duty is relieved or prevented from working on a day District agencies are closed by order of the Mayor, he or she is entitled to the same pay for that day as for a day on which an ordinary day's work is performed.

Section K:

1. Compensation Unit 19 may send one delegate to participate in the Compensation Units 1 and 2 Labor-Management Benefits Committee, provided that such arrangement is not objectionable to Compensation Units 1 and 2. The Employer shall promptly provide the Union president a copy of materials provided to, and those generated by, members of the Compensation Units 1 & 2 Labor-Management Benefits Committee, if such materials impact the benefits of bargaining unit members.

2. The Employer will consult with the Union concerning proposals to change the health insurance, life insurance and retirement programs applicable to the bargaining unit members.

Section L:

In the event the Employer proposes improvements in any of the benefits in Section A-J or proposes adding new benefits generally applicable to employees under the personnel authority of the Mayor, the Employer shall notify the Union of the bargaining unit members' eligibility for such benefits and shall consult with the Union concerning the proposal(s).

ARTICLE 6 CONTINUING MEDICAL EDUCATION

Effective for expenses incurred during fiscal year 2014, the Employer shall increase the reimbursement for each bargaining unit doctor from $750.00 per fiscal year to $1,500.00 per fiscal year for expenses incurred in conjunction with continuing medical education, training conferences, or board examinations.

ARTICLE 7 SICK LEAVE INCENTIVE PROGRAM

The Employer agrees to provide time off in accordance with the following:

Section A:

A full-time employee who is in a pay status for the leave year shall accrue annually:

1. Three (3) days off for utilizing a total of no more than two (2) days of accrued sick leave.

2. Two (2) days off for utilizing a total of more than two (2) but not more than four (4) days of accrued sick leave.

3. One (1) day off for utilizing a total of more than four (4) but no more than five (5) days of accrued sick leave.

Section B:

Employees in a non-pay status for no more than two (2) pay periods for the leave year shall remain eligible for incentive days under this Article. Sick leave usage for maternity or catastrophic Illness/injury, not to exceed two (2) consecutive pay periods, shall not be counted against sick leave for calculating eligibility for incentive leave under this Article.

Section C:

Time off pursuant to a sick leave incentive award shall be selected by the employee and requested at least three (3) full workdays in advance of the leave date. Requests for time off pursuant to an incentive award shall be given priority consideration and the employee's supervisor shall approve such requests for time off unless staffing needs or workload considerations dictate otherwise. If the request is denied, the employee shall request and be granted a different day off within one (1) month of the date the employee initially requested. Requests for time off shall be made on the standard "Application for Leave" form.

Section D:

All incentive days must be used in full-day increments following the leave year in which they were earned. Incentive days may not be substituted for any other type of absence from duty. There shall be no carryover or payment for any unused Incentive days.

Section E:

Part-time employees are not eligible for the sick leave incentive as provided in this Article.

Section F:

This program shall take effect in Leave Year 2014.

ARTICLE 8 METRO PASSES

Effective October 1, 2014, the District of Columbia Government shall subsidize the cost of transit passes for personal use by employees by not less than twenty-five dollars ($25.00) per month for employees according to the same terms and conditions as the benefit is available to employees in Compensation Units 1 and 2.

ARTICLE 9 GRIEVANCES

The Compensation Agreement shall be incorporated by reference into the working conditions agreement in order to utilize the grievance/arbitration procedure in that agreement to consider alleged violations of this Agreement.

ARTICLE 10 FINALITY OF AGREEMENT

This Agreement represents the complete agreement of the Parties with respect to all compensation matters which were or could have been negotiated. Compensation matters not referred to in the Agreement shall be provided in accordance with law. The parties waive the right to negotiate with respect to any matter referred to or not referred to herein for the duration of this Agreement except upon mutual agreement

ARTICLE 11 SAVINGS CLAUSE

Section A:

In the event that any provision of this Agreement shall at any time be declared invalid by a court of competent authority or other competent authority, such decision shall not invalidate the entire Agreement, it being the intent of the parties that all valid provisions shall remain in full force and effect. In the event any provision is invalidated under this Article, such provision shall be renegotiated at the request of either party.

Section B:

Any future legislation, ordinance or order, which improves the benefits received by employees covered by this Contract, shall automatically be applied to such employees.

Section C:

In the event of action by the President or Congress of the United States, which results in any change in relationship or status as between the Federal Government and the Government of the District of Columbia, any directly affected contract provision will be subject to immediate renegotiation.

ARTICLE 12 DURATION

Section A:

This Agreement shall remain in effect to and including September 30, 2016. The Agreement shall be automatically renewed from year to year thereafter until changed by the parties in the following manner: written notice by a party of its desire to renegotiate the agreement: such notice to be given during the period 120 days to 90 days prior to the first date of a fiscal year, for the purposes of negotiating a compensation agreement for the subsequent fiscal year (e.g., for the purpose of negotiating a compensation agreement for FY 2017, notice would be served 120 to 90 days prior to the first day of FY 2016).

Section B:

In the event that a timely notice to modify the provisions of this Agreement has been served, but the parties have not negotiated a successor contract as of September 30, 2016, it is hereby agreed that all of the provisions of this Agreement shall remain in full force and effect until a successor agreement is achieved through collective bargaining or through the appropriate procedures under the Comprehensive Merit Personnel Act.

Signed in Washington, D.C., this 21st day of August, 2014

On Behalf of the District of Columbia Doctors Council

Jean-Joel Villier, MD
President, D.C. Doctors Council

Wendy Kahn, Esq.
Chief Negotiator,
D.C. Doctors Council

On Behalf of the Employing District Agencies:

Roger A. Mitchell, Jr.
Chief Medical Examiner
D.C. Office of the Chief Medical Examiner

Beverly Fields, Labor Liaison
D.C. Office of the Chief Medical Examiner

Laura L. Nuss, Director
D. C. Department of Disability Services

Kehinde Asuelimen, Labor Liaison
D.C. Department of Disability Services

Joxel Garcia, M.D., Acting Director
D.C. Department of Health

Earl Murphy, Labor Liaison
D.C. Department of Health

Neil Stanley, Director
D.C. Department of Youth Rehabilitative Services

Adam Aljoburi, Labor Liaison
D.C. Department of Youth Rehabilitative Services

On Behalf of the D.C. Office of Labor Relations and Collective Bargaining

Dean Aqui
Interim Director

APPROVAL

This Compensation Collective Bargaining Agreement between the District of Columbia Government and the Doctors Council of the District of Columbia dated Aug 21, _____, 2014 has been reviewed in accordance with §1715(a) of the District of Columbia Comprehensive Merit Personnel Act of 1978, (§ 1-617.15(a), D.C. Official Code 2001 Ed.), and is hereby approved this 25th day of Aug, 2014.

Vincent C. Gray

Vincent C. Gray

TABLE OF CONTENTS

PREAMBLE

A. This Agreement is entered into on March 29, 2004 between the District of Columbia Government and its Office of the Chief Medical Examiner (hereinafter referred to as the "Employer") and 1199 Metropolitan District DC National Union of Hospital and Health Care Employees, (NUHHCE), AFSCME, AFL-CIO (hereinafter referred to as the "Union"). The term "Employer" as used herein shall apply interchangeably to those officials or their authorized designees as the individual provisions of the Agreement may be applicable or as the authority is established by law.

B. All citations to the District of Columbia Official Code shall be to the 2001 Edition, as it is amended or subsequently recodified.

Section 2:

The Union is the exclusive representative of all employees in the above-referenced unit and, as such, is entitled to act for all employees in the unit and is responsible for representing the interests of all such employees without discrimination and without regard to union membership.

Section 3:

Issues involving unit definition and its scope may be referred by either party to the Public Employee Relations Board for resolution under appropriate procedures.

ARTICLE 3

MANAGEMENT RIGHTS

D.C. Official Code § 1-617.08 provides:

> "(a) The respective personnel authorities (management) shall retain the sole right in accordance with applicable laws and rules and regulations:
>
> (1) To direct employees of the agencies;
>
> (2) To hire, promote, transfer, assign and retain employees in positions within the agency and to suspend, demote, discharge or take other disciplinary action against employees for cause;
>
> (3) To relieve employees of duties because of lack of work or other legitimate reasons;

Section 2:

Allegations of discrimination based on statutorily protected individual employment rights including but not limited to the D.C. Human Rights Act may not be grieved under this Agreement and shall be filed with the appropriate agency or court as provided by the relevant statute.

ARTICLE 5

RIGHTS OF EMPLOYEES

Section A - General:

1. All employees shall be treated fairly, equitably and with respect, in accordance with District of Columbia laws, rules, regulations and the provisions of this Agreement.

2. The Employer and Union agree that employees shall be free from restraint, interference, coercion, or discrimination in the exercise of their right to organize and designate representatives of their own choosing for the purpose of collective bargaining and the presentation of grievances.

Section B - Classification:

1. An employee in the bargaining unit may discuss/review his/her job classification in terms of title, series, grade or description with the appropriate supervisor, who will meet promptly with the employee and his/her representative to discuss the matter. Such request may be presented orally to the appropriate supervisor. If the matter is not satisfactorily settled at this level, the employee may initiate a classification appeal in accordance with the classification appeal procedures in the CMPA.

will appear on the employee's evaluation form or on a paper attached thereto. Appeals of performance ratings are limited to those provided by D.C. Official Code §1-606.03 and are otherwise not grievable.

ARTICLE 6

UNION REPRESENTATION

Section 1:

The Union shall be given the opportunity to be represented at formal meetings between the Employer and employees or employee representative concerning the implementation of this contract.

Section 2:

The Union may designate one (1) steward.

Section 3:

The Union will supply, in writing, and maintain on a current basis: (a) a complete list of Union officers and its steward and (b) a copy of the Union's constitution, by-laws, and statement of objectives to the Employer and the Office of Labor Relations and Collective Bargaining.

Section 4:

The Employer will deal with officers and the steward, designated in accordance with Section 3 above, as Union representatives, as provided for in this Agreement.

Section 5:

The Union will notify the Employer, in writing, of non-employee officials of the Union who are authorized to represent the Union in dealings with the Employer. Such dealings will be through

of the time of return. The Employee must submit the attached Official Time Form each pay period to memorialize the use of approved official time for time and attendance accounting. If the duty involves contacting an employee, when the employee has designated the officer or steward as his/her representative in accordance with the Agreement, the Union representative will contact the immediate supervisor of such employee and obtain that supervisor's permission to contact or meet with the employee. If the immediate supervisor is not available, permission may be given by the next level supervisor. In matters related to discipline or in matters where discipline may be a potential outcome, such permission will be given unless the work situation or emergency dictates otherwise; and a confidential place for discussing the matter will be made available upon request, subject to availability. The Union representative will report back to his or her supervisor upon completion of duties arising from this Agreement and return to his or her place of work and performance of his/her job, and will lose no pay or other benefits as a result of such absences, provided the total time thus spent is kept to a minimum, the representative has received prior authorization and the representative has submitted the appropriate Official Time Form, as attached.

Section 8:

The Employer will provide notice to the Union prior to effecting reassignments of Union representatives if such changes are expected to exceed fifteen (15) calendar days.

Section 9:

Section 3:

The LMCC will meet quarterly or more frequently, as needed, provided either party furnishes the other with a written agenda of the topics to be discussed at least seven (7) calendar days prior to the meeting. In the absence of such an agenda, no meeting shall be held, except by mutual agreement. If the parties deem it necessary to have an emergency meeting, such a meeting may be scheduled prior to the quarterly meeting.

Section 4:

The LMCC will consist of two (2) members representing the Union and up to two (2) members representing the Employer. Each party shall designate a representative who has authority to represent its position. If issues are not resolved at the LMCC meeting, the parties agree to furnish a response to the status of the unresolved agenda items within fifteen (15) calendar days. The fifteen (15) day time limit may be waived upon request by the Employer or the Union. The Union may designate up to three (3) alternates. Each party may have other officials who are not employees of the OCME attend the meeting as needed.

Section 5:

Both the Employer and the Union recognize the importance of shop stewards and supervisors as key people in maintaining a constructive labor-management relationship. The parties agree to encourage constructive dealings between supervisors and stewards, to resolve problems and facilitate labor-management communication at the work level, on personnel policies and practices and working conditions. Meetings between individual supervisors and stewards on matters appropriate for discussion at that level may be arranged at the request of either party.

ARTICLE 8

UNAUTHORIZED ACTIVITIES

Section 1:

It shall be unlawful for any OCME employee to participate in, authorize or ratify a strike against the Employer.

Section 2:

The term "strike," as used herein, means a concerted refusal to perform duties or any concerted work stoppage or slowdown not authorized by the Employer. The Union agrees that it has an affirmative duty to disavow any strike, and to publicly encourage employees to return to work, in accordance with the Comprehensive Merit Personnel Act, D.C. Official Code Sections 1-617.04 and 1-617.05.

Section 3:

No lockout of employees shall be instituted by the Employer except in situations where employees strike illegally or in cases where the Employer deems it necessary to protect employees, the public, government property or national security.

ARTICLE 9

ATTENDANCE AND LEAVE

Leave shall be provided in accordance with D.C. Official Code §1-612.03, the District Personnel Manual Chapter 12 and as described within the Compensation Agreement. Additionally, leave shall be provided in accordance with the terms of this Article, to the extent that the terms do not conflict with law, rule or regulation.

2. Requesting Sick Leave:

Sick leave shall be requested in accordance with Chapter 12 of the District Personnel Manual.

3. Granting Sick Leave

Sick leave shall be granted in accordance with Chapter 12 of the District Personnel Manual.

4. Advance Sick Leave

The Chief Medical Examiner will consider requests for advance sick leave in accordance with the applicable District policies and regulations and act on the request in a timely manner.

C. Leave Without Pay (LWOP):

The retention and accumulation of rights, benefits and privileges by employees who are on leave without pay shall be subject to the applicable District law and personnel regulations.

D. Absence Without Leave (AWOL)

Subject to the District Personnel Manual Chapter 12, employees may be charged absent without leave (AWOL). An AWOL charge may be changed later to an appropriate type of leave if the leave-approving official determines that the employee has satisfactorily explained the absence or presented documentation acceptable to the leave-approving official.

E. Maternity and Paternity Leave

Maternity and paternity leave shall be requested and approved in accordance with existing regulations, inclusive of the provisions of the Federal Family and Medical Leave Act and the District of Columbia Family and Medical Leave Act.

Employees will report to work, ready to perform the duties of their positions, at the scheduled starting time of their tours of duty.

ARTICLE 12

SAFETY AND HEALTH

Section 1 - Working Conditions:

A. The OCME shall make every effort to provide and maintain safe and healthful working conditions for all employees as required by applicable laws and regulations. It is understood that the OCME may exceed standards established by regulations consistent with the objectives set by law. The Union will cooperate in these efforts by encouraging its members to work in a safe manner and to obey established safety practices and regulations.

B. The OCME will provide proper equipment for employees as is determined necessary by the Employer.

Section 2 - Reporting Unsafe Conditions:

A. If an employee observes a condition, which he or she believes to be unsafe, the employee should report the condition to the immediate supervisor.

B. If the supervisor and employee agree that a condition constitutes an immediate hazard to the health and safety of the employee, the supervisor shall take immediate precautions to protect the employee.

C. If the supervisor and employee do not agree that a condition constitutes an immediate hazard to the health and safety of the employee, the matter may be immediately referred by the employee to the next level supervisor or designee. The supervisor or designee shall meet as soon

Section 5 - Safety Training:

The OCME shall provide safety training to employees which the Employer deems necessary for performance of their job. Issues involving safety training may be presented to the RACC or an established subcommittee of the RACC. Issues concerning safety training may also be raised at LMPC meetings.

Section 6 - Examinations and Tests:

A. The Employer shall, where it deems appropriate, provide training regarding appropriate health guidelines governing communicable diseases.

B. Physical examinations and tests may be required by the Employer in order to comply with infection control criteria and requirements as set forth by regulating agencies. Except in circumstances deemed exigent by the Chief Medical Examiner or his/her designee, prior to requiring any new or additional examination or test under this paragraph, the Employer will notify the Union of the basis for the examination or test and give the Union an opportunity to consult.

Section 7 - Risk Assessment Control Committee:

A member of the bargaining unit designated by the Employer shall have the right to serve on the RACC.

Section 8 - Medical Qualification Requirements:

The OCME agrees to abide by the provisions of the appropriate regulations as dictated by District of Columbia law and regulation.

Section 9 - Employee Health Services:

Section 4:

Union requests for use of facilities for meetings during non-work time shall be addressed to the Employer's designated representative, shall contain the information prescribed by the Employer and shall be submitted as far in advance as practical.

ARTICLE 14

IDENTIFICATION DEVICES

The Employer agrees that employees may wear, on their uniform or other work clothing, while on duty, an unobtrusive membership pin indicating membership in any labor organization, provided that such pin is not larger than one and one-quarter inches in diameter, bears no campaign propaganda and the wearing of such pin will present no hazard or potential hazard to the employee or to the public.

ARTICLE 15

PROMOTIONAL BULLETINS

Promotion bulletins announcing positions within the units which are vacant and are scheduled to be filled under competitive promotion procedures will be posted on bulletin boards for at least ten (10) calendar days. Promotion bulletins for positions within the unit will indicate, at a minimum, the area of considerations, duties of the position, qualifications required, method of application and statement of equal opportunity. The Union President shall be furnished with copies of all vacancy announcements, cancellations, corrections or amendments for positions within the bargaining unit.

against whom adverse action is proposed shall be entitled to at least thirty (30) days advance written notice of proposed adverse action (or fifteen (15) days if corrective action is proposed). The notice will identify at a minimum the causes and reasons for the proposed action.

Section 5:

The Employer agrees to permit an employee with his or her right to union representation in corrective or adverse actions, pursuant to that employee's request. The material upon which the proposed discipline is based shall be made available to the employee and his/her authorized representatives for review. The employee or his/her authorized representative will be entitled to receive a copy of the material upon written request.

Section 6:

An employee shall be entitled to answer the notice of proposed corrective or adverse action, as is provided for by District of Columbia Personnel Manual, Chapter 16.

Section 7:

Except in cases of summary discipline, which shall be administered pursuant to the applicable Sections of the DPM, the deciding official shall issue a written decision at the earliest practicable date from the date of receipt of the notice of proposed action which shall withdraw the notice of proposed action or sustain the proposed action in whole or in part. If the proposed action is sustained in whole or in part, the written decision shall identify which causes have been sustained and which causes have been dismissed, describe whether the proposed penalty has been sustained or reduced and inform the employee of his or her right to appeal or grieve the decision, and the right to be represented. The final decision shall also specify the effective date of this action.

ARTICLE 17

GRIEVANCE PROCEDURE

Section 1 - Definitions:

A. Any grievance or dispute which may arise between the parties involving the application, meaning or interpretation of this Agreement including adverse actions against an employee, as defined by District Personnel Manual Chapter 16, shall be settled as described in this Article unless otherwise agreed to by the parties.

B. Corrective actions of an employee, as defined by the District Personnel Manual Chapter 16, may only be grieved pursuant to the grievance system set forth in the District Personnel Manual, Chapter 16.

C. At any step of the grievance procedure, a grievance meeting may be held at the mutual agreement of the parties.

D. All time within this Article shall be measured in workdays. Workdays shall be defined as Monday through Friday (excluding statutory holidays and days when the District of Columbia Government is closed by official act of the Mayor).

Section 2 - Procedure:

This procedure is designed to enable the parties to settle grievances at the lowest possible administrative level. Therefore, grievances shall be filed at the lowest level where resolution is possible. Accordingly, a grievance may be filed at the step in the grievance procedure where the alleged action which precipitated the grievance occurred.

representative of District 1199 NUHHCE) within fifteen (15) working days after the receipt of the written grievance.

Step 4. If the grievance is still unresolved, the Union may, by written notice to the Chief Medical Examiner and to the Office of Labor Relations and Collective Bargaining, request arbitration within twenty (20) days after the reply at Step 4 is due or received, whichever is sooner.

Section 3 - Union Participation:

A. Employees shall notify the Union in writing of all second step grievances filed individually by an employee. The Union shall upon request have the right to have a representative present at any grievance meeting and shall be given at least forty-eight (48) hours notice of all grievance meetings.

B. Any grievance of a general nature affecting a large group of employees and which concerns the misinterpretation, misapplication, violation or failure to comply with the provisions of the Agreement shall be filed at the option of the Union at the Step or level of supervision where the grievance originates without resorting to previous steps.

Section 4 - Who May Grieve:

Either an employee or the Union may raise a grievance, and if raised by the employee, the Union may associate itself therewith at any time if the employee so elects. Whenever the Union shall raise or is associated with a grievance under this procedure, such a grievance shall become the Union's grievance with the Employer. If raised by the Union, the employee may not thereafter

raise the grievance him/herself, and if raised by the employee, he/she may not thereafter cause the Union to raise the same grievance independently.

Section 5 - Selection of the Arbitrator:

The arbitration proceeding shall be conducted by an arbitrator to be selected by the Office of Labor Relations and Collective Bargaining and the Union within a reasonable period after notice of intent to arbitrate is received. Except in cases of mutual agreement as to the appointment of an arbitrator, the Federal Mediation and Conciliation Service (FMCS) shall be requested by the party demanding arbitration to provide a list of seven (7) arbitrators from the sub-regional area from which an arbitrator shall be selected after receipt of the list by both parties. When either party requests a panel, the FMCS shall be provided with the name and address of the Office of Labor Relations and Collective Bargaining as the representative of the Employer. The Party requesting arbitration shall be required to bear the fees associated with the panel request and any initial administrative fees. Both the Employer and the Union may strike three (3) names from the list using the alternate strike method. The party requesting arbitration shall strike the first name. The arbitration hearing shall be conducted pursuant to the American Arbitration Association guidelines unless modified by this Agreement.

Section 6 - Decision of the Arbitrator:

A. Should the issue of arbitrability of a particular grievance arise, the Arbitrator shall not have the authority to decide the issue on the merits until the jurisdictional issues related to arbitrability of the grievance are finally resolved. A party may raise the issue of arbitrability at any time prior to and including the first day of any hearing conducted by an arbitrator.

B. The Parties may jointly request that particular issues be presented for mediation prior to the arbitration of the disputes. The parameters of such an agreement to mediate will be subject to the consensus of the parties.

C. Witnesses to arbitration hearings shall only be released from duty during the time they are actually required to provide evidence and for reasonable travel time to and from the location of the arbitration hearing.

D. No recording devices may be used in an arbitration hearing, except as provided for in Section 7, above or as directed by the Arbitrator. No person shall be present at any step for the purpose of recording the discussion, except as provided for in Section 7, above, or directed by the Arbitrator.

E. A settlement conference shall be held at least one-month prior to the arbitration hearing so as to attempt to resolve any or all issues related to the grievance. The settlement of a grievance prior to arbitration shall not constitute a precedent in the settlement of grievances.

F. If the Parties fail to agree on a joint stipulation of the issue(s), the issue shall be framed by the Arbitrator.

G. The Arbitration hearing shall not be open to the public or to individuals who are not directly related to the proceeding, unless otherwise agreed by the parties. In no event may members of other unions observe or participate in an arbitration proceeding under this Article, unless that individual is present to provide evidence as a witness in the proceeding.

Section 4 – Access by Union:

Upon presentation of written authorization by an employee, the Union representative may examine the employee's personnel file and make copies of material needed for representation of the employee.

ARTICLE 19

PROFESSIONAL DEVELOPMENT

Section 1 - Continuing Education:

A. The Employer encourages bargaining unit members to participate in Continuing Professional Education Programs, which are relevant to the scope of the employee's responsibilities.

B. Requests for administrative leave may be granted upon approval of the Chief Medical Examiner or designee. Employees shall be provided, pursuant to advance approval by the Chief Medical Examiner or his/her designee, up to five business days of administrative leave annually to attend Category I CME training or equivalent requirements for nurses. The purpose of this administrative leave is to satisfy the requisite professional licensure or certification requirements.

C. The Employer may, within determination of its budgetary needs and limitations pay for tuition, travel, lodging and meals in order to permit attendance at the continuing education activity.

D. Requests for approval of leave or funds under this Section shall be made as far in advance as practicable through supervisory channels.

Section 2:

The counseling may include information on voluntary deductions, benefits, insurance, and assistance in preparing the necessary retirement papers.

ARTICLE 21

EMPLOYEE ASSISTANCE PROGRAM

Section 1:

The Employer will continue to counsel and make appropriate referrals to the Employee Assistance Program which includes counseling and referral services to employees to deal with a variety of needs and problems such as job performance, emotional, family, drug, alcohol and marital problems.

Section 2:

The Employer recognizes the value of Union cooperation and support for the Employee Assistance Programs and the need to maintain open lines of communication on the program with the Union. The Union agrees to support the program actively. Meetings between designated representatives of the Employer and the Union may be held at the request of either party as the need arises.

Section 3:

Employer-Union communications will be consistent with applicable confidentiality requirements of the program.

Section 4:

ARTICLE 26

Union Security

Section 1:

The terms and conditions of this Agreement shall apply to all employees in the bargaining unit without regard to Union membership.

Section 2 – Dues Checkoff:

Pursuant to D.C. Official Code §1-617.07, the Employer shall deduct dues from the bi-weekly salaries of those members who execute an appropriate membership/union dues deduction authorization form. The Union shall transmit any dues deduction authorization forms to the Employer together with an appropriate D.C. government transmittal form when such form becomes available. The Employer shall afford the Union with an opportunity to meet with any new bargaining unit members within two weeks of the employee's hiring orientation and, upon written request of any official of the Union, the Employer shall notify the Union in writing of the name and home address of any new bargaining unit member. Upon receipt of such notification, the Union shall bear the responsibility of providing any applicable legal notices to new members who authorize withholding. The amount to be deducted shall be certified to the Office of Labor Relations and Collective Bargaining in writing by the appropriate official of 1199 NUHHCE. It is the responsibility of the employees and the Union to bring errors or changes in status to the attention of the Employer. Corrections or changes will be made at the earliest opportunity after notification is received, but in no case will changes be made retroactively.

Section 3 – Service Fees:

Section 6:

When a service fee is not in effect, the Union may require that an employee who does not pay dues or service fees shall pay reasonable costs incurred by the Union in representing such employees in grievances, adverse actions or appeal proceedings within the provisions of the CMPA.

ARTICLE 27

EFFECTIVE DATE, DURATION, AND AMENDMENT

Section 1:

This Agreement shall be in full force and effect from the date of approval through May 30, 2007. If either party wishes to terminate or modify this Agreement, that party shall notify the other party in writing of its intent to modify or terminate said Agreement during the period commencing ninety (90) days prior to but no later than sixty days prior to the expiration of the Agreement. If neither party gives notice to terminate or modify prior to sixty (60) days before the expiration of the contract, the Agreement shall be automatically renewed for additional one-year periods unless changed by the parties by mutual consent.

Section 2:

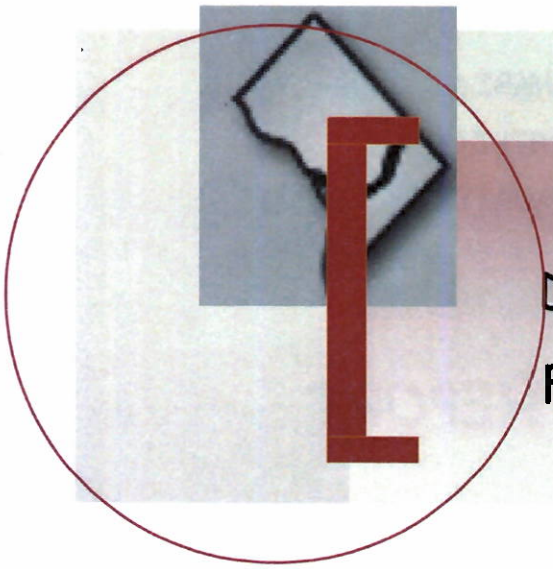
s, who do mutually waive the right to negotiate on these subjects during the life of this Agreement, except by mutual consent.

APPROVAL

This collective bargaining agreement between the District of Columbia Office of the Chief Medical Examiner and 1199 Metropolitan District DC National Union of Hospital and Health Care Employees, (NUHHCE), AFSCME, AFL-CIO, dated March 29, 2004, has been reviewed in accordance with Section 1-617.15 of the District of Columbia Official Code (2001 Ed.) and is hereby approved on this 28th day of April, 2004.

Anthony G. Williams

Anthony Williams, Mayor



District of Columbia Developmental Disabilities Fatality Review Committee

2011 Annual Report

The Honorable Vincent Gray, Mayor
District of Columbia Government

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

Table of Contents

INTRODUCTION

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

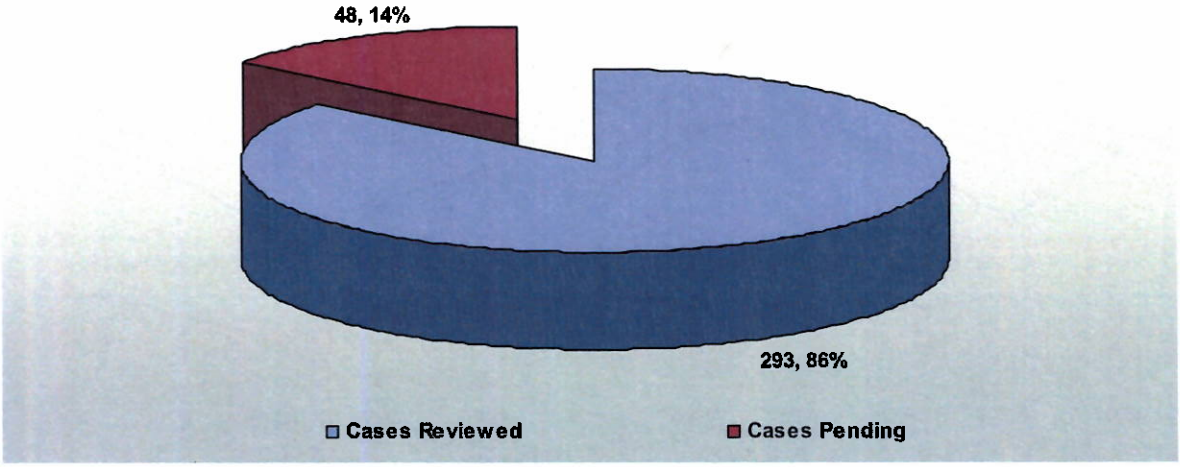
The 2011 Annual Report is a summary of the work performed by the Developmental Disabilities Fatality Review Committee (DD FRC) during calendar year 2011. It provides a synopsis of the total population identified by the Committee annually as meeting the criteria for review and the data that is specific to the 41 fatalities reviewed during calendar year 2011.

The DD FRC was re-established in September 2009, under the auspices of the Office of the Chief Medical Examiner (OCME). It is a multi-disciplinary, multi-agency effort established for the purpose of conducting retrospective reviews of relevant service delivery systems and the events surrounding the deaths of District wards and residents 18 years of age and older who received services and/or supports from DDS. One goal of the DD FRC is to make recommendations to improve the supports and services received by the citizens of the District of Columbia.

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

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

Figure 1: DD FRC Cases Reviewed since 2001



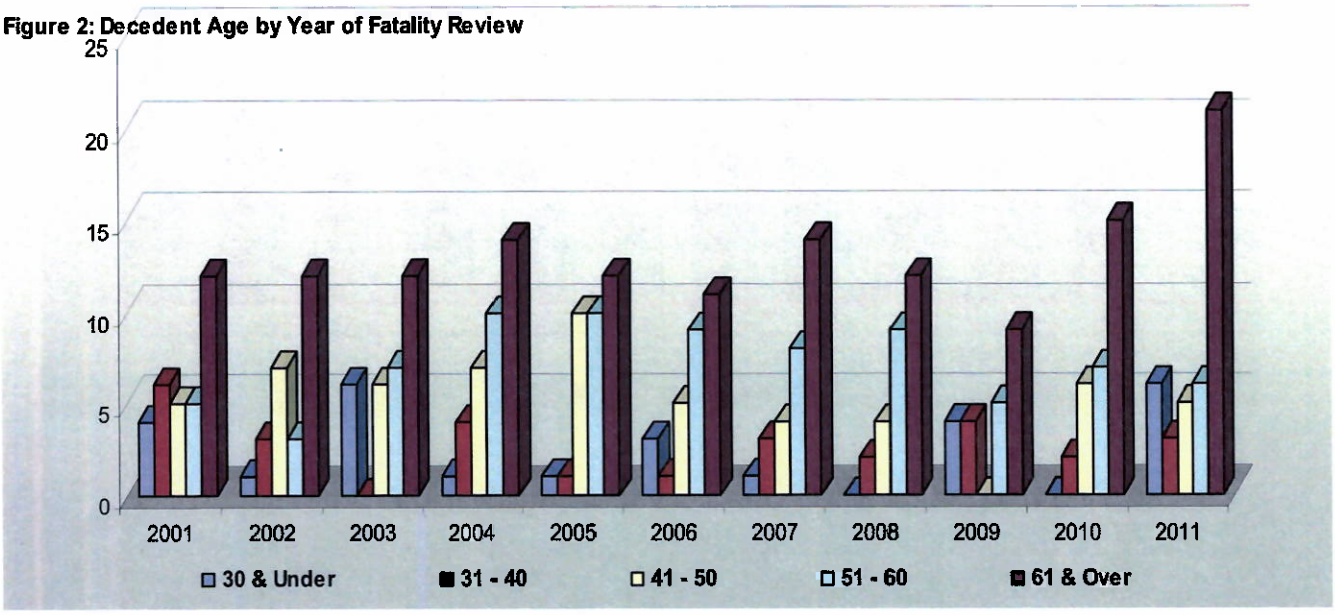
As figure 1 above illustrates, the DD FRC has reviewed 293 of the 341 fatalities identified between 2001 and 2011. Of these fatalities, 48 were pending review as of December 2011. Thirty-three of these include fatalities of individuals with intellectual disabilities who died between 2002 and 2005 whose deaths were not formally investigated. The Committee will convene a special meeting to address the review of these fatalities.

Decedent Demographics - Total Mortality Population Identified

Age of Decedents

Based on fatalities reviewed, the relationship between age and mortality has historically demonstrated the mortality rate increasing as individuals begin to age (see Figure 2). Annually the majority of the fatalities reviewed have involved individuals who were in the age group of 61 years or older. Overall, this trend among the DDS population has remained constant since the inception of the fatality review process in 2001. Additionally, the trend among the DDS population is also consistent with the expected national trend of mortality increasing with age for the broader population.

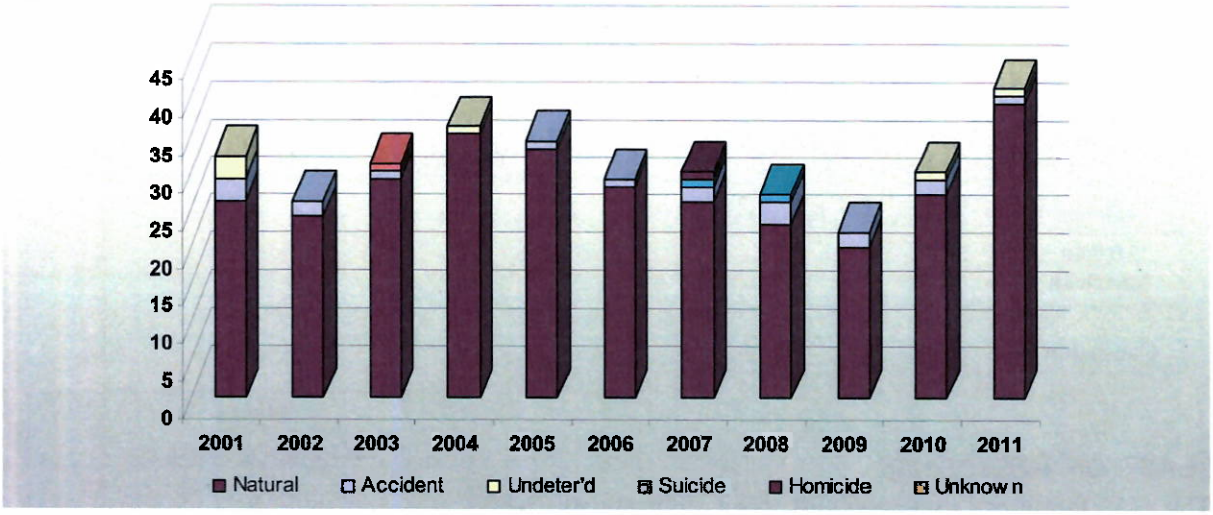
Figure 2: Decedent Age by Year of Fatality Review



Manner of Death - Total Deaths Reviewed

As illustrated in figure 5, the leading manner of death for individuals reviewed by the DD FRC are Natural. Since the inception of this Committee, 317 individuals receiving DDS services died of natural causes, and 18 individuals died as a result of Accidents. There was one Homicide in 2007 and two Suicide deaths—one occurring in 2007, the other in 2008. Of the Undetermined deaths there were three in 2001, one in 2004 and 2010, and one in 2011.

Figure 5: DD FRC Manner of Death 2001-2011



Section II: Summary of 2011 Case Review Findings

During calendar year 2011, the DD FRC reviewed the fatalities of 41 individuals diagnosed with intellectual and developmental disabilities who received services through the Department on Disability Services. These reviews were limited to fatalities that occurred between 2009 and 2011. The majority involved 29 fatalities that occurred in 2010. Section II will cover the data and findings that resulted from the 41 fatalities reviewed.

Age/Gender and Motality

The ages of the 41 individuals whose fatalities were reviewed ranged from 21 to 87 years of age; the average age was 58 years. As Figure 5 illustrates, 21 (51%) of the 41 fatalities reviewed involved individuals over the age of 60 years of age. There were six individuals between the ages of 51 and 60 years of age and five between 41 and 50 years of age. Six of the individuals were between the ages of 21 and 30 years of age. Of the 41 fatalities reviewed, there were 28 male and 13 female decedents.

Figure 6: Age of 2011 DDS FRC Decedent Population

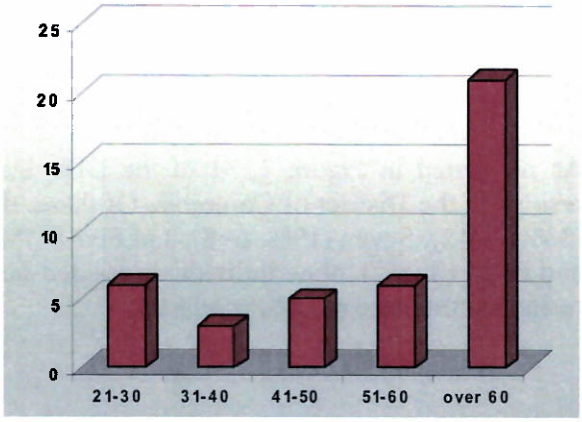
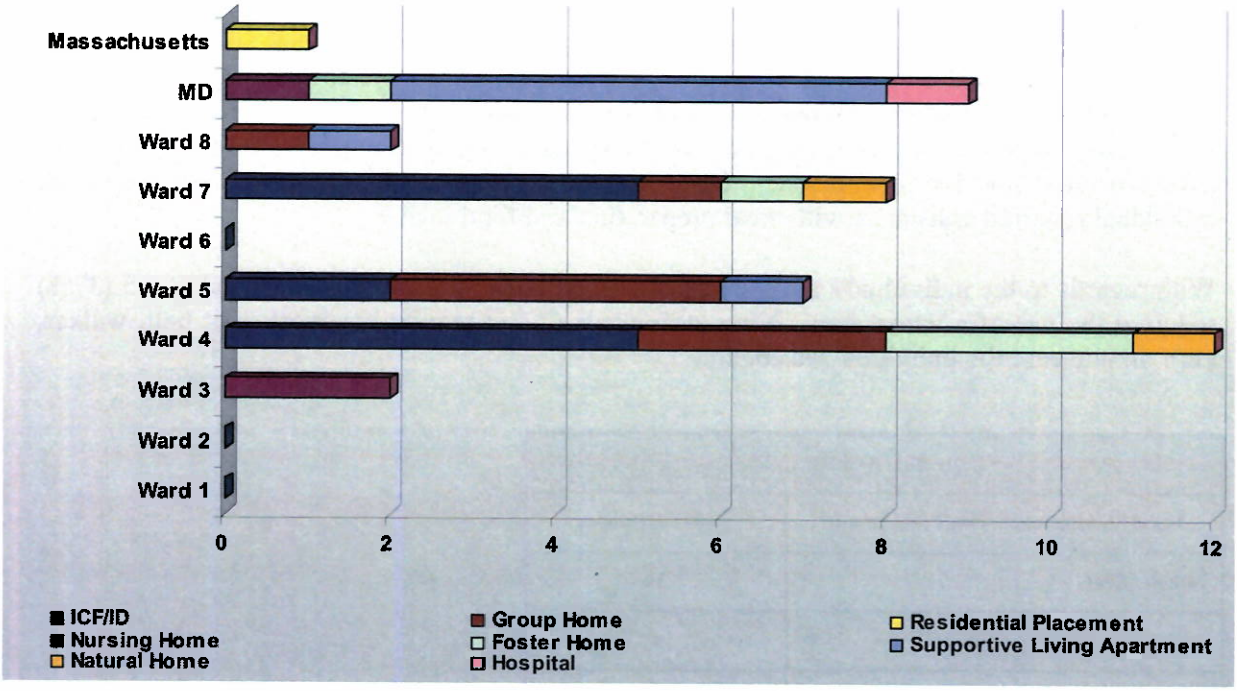


Figure 7: 2011 DD FRC Individual's Placement/Location



LOCATION OF FATALITY

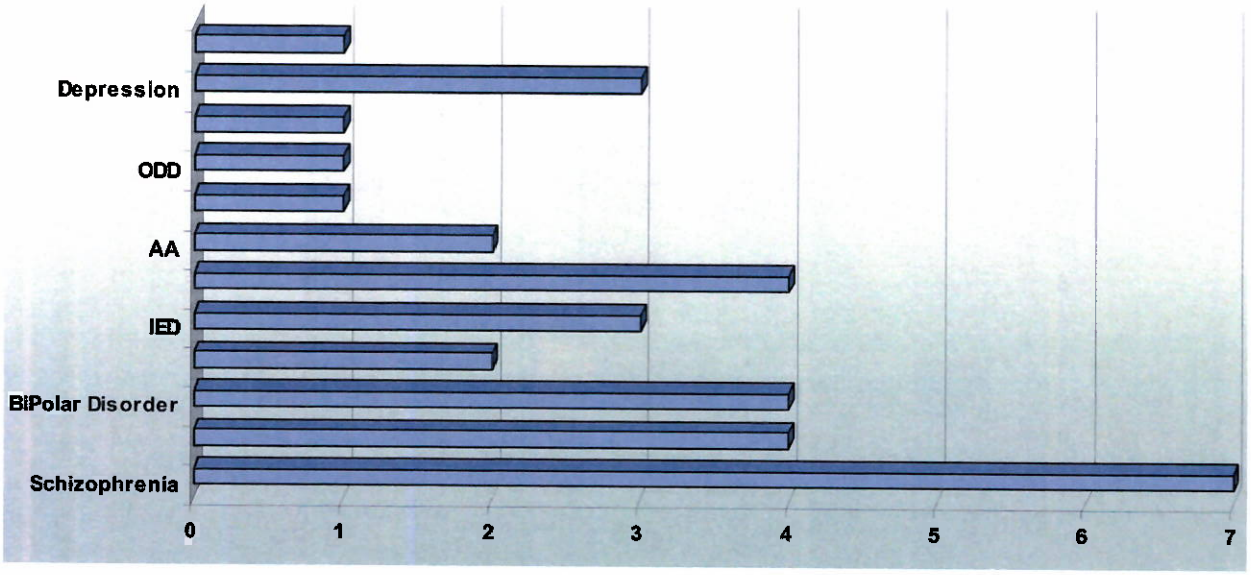
The fatality reviews revealed that the deaths occurred in different locations including hospitals, nursing facilities, and residential placements. As depicted in Table 5, 27 of the individuals died during a hospital admission. Six individuals died in their place of residence with hospice services in place. Another 6 individuals died in their place of residence, and 2 individuals died in a nursing facility.

Table 5:
Location of Fatality

Place of Death	# of *Individuals*
Hospital following inpatient Admission	**27**
Nursing Facility	**2**
Residential Placement with Hospice	**6**
Residential Placement w/o Hospice	**6**

Mental Health Diagnosis

Figure 8: Mental Health Diagnosis in DD FRC Individuals



The mortality investigative report provides information regarding the diagnosis of individual's with mental health illness as well as the individual's cognitive and adaptive level of functioning. Eighteen of the 41 DD FRC individuals were diagnosed with one or more mental health disorders. A numerical list of these disorders is provided in Figure 8 above. Table 8 provides the individual's level of functioning as related to intellectual disability as provided in the mortality investigative report.

- Individuals with *Profound Intellectual Disabilities* require high levels of supervision and structure with activities of daily living.
- Individuals with *Severe Intellectual Disabilities* may obtain self care and communication skills however will also need supervision and a structured living environment.
- Individuals with *Moderate Intellectual Disabilities* may require some supervision and can perform successfully in a supervised living environment.
- Individuals with *Mild Intellectual Disabilities* can perform independently with the appropriate community and social support.

Table 8: DDS FRC Individual's Cognitive and Adaptive Level of Functioning

Level of Functioning	Cognitive	Adaptive
Profound	18	23
Severe	9	6
Moderate	4	3
Mild	7	6
Unknown*	3	3

* The mortality investigative report did not contain information pertaining to the consumer's level of functioning.

Table 9: Causes of Death - 2011 Fatalities Reviewed	
Cause of Death	***# of Fatalities (N=41)***
Cardiovascular System Disorder	12
Respiratory Disease	4
Cancer	1
Gastrointestinal System	3
Central Nervous System	7
Infection	1
Infectious Disease	7
Blunt Impact	2
Genetic Disorder	1
Diabetes	2

SECTION III: DD FRC 2011 RECOMMENDATIONS

During calendar year 2011, the DD FRC issued the following recommendations based on the 41 fatalities of individuals with intellectual disabilities completed by the Committee.

FRC Recommendation	*Status*
The Department on Disability Services shall implement a seizure protocol and provide in-service training to providers for managing seizures.	The Department on Disability Services Health and Wellness nurses will provide technical assistance to the provider community that serve and support individuals with seizure disorders. The technical assistance will include but is not limit to training on signs and symptoms of seizures. The Health and Wellness nurses along with the Service Coordinator will identify persons on their case load with seizure disorders to ensure proper health services are being rendered. The Department on Disability Services Service Coordinators will identify all persons on their case load with a seizure disorder. This information will be shared with the Health and Wellness nurse assigned to that provider. The Health and Wellness nurse will develop dialog with providers and offer technical assistance to the provider in the area of training and treatment of individuals they serve with a seizure disorder. The Department on Disability Services has included a section on their monitoring tool which gathers data on unmet needs of the individual. This information will be shared with the Health and Wellness nurse assigned to that provider and will be entered into the MCIS system for follow up. The Health and Wellness nurse will monitor the issues until closed in the system due to the issue being rectified. Persons being served by The Department on Disability Services with seizure disorders will receive all needed services. Also the providers serving these individuals will be better trained to provide the services and support needed to the individual. The Department on Disability Services will collect random samples of data from the monitoring tool unmet needs section and analyze to ensure less of the individual being served by DDA will have unmet needs.

FRC Recommendation	*Status*
The Department on Developmental Services shall ensure Primary Care Physicians timely obtain a review (Phenobarbital) Dilantin levels and maintain these levels in the therapeutic ranges for the management of seizure in individuals.	DDS will continue to encourage providers to adhere to the Health and Wellness Standards which outline the responsibility of the provider nurse to share all health concerns with the primary care physician. There are specific guidelines outlined in the Health and Wellness Standards which state how often Dilantin levels are reviewed and what must happen if the levels are not within normal limits. DDS Service Coordinators will collaborate with the Health and Wellness Director when problems or issues are discovered during monthly monitoring. DDS Service Coordinators will record any issues or problems during their monthly monitoring, which will be included on the monthly monitoring tool that is entered in the MCIS system. Any issues or problems discovered by the Service Coordinator will be put into the Alert Resolution System for monitoring and follow up. DDS Service Coordinators checked their case loads for individuals diagnosed with seizure disorder. Once identified, the Service Coordinator ensured the provider nurse followed the Health and Wellness Standards which states the primary physician should review all lab work to ensure it is within normal limits. It also gives the primary care physician an opportunity to treat any problems noted in the lab report in a timely manner.

FRC Recommendation	*Status*
The Department on Disability Services should develop and disseminate a policy related to the emergency transport of consumers.	All providers supporting individuals eligible fords/ DDA services will have an emergency transport policy to ensure individuals in need of transport are transported using proper services. DDS Quality Improvement Specialist along with staff from Provider resources will conduct an audit of all providers to ensure providers have a policy on emergency transport for individuals in need. DDS Mortality Review Coordinators received a copy of the District of Columbia's Emergency Transport Policy which has been uploaded to the DDS website for review by all providers. Provider's supporting services individuals eligible for DDS/DDA services will have an emergency transport policy as part of their standard policy and procedures. Individuals being served by DDS in need of emergency transport to medical facilities will be transported according to the providers emergency transport policy. The results of this policy will decrease the number of providers transporting individual in company vans to medical facilities.
As a lack of noting allergies and serious side effects can occur with any provider, the Developmental Disabilities Administration shall send a transmittal to all providers to alert them of this possibility and take steps towards prevention. The consumer's allergic reactions should be noted in the Health Passport and this information must be available to each health provider. This requirement must be added/reemphasized in Phase II of the DDS competency base training for providers.	DDS will continue to monitor the updating of the Health passports to ensure all allergies and allergic reactions are listed on the Health Passport and the HCMP. The DDS Health and Wellness Unit along with the Service Coordinators will monitor the updating of the Health Passports monthly. Service Coordinators will work close with the provider nurses to ensure they are updating the Health Passports and monitoring allergic reactions and allergies of the individual's they serve. Health and Wellness nurses along with the Services Coordinators have met and discussed the importance of being aware of all individual allergies and allergic reactions to medications with the provider nurse. Service Coordinators have checked the status of Phase II training completion date to ensure the provider is current with all DDS training requirements. The allergies and allergic reactions of all individuals are listed on the Health Passport which accompanies the individual to all medical appointments and hospital visits.

ENDNOTE

Endnote # 1 (Page 2)	Information on the total consumer population was provided by the Department of Disability Services.

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

Mayor's Order 2009-225
December 22, 2009

SUBJECT: Revitalization –District of Columbia Developmental Disabilities Fatality Review Committee

ORIGINATING AGENCY: Office of the Mayor

By virtue of the authority vested in me as Mayor of the District of Columbia by section 422(2) of the District of Columbia Home Rule Act ("Home Rule Act"), as amended, 87 Stat. 790, Pub. L. No. 93-198, D.C. Official Code § 1-204.22(2) and (11) (2001), it is hereby **ORDERED** that:

I. ESTABLISHMENT

There is hereby revitalized in the Executive Branch of the government of the District of Columbia the District of Columbia Development Disabilities ("DD") Fatality Review Committee (hereinafter referred to as the "Committee").

II. PURPOSE

The Committee shall examine events and circumstances surrounding the deaths of District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability in order to: gather and analyze empirical evidence about fatalities in this population; safeguard and improve the health, safety and welfare of District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability; reduce the number of preventable deaths; and promote improvement and integration of both the public and private systems serving District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability. For purposes of this Mayor's Order, "District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability" may be defined as an individual who is committed by a court to the care and custody of the District of Columbia Department on Disability Services ("DDS"), or who meets DDS eligibility requirements for voluntary admission and is admitted by a court to receive services, or is under the supervision of DDS or of a program contracted by DDS to deliver such services, for reasons of an intellectual disability and/or a qualifying developmental disability. The phrase "District residents over the age of 18 years with an intellectual and/or qualifying developmental disability" is intended to include persons who are committed to the care and custody of the District or its residential providers in accordance with the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978 (Mentally Retarded Citizens Act), effective March 3, 1979, D.C. Law 2-137, D.C. Official Code § 7-1301.01 *et seq.* (2008 Repl. and 2009 Supp.), and therefore includes "wards of the District of Columbia government" under section 2906 (b) (7) of the Fiscal Year 2001 Budget

1. Methods by which deaths of District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability are identified and reported to ensure expeditious reviews;

2. A process by which fatality cases are screened and selected for review;

3. A method for ensuring that all information identifying District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability, their families and others associated with the cases or the circumstances surrounding the deaths, including witnesses and complainants, is protected against undue disclosure. This is to ensure that steps are taken to protect the right to privacy of an individual and his or her family in conducting investigations. Disseminating information to Committee members, reporting as required by the Mayor's Order, and maintaining case records for the Committee;

4. A method for gathering individual and cumulative data from the reviews;

5. A method for reviewing whether recommendations generated by the Committee are being implemented and identifying problems related to obstacles/barriers to implementation; and

6. A method for evaluating the work of the Committee that takes into account community responses to the deaths of District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability.

B. On or about December 30th of each year, beginning in 2010, producing an annual report that provides information obtained from the reviews of deaths that occurred during the previous calendar year. The annual report shall be submitted to the Mayor and made available to the public. The information to be contained in the report shall include at a minimum:

1. Statistical data on all fatalities of District residents over the age of 18 with an intellectual disability and/or a qualifying developmental disability reviewed by the Committee, including numbers reviewed, demographic characteristics of the subjects, and causes and manners of deaths;

2. Analyses of the data generated by the reviews to demonstrate the types of cases reviewed (which may include illustrative case vignettes without identifying information), similarities or patterns of factors causing or contributing to the deaths and trends (including temporal and geographic); and

3. Recommendations generated from the reviews, including service enhancements, systemic improvements or reforms, and changes in laws, policies, procedures or practices that would better protect District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability and that could prevent future deaths.

VI. TERMS

A. Public members appointed to the Committee shall serve for three (3) year terms, except that of the members first appointed, one-half shall be appointed for three (3) year terms and one-half for two (2) year terms. The date on which the first members are installed shall become the anniversary date for all subsequent appointments.

B. Members appointed to represent District government agencies shall serve only while employed in their official positions and shall serve at the pleasure of the Mayor.

C. A public member may be reappointed for a minimum of two (2) full terms based on the approval of the Mayor.

D. A member appointed to fill an unexpired term shall serve for the remainder of that term.

E. A member may hold over after the member's term expires until reappointed or replaced.

F. A public member may be excused from a meeting for an emergency reason. A public member who fails to attend three (3) consecutive meetings shall be deemed to be removed from the Committee and a vacancy created. Such vacancies shall be filled by the Mayor, in accordance to the composition outlined in Section V of this Mayor's Order.

G. A public member may be removed by the Mayor for personal misconduct, neglect of duty, conflict of interest violations, incompetence, or official misconduct. Prior to removal, the public member shall be given a copy of any charges and an opportunity to respond within ten (10) business days following receipt of the charges. Upon a review of the charges and the response, the Director of the Office of Boards and Commissions, Executive Office of the Mayor, shall refer the matter to the Mayor with a recommendation for a final decision or disposition. A public member shall be suspended by the Director of the Office of Boards and Commissions, Executive Office of the Mayor, on behalf of the Mayor, from participating in official matters of the Committee pending the consideration of the charges.

VII. ORGANIZATION

A. The Mayor shall appoint the Chief Medical Examiner and the DDS Deputy Director for the Developmental Disabilities Administration, or the functional equivalent, as Co-Chairpersons of the Committee and they shall serve in these capacities at the pleasure of the Mayor.

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

X. CASE REVIEW CRITERIA AND PROCEURES

A. Case Review Criteria

The Committee shall review the following deaths:

1. All deaths of District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability shall be reviewed by the Committee. Factors of particular concern for review include:

   a. All violent or sudden/unexplained manners of death (*i.e.*, homicide, suicide, accident or undetermined), which include all deaths caused by injuries or illness, including but not limited to:
      i. Fractures;
      ii. Blunt trauma;
      iii. Burns;
      iv. Asphyxia or drowning;
      v. Poisoning or intoxication;
      vi. Gunshot wounds;
      vii. Stabbing or cutting wounds;
      viii. Falls;
      ix. Sepsis;
      x. Gastrointestinal blockages; or
      xi. Seizures.

   b. Abuse, either physical or sexual;

   c. Neglect, including medical and custodial;

   d. Malnourishment or dehydration; and

   e. Circumstances or events deemed suspicious.

2. The Committee may, at its discretion, review groups of sudden, unexpected or unexplained deaths of District residents with an intellectual disability and/or a

4. Based on the case discussion, the Committee shall formulate applicable recommendations as enumerated above in section III.d and section IV.a and b.3, for further consideration and possible inclusion in the annual report.

XI. CASE NOTIFICATION PROCEDURES

A. District agencies and service providers contracted by the District to serve District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability shall provide written notification to the Committee within twenty-four (24) hours of any death of a District resident over the age of 18 years with an intellectual disability and/or a qualifying developmental disability, or within twenty-four (24) hours of becoming aware of such a death. The sources of notifications will include but are not limited to the:

1. Department on Disability Services (DDS), Developmental Disabilities Administration (DDA);
2. Office of the Chief Medical Examiner (OCME);
3. Metropolitan Police Department (MPD);
4. Office of the Attorney General (OAG);
5. Department of Health (DOH); and
6. Department of Health Care Finance (DHCF).

B. Case notification reports should include:

1. Demographic data (*i.e.* name, age/date of birth, race, gender);
2. Address;
3. Parent/guardian;
4. Circumstances of the death (*i.e.* date, time, location, activities, risk factors, witnesses or sources of information); and
5. Agencies investigating the death.

C. MPD, DDS, DOH and DHCF shall provide the Committee copies of all death reports resulting from any investigations that are conducted concerning the population covered by the Order (*see* Section X: Case Review Criteria). The OCME shall provide the Committee with a copy of all autopsy reports resulting from autopsies and death investigations conducted for District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability. These reports shall be provided within five (5) days after they are completed.

XII. NOTIFICATION OF PARTICIPANTS

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

3. Initials only will identify third persons in materials for distribution.

XV. RECOMMENDATIONS

A. Draft recommendations shall be developed during case review meetings based on issues raised during specific deaths or trends documented from numerous deaths reviewed.

B. Draft recommendations shall be redistributed for finalization and adoption based on consensus of the Committee during subsequent case review meetings prior to transmission to relevant agencies.

C. Final recommendations shall be transmitted to relevant agencies and the Office of the City Administrator and/or Mayor within thirty (30) days of finalization/adoption with request for response within sixty (60) days of receipt. Final adopted recommendations shall also be incorporated into the annual report.

D. Representatives of agencies, institutions and programs may be invited to full Committee meetings to present their plans for, or progress made towards implementing the recommendations.

XVI. COMPENSATION

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

XVII. ADMINISTRATION

The Office of the Chief Medical Examiner shall provide administrative support and legal counsel for the Committee.

XVIII. LEGAL APPLICATION

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

GLOSSARY OF TERMS

TERMS	*DEFINITIONS*
Autopsy Report	A detailed report consisting of the autopsy procedure, microscopic and laboratory findings, a list of diagnoses, and a summary of the case.
CRF/ID	Community Residential Facility for individuals diagnosed with an intellectual disability .
Group Home	Licensed homes for persons with intellectual disabilities that range in size from four (4) to eight (8) customers
Hospice	A program or facility that provides special care for people who are near the end of life and for their families
ICF/IDD	A licensed residential facility certified and funded through Title XIX (Medicaid) for consumers diagnosed with an intellectual disability . Consumers receive 24 hour skilled supervised care.
Level of Disability	Cognitive and adaptive impairment ranging from mild to profound
Life Expectancy	The average expected length of life; the number of years somebody is expected to live
Medicaid Waiver	Provides rehabilitative, behavioral, and medical supports to individuals with intellectual and developmental disabilities in residential community , and private home settings.
Natural Home	Consumers residing in the home of a parent, family members or independently
Neurological Conditions	Disorders of the neuromuscular system (the central, peripheral, and autonomic nervous systems, the neuromuscular junction, and muscles)
Nursing Home	A long-term healthcare facility that provides full-time care and medical treatment for people who are unable to take care of themselves
Skilled Care	An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons
Specialized Home Care	A private home living environment for three (3) or less individuals (also includes foster care)
Supervised Apartments	Typically a living arrangement for one to three customers with mental retardation, with drop-in twenty-four hour supervision. Supervised Apartments may be single units grouped in a cluster within an apartment complex, or scattered throughout a complex
Ward	An administrative or electoral division of an area/city, e.g., Wards 1-8 in the District or Individuals under the custody and care of the District of Columbia

CAUSES OF DEATH - 2011 DD FRC DEATHS REVIEWED

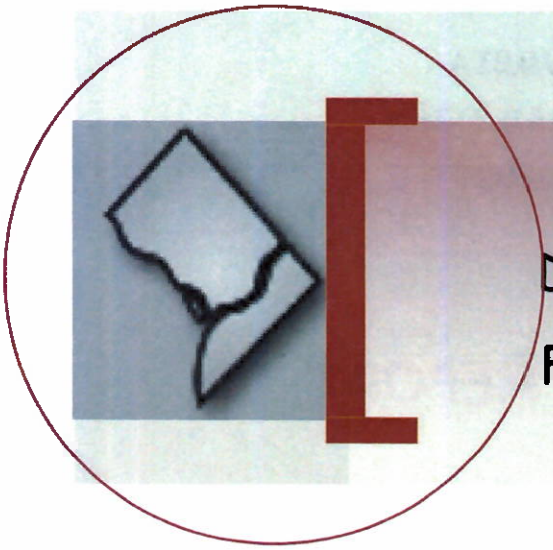
Deaths Reviewed that occurred in 2010:

Age/Race/ Sex	*Cause of Death*	*Manner of Death*
81/Wht/Female	Congestive heart failure, Hypertensive and atherosclerotic cardiovascular disease	Natural
85/Wht/Male	End Stage Chronic Obstructive Pulmonary Disease	Natural
25/Blk/Female	Chronic Respiratory Failure Secondary to Pneumonia due to Cerebral Palsy	Natural
73/Blk/Male	Cardiac Arrest due to Cardiac Arrhythmia	Natural
71/Blk/Male	Massive Left Subdural Hematoma Status Post Fall	Accident
75/Blk/Female	Hypoxic Respiratory Failure due to Mitral Stenosis	Natural
64/Blk/Female	Complications of Chronic Seizure Disorder of Undetermined Etiology	Natural
38/Blk/Male	Peritonitis due to Small Bowel Obstruction Complicating Right Lower Quadrant Surgical Adhesion	Natural
70/Wht/Male	Chronic Obstructive Pulmonary Disease	Natural
89/Blk/Female	Hypertensive and Arteriosclerotic Cardiovascular Disease with End Stage Renal Disease	Natural
69/Blk/Male	Complications following Colostomy for Treatment of Bowel Obstruction of Undetermined Etiology	Natural

Deaths Reviewed that occurred in 2011:

48/Blk/Male	Aspiration Pneumonia complicating Reflux Esophagogastritis in the setting of Cerebral Palsy and Seizure Disorder	Natural
78/Wht/Male	Hypertensive and Arteriosclerotic Cardiovascular Disease	Natural
47/Blk/Female	Complications following Aspiration Pneumonia due to Down's Syndrome	Natural
56/Blk/Male	Sepsis due to Pneumonia due to Down Syndrome	Natural
56/Blk/Female	Hypertensive and Arteriosclerotic Cardiovascular Disease	Natural
57/Blk/Male	End Stage Liver Disease	Natural
57/Blk/Female	Hypertensive Atherosclerotic Cardiovascular Disease	Natural

Government of the District of Columbia
Office of the Chief Medical Examiner,
Fatality Review Unit
Developmental Disabilities Fatality Review Committee
401 E Street SE
Washington, D.C. 20024



DISTRICT OF COLUMBIA DEVELOPMENTAL DISABILITIES FATALITY REVIEW COMMITTEE

2010 ANNUAL REPORT

The Honorable Vincent Gray, Mayor
District of Columbia Government

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

Table of Contents

INTRODUCTION

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

Margaret Meade

The 2010 Annual Report is a summary of the work performed by the Developmental Disabilities Fatality Review Committee (DD FRC) during calendar year 2010. It provides a synopsis of the total population identified by the Committee annually as meeting the criteria for review and the data that is specific to the 30 deaths reviewed during calendar year 2010.

The DD FRC was re-established in September 2009, under the auspices of the Office of the Chief Medical Examiner (OCME). It is a multi-disciplinary, multi-agency effort that was established for the purpose of conducting retrospective reviews of relevant service delivery systems and the events that surrounded the deaths of District wards and residents 18 years of age and older who received services and/or supports from DDS. One goal of the DD FRC is to make recommendations to improve care and service delivery to citizens of the District.

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

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

Table 2: Status of Deaths Identified and Review By Calendar Year			
Year	*# Deaths Identified By Year*	*# Deaths Reviewed By Year*	*# Deaths Pending Review*
2010	35	30	5
2009	29	25	4
2008	27	27	0
2007	30	21	9
2006	30	23	7
2005	34	24	10
2004	36	26	10
2003	31	23	8
2002	26	21	5
2001	32	32	0

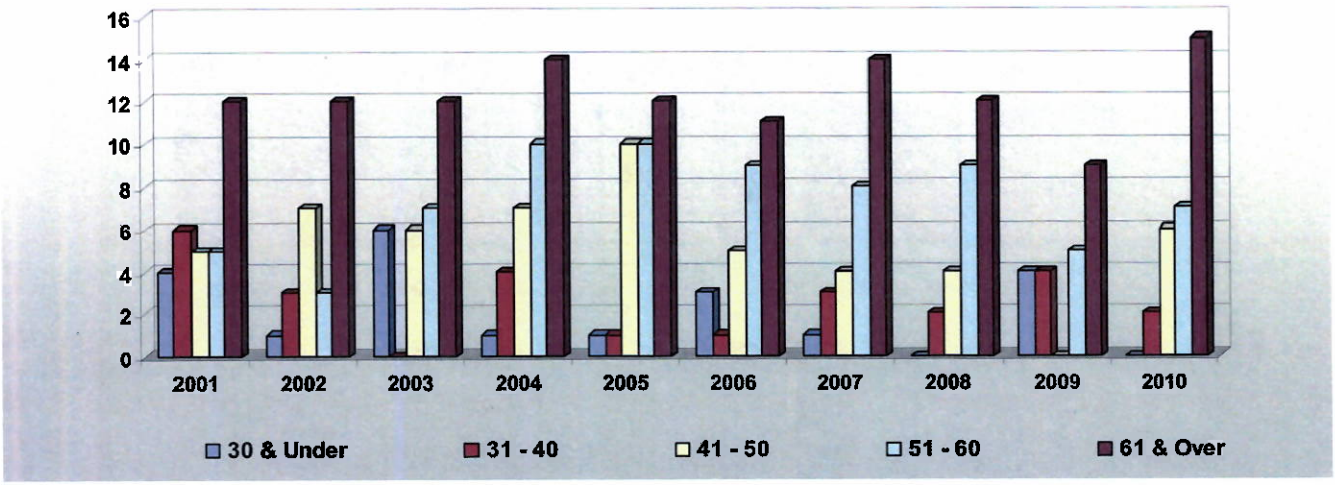
Table 2 summarizes the deaths identified as meeting the DDS FRC criteria for review by calendar years since the Committee's inception. Of the 310 deaths identified, 252 were reviewed and 58 were pending review as of December 31, 2010.

Demographic Decedent Data - Total Mortality Population Identified

Age of Decedents

Based on cases reviewed, the relationship between age and mortality has historically demonstrated the mortality rate increasing as DDS consumers begin to age (see Figure 1). Annually the majority of the deaths reviewed have involved DDS consumers who were in the age group of 61 years of age or older. Overall, this trend among the DDS population has remained constant since the inception of the fatality review process in 2001. Additionally, the trend among the DDS population is also consistent with the expected national trend of mortality increasing with age for the broader population.

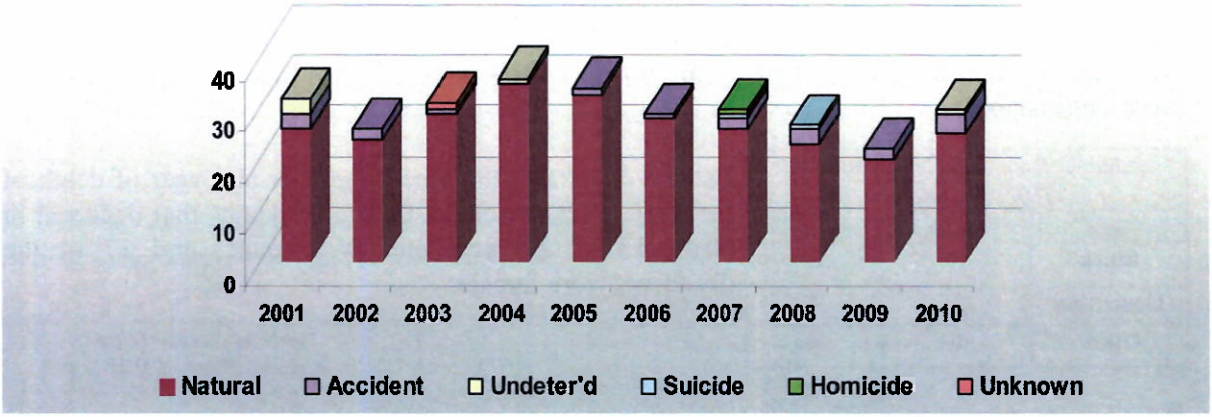
Figure 1: Age DDS FRC Decedents by Year



Manner of Death - Total Deaths Identified

Historically, the leading manner of death for DD FRC cases was Natural. Since the inception of this Committee, 269 DDS consumers died of natural causes. During this ten year span, 19 consumers died of Accidental causes. There was one Homicide in 2007 and two Suicide deaths—one occurring in 2007 and the other in 2008. Of the Undetermined deaths there were three in 2001, one in 2004 and 2010.

Figure 4: DD FRC Decedent 2001-2010



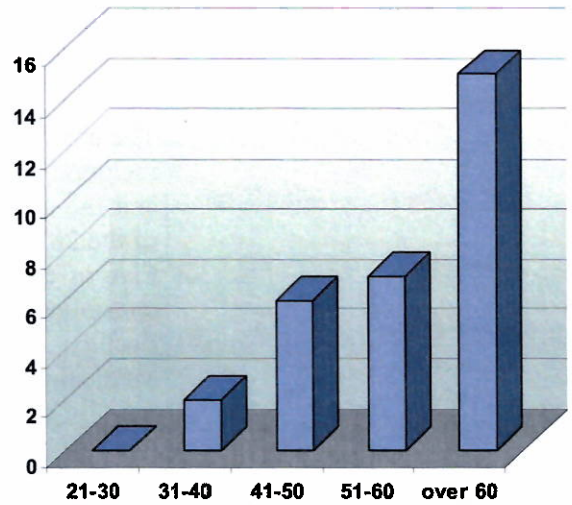
Section II: Summary of 2010 Case Review Findings

During calendar year 2010, the DD FRC reviewed the deaths of 30 consumers diagnosed with intellectual and developmental disabilities who received services through the Department on Disability Services. These reviews were limited to deaths that occurred between 2007 and 2010. The majority involved 19 fatalities that occurred in 2009. Section II will cover the data and findings that resulted from the 30 cases reviewed.

Age/Gender and Motality

The ages of the 30 decedents whose deaths were reviewed ranged from 32 to 90 years of age; the average age was 61 years of age. As Figure 5 illustrates, 15 (50%) of the 30 cases reviewed involved DDS consumers over the age of 60 years of age. There were seven consumers between the ages of 51 and 60 years of age and six between 40 and 50 years of age. Of the 30 deaths reviewed none of the consumers were younger than 32 years old. Of the 30 deaths reviewed, there were 17 female and 13 male decedents.

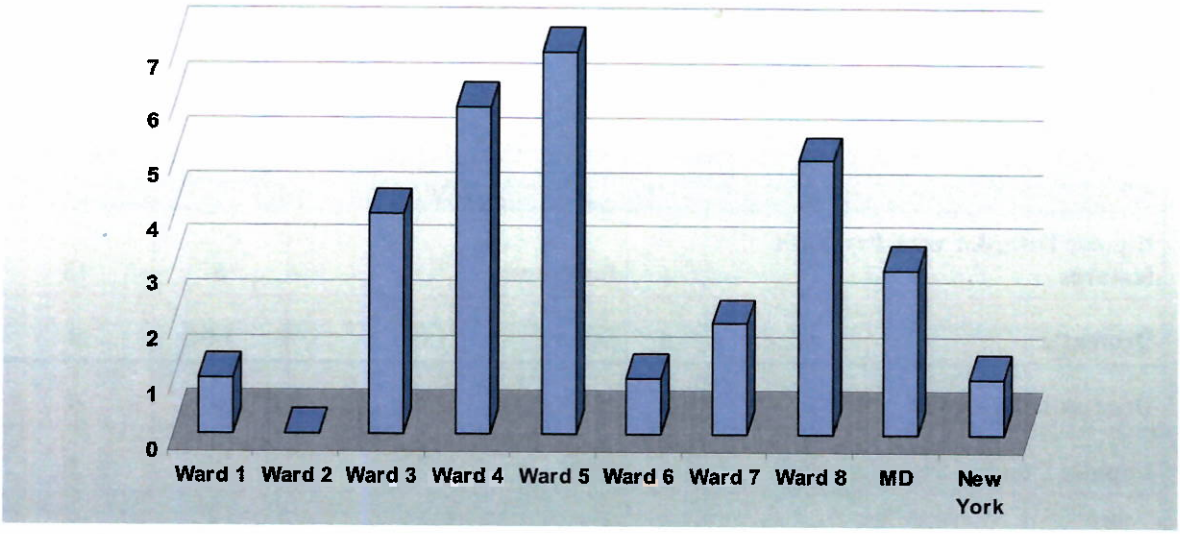
Figure 5: 2010 DD FRC Decedents



Ward of Residence

Ward of residence refers to the DDS consumer's residential address at the time of the fatal event. As illustrated in Figure 6, 26 of the consumer's resided in the District of Columbia. Of these, the majority resided in Wards Five (7) and Four (6). Three consumers resided in Maryland, and one consumer resided in New York.

Figure 6: 2010 DD FRC Decedent Ward of Residence



Mobility and Feeding Impairments

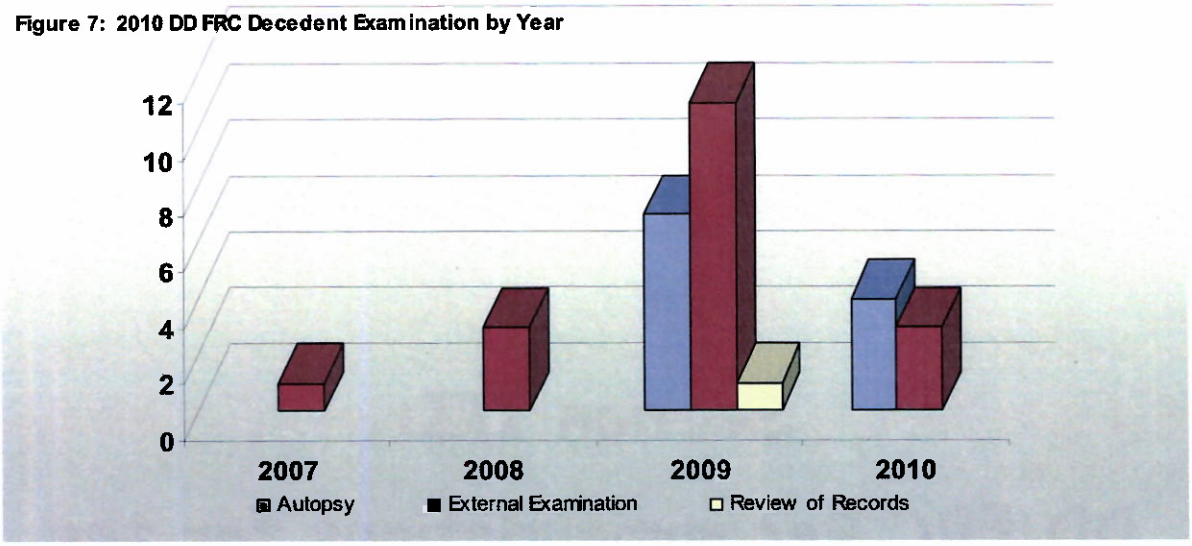
Mobility and feeding impairments are recognized problems that place individuals at higher risk of morbidity and mortality. The independent investigative reports provided to the DD FRC provide detailed information related to these risks and the Committee considers these factors as part of the case evaluation process. Based on the 30 deaths reviewed, seven involved consumers who used wheelchairs; and five functioned with support (i.e., leg braces, walker, cane, etc.). Four of the consumers had a gastronomy tube in place for assistance with feeding. Of the 30 cases reviewed, 19 of the consumers were independent with their feeding abilities and 17 were able to ambulate without supports.

Table 7: Feeding and Mobility

Feeding Method		*Mobility*	
G-Tube	4	Wheelchair	7
With Assistance	7	Bedridden	1
Independent	19	With support	5
		Without support	17

deaths (N=25). There were four deaths that were Accidents, and one Undetermined manner of death.

Figure 7: 2010 DD FRC Decedent Examination by Year



CAUSE OF DEATH

Table 9 provides a list of the causes of death associated the 30 deaths reviewed during 2010. Nine resulted from disorders of the Cardiovascular System, mainly Hypertension and Arteriosclerosis. The second leading cause of death was Cancer, as observed in five cases. Other natural causes include Viral/Bacterial Infection, Respiratory Infection, Sepsis, Gastrointestinal Disorders, Neurological Disorders, and Hepatic Disease. Two of the Accidental deaths were the result of Asphyxia (aspiration of food).

Table 9: Causes of Death - 2010 Deaths Reviewed

Causes of Death	*# of Deaths (N=30)*
Cardiovascular System Disorder	**9**
Respiratory Infection	**3**
Cancer	**5**
Gastrointestinal System	**1**
Hepatic Disease	**1**
Asphyxia	**2**
Blunt Injury	**1**
Sepsis	**3**
Viral/Bacterial Infection	**4**
Neurological Disorder	**1**

SECTION III: DD FRC 2010 RECOMMENDATIONS

During calendar year 2010, the DD FRC issued the following recommendations based on the review of 30 cases:

FRC Recommendation	*Status*
OCME will share with DDS factors underlying reasons for external examination rather than autopsy in determining causes of death for decedents.	Dr. Pierre-Louis (Chief Medical Examiner) gave a presentation at the MRDDA/FRU meeting on August 17, 2010. The presentation addressed the Mission and Function of OCME and included a discussion on what determines whether an autopsy is internal or external. DDA staff and Liberty Healthcare (new Investigation contractor) were in attendance.
OCME and DDS will work together to gather better clinical information to help in deciding whether an autopsy rather than an external examination is conducted to determine cause of death.	DDS has provided all the requested information to OCME to help in the decision making of whether a autopsy or external examination is needed.
DDS should ensure the management of psychotropic medications is consistent with generally accepted practices that include: a) Clearly defined psychiatric diagnoses that are not mutually exclusive and are based on accepted based on clinical criteria; b) The avoidance of polypharmacy (inter-and intra-class); c) The lowest possible dosages and appropriate titrations; d) Avoidance of long term use of benzodiazepines; e) Comprehensive psychiatric monitoring to include documentation of diagnostic concerns, medical issues, mental status examination, discussion of side effects, or psychosocial concerns affecting behavior, and documentation of vegetative symptoms when indicated.	DDS will file the sign in sheet and the Human Rights meeting minutes in the individual's files to ensure a meeting is being held and that the medications are being monitored by a Psychiatrist

DD FRC 2010 Recommendations Continued

FRC Recommendation	*Status*
DDS should ensure the residential provider implements the following recommendation: • Careco should implement the use of a skin integrity • assessment tool (i.e. the Braden Scale assessment) on individuals deemed at risk. • Careco should document the treatment of skin integrity problems to include wound measurements and staging, also appropriate consultation with a nutritionist. • Careco should implement a policy and training around pain management and assessment. • Careco should implement a policy for the use of PRN medications that mandate a nursing assessment prior to their administration as well as strict limitation on their use with stated parameters advising staff when to notify the nurse or physician. • Careco should ensure that for health care problems (such as constipation) identified on the HCMP, the records should include documentation on what treatment was provided and an analysis of associated risks (i.e. chronic constipation, and records of bowel habits).	DDS sent these recommendation to the provider on 12/1/09 and requested a plan of correction which the provider sent on 12/5/09. The Quality Improvement Specialist reviewed the plan of correction and closed the issues on 12/30/09. DDS Quality Improvement Specialist reviewed the plan of correction submitted by the provider on 12/9/09, to ensure the provider was implementing the plan of correction as it was written. The Quality Improvement Specialist monitors the plan of correction until all issues are corrected. DDS Quality Improvement Specialist reviewed the plan of correction submitted by the provider on 12/9/09, to ensure the provider was implementing the plan of correction as it was written. The Quality Improvement Specialist monitors the plan of correction until all issues are corrected. The provider in this case will make the changes suggested and they will provide optimal care to all the individuals they serve. DDS Service Coordinators will continue to monitor the continued compliance during monthly visits and monitoring.
DDS should develop a process to ensure that record requests are complied with by hospitals.	DDS will explore using the FRC subpoena power to ensure hospitals comply with record requests in a timely manner. DDS legal department is researching the FRC subpoena power rules. DDS Mortality Review Coordinator continues to develop working relationships with area hospital staff to ensure requests are being sent timely. The DDS Mortality Review Coordinator has started tracking record request weekly with complete follow up phone calls and letters to medical records directors as needed. DDS will be able to provide the death investigation company with a complete file from the hospitals to ensure all records are available for review.
DDS should encourage Service Coordinators to clearly document follow up of identified problems/issues through resolution.	All identified issues are entered in the Alert Resolution System and are monitored until they are closed. The issues must go through 3 levels of resolution until the issue is closed. The Service Coordinator is required to record all progress toward the resolution of an issue. Once the Service Coordinator has completed all the work resolving an issue, his or her supervisor must review the Service Coordinator's work before the issue can be closed in the system.

ENDNOTES

Endnote # 1 (Page 2)	Information on the total consumer population was provided by the Department of Disability Services.

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

Mayor's Order 2009-225
December 22, 2009

SUBJECT: Revitalization –District of Columbia Developmental Disabilities Fatality Review Committee

ORIGINATING AGENCY: Office of the Mayor

By virtue of the authority vested in me as Mayor of the District of Columbia by section 422(2) of the District of Columbia Home Rule Act ("Home Rule Act"), as amended, 87 Stat. 790, Pub. L. No. 93-198, D.C. Official Code § 1-204.22(2) and (11) (2001), it is hereby **ORDERED** that:

I. ESTABLISHMENT

There is hereby revitalized in the Executive Branch of the government of the District of Columbia the District of Columbia Development Disabilities ("DD") Fatality Review Committee (hereinafter referred to as the "Committee").

II. PURPOSE

The Committee shall examine events and circumstances surrounding the deaths of District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability in order to: gather and analyze empirical evidence about fatalities in this population; safeguard and improve the health, safety and welfare of District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability; reduce the number of preventable deaths; and promote improvement and integration of both the public and private systems serving District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability. For purposes of this Mayor's Order, "District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability" may be defined as an individual who is committed by a court to the care and custody of the District of Columbia Department on Disability Services ("DDS"), or who meets DDS eligibility requirements for voluntary admission and is admitted by a court to receive services, or is under the supervision of DDS or of a program contracted by DDS to deliver such services, for reasons of an intellectual disability and/or a qualifying developmental disability. The phrase "District residents over the age of 18 years with an intellectual and/or qualifying developmental disability" is intended to include persons who are committed to the care and custody of the District or its residential providers in accordance with the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978 (Mentally Retarded Citizens Act), effective March 3, 1979, D.C. Law 2-137, D.C. Official Code § 7-1301.01 *et seq.* (2008 Repl. and 2009 Supp.), and therefore includes "wards of the District of Columbia government" under section 2906 (b) (7) of the Fiscal Year 2001 Budget

1. Methods by which deaths of District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability are identified and reported to ensure expeditious reviews;

2. A process by which fatality cases are screened and selected for review;

3. A method for ensuring that all information identifying District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability, their families and others associated with the cases or the circumstances surrounding the deaths, including witnesses and complainants, is protected against undue disclosure. This is to ensure that steps are taken to protect the right to privacy of an individual and his or her family in conducting investigations. Disseminating information to Committee members, reporting as required by the Mayor's Order, and maintaining case records for the Committee;

4. A method for gathering individual and cumulative data from the reviews;

5. A method for reviewing whether recommendations generated by the Committee are being implemented and identifying problems related to obstacles/barriers to implementation; and

6. A method for evaluating the work of the Committee that takes into account community responses to the deaths of District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability.

B. On or about December 30th of each year, beginning in 2010, producing an annual report that provides information obtained from the reviews of deaths that occurred during the previous calendar year. The annual report shall be submitted to the Mayor and made available to the public. The information to be contained in the report shall include at a minimum:

1. Statistical data on all fatalities of District residents over the age of 18 with an intellectual disability and/or a qualifying developmental disability reviewed by the Committee, including numbers reviewed, demographic characteristics of the subjects, and causes and manners of deaths;

2. Analyses of the data generated by the reviews to demonstrate the types of cases reviewed (which may include illustrative case vignettes without identifying information), similarities or patterns of factors causing or contributing to the deaths and trends (including temporal and geographic); and

3. Recommendations generated from the reviews, including service enhancements, systemic improvements or reforms, and changes in laws, policies, procedures or practices that would better protect District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability and that could prevent future deaths.

VI. TERMS

A. Public members appointed to the Committee shall serve for three (3) year terms, except that of the members first appointed, one-half shall be appointed for three (3) year terms and one-half for two (2) year terms. The date on which the first members are installed shall become the anniversary date for all subsequent appointments.

B. Members appointed to represent District government agencies shall serve only while employed in their official positions and shall serve at the pleasure of the Mayor.

C. A public member may be reappointed for a minimum of two (2) full terms based on the approval of the Mayor.

D. A member appointed to fill an unexpired term shall serve for the remainder of that term.

E. A member may hold over after the member's term expires until reappointed or replaced.

F. A public member may be excused from a meeting for an emergency reason. A public member who fails to attend three (3) consecutive meetings shall be deemed to be removed from the Committee and a vacancy created. Such vacancies shall be filled by the Mayor, in accordance to the composition outlined in Section V of this Mayor's Order.

G. A public member may be removed by the Mayor for personal misconduct, neglect of duty, conflict of interest violations, incompetence, or official misconduct. Prior to removal, the public member shall be given a copy of any charges and an opportunity to respond within ten (10) business days following receipt of the charges. Upon a review of the charges and the response, the Director of the Office of Boards and Commissions, Executive Office of the Mayor, shall refer the matter to the Mayor with a recommendation for a final decision or disposition. A public member shall be suspended by the Director of the Office of Boards and Commissions, Executive Office of the Mayor, on behalf of the Mayor, from participating in official matters of the Committee pending the consideration of the charges.

VII. ORGANIZATION

A. The Mayor shall appoint the Chief Medical Examiner and the DDS Deputy Director for the Developmental Disabilities Administration, or the functional equivalent, as Co-Chairpersons of the Committee and they shall serve in these capacities at the pleasure of the Mayor.

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

X. CASE REVIEW CRITERIA AND PROCEURES

A. Case Review Criteria

The Committee shall review the following deaths:

1. All deaths of District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability shall be reviewed by the Committee. Factors of particular concern for review include:

   a. All violent or sudden/unexplained manners of death (*i.e.*, homicide, suicide, accident or undetermined), which include all deaths caused by injuries or illness, including but not limited to:
      i. Fractures;
      ii. Blunt trauma;
      iii. Burns;
      iv. Asphyxia or drowning;
      v. Poisoning or intoxication;
      vi. Gunshot wounds;
      vii. Stabbing or cutting wounds;
      viii. Falls;
      ix. Sepsis;
      x. Gastrointestinal blockages; or
      xi. Seizures.

   b. Abuse, either physical or sexual;

   c. Neglect, including medical and custodial;

   d. Malnourishment or dehydration; and

   e. Circumstances or events deemed suspicious.

2. The Committee may, at its discretion, review groups of sudden, unexpected or unexplained deaths of District residents with an intellectual disability and/or a

4. Based on the case discussion, the Committee shall formulate applicable recommendations as enumerated above in section III.d and section IV.a and b.3, for further consideration and possible inclusion in the annual report.

XI. CASE NOTIFICATION PROCEDURES

A. District agencies and service providers contracted by the District to serve District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability shall provide written notification to the Committee within twenty-four (24) hours of any death of a District resident over the age of 18 years with an intellectual disability and/or a qualifying developmental disability, or within twenty-four (24) hours of becoming aware of such a death. The sources of notifications will include but are not limited to the:

1. Department on Disability Services (DDS), Developmental Disabilities Administration (DDA);
2. Office of the Chief Medical Examiner (OCME);
3. Metropolitan Police Department (MPD);
4. Office of the Attorney General (OAG);
5. Department of Health (DOH); and
6. Department of Health Care Finance (DHCF).

B. Case notification reports should include:

1. Demographic data (*i.e.* name, age/date of birth, race, gender);
2. Address;
3. Parent/guardian;
4. Circumstances of the death (*i.e.* date, time, location, activities, risk factors, witnesses or sources of information); and
5. Agencies investigating the death.

C. MPD, DDS, DOH and DHCF shall provide the Committee copies of all death reports resulting from any investigations that are conducted concerning the population covered by the Order (*see* Section X: Case Review Criteria). The OCME shall provide the Committee with a copy of all autopsy reports resulting from autopsies and death investigations conducted for District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability. These reports shall be provided within five (5) days after they are completed.

XII. NOTIFICATION OF PARTICIPANTS

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

3. Initials only will identify third persons in materials for distribution.

XV. RECOMMENDATIONS

A. Draft recommendations shall be developed during case review meetings based on issues raised during specific deaths or trends documented from numerous deaths reviewed.

B. Draft recommendations shall be redistributed for finalization and adoption based on consensus of the Committee during subsequent case review meetings prior to transmission to relevant agencies.

C. Final recommendations shall be transmitted to relevant agencies and the Office of the City Administrator and/or Mayor within thirty (30) days of finalization/adoption with request for response within sixty (60) days of receipt. Final adopted recommendations shall also be incorporated into the annual report.

D. Representatives of agencies, institutions and programs may be invited to full Committee meetings to present their plans for, or progress made towards implementing the recommendations.

XVI. COMPENSATION

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

XVII. ADMINISTRATION

The Office of the Chief Medical Examiner shall provide administrative support and legal counsel for the Committee.

XVIII. LEGAL APPLICATION

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

GLOSSARY OF TERMS

TERMS	*DEFINITIONS*
Autopsy Report	A detailed report consisting of the autopsy procedure, microscopic and laboratory findings, a list of diagnoses, and a summary of the case.
CRF/MR	Community Residential Facility for individuals diagnosed with an intellectual disability (MR)
Group Home	Licensed homes for persons with mental retardation that range in size from four (4) to eight (8) customers
Hospice	A program or facility that provides special care for people who are near the end of life and for their families
ICF/MR	A licensed residential facility certified and funded through Title XIX (Medicaid) for consumers diagnosed with an intellectual disability (MR). Consumers receive 24 hour skilled supervised care.
Level of Disability	Cognitive and adaptive impairment ranging from mild to profound
Life Expectancy	The average expected length of life; the number of years somebody is expected to live
Medicaid Waiver	Provides rehabilitative, behavioral, and medical supports to individuals with intellectual and developmental disabilities in residential community , and private home settings.
Natural Home	Consumers residing in the home of a parent, family members or independently
Neurological Conditions	Disorders of the neuromuscular system (the central, peripheral, and autonomic nervous systems, the neuromuscular junction, and muscles)
Nursing Home	A long-term healthcare facility that provides full-time care and medical treatment for people who are unable to take care of themselves
Skilled Care	An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons
Specialized Home Care	A private home living environment for three (3) or less individuals (also includes foster care)
Supervised Apartments	Typically a living arrangement for one to three customers with mental retardation, with drop-in twenty-four hour supervision. Supervised Apartments may be single units grouped in a cluster within an apartment complex, or scattered throughout a complex
Ward	An administrative or electoral division of an area/city, e.g., Wards 1-8 in the District or Individuals under the custody and care of the District of Columbia

CAUSES OF DEATH - 2010 DD FRC DEATHS REVIEWED

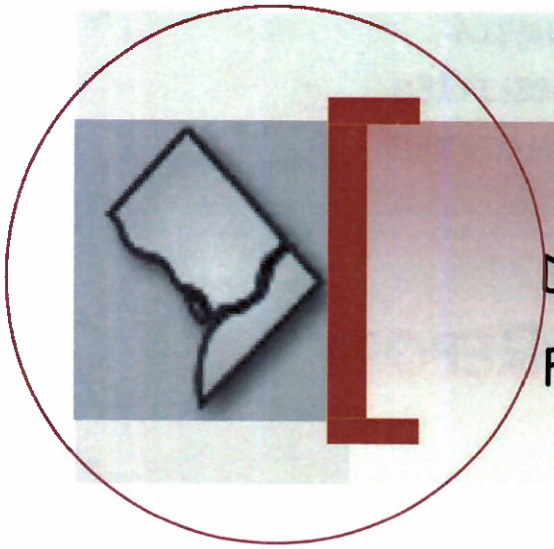
Deaths Reviewed that occurred in 2009 Cont'd.:

Age/Race Sex	*Cause of Death*	*Manner of Death*
78/Blk/Male	Complications of Metastasis Carcinoma of Rectum	Natural
57/Blk/Female	Toxic Epidermal Necrolysis due to Septic Shock due to Multiorgan Failure due to Disseminated Intravascular Coagulation	Natural
90/Wht/Female	Hypertensive and Arteriosclerotic Cardiovascular Disease	Natural

Deaths Reviewed that occurred in 2010:

71/Wht/Male	Complications of Left Femur Fracture	Undetermined
41/Blk/Male	Complications of Non-Hodgkin's Lymphoma	Natural
41/Blk/Female	Asphyxia due to Aspiration of Bolus of Food	Accident
55/Blk/Male	Acute Ischemic Enterocolitis, Undetermined Etiology	Natural
61/Blk/Male	Anoxic Encephalopathy Due to Asphyxia with Cardiopulmonary Arrest Following Obstruction of Airway due to Aspiration of Food	Accident
44/Blk/Male	Non-Hodgkin Lymphoma	Natural
65/Blk/Female	Complications of Multiple Myeloma	Natural

Government of the District of Columbia
Office of the Chief Medical Examiner,
Fatality Review Unit
Developmental Disabilities Fatality Review Committee
1910 Massachusetts Avenue SE, Building #27
Telephone: (202) 698-9000
For Additional Copies of the Report Contact DD FRC



DISTRICT OF COLUMBIA DEVELOPMENTAL DISABILITIES FATALITY REVIEW COMMITTEE

2009 ANNUAL REPORT

The Honorable Vincent Gray, Mayor
District of Columbia Government

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

TABLE OF CONTENTS

INTRODUCTION

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

Margaret Meade

The 2009 Annual Report is a summary of the work performed by the Developmental Disabilities Fatality Review Committee (DD FRC) during calendar year 2009. It provides a synopsis of the total population identified by the Committee annually as meeting the criteria for review and the data that is specific to the 22 deaths reviewed during calendar year 2009.

DD FRC (formerly the MRDD FRC) was re-established in September 2009, under the auspices of the Office of the Chief Medical Examiner (OCME). It is a multi-disciplinary, multi-agency effort that was established for the purpose of conducting retrospective reviews of relevant service delivery systems and the events that surrounded the deaths of District wards and residents 18 years of age and older who received services and/or supports from the Department on Disability Services . One goal of the DD FRC is to make recommendations to improve care and service delivery to he citizens of the District receiving disability services.

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

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

Table 2 below summarizes the status of the 275 deaths identified as meeting the DD FRC criteria for review by calendar years since the Committee's inception. Of the 275 deaths identified since 2001, 219 were reviewed by the DD FRC. As of December 31, 2009, 56 cases were pending review.

Table 2: Status of Deaths Identified and Review By Calendar Year

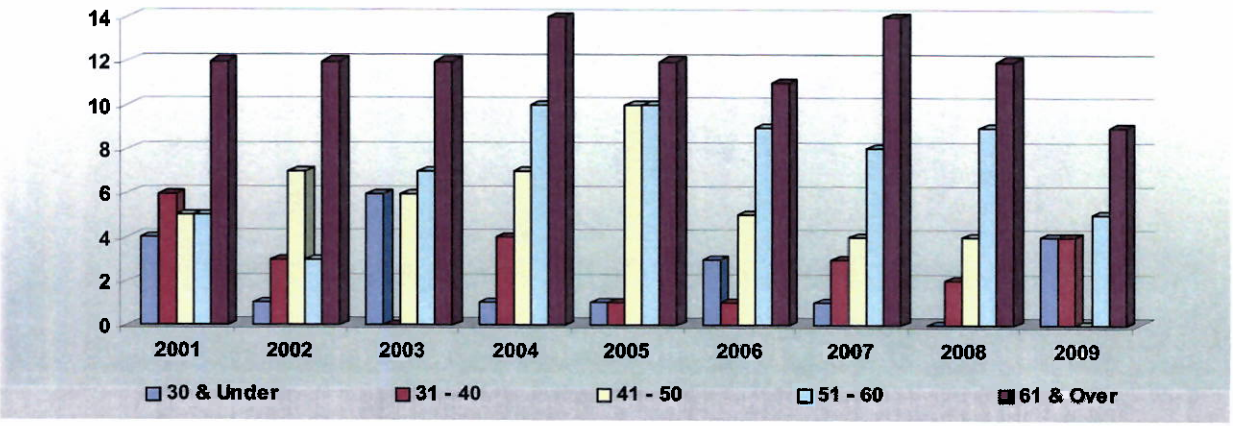
Year	# Deaths Identified By Year	# Deaths Reviewed By Year	# Deaths Pending Review
2009	29	22	7
2008	27	27	0
2007	30	21	9
2006	30	23	7
2005	34	24	10
2004	36	26	10
2003	31	23	8
2002	26	21	5
2001	32	32	0

Demographic Decedent Data - Total Mortality Population Identified

Age of Decedents

Based on the cases reviewed by the DD FRC, the relationship between age and mortality has historically demonstrated the mortality rate increasing as DDS consumers begin to age (see Figure 1). Annually the majority of the deaths reviewed have involved DDS consumers who were in the age group of 61 years of age or older. Overall, this trend among the DDS population has remained constant since the inception of the fatality review process in 2001. Additionally, the trend among the DDS population is also consistent with the expected national trend of mortality increasing with age for the broader population.

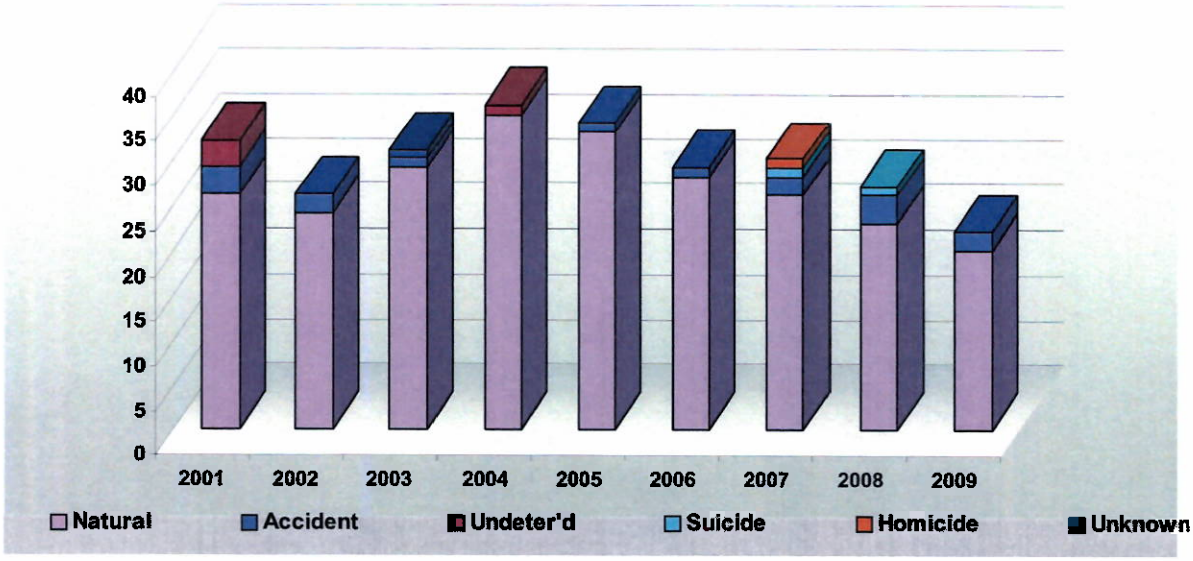
Figure 1: DD FRC Decedent Age by Year



Manner of Death - Total Deaths Identified

Historically, the leading manner of death for DD FRC cases was Natural. Since the inception of this Committee, Natural deaths have represented from 81% to 97% of the total fatalities identified annually. The second leading manner of death is Accident. Accidental deaths of DDS consumers have occurred in every calendar year with the exception of 2004. During this eight year span, there was one Homicide in 2007 and two Suicide deaths, one occurred in 2007 and the other in 2008; of the Undetermined deaths there were three in 2001 and one in 2004.

Figure 4: 2009 DD FRC Decedent Manner of Death



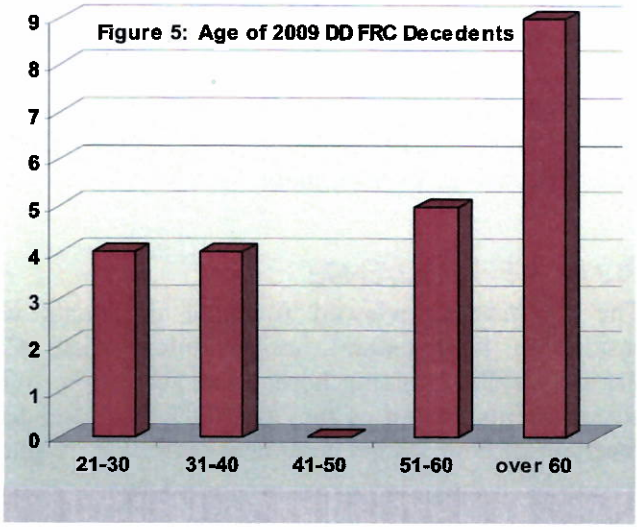
Section II: Summary of 2009 Case Review Findings

During calendar year 2009, the DD FRC reviewed the deaths of 22 consumers diagnosed with intellectual and developmental disabilities served by DDS. These reviews were limited to deaths that occurred in 2007 and 2008 that involved 20 fatalities that occurred in 2008. Section II will cover the data and findings that resulted from the 22 cases reviewed.

Age/Gender and Mortality

The ages of the 22 decedents whose deaths were reviewed ranged from 21 to 94 years of age; the average age was 53 years. As Figure 5 illustrates, 14 of the 22 cases reviewed involved DDS consumers over the age of 50 years. There were four decedents between the ages of 21 and 30 years, and four between 31 and 40 years.

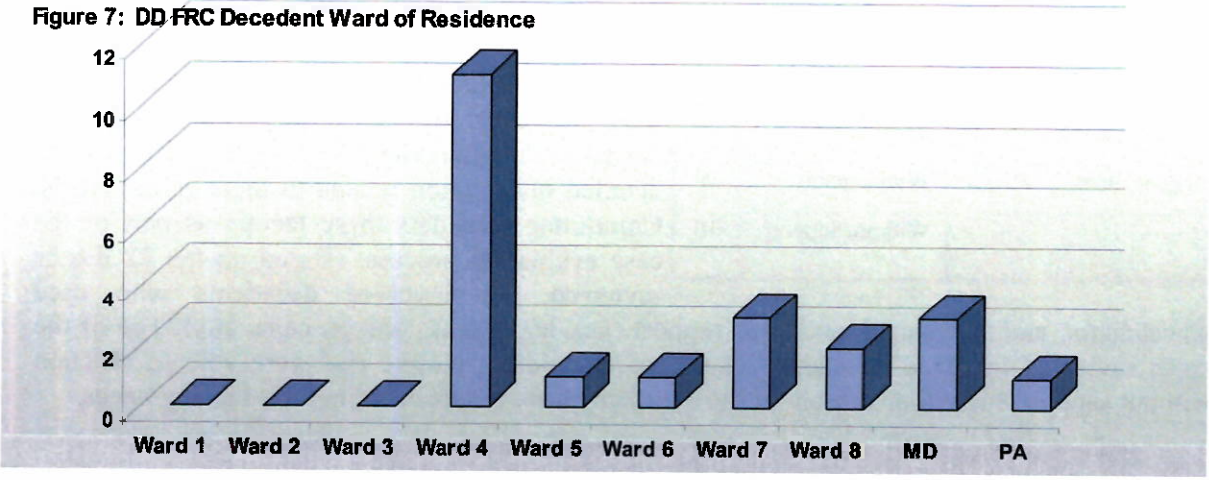
Figure 5: Age of 2009 DD FRC Decedents



the decedents received individualized Medicaid Waiver services in their living environment.

WARD OF RESIDENCE

Figure 7: DD FRC Decedent Ward of Residence



Ward of residence refers to the decedent's residential address at the time of the death. Figure 7 illustrates the decedents' District Ward or State of residence at the time of death. Of the 22 deaths reviewed, 18 of the decedents resided either in their natural home, ICF, Nursing home, or supportive living environment located within the District of Columbia. The greatest number of decedents reviewed resided in Wards Four (N=11) and Seven (N=3). Of the 22 deaths reviewed, 3 decedents resided in nursing facilities in Maryland.

Table 5: 2009 DD FRC Location of Death

Place of Death	*2009(N=22)*
Hospital	**12**
Nursing Home	**7**
Private Home	**3**

LOCATION OF DEATH

In the case reviews of the 22 DDS FRC decedents, records indicate the fatal events occurred in locations that included hospitals, nursing homes, and the decedent's private home. As Shown in Table 5, 12 of the decedents died following admission to a hospital. Seven decedents died in a nursing facility, and the remaining 3 decedents died in their natural home.

expectancy may be shortened. It is not uncommon that severity of cognitive impairment is correlated to other health risks. As Table 7 depicts, of the 22 cases reviewed during 2009, 15 decedents had a DSM-IV Axis I diagnoses (Endnote #3, see page 12). The Axis I diagnostic disorders represented were: Bi-polar Disorder; Dementia, Schizophrenia, Intermittent Explosive Disorder N.O.S., and Substance Abuse. Although the District records levels of Mental Retardation in terms of both cognitive and adaptive functioning, diagnostic levels are usually made in terms of cognitive functioning. The following degrees of severity reflect the levels of intellectual (cognitive) impairment of the decedents reviewed:

- Profound Mental Retardation, 11
- Severe, 1
- Moderate, 5
- Mild, 5

Cause and Manner of Death

Mayor's Order 2006-123, "Autopsies of Deceased Clients of the Mental Retardation and Developmental Disability Administration" requires the Office of the Chief Medical Examiner to perform the appropriate physical examination (autopsy, or external examination) on all persons with mental retardation or developmental disabilities who received services from the Department on Disability Services. Of the 22 cases reviewed in 2009, 9 decedents were autopsied and 11 decedents had external examinations. Medical examiners reviewed the medical records of the remaining two decedents. Of the 11 decedents that received External Examinations, one died in 2007, and ten died during 2008.

Manner of Death

Manner of death refers to the circumstantial events surrounding the death. The manner of death, as determined by the forensic pathologist, is an opinion based on the known medical and investigatory facts concerning the circumstances leading to and surrounding the death, in conjunction with the findings at autopsy and laboratory tests. Twenty of the 22 decedents reviewed in 2009 were determined to be Natural deaths. The remaining 2 deaths were determined to be Accidents.

Cause of Death

As Table 8 indicates, of the 22 deaths reviewed during 2009, ten resulted from diseases of the Cardiovascular System, mainly Hypertension and Arteriosclerosis. In four cases, Gastrointestinal Systems disorders were the causes of the death. Cancer and Respiratory disease caused two deaths, while Blunt Injury, Genetic Disorder, Sepsis, and Intoxication were the individual causes of death in four cases.

SECTION III: DD FRC 2009 RECOMMENDATIONS

FRC Recommendation	Response
DDS should provide training for group home and other facility staff related to how to handle emergencies including the medical documentation that should be made available at time of transport to the hospital.	DDS provided mandatory training to the provider community which include: emergency protocols as well as the Health Passport (which is the medical documentation that accompanies individuals when they are sent to a hospital). DDS continue to monitor providers that are in need of the mandatory DDS training to verify that all provider staff training is up to date. Quality Management Division BASA team ensures that providers have current Medical passports for all the individuals they serve. The BASA team ensures all the information is current and accurate. DDS BASA team reviews all Medical passport and emergency plans for the agency certification. Quality Management Division Specialist along with Service Coordination ensure that all individuals being served by DDS have a current and accurate Health Passport. As of 1/2009 all individuals being served by DDS have current Health Passports, that include all medical diagnosis, medication, and medical history.
DDS should ensure that Associated Community Services, Inc. implements the following recommendations include in the Columbus Report: 1. Ensure that the problems identified regarding adequate follow-up of abnormal tests are addressed in a timely manner. 2. Develop an active problem list that is current and comprehensive and is prominently filed in the record so that all health care providers have easy access to this information. 3. Develop a process to ensure that Health Care Plans are dated, signed and contain accurate information about the individual.	DDS Quality Improvement and enhancement team reviews all Medical passports and Health Care Management Plans for the agency certification. Quality Management Division Specialist along with Service Coordination ensures that all individuals being served by DDS have a current and accurate Health Passport and Health Care Management Plan. The plan must be signed and dated by the provider RN, also show oversight by the provider nurse in her monthly nursing notes.
DDS Should ensure that case managers and IDT's follow-up to ensure needed services are provided in a timely manner and clearly document any barriers related to not obtaining needed services (i.e. physical therapy, etc.).	DDS service coordinator monitoring tool has a section that outlines all services provided and services needed. Service coordinators monitor each individual monthly to ensure all services needed are provided. During monitoring reviews, the service coordinator will check on services needed but not provided to the individual and put notes in the MCIS system along with steps taken to ensure that individual receives the services they need. If services go a month without being provided an alert is put into the Alert Resolution System to be monitored until resolved. The service coordination monitoring tool was modified in August 2006, to ensure it specifies services to be provided and any unmet needs.

FRC Recommendation	Status
DDS should ensure that the provider addresses the following recommendations highlighted in the Columbus Report: 1. DC Health Care, Inc's PCP should provide plans to address the following: Need for documentation of rationales, especially for choosing a new gastroenterologist in 11/07 and for new medications in the regimen after a hospitalization; Need to provide adequate information (past medical history, results of diagnostic tests) to consultants; Need to document the basis for medical decisions; How to address timeliness of care and lack of follow-up of recommendations; Diagnosis and treatment of H. pylori; Use of rectal suppositories for constipation; Chronic iron therapy; Diet recommendations for gastroparesis; Accuracy of physical examination findings on annual medical evaluations; and Need to document medications indications in the physician orders. 2. DC Health Care, Inc. should provide plans to address the following: Need to provide quality information in quarterly pharmacy reviews; Need to provide quality information on the Health Passport; Need for the signature of staff who document on consultation forms; and Need for more in-depth discussion of health information in the ISP. 3. DC Health Care, Inc. should ensure nursing staff complete one comprehensive Health Care Management Plan that is maintained current for each individual supported and that nursing progress notes are documented at a frequency commensurate with the individual's health issues and whenever a change in condition occurs.	DDS has forwarded a copy of the Columbus recommendations to DC Heath Care Inc., via email. A hard copy was also mailed to the provider's corporate office. DDS has forwarded the Columbus recommendations to DC Health Care Inc., via email. A hard copy was also mailed to their corporate office. DC Health Care Inc., was given two weeks to respond to recommendations from the date received and requested to describe in detail ,action steps to satisfy the recommendations. **Update 12/10/09:** Columbus recommendations were mailed out on June 10, 2009. DC Health Care Inc., sent their response on June 25, 2009. The Quality Improvement Specialist assigned to DC Health Care Inc., has completed monitoring of DC Health Care Inc., September 2009. As of 10/2009 these recommendations are closed. DC Health Care Inc., is still working on answering the recommendations from Columbus. DDS Quality Management Division Specialist is working with DC Health Care Inc., to ensure they are responding to the recommendations and implementing their written plan of correction. **Update 12/10/09:** The Quality Improvement Specialist assigned to DC Health Care Inc., has completed monitoring of DC Health Care Inc., on September 2009. As of 10/2009 these recommendations are closed. DC Health Care Inc., will provide better health care monitoring, oversight and timeliness of scheduled appointments for individuals being served. Quality Management Division Specialist assigned to DC Health Care Inc., will monitor this provider on an on-going basis to ensure the provider remains in compliance with their plan of corrections and report progress monthly MCIS notes, as well as at monthly staff meetings

ENDNOTES

Endnote # 1	Information on the total consumer population was provided by the Department of Disability Services.

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

Mayor's Order 2009-225
December 22, 2009

SUBJECT: Revitalization –District of Columbia Developmental Disabilities Fatality Review Committee

ORIGINATING AGENCY: Office of the Mayor

By virtue of the authority vested in me as Mayor of the District of Columbia by section 422(2) of the District of Columbia Home Rule Act ("Home Rule Act"), as amended, 87 Stat. 790, Pub. L. No. 93-198, D.C. Official Code § 1-204.22(2) and (11) (2001), it is hereby **ORDERED** that:

I. ESTABLISHMENT

There is hereby revitalized in the Executive Branch of the government of the District of Columbia the District of Columbia Development Disabilities ("DD") Fatality Review Committee (hereinafter referred to as the "Committee").

II. PURPOSE

The Committee shall examine events and circumstances surrounding the deaths of District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability in order to: gather and analyze empirical evidence about fatalities in this population; safeguard and improve the health, safety and welfare of District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability; reduce the number of preventable deaths; and promote improvement and integration of both the public and private systems serving District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability. For purposes of this Mayor's Order, "District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability" may be defined as an individual who is committed by a court to the care and custody of the District of Columbia Department on Disability Services ("DDS"), or who meets DDS eligibility requirements for voluntary admission and is admitted by a court to receive services, or is under the supervision of DDS or of a program contracted by DDS to deliver such services, for reasons of an intellectual disability and/or a qualifying developmental disability. The phrase "District residents over the age of 18 years with an intellectual and/or qualifying developmental disability" is intended to include persons who are committed to the care and custody of the District or its residential providers in accordance with the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978 (Mentally Retarded Citizens Act), effective March 3, 1979, D.C. Law 2-137, D.C. Official Code § 7-1301.01 *et seq.* (2008 Repl. and 2009 Supp.), and therefore includes "wards of the District of Columbia government" under section 2906 (b) (7) of the Fiscal Year 2001 Budget

1. Methods by which deaths of District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability are identified and reported to ensure expeditious reviews;

2. A process by which fatality cases are screened and selected for review;

3. A method for ensuring that all information identifying District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability, their families and others associated with the cases or the circumstances surrounding the deaths, including witnesses and complainants, is protected against undue disclosure. This is to ensure that steps are taken to protect the right to privacy of an individual and his or her family in conducting investigations. Disseminating information to Committee members, reporting as required by the Mayor's Order, and maintaining case records for the Committee;

4. A method for gathering individual and cumulative data from the reviews;

5. A method for reviewing whether recommendations generated by the Committee are being implemented and identifying problems related to obstacles/barriers to implementation; and

6. A method for evaluating the work of the Committee that takes into account community responses to the deaths of District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability.

B. On or about December 30th of each year, beginning in 2010, producing an annual report that provides information obtained from the reviews of deaths that occurred during the previous calendar year. The annual report shall be submitted to the Mayor and made available to the public. The information to be contained in the report shall include at a minimum:

1. Statistical data on all fatalities of District residents over the age of 18 with an intellectual disability and/or a qualifying developmental disability reviewed by the Committee, including numbers reviewed, demographic characteristics of the subjects, and causes and manners of deaths;

2. Analyses of the data generated by the reviews to demonstrate the types of cases reviewed (which may include illustrative case vignettes without identifying information), similarities or patterns of factors causing or contributing to the deaths and trends (including temporal and geographic); and

3. Recommendations generated from the reviews, including service enhancements, systemic improvements or reforms, and changes in laws, policies, procedures or practices that would better protect District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability and that could prevent future deaths.

VI. TERMS

A. Public members appointed to the Committee shall serve for three (3) year terms, except that of the members first appointed, one-half shall be appointed for three (3) year terms and one-half for two (2) year terms. The date on which the first members are installed shall become the anniversary date for all subsequent appointments.

B. Members appointed to represent District government agencies shall serve only while employed in their official positions and shall serve at the pleasure of the Mayor.

C. A public member may be reappointed for a minimum of two (2) full terms based on the approval of the Mayor.

D. A member appointed to fill an unexpired term shall serve for the remainder of that term.

E. A member may hold over after the member's term expires until reappointed or replaced.

F. A public member may be excused from a meeting for an emergency reason. A public member who fails to attend three (3) consecutive meetings shall be deemed to be removed from the Committee and a vacancy created. Such vacancies shall be filled by the Mayor, in accordance to the composition outlined in Section V of this Mayor's Order.

G. A public member may be removed by the Mayor for personal misconduct, neglect of duty, conflict of interest violations, incompetence, or official misconduct. Prior to removal, the public member shall be given a copy of any charges and an opportunity to respond within ten (10) business days following receipt of the charges. Upon a review of the charges and the response, the Director of the Office of Boards and Commissions, Executive Office of the Mayor, shall refer the matter to the Mayor with a recommendation for a final decision or disposition. A public member shall be suspended by the Director of the Office of Boards and Commissions, Executive Office of the Mayor, on behalf of the Mayor, from participating in official matters of the Committee pending the consideration of the charges.

VII. ORGANIZATION

A. The Mayor shall appoint the Chief Medical Examiner and the DDS Deputy Director for the Developmental Disabilities Administration, or the functional equivalent, as Co-Chairpersons of the Committee and they shall serve in these capacities at the pleasure of the Mayor.

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

X. CASE REVIEW CRITERIA AND PROCEURES

A. Case Review Criteria

The Committee shall review the following deaths:

1. All deaths of District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability shall be reviewed by the Committee. Factors of particular concern for review include:

   a. All violent or sudden/unexplained manners of death (*i.e.*, homicide, suicide, accident or undetermined), which include all deaths caused by injuries or illness, including but not limited to:
      i. Fractures;
      ii. Blunt trauma;
      iii. Burns;
      iv. Asphyxia or drowning;
      v. Poisoning or intoxication;
      vi. Gunshot wounds;
      vii. Stabbing or cutting wounds;
      viii. Falls;
      ix. Sepsis;
      x. Gastrointestinal blockages; or
      xi. Seizures.

   b. Abuse, either physical or sexual;

   c. Neglect, including medical and custodial;

   d. Malnourishment or dehydration; and

   e. Circumstances or events deemed suspicious.

2. The Committee may, at its discretion, review groups of sudden, unexpected or unexplained deaths of District residents with an intellectual disability and/or a

4. Based on the case discussion, the Committee shall formulate applicable recommendations as enumerated above in section III.d and section IV.a and b.3, for further consideration and possible inclusion in the annual report.

XI. CASE NOTIFICATION PROCEDURES

A. District agencies and service providers contracted by the District to serve District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability shall provide written notification to the Committee within twenty-four (24) hours of any death of a District resident over the age of 18 years with an intellectual disability and/or a qualifying developmental disability, or within twenty-four (24) hours of becoming aware of such a death. The sources of notifications will include but are not limited to the:

1. Department on Disability Services (DDS), Developmental Disabilities Administration (DDA);
2. Office of the Chief Medical Examiner (OCME);
3. Metropolitan Police Department (MPD);
4. Office of the Attorney General (OAG);
5. Department of Health (DOH); and
6. Department of Health Care Finance (DHCF).

B. Case notification reports should include:

1. Demographic data (*i.e.* name, age/date of birth, race, gender);
2. Address;
3. Parent/guardian;
4. Circumstances of the death (*i.e.* date, time, location, activities, risk factors, witnesses or sources of information); and
5. Agencies investigating the death.

C. MPD, DDS, DOH and DHCF shall provide the Committee copies of all death reports resulting from any investigations that are conducted concerning the population covered by the Order (*see* Section X: Case Review Criteria). The OCME shall provide the Committee with a copy of all autopsy reports resulting from autopsies and death investigations conducted for District residents over the age of 18 years with an intellectual disability and/or a qualifying developmental disability. These reports shall be provided within five (5) days after they are completed.

XII. NOTIFICATION OF PARTICIPANTS

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

3. Initials only will identify third persons in materials for distribution.

XV. RECOMMENDATIONS

A. Draft recommendations shall be developed during case review meetings based on issues raised during specific deaths or trends documented from numerous deaths reviewed.

B. Draft recommendations shall be redistributed for finalization and adoption based on consensus of the Committee during subsequent case review meetings prior to transmission to relevant agencies.

C. Final recommendations shall be transmitted to relevant agencies and the Office of the City Administrator and/or Mayor within thirty (30) days of finalization/adoption with request for response within sixty (60) days of receipt. Final adopted recommendations shall also be incorporated into the annual report.

D. Representatives of agencies, institutions and programs may be invited to full Committee meetings to present their plans for, or progress made towards implementing the recommendations.

XVI. COMPENSATION

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

XVII. ADMINISTRATION

The Office of the Chief Medical Examiner shall provide administrative support and legal counsel for the Committee.

XVIII. LEGAL APPLICATION

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

GLOSSARY OF TERMS

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

CAUSES OF DEATH - 2009 DD FRC DEATHS REVIEWED

Deaths Reviewed that occurred in 2008 Cont'd.:

Age/Race Sex	*Cause of Death*	*Manner of Death*
36/Blk/Female	Pulmonary Thromboembolism due to Deep Leg Vein Thrombosis	Natural
57/Blk/Female	Urosepsis Pneumonia due to Cerebral Palsy, due to Encephalopathy, due to Obstetric Complications	Natural

Government of the District of Columbia
Office of the Chief Medical Examiner,
Fatality Review Unit
Developmental Disabilities Fatality Review Committee
1910 Massachusetts Avenue SE, Building #10
Telephone: 202-698-9000
For Additional Copies of the Report Contact DDS FRC

District of Columbia

Mental Retardation and Developmental Disabilities

Fatality Review Committee

2007 Annual Report

Adrian M. Fenty, Mayor
District of Columbia Government

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

Table of Contents

INTRODUCTION

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

Margaret Meade

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

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

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

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

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

Table 2: Status of Deaths Identified and Review By Calendar Year

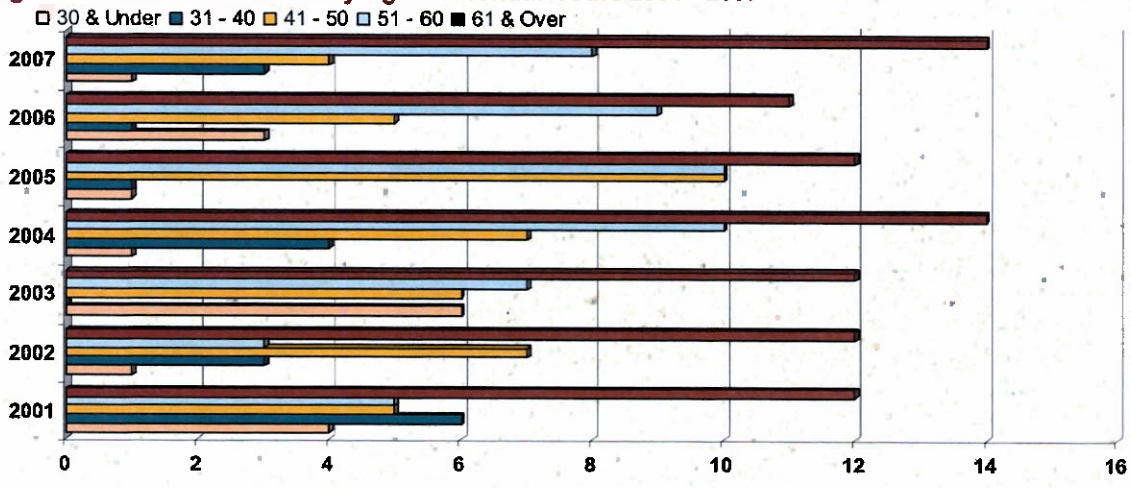
Year	# Deaths Identified By Year	# Deaths Reviewed By Year	# Deaths Pending Review
2007	30	21	9
2006	30	19	11
2005	34	24	10
2004	36	26	10
2003	31	23	8
2002	26	21	5
2001	32	32	0
Total	219	166	53

Demographic Decedent Data - Total Mortality Population Identified

Age of Decedents

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

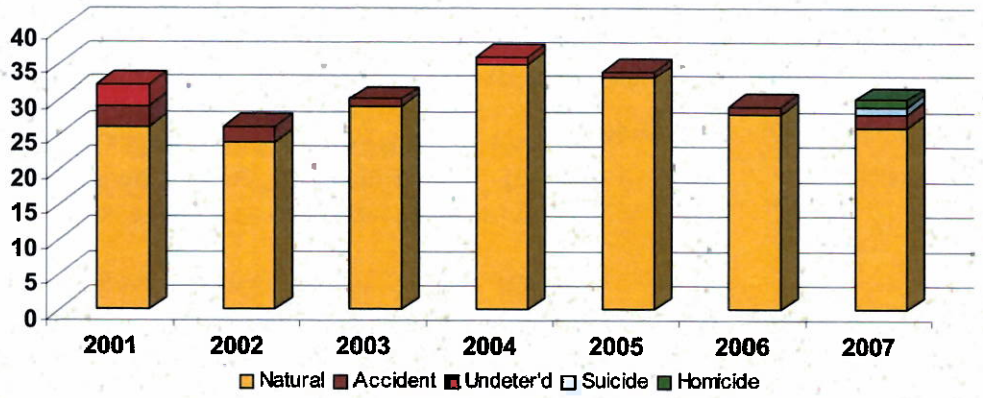
Figure 1: Number of Deaths By Age - Calendar Years 2001 - 2007



Manner of Death - Total Deaths Identified

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

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

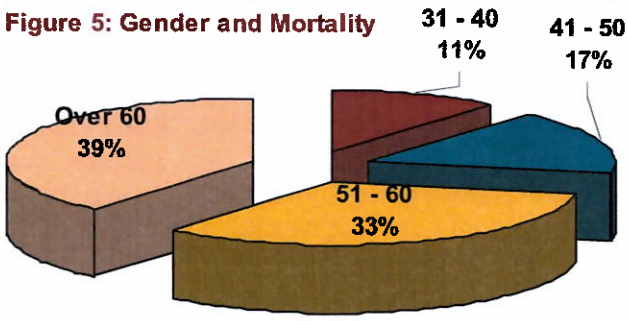


Section II: Summary of 2007 Case Review Findings

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

Age/Gender and Mortality

Figure 5: Gender and Mortality



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

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

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

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

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

Location of Death

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

Table 7: Location of Death By Year

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

Mobility and Feeding Impairments

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

Table 8: Feeding and Mobility

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

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

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

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

Manner of Death

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

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

Cause of Death

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

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

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

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

ENDNOTES

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

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

Mayor's Order 2005-143
September 30, 2005

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

ORIGINATING AGENCY: Office of the Mayor

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

I. RE-ESTABLISHMENT

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

II. PURPOSE

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

2. A process by which fatality cases are screened and selected for review;

3. A method for ensuring that all information identifying District wards over the age of 18 years with mental retardation or a developmental disability, their families and others associated with the cases or the circumstances surrounding the deaths, including witnesses and complainants, is protected against undue disclosure. This is to ensure that steps are taken to protect the right to privacy of an individual and his or her family in conducting investigations, disseminating information to Committee members, reporting as required by the Mayor's Order, and maintaining case records for the Committee;

4. A method for gathering individual and cumulative data from the reviews;

5. A method for reviewing whether recommendations generated by the Committee are being implemented and identifying problems related to obstacles/barriers to implementation; and

6. A method for evaluating the work of the Committee that takes into account community responses to the deaths of District wards with mental retardation or a developmental disability.

b. On or about December 31st of each year, producing an annual report that provides information obtained from the reviews of deaths that occurred during the previous calendar year. The annual report shall be submitted to the Mayor and made available to the public. The information to be contained in the report shall include at a minimum:

1. Statistical data on all fatalities of District wards with mental retardation or a developmental disability reviewed by the Committee, including numbers reviewed, demographic characteristics of the subjects, and causes and manners of deaths;

2. Analyses of the data generated by the reviews, to demonstrate the types of cases reviewed (which may include illustrative case vignettes without identifying information), similarities or patterns of factors causing or contributing to the deaths, and trends (including temporal and geographic); and

3. Recommendations generated from the reviews, including service enhancements, systemic improvements or reforms, and changes in laws,

B. Two (2) physicians who practice in the District with experience in the evaluation and treatment of persons with mental retardation or developmental disabilities;

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

VI. TERMS

a. Public members appointed to the Committee shall serve for three (3) year terms, except that of the members first appointed, one-half shall be appointed for three (3) year terms and one-half for two (2) year terms. The date on which the first members are installed shall become the anniversary date for all subsequent appointments.

b. Members appointed to represent District government agencies shall serve only while employed in their official positions and shall serve at the pleasure of the Mayor.

c. A public member shall not serve more than two (2) consecutive full terms.

d. A member appointed to fill an unexpired term shall serve for the remainder of that term.

e. A member may hold over after the member's term expires until reappointed or replaced.

f. A public member may be excused from a meeting for an emergency reason. A public member who fails to attend three (3) consecutive meetings shall be deemed to be removed from the Committee, and a vacancy created. Such vacancies shall be filled by the Mayor as outlined in section V of this Mayor's Order.

g. A public member may be removed by the Mayor for personal misconduct, neglect of duty, conflict of interest violations, incompetence, or official misconduct. Prior to removal, the public member shall be given a copy of any charges and an opportunity to respond within 10 business days following receipt of the charges. Upon a review of the charges and the response, the Director of the Office of Boards and Commissions, Executive Office of the Mayor, shall refer the matter to

c. Case review meetings of the full Committee shall be held monthly, if there are cases for review. After procedures have been established and tested, the Committee may consider holding case review meetings every other month (bi-monthly), if practicable. The full Committee may also convene additional meetings as needed for additional case reviews, or for other specific purposes of the Committee, including the development of recommendations or preparation of the annual report.

d. The Committee shall conduct multi-disciplinary reviews of the events and circumstances surrounding the deaths of District wards over the age of 18 years with mental retardation or a developmental disability as defined in section II, above, in order to provide the data to fulfill the purposes and duties of the Committee as enumerated in sections II and III, respectively.

e. Case reviews will occur at the first Committee meeting after the Committee receives notification of the fatality, or at the first meeting after sufficient materials are received for conducting the review. The review may be preliminary, pending conclusion of the investigation and prosecution, or release by the prosecutor to conduct the review, at which time a comprehensive review shall be conducted.

f. The case review process shall include presentation of the case summary, followed by presentations of relevant information concerning the death by any agencies or persons involved with District wards over the age of 18 years with mental retardation or a developmental disability or investigating the event.

g. Following presentation of the facts, the Committee will discuss the case and any issues that it raises, guided by the following principles and questions:

1. What factors or circumstances caused or contributed to the death? (This may include consideration of social service delivery and coordination to District wards over the age of 18 years with mental retardation or a developmental disability and their families and compliance with, or development of, applicable or needed laws, procedures and regulations.)

2. What responses and investigations resulted from the death? (This includes whether all necessary agencies were notified and responded, and whether any corrective actions were instituted.)

1. By a special process server, at least 18 years of age, designated by the Committee from among the staff of the Committee or any office or organization designated by the Committee; provided, that the special process server is not directly involved in the investigation; or

2. If, after a reasonable attempt, personal service on a witness or witness' agent cannot be obtained, a special process server identified in paragraph (1) may serve a subpoena by registered or certified mail not less than eight (8) business days before the date the witness must appear or the documents must be produced.

3. If a witness who has been personally summoned neglects or refuses to obey the subpoena issued pursuant to this section, the Committee may apply to the Superior Court of the District of Columbia for an order compelling the witness so summoned to obey the subpoena.

XI. CASE REVIEW CRITERIA AND PROCEDURES

a. All deaths of District wards over the age of 18 years with mental retardation or a developmental disability shall be reviewed by the Committee.

b. Factors of particular concern for review include:

1. All violent or unexplained manners of death (i.e., homicide, suicide, accident or undetermined), which include all deaths caused by injuries, including:

A. Fractures;

B. Blunt trauma, including fractures;

C. Burns;

D. Asphyxia or drowning;

E. Poisoning or intoxication;

F. Gunshot wounds; or

G. Stabbing or cutting wounds;

5. Metropolitan Police Department (MPD);

6. Office of the Inspector General (OIG);

7. Office of the Attorney General (OAG);

8. Department of Health (DOH); and

9. Department of Mental Health (DMH).

b. Case notification reports should include for the affected District ward over the age of 18 years with mental retardation or a developmental disability:

1. Demographic data (name, age/date of birth, race, gender);

2. Address;

3. Parents/guardians;

4. Circumstances of the death (date, time, location, activities, risk factors, witnesses or sources of information);

5. Agencies investigating the death; and

6. History of the involvement of government agencies or contacted service providers.

c. MPD, DHS (OIC and MRDDA), DOH and OIG shall provide the Committee copies of all death reports resulting from any investigations that are conducted concerning District wards over the age of 18 years with mental retardation or a developmental disability. The OCME shall provide the Committee copies of all autopsy reports resulting from autopsies and death investigations conducted on District wards over the age of 18 years with mental retardation or a developmental disability. These reports shall be provided within five (5) days after they are completed.

XIII. NOTIFICATION OF PARTICIPANTS

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

d. Methods for ensuring that all information identifying third persons such as witnesses, complainants, agency, institution, or program staff or professionals involved with the family are protected against disclosure are:

1. The same procedures established for District wards over the age of 18 years with mental retardation or a developmental disability and their families above shall be followed for these entities.

2. Access to primary documents will be limited to the staff of the Committee and the chair of the review meeting.

3. Initials only will identify third persons in materials for distribution.

XVI. RECOMMENDATIONS

a. Draft recommendations shall be developed by the Committee Coordinator based on issues raised during the reviews.

b. Draft recommendations shall be distributed to agencies and members for review and comment. Recommendations shall be finalized based on the comments received, including discussion at meetings of the full Committee.

c. Final recommendations shall be incorporated into the annual report and forwarded to the Mayor. Interim recommendations may be forwarded to the affected entities for expeditious implementation, at the approval of the Committee.

d. Representatives of agencies, institutions and programs may be invited to full Committee meetings to present their plans for, or progress made towards, implementing the recommendations.

XVII. COMPENSATION

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

XVIII. ADMINISTRATION

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

CAUSES OF DEATH - 2007 MRDD FRC DEATHS REVIEWED

2006 Deaths Reviewed:

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

2007 Deaths Reviewed:

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

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

ACKNOWLEDGEMENT

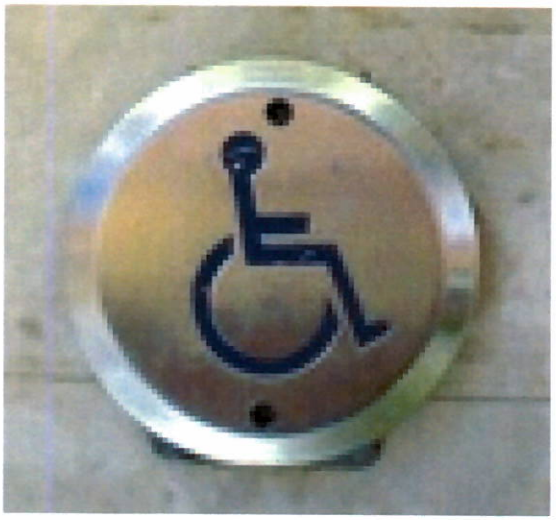
We wish to acknowledge the dedication and unwavering support of the public servants, private agency/program representatives, university, and community volunteers who serve as members of the District of Columbia Mental Retardation and Developmental Disabilities Fatality Review Committee. It is an act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

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

DISTRICT OF COLUMBIA

MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES FATALITY REVIEW COMMITTEE

2006 ANNUAL REPORT



Adrian M. Fenty, Mayor
Government of the District of Columbia

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

TABLE OF CONTENTS

INTRODUCTION

The 2006 Annual Report is a summary of the work performed by MRDD FRC. It covers data that is specific to 21 decedents diagnosed with intellectual and developmental disabilities (MRDD) who received services from DDS and whose deaths occurred during calendar years 2002 through 2006. It also provides descriptive statistics of 30 individuals who died during 2006 calendar year and received supports from DDS.

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

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

The fatality review process includes examination of relevant policies and statutes, independent investigative reports, and reports of forensic autopsies. This information highlights each deceased individual's social history, including family and care giver relationships, as well as living conditions prior to death; medical diagnosis and history; services provided; and cause and manner of death. These reviews examine compliance with District laws and regulations, agency policies and practices, and recommendations by service providers. Many reviews result in the identification of systemic problems and gaps in services that may impact the consumers' quality of life. The Committee recommends systemic strategies to reduce the number of preventable deaths or improve the quality of life for persons diagnosed with an intellectual or developmental disability who were under the care of DDS.

The District of Columbia Code defines mental retardation as a significantly "sub-average general intellectual level" determined in accordance with standard measurements as recorded in the Manual of Terminology and Classification in Mental Retardation, 1973.[1] DDS's eligibility criteria for identification of persons with mental retardation are:

1. Current cognitive assessment (within 3 years prior to application date) with accepted IQ test scoring 75 or below.
2. Current adaptive assessment (within 3 years prior to application date) showing adaptive functioning in the Mild range or below, or indicating that the individual needs supports in at least 2 out of 10 areas of adaptive living.
3. A cognitive assessment before the age of 18 years showing IQ of 75 or below.

[1] D.C. Official Code *§7-1301.03(19) (2001)*

Table 2: FRC Cases Pending Review

Year	Number of Deaths By Year N=189	Number Of Cases Reviewed By Year	Number of Cases Pending Review N=57
2006	30	6	24
2005	34	24	10
2004	36	26	10
2003	31	23	8
2002	26	21	5
2001	32	32	0
Total	189	132	57

SUMMARY OF 2006 CASE REVIEW FINDINGS

The information contained in this section will cover the data and findings that resulted from cases reviewed during calendar year 2006 (N=21). Data in these tables also clearly specifies the year of the death although the review occurred during 2006.

AGE/GENDER AND MORTALITY

In calendar year 2006, the FRC reviewed the deaths of 21 persons diagnosed with MRDD who ranged in age from 19 to 86 years Of the 21 deaths reviewed, twenty-nine percent (N=6) were 61 years of age and older. Thirty-three percent (N=7) were between the ages of 51 through 60 years, and twenty-nine percent (N=6) were ages 41 through 50. There was one decedent in each age category of 31 through 40, and 18 through 20 years. There were no decedents in the 21 through 30-year age range.

Based on a seven year review of MRDD FRC data (2000 through 2006), the largest number of deaths involved individuals 61 years of age and older. Overall, the relationship between mortality and age has continued, since 2000, to support the expected trend of mortality increasing with age. After the age of 50 years, the death rate increases dramatically, in line with the overall population trends. The average age of death for calendar years 2000-2006 was 57 years.

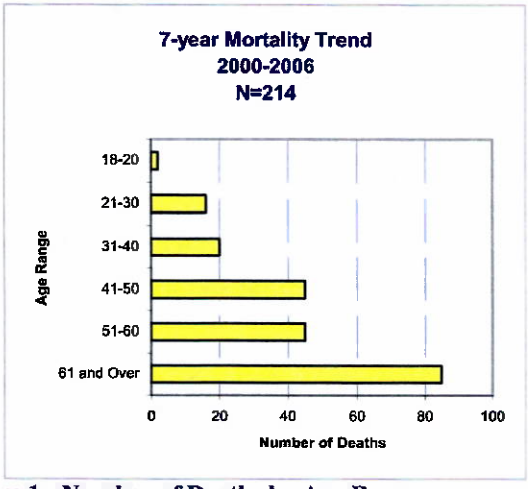


Figure 1: Number of Deaths by Age Range

WARD DATA

Ward of residence refers to the decedent's residential address at the time of the death. Addresses include natural homes, foster homes, Intermediate Care Facilities for persons with mental retardation (hereinafter referred as ICF/MR), supervised apartments, group homes, and nursing homes.

Table 5: Ward/Jurisdiction of Residence at Time of Death (N=21)

District Ward/ Jurisdiction District	Deaths Reviewed by Calendar Year N=21				
	2002 N=2	2003 N=2	2004 N=1	2005 N=10	2006 N=6
One	0	1	0	1	0
Two	0	0	0	0	0
Three	0	0	0	0	0
Four	0	0	0	1	1
Five	0	0	0	0	1
Six	1	0	0	3	1
Seven	0	0	1	2	1
Eight	0	0	0	1	0
Maryland	1	1	0	2	1
Virginia	0	0	0	0	1

Table 5 illustrates the decedents' ward or jurisdiction of residence at the time of death by year of death for the total number of cases (N=21) reviewed in 2006. Of the deaths reviewed, 15 decedents resided in the District and six resided in Maryland or Virginia. Of the District residents, the largest numbers of decedents reviewed resided in Wards Six and Seven (N=9).

Decedents Residing in the District of Columbia

- Of the two 2002 decedents, one (50%) lived in Ward Six of the District. This decedent was a 31-year-old Black male who lived in a nursing home.
- Of the two 2003 decedents, one (50%) lived in Ward One of the District. This decedent was a 50-year-old Black male who resided in an ICF/MR.
- The 2004 decedent (N=1) lived in the District. This decedent was a 68-year-old Black female who resided in an ICF/MR in Ward Seven.
- Of the 2005 decedents (N=10), eight (80%) lived in the District, in Wards One, Four, Six, Seven, and Eight. One (12.5%) consumer lived in a nursing home, one (12.5%) lived in their natural home, three (37.5%) resided in a group home setting, and three (37.5%) resided in an ICF/MR. The race of these decedents included six Blacks (75%) and two Whites (25%) with their ages ranging from 41 to 86 years.
- Of the 2006 decedents (N=6), four lived in Wards One, Four, Five, Six, and Seven of the District. Three of the decedents lived in an ICF/MR (75%) and one (25%) lived in a supervised apartment setting. Two of the decedents were Black (50%), and two were White (50%) ranging in age from 59 to 79 years.

District of Columbia (see OCME Annual Reports 2003 through 2006), diseases of the cardiovascular system predominate as the most prevalent cause of death in the DDS population reviewed. Table 7 lists the proximate causes of death or the underlying pathological condition responsible for the demise in the 21 decedents whose cases were reviewed. The cause of death, as listed below, can bring death about by different mechanisms or terminal events such as arrhythmia, bronchopneumonia, asphyxia, etc.

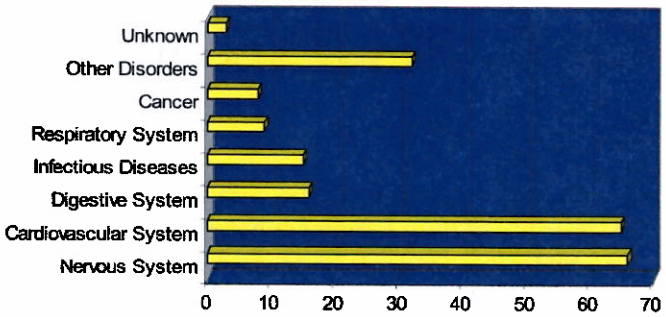
Table 7: Cause of Death

Cause of Death	Number of Deaths N=21
Cardiovascular Diseases	7
Primary Neurologic Disease	5
Cancer	2
Infectious Diseases	2
Gastrointestinal System Disorders/Conditions	2
Primary Pulmonary Conditions	2
Choking	1

As Table 7 illustrates, Hypertensive Cardiovascular Diseases were the most prevalent in the population reviewed. They were also a contributing factor in three cases. The primary disorders of the Nervous System resulted in five deaths. Seizures were the mechanism of death in three of the deaths and were contributing factors in another three deaths. Ailments of the Respiratory System were responsible for two deaths, one of which was due to complications of Sarcoidosis. In two cases, death was due to infectious diseases, and of these cases, one case was due to Acquired Immune Deficiency Syndrome. There were two cases of cancer (stomach and ovary). Two deaths were caused by disorders of the digestive system, and finally, choking due to aspiration of food material into the airway was the cause of death of one decedent.

As Figure 7 illustrates, a review of the deceased MRDD population spanning calendar years 2000-2006 revealed that the majority of the decedents succumbed to disorders of the nervous system (N=66 or, 31%). Diseases of the cardiovascular system were the second leading cause with 65 cases (30%). Illnesses of the gastrointestinal system (N=16, or 7%) and infectious diseases (N=15, or 7%) remained the third and fourth leading causes of death respectively in this population.

Figure 7: Leading Causes of Death
Leading Cause of Death 2000-2006
N-214



Disorders of the respiratory system were the fifth leading cause with nine fatalities (4%), followed by eight cases of cancer. Thirty-two cases (15%) were categorized as other disorders to include: blood diseases, choking on food material, diabetes mellitus, morbid obesity, motor vehicle accidents, complications resulting

Table 9: Manner of Death by Year

Manner of Death	N=21					Percentage
	2002 N=2	2003 N=2	2004 N=1	2005 N=10	2006 N=6	
Natural	2	2	1	9	6	95%
Accident	0	0	0	1	0	5%

As shown in Table 9, the majority (N=20, or 95%) of the deaths reviewed was determined to be Natural; one (5%) was Accidental. There were no fatalities attributed to Suicide, Homicide or Undetermined manners of death.

Cerebral palsy (CP) is divided into four major classifications to describe the different movement impairments. These classifications reflect the area of brain that has been damaged. The four major classifications are:

Spastic: By far the most common type of CP, occurring in about 70% of all cases. Persons with this type are hypertonic and have an essentially neuromuscular condition stemming from damage to the corticospinal tract, motor cortex, or pyramidal tract that affects the nervous system's ability to receive gamma amino butyric acid in the area(s) affected by the spasticity.

Athetoid: Also called dyskinetic, mixed muscle tone, or hypertonia. Individuals with athetoid CP have trouble holding themselves in an upright, steady position for sitting or walking, and often show involuntary motions. Because of their mixed tone and trouble keeping a position, they may not be able to hold onto things (like a toothbrush or fork or pencil). About one-fourth of all people with CP have the athetoid type.

Ataxic: Damage to the cerebellum which results in problems with balance, especially while walking. It is the most unusual (rare) type, occurring in at most 10% of all cases. Some of these individuals have hypertonia and tremors. Motor skills like writing, typing, or using scissors might be difficult and it is common for these individuals to have difficulty with visual or auditory processing of objects and instability in balance and relation to gravity.

Mixed: In 30 percent of all CP cases, the spastic form is found along with one of the other types. CP's resultant motor disorder(s) are sometimes, though not always, accompanied by "disturbances of sensation, cognition, communication, perception, and/or behavior, and/or by a seizure disorder"

Although CP is a non-progressive disorder, meaning the actual brain damage does not worsen, the symptoms can become worse over time due to 'wear and tear' and secondary deformities, such as hip dislocation and scoliosis of the spine, are common. Each type of CP is characterized by abnormal muscle tone, posture, reflexes, or motor development and coordination. The classical symptoms are spasticity, unsteady gait, and dysarthria, and soft tissue findings consisting largely of decreased muscle mass, but taken on the whole, CP symptomatology is as diverse as the individuals who have it. People who suffer from CP tend to develop arthritis at a younger age due to secondary symptoms such as seizures, spasms, and other involuntary movements, speech or communication disorders, hearing or vision impairments, cognitive disabilities, learning disabilities, and/or behavioral disorders.

There is mental retardation in 60% of the cases of CP, due to brain damage, and survival has been shown to be associated with the ability to ambulate, roll, and self-feed. Treatment and therapy may include physical, occupational, and speech therapy; drugs to control seizures, alleviate pain, relaxing muscle spasms, and contracting muscles; surgery to correct anatomical abnormalities or release tight muscles; braces and other orthotic devices; wheelchairs and rolling walkers; and communication aids such as computers with attached voice synthesizers. Overall, cerebral palsy ranks among the most costly congenital conditions in the world to manage effectively.[5]

[5] "Cerebral Palsy." (National Center on Birth Defects and Developmental Disabilities, October 3, 2002), www.cdc.gov

Total N=100	Level of Disability	Percentage of Population	No Risk Factors Identified	Mobility Limitations	Feeding Impairments	Both Risk Factors
Mild	13	13%	7	3	3	1
Moderate	20	20%	8	10	2	0
Severe	22	22%	8	13	4	3
Profound	45	45%	9	34	20	18

- Of the 45 decedents classified as profoundly retarded, 34 (75%) had mobility limitations; 20 (45%) had feeding impairments; 18 (41%) of the decedents experienced both risk factors; and nine (20%) of the decedents had none of the identified risk factors.
- Of the 22 decedents classified as severely retarded, 13 (59%) had mobility limitations; four (18%) had a feeding impairment; three (14%) of these decedents experienced both risk factors; and eight (36%) of the decedents had none of the identified risk factors.
- Of the 20 decedents classified as moderately retarded, 10 (50%) had mobility limitations; two (10%) had a feeding impairment; none of this group had both risk factors; and eight (40%) had none of the identified risk factors.
- Of the 13 decedents classified as mildly retarded, three (23%) of the decedents had mobility limitations[8]; three (23%) had a feeding impairments; one (7%) had both risk factors present; and seven (54%) had none of the identified risk factors

As highlighted in Table 11, in line with expected trends, the relationship between level of mental retardation and mortality shows that persons with the most significant disabilities and health care needs (severe and profound, N=66 (67%) had a higher rate of mortality during 2004 through 2006 calendar years. Overall, 68% of the decedents (N=67) had at least one of the identified risk factors associated with increased mortality.

[8] Mobility limitations include the use of adaptive equipment, and/or wheelchair-dependent.

Fatality Review Committee Handbook
Mayor's Order

Mental Retardation Developmental Disabilities Review Committee

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

Mayor's Order 2005-143
September 30, 2005

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

ORIGINATING AGENCY: Office of the Mayor

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

I. **RE-ESTABLISHMENT**

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

II. **PURPOSE**

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

2. A process by which fatality cases are screened and selected for review;

3. A method for ensuring that all information identifying District wards over the age of 18 years with mental retardation or a developmental disability, their families and others associated with the cases or the circumstances surrounding the deaths, including witnesses and complainants, is protected against undue disclosure. This is to ensure that steps are taken to protect the right to privacy of an individual and his or her family in conducting investigations, disseminating information to Committee members, reporting as required by the Mayor's Order, and maintaining case records for the Committee;

4. A method for gathering individual and cumulative data from the reviews;

5. A method for reviewing whether recommendations generated by the Committee are being implemented and identifying problems related to obstacles/barriers to implementation; and

6. A method for evaluating the work of the Committee that takes into account community responses to the deaths of District wards with mental retardation or a developmental disability.

b. On or about December 31st of each year, producing an annual report that provides information obtained from the reviews of deaths that occurred during the previous calendar year. The annual report shall be submitted to the Mayor and made available to the public. The information to be contained in the report shall include at a minimum:

1. Statistical data on all fatalities of District wards with mental retardation or a developmental disability reviewed by the Committee, including numbers reviewed, demographic characteristics of the subjects, and causes and manners of deaths;

2. Analyses of the data generated by the reviews, to demonstrate the types of cases reviewed (which may include illustrative case vignettes without identifying information), similarities or patterns of factors causing or contributing to the deaths, and trends (including temporal and geographic); and

3. Recommendations generated from the reviews, including service enhancements, systemic improvements or reforms, and changes in laws,

B. Two (2) physicians who practice in the District with experience in the evaluation and treatment of persons with mental retardation or developmental disabilities;

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

VI. **TERMS**

a. Public members appointed to the Committee shall serve for three (3) year terms, except that of the members first appointed, one-half shall be appointed for three (3) year terms and one-half for two (2) year terms. The date on which the first members are installed shall become the anniversary date for all subsequent appointments.

b. Members appointed to represent District government agencies shall serve only while employed in their official positions and shall serve at the pleasure of the Mayor.

c. A public member shall not serve more than two (2) consecutive full terms.

d. A member appointed to fill an unexpired term shall serve for the remainder of that term.

e. A member may hold over after the member's term expires until reappointed or replaced.

f. A public member may be excused from a meeting for an emergency reason. A public member who fails to attend three (3) consecutive meetings shall be deemed to be removed from the Committee, and a vacancy created. Such vacancies shall be filled by the Mayor as outlined in section V of this Mayor's Order.

g. A public member may be removed by the Mayor for personal misconduct, neglect of duty, conflict of interest violations, incompetence, or official misconduct. Prior to removal, the public member shall be given a copy of any charges and an opportunity to respond within 10 business days following receipt of the charges. Upon a review of the charges and the response, the Director of the Office of Boards and Commissions, Executive Office of the Mayor, shall refer the matter to

c. Case review meetings of the full Committee shall be held monthly, if there are cases for review. After procedures have been established and tested, the Committee may consider holding case review meetings every other month (bi-monthly), if practicable. The full Committee may also convene additional meetings as needed for additional case reviews, or for other specific purposes of the Committee, including the development of recommendations or preparation of the annual report.

d. The Committee shall conduct multi-disciplinary reviews of the events and circumstances surrounding the deaths of District wards over the age of 18 years with mental retardation or a developmental disability as defined in section II, above, in order to provide the data to fulfill the purposes and duties of the Committee as enumerated in sections II and III, respectively.

e. Case reviews will occur at the first Committee meeting after the Committee receives notification of the fatality, or at the first meeting after sufficient materials are received for conducting the review. The review may be preliminary, pending conclusion of the investigation and prosecution, or release by the prosecutor to conduct the review, at which time a comprehensive review shall be conducted.

f. The case review process shall include presentation of the case summary, followed by presentations of relevant information concerning the death by any agencies or persons involved with District wards over the age of 18 years with mental retardation or a developmental disability or investigating the event.

g. Following presentation of the facts, the Committee will discuss the case and any issues that it raises, guided by the following principles and questions:

1. What factors or circumstances caused or contributed to the death? (This may include consideration of social service delivery and coordination to District wards over the age of 18 years with mental retardation or a developmental disability and their families and compliance with, or development of, applicable or needed laws, procedures and regulations.)

2. What responses and investigations resulted from the death? (This includes whether all necessary agencies were notified and responded, and whether any corrective actions were instituted.)

1. By a special process server, at least 18 years of age, designated by the Committee from among the staff of the Committee or any office or organization designated by the Committee; provided, that the special process server is not directly involved in the investigation; or

2. If, after a reasonable attempt, personal service on a witness or witness' agent cannot be obtained, a special process server identified in paragraph (1) may serve a subpoena by registered or certified mail not less than eight (8) business days before the date the witness must appear or the documents must be produced.

3. If a witness who has been personally summoned neglects or refuses to obey the subpoena issued pursuant to this section, the Committee may apply to the Superior Court of the District of Columbia for an order compelling the witness so summoned to obey the subpoena.

XI. **CASE REVIEW CRITERIA AND PROCEDURES**

a. All deaths of District wards over the age of 18 years with mental retardation or a developmental disability shall be reviewed by the Committee.

b. Factors of particular concern for review include:

1. All violent or unexplained manners of death (i.e., homicide, suicide, accident or undetermined), which include all deaths caused by injuries, including:

A. Fractures;

B. Blunt trauma, including fractures;

C. Burns;

D. Asphyxia or drowning;

E. Poisoning or intoxication;

F. Gunshot wounds; or

G. Stabbing or cutting wounds;

5. Metropolitan Police Department (MPD);

6. Office of the Inspector General (OIG);

7. Office of the Attorney General (OAG);

8. Department of Health (DOH); and

9. Department of Mental Health (DMH).

b. Case notification reports should include for the affected District ward over the age of 18 years with mental retardation or a developmental disability:

1. Demographic data (name, age/date of birth, race, gender);

2. Address;

3. Parents/guardians;

4. Circumstances of the death (date, time, location, activities, risk factors, witnesses or sources of information);

5. Agencies investigating the death; and

6. History of the involvement of government agencies or contacted service providers.

c. MPD, DHS (OIC and MRDDA), DOH and OIG shall provide the Committee copies of all death reports resulting from any investigations that are conducted concerning District wards over the age of 18 years with mental retardation or a developmental disability. The OCME shall provide the Committee copies of all autopsy reports resulting from autopsies and death investigations conducted on District wards over the age of 18 years with mental retardation or a developmental disability. These reports shall be provided within five (5) days after they are completed.

XIII. NOTIFICATION OF PARTICIPANTS

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

d. Methods for ensuring that all information identifying third persons such as witnesses, complainants, agency, institution, or program staff or professionals involved with the family are protected against disclosure are:

1. The same procedures established for District wards over the age of 18 years with mental retardation or a developmental disability and their families above shall be followed for these entities.

2. Access to primary documents will be limited to the staff of the Committee and the chair of the review meeting.

3. Initials only will identify third persons in materials for distribution.

XVI. RECOMMENDATIONS

a. Draft recommendations shall be developed by the Committee Coordinator based on issues raised during the reviews.

b. Draft recommendations shall be distributed to agencies and members for review and comment. Recommendations shall be finalized based on the comments received, including discussion at meetings of the full Committee.

c. Final recommendations shall be incorporated into the annual report and forwarded to the Mayor. Interim recommendations may be forwarded to the affected entities for expeditious implementation, at the approval of the Committee.

d. Representatives of agencies, institutions and programs may be invited to full Committee meetings to present their plans for, or progress made towards, implementing the recommendations.

XVII. COMPENSATION

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

XVIII. ADMINISTRATION

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

Appendix B

2006 MRDD FATALITY REVIEW RECOMMENDATIONS

During calendar year 2006, based on the review of 21 cases, the MRDD FRC made 26 new recommendations, and re-issued several recommendations from previous years. These recommendations focused on issues of guardianship, end-of-life preparedness, training, and health care. The FRC also made recommendations to improve timeliness for obtaining information and data required for reviews, and improve the District's overall review process, and collaborative methods of operating. Further, the FRC began to conduct a more thorough evaluation of the review process and operational modalities currently in place. It is the FRC membership's hope that this evaluation will assist in identifying systemic issues and concerns that are obstructive to the process, and assist in devising ways to streamline information to allow the FRC to operate more efficiently. The FRC recommendations issued in 2006 are as follows:

FRC Recommendation	Status
DDS should review care provided by hospitals and group homes, and provide a report of the findings to the FRC committee within ten (10) business days.	DDS responded timely with a written response to the investigative request.
DDS should ensure all individuals, especially those with medical conditions that will likely warrant ongoing diagnostic testing and medical treatment, have legally be appointed guardians who can assist in decision-making and prevent treatment delays.	Lengthy Response Received and on File
DDS should review this provider's current organizational structure to determine whether RN assignment provides a sufficient number of registered nurses to ensure there is adequate health care oversight and LPN supervision.	DDS has completed the review of the provider's organizational structure to determine whether there was sufficient RN supervision of the LPN.
DDS should hire an independent contractor to review a sample of ISP's to ensure the quality of the documentation and care.	DDS will take the "Person Centered Agenda" forward in partnership with key stakeholders, public and private, that are interested in developing a more responsive and individualized person-centered plan.
DDS should proactively review end-of-life planning in the ISP for all consumers, along with guardianship/decision-maker at least on an annual basis.	DDS has revised the Individual Support Plan (ISP) to incorporate the decision-making process that allows guardians to support individuals in making appropriate decisions for the care of the individuals that lack the capacity to make decisions for themselves.
DDS should consider mandatory training on end-of-life issues for all staff	DDS provide a comprehensive curriculum of resources, and materials aimed at enhancing the skills of staff involved in end-of-life and critical care issues. The training includes didactic presentations on pain related issues (see attachment 1:Pain Management Presentation), and guardianship for health care decisions
DDS should develop an agreement with their providers to legally	In lieu of developing an agreement with providers, a formalized agreement will be

MRDD FRC.	Review meetings. DDS will invite agency representatives as requested to FRC meetings beginning January 2008.
DDS should contact the Epilepsy Foundation regarding smoking cessation guidelines and educational material for consumers with seizures.	DDS will direct the Health and Wellness Unit Manager to do so in January 2008.
DDS should incorporate an on-going training program for all clinical and direct-care staff, to include documentation, nutritional and pain management curriculums.	Lengthy Response Received and on File
DDS should conduct training on the proper transfer of records and consumer information via the medical passport when consumers are transferred between hospitals and other long-term care facilities.	This information is thoroughly covered in the DDS mandated Medical/Dental policy training for all staff working with people with disabilities.
DDS should seek measures to maintain consumers in one hospital/facility (regardless of the number of emergency admissions, as appropriate) to maintain continuity of care.	Pending Response: Recommendations required amendment
DDS should establish policies and practices that require staff to contact the primary care physician for emergency admissions to allow direct admission to a hospital to prevent and/or reduce emergency room visits.	DDS commits to support this practice beginning immediately through case management, clinical standards, and training.
DDS should instruct all providers and staff to contact 911 (EMS) immediately upon signs of respiratory distress.	DDS guidance to providers clearly requires agency staff to contact 911 in the event of respiratory distress. DDS through the Training Dept., Case Management, and Quality Enhancement will reiterate this requirement through training, case management, and technical assistance activities.
DDS should include the requirement of a complete medical passport (with periodic updated data) for each consumer is included in the Provider's contractual agreement with the District.	DDS is implementing a Basic Assurance Standards Authorization process.
DDS should continue its efforts to ensure those consumers in need of a guardian are accommodated.	Efforts to gain guardianship and/or alternative decision makers for people who need them are an ongoing priority and part of the delivery system.

Appendix D

GLOSSARY OF TERMS

	Definition
Age	The length of somebody's or something's existence: the length of time that somebody or something has existed, usually expressed in years
Autopsy Report	A detailed report consisting of the autopsy procedure, microscopic and laboratory findings, a list of diagnoses, and a summary of the case
Cause of Death	The underlying pathological condition or injury that initiates the chain of events which brings about the demise
Cerebral Palsy	An umbrella term encompassing a group of non-progressive, non-contagious neurological disorders that cause physical disability in human development, specifically movement and posture
CRF	Community Residential Facility for individuals diagnosed with an intellectual disability (MR)
Gender	The sex of a person or organism (male or female), or of a whole category of people or organisms
Group Home	Licensed homes for persons with mental retardation that range in size from four (4) to eight (8) customers
Hospice	A program or facilities that provide special care for people who are near the end of life and for their families
Hospital	An institution where people receive medical, surgical, or psychiatric treatment and nursing care
ICF/MR	A licensed residential facility, which is certified and funded through Title XIX (Medicaid) for consumers diagnosed with an intellectual disability (MR)
Leading Cause of Death	The largest number of deaths for all ages by cause.
Level of Disability	Cognitive and adaptive impairment ranging from mild to profound
Life Expectancy	The average expected length of life: the number of years that somebody can be expected to live
Manner of Death	Events surrounding the death
Mental Retardation	Below-average general and intellectual level of functioning
Natural Home	Consumers residing in the home of a parent, family members or independently
Neurologic Conditions	Disorders of the neuromuscular system: The central, peripheral, and autonomic nervous systems, the neuromuscular junction, and muscles

ACKNOWLEDGEMENT

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

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

District of Columbia

Mental Retardation and Developmental Disabilities

Fatality Review Committee

2005

Annual Report

Special Edition

Presented to

Anthony A. Williams
Mayor

Edward D. Reiskin
Deputy Mayor for Public Safety and Justice

EXECUTIVE SUMMARY

The Mental Retardation and Developmental Disabilities Fatality Review Committee presents the 2005 Annual Report/Special Edition. The Mental Retardation and Developmental Disability Fatality Review Committee was established in February 2001, by Mayor's Order 2001-27 and re-established in September of 2005 by Mayor's Order 2005-143. The Mayor's Order 2005-143 mandates that the Fatality Review Committee examine events that surround the deaths of individuals 18 years of age and older diagnosed with mental retardation and other developmental disabilities, which are wards of the District of Columbia or receiving care from the Mental Retardation and Developmental Disabilities Administration.

The Fatality Review Committee is comprised of members who represent public and private community organizations from a broad range of disciplines including health, mental health, education, mental retardation, social services, public safety, legal, and law enforcement. These individuals come together as a collective body for the purpose of examining and evaluating relevant facts associated with services and interventions provided to deceased persons diagnosed with mental retardation and other developmental disabilities.

During calendar year 2005, 34 persons died who were diagnosed with mental retardation and other disabilities and served by the Mental Retardation and Developmental Disabilities Administration. The Fatality Review Committee reviewed 31 cases during the same calendar year. These reviews represented deaths that occurred during calendar years 2003 through 2005. During the fatality review meetings, the FRC examines an independent investigative report of each individual's death that includes a summary of the forensic autopsy report. The reports highlight each deceased individual's social history, including family and care giver relationships and living conditions prior to death; medical diagnosis and medical history; services provided; and cause and manner of death. Many of the fatality reviews lead to the identification of systemic health care and other service concerns. The Fatality Review Committee makes recommendations to promote comprehensive health care and improve the quality of life for persons diagnosed with mental retardation and other disabilities.

Recommendations made by the Fatality Review Committee, during the period covered by this report, related primarily to coordination of care, case record documentation, and end of life issues. The recommendations impact policy, legislative principles, clinical practice, community resources, and city budget allocations.

Summary of Findings for Deaths Reviewed in 2005

- **97% of the cases reviewed were autopsied**
- **97% of the deaths were attributed to natural causes**
- **43% of the decedents were over the age of 60 years**
- **81% of the decedents died in a hospital setting**
- **100% of the Fatality Review Committee's recommendations received responses**

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

MRDD FATALITY REVIEW PROCESS

Since its establishment in 2001, the FRC has had the opportunity to evaluate some of the operational deficiencies and barriers associated with the fatality review process and the MRDDA system. These barriers have often impacted the FRC's ability to operate effectively, efficiently, and in the manner intended. The FRC members realize that many of the concerns that have surfaced are the result of an inability to anticipate the challenges associated with diversity of the distinct operating structures, laws, policies and practices of the various disciplines and agencies, which may conflict with the purpose and goal of the committee. Some of the more critical system obstacles include the following:

- **Document Ownership**

Since the creation of the FRC, there has been persistent confusion related to the distinction between the oversight operating structure provided by the Office of the Chief Medical Examiner (OCME) and related protocols for the FRC and the agency responsible for servicing the decedent population covered by the FRC, MRDDA. The FRC operates under the auspices of the OCME Examiner with oversight responsibility provided by the Deputy Mayor for Public Safety and Justice. The OCME has responsibility for the effective implementation of all fatality review processes that operate within the District, including MRDD, Domestic Violence, and Child Fatality Review Committees. The OCME Fatality Review Unit carries out these responsibilities.

The confusion has resulted in numerous problems for the FRC and has culminated in the need to clarify the roles and responsibilities of each group specifically related to the fatality review function, the lines of authority, confidentiality, public disclosure of information, the custody and maintenance of fatality review documents and related material, and other mandated reporting as required.

The FRC is responsible for conducting multidisciplinary, multi-agency reviews of only those deaths of individuals who were committed to and are under the care of MRDDA. This Administration, under the auspices of the Department of Human Services, and the Deputy Mayor for Children, Youth, Families and Elders, continues to serve as the primary public agency responsible for providing comprehensive

reviews timely, determine appropriateness of the services provided, and make appropriate recommendations for services, polices, and legislative improvements. At the close of 2005, 48 deaths occurred between calendar years 2002 and 2005 that were out of compliance with the case review timeframes; due to investigative reports not completed for review by the FRC.

- **FRC Recommendations**

The fundamental goal of the fatality review process is to identify issues which impact citizens with mental retardation and intellectual disabilities, and practices that would reduce the number of preventable deaths and improve the overall quality of life. Thus, during case review meetings, risk factors, systems gaps/issues, and broad prevention strategies are highlighted. Historically, the majority of FRC recommendations have been geared towards improving services provided by MRDDA, its contractors, and other service providers. These recommendations are driven by the case-specific facts and information, including circumstances leading to and surrounding the individual's death. Once adopted by the FRC, they are forwarded to the appropriate public and private agencies and programs for consideration and response.

The FRC has struggled with the challenge of devising an effective strategy for assuring acceptance and implementation of recommendations. The FRC has established a mechanism for tracking and monitoring responses from relevant agencies and programs. Although responses to recommendations have increased, it has not resulted in ensuring that recommendations are implemented in a manner that affects broad systemic changes and improvements. As a result, the FRC continues to highlight problems that are directly related to appropriateness of care, compliance with policies, workforce development, end of life preparedness, guardianship concerns, and documentation.

The FRC has made recommendations to improve timeliness for obtaining information and data required for reviews, and improve the District's overall review process and collaborative methods of operating. Further, the FRC began to conduct a more thorough evaluation of the review process and operational modalities currently in place. It is the FRC's membership's hope that this evaluation will assist in identifying systemic issues and concerns that are obstructive to the process, and assist in devising ways to streamline information to allow the FRC to operate more efficiently.

SUMMARY OF CASE REVIEW FINDINGS

The information contained in this section will cover the data and findings that resulted from cases reviewed during calendar year 2005 (N=31). Data in these tables also clearly specifies the year of the death despite the fact that the review occurred during 2005.

- **AGE AND MORTALITY**

In calendar year 2005, the FRC reviewed the deaths of 31 persons diagnosed with MRDD who ranged in age from 19 to 93 years. As with previous FRC years, the largest number of deaths identified and reviewed involved individuals who were over the age of 60 years. Of the 31 deaths reviewed, forty-three percent (N=13) were 61 years of age and older, Twenty-six percent (N = 8) were between the ages of 51 through 60 years; eighteen percent (N= 6) were ages 41 through 50; six percent (N=2) were 31 through 40, and three percent were between the ages of 21 through 30 (N=1) and three percent were 18 through 20 years (N=1). Table 3 below depicts the age ranges of the decedents by gender. As illustrated, there was no significant statistical difference in the number of male and female persons who died (N=15 and 16 respectively).

Figure 2: Age of Decedents Reviewed

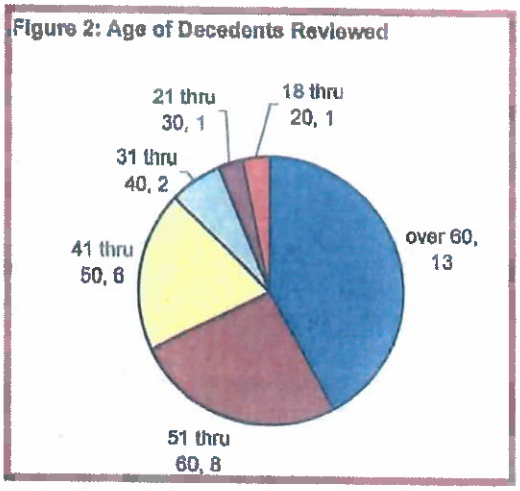


Table 3: Decedents by Age Range and Gender of Cases Reviewed (N=31)

Age Range	2003 N=5		2004 N=12		2005 N=14	
	Male N=3	Female N=2	Male N=4	Female N=8	Male N=8	Female N=6
18-20	1	0	0	0	0	0
21-30	1	0	0	0	0	0
31-40	0	0	1	1	0	0
41-50	0	0	1	1	3	1
51-60	1	0	1	2	2	2
61-over	0	2	1	4	3	3

Of the 2003 deaths reviewed (N=5), three were males who ranged in age from 19 to 57 years, and two were females who ranged in age from 65 to 84. Of the 2004 deaths reviewed (N=12), four were males who ranged in age from 37 to 68 years, and eight were females who ranged in age from 34 to 93 years. Of the 2005 decedents (N=14), eight were males who ranged in age from 41 to 75 years, and six were female who ranged in age from 48 to 87 years.

Table 5: Ward/Jurisdiction of Residence at Time of Death (N=31)

District Ward/ Jurisdiction	Deaths by Calendar Year		
	2003 N=5	2004 N=12	2005 N=14
One	1	0	0
Two	0	0	1
Three	1	0	0
Four	1	3	1
Five	0	2	0
Six	0	0	0
Seven	1	5	7
Eight	0	2	3
Maryland	1	0	1
Virginia	0	0	1

The largest number of deaths reviewed involved decedents who resided in the District of Columbia at the times of their deaths (N=28 or 90%). Three decedents had been placed by MRDDA in out-of-state facilities in Maryland and Virginia.

- **Decedents Residing in the District of Columbia**

- Of the 28 decedents who resided in the District at the time of their deaths, the largest number resided in Wards Four, Seven and Eight (N=23, or 82%) with the majority of these decedents residing in Ward Seven (N=13, or 46%).
- Of the five 2003 decedents, four (80%) lived in District, residing in Wards One, Three, Four and Seven. Three decedents (60%) lived in ICF/MR facilities and one decedent (20%) in a group home setting. The race of these four decedents included three Blacks and one White with their ages ranging from 19 to 84 with the majority over the age of 50 years (N=3).
- All of the 2004 decedents (N=12) lived in the District, residing in Wards Four, Five, Seven and Eight. Three decedents (25%) resided in Ward Four; two (16%) in Ward Five; five (42%) in Ward Seven, and two (16%) in Ward Eight. Of these decedents, eight (67%) lived in ICF/MR facilities, one (8%) in a group home facility, one (8%) in foster care, one (8%) in a nursing home and one (8%) at St. Elizabeth hospital. The race of the 12 decedents included nine Blacks and three Whites with their ages ranging from 37 to 93 years with the majority over the age of 50 (N=8).
- Of the 2005 decedents (N=14), 12 (86%) lived in the District, residing in Wards Two, Four, Seven and Eight. One decedent (7%) resided in Ward One; one (7%) in Ward Four; five (36%) in Ward 7 and two (14%) in Ward Eight. Six decedents (43%) lived in nursing home facilities and six (43%) in ICF/MR facilities. The races of these decedents included eleven Blacks and one White with their ages ranging from 41 to 87 with the majority over the age of 50 (N=8).

- Of the 2003 decedents (N=5), the District's OCME accepted jurisdiction and performed autopsies on three decedents (60%) and Maryland and Virginia each conducted one autopsy.
- Of the 2004 decedents (N=12), OCME accepted jurisdiction and performed autopsies on 11 decedents (92%) and one case was not autopsied.
- Of the 2005 decedents (N=14), OCME accepted jurisdiction and performed autopsies on 12 (86%) and one case was autopsied in Maryland and Virginia respectively.
- For all years combined (2003, 2004 and 2005), five autopsies (16%) were performed in out-of-state facilities, and in one case (3%) no autopsy was performed.

- **Cause of Death**

Consistent with observations in the general population of Washington, DC (see OCME Annual Reports 2003 and 2004), diseases of the cardiovascular system predominate as the most prevalent cause of death in the MRDD population reviewed. Ten cases were the result of Hypertensive and/or Atherosclerotic Cardiovascular disease; and one death was the result of Valvular Disease of the heart (Mitral Valve Insufficiency).

Table 7 lists the proximate causes of death or the underlying pathological condition responsible for the demise in the 31 cases reviewed. The cause of death[4], as listed below, can bring death about by different mechanisms or terminal events such as arrhythmia, bronchopneumonia, asphyxia, etc.

Table 7: Cause of Death

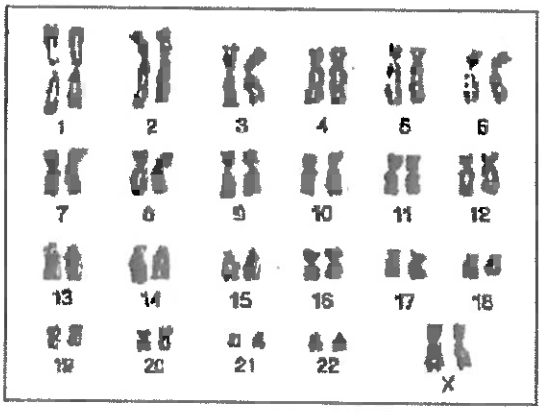
Cause of Death	Number of Deaths N=31
Cardiovascular Diseases (Hypertension, Atherosclerosis, and Mitral Valve Insufficiency)	11
Infectious Diseases	6
Cancer (breast, ovary, and esophagus)	3
Primary Neurologic Disease	3
Gastrointestinal tract	2
Primary Pulmonary Conditions	2
Melodysplastic Disorder	1
Morbid Obesity	1
Therapeutic Complications	1
Chocking (due to aspiration of a bolus of food)	1

The results in Table 7 indicate that infectious diseases followed Cardiovascular disorders in number with six deaths; 4 involving the respiratory system; one, the urinary tract; and

[4] Cause of death is defined as the underlying pathological condition or injury that initiates the chain of events which brings about the demise.

Down Syndrome: An Educational Overview

Each year, the FRC would like to take the opportunity to share an educational overview of various disorders that affect the MRDD population in the District. This year, we present an educational overview of Down syndrome. Down syndrome is defined as the most common and readily identifiable chromosomal condition associated with mental retardation and is caused by a chromosomal abnormality. For some unexplained reason, an accident in cell development results in 47 instead of the usual 46 chromosomes. This extra chromosome changes the orderly development of the body and brain. In most cases, the diagnosis of Down syndrome is made according to results from a chromosome test administered shortly after birth. Down syndrome is a genetic condition caused by extra genetic material (genes) from the 21st chromosome. Research has linked an association between a mother's age and the chances of having a baby with Down syndrome.



This is a picture of a normal set of chromosomes. Note the 22 evenly paired chromosomes plus the sex chromosomes. The XX means that this person is a female. The test in which blood or skin samples are checked for the number and type of chromosomes is called a karyotype, and the results look like this picture. The incidence of Down syndrome has been reported as 1 in 800 live births to 1 in 1,100 live births. A recent estimate in the United States puts the incidence at about 1 in 1,000. There is much speculation on the cause of Down syndrome due to chromosomal abnormalities. Nationally, the average of age of death of individuals with Down syndrome is 55.8 years. The Down Syndrome life expectancy has also been found to be dependent on the intelligence of the person with Down Syndrome. The Down Syndrome life expectancy of a 1-year-old child with Down syndrome with IQ 45 to 70-mild/moderate intellectual retardation is around 55 years. With IQ 19 or below - profound mental retardation - the Down syndrome life expectancy is about 43 years. (Based on research carried out by Strauss D, Eyman RK, 1996).

In the District of Columbia, the mean age of death for the six individuals diagnosed with Down Syndrome is 54 years, 8 months, about one year less than the national average. This average, 54-8, may be spuriously high. The range of age at death is from 45 years to 73 years, 3 months (R = 28-3) and the median is 52-2 (45, 47-8, 50-2, 54-4, 58-10 and 73-3). Obviously (for our sample of six decedents ages at death) there is a significantly high outlier. However, without knowing the number of cases, range, and median, of the national sample or population that the mean of 55.8 is based upon, we cannot know if our mean of 54.8 is significant (statistically).

- **Neuropsychiatric Disorders**

Table 9 provides a numerical summary of the first two axis' of the Mutiaxial System (DSM-IV-TR). Axis I is for reporting Clinical Disorders or conditions and Other Conditions That May Be a Focus of Clinical Attention. In addition, Axis I is for reporting Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence excluding Mental Retardation. Axis II is for reporting Mental Retardation and Personality Disorders. Mental Retardation has been distinguished by cognitive functioning, adaptive functioning and level of severity. When significant neurologic dysfunction is associated with other organ system anomalies, an individual's life expectancy may be shortened.

Table 9: Neuropsychiatric Disorders by Axis

Axis I		Axis II		
Disorders	Decedents N=10	Level of Severity	Decedents N=31	
			Cognitive	Adaptive
Intermittent Explosive Disorder	2	Mental Retardation Profound	12	14
Depressive Disorder NOS	1	Mental Retardation Severe	8	10
Dementia NOS	2	Mental Retardation Moderate	8	5
Psychotic Disorder	1	Mental Retardation Mild	3	2
Schizophrenia	3			
Organic Mood Disorder	1			

These are the various underlying Neuropsychiatric Disorders reported singularly or in combination in the 2005 (N=31) cases reviewed. The degrees of severity reflect the level of intellectual (cognitive) impairment. Of the deaths reviewed (N=31), twelve, (38%) were diagnosed with Profound Mental Retardation, eight (26%) were Severe, eight (26%) were Moderate, and three (10%) were Mild.

OVERVIEW FOR CALENDAR YEARS 2000 THROUGH 2005

During calendar year 2005, the FRC conducted a retrospective review of death trends from calendar years 1991 through 2005.[5] As in most retrospective reviews, a major barrier was locating data because some information was difficult to obtain or no longer existed. For example, many death certificates lacked information on type of residence where the decedent lived at the time of death, or information on health care interventions provided. Thus, as Table 10 illustrates, the FRC was able to gather partial information related to fatalities for calendar years 1991 through 1999. Due to these data gaps, the FRC was limited in its ability to fully analyze this information. Therefore, data from 1991 through 1999 calendar years is provided as a historical reference only and the major emphasis of this analysis focuses on more complete data for calendar years 2000 through 2005.[6]

Table 10: District of Columbia MRDDA Population and Deaths 1991 to 2005

Year	Population	Number of Deaths N=372	Percentage
2005	1993	34	1.7%
2004	1915	36	1.9%
2003	1790	31	1.7%
2002	1703	26	1.5%
2001	1547	32	2%
2000	1608	25	1.5%
1999	Unavailable	24	Unavailable
1998	1354	23	1.6%
1997	Unavailable	16	Unavailable
1996	Unavailable	17	Unavailable
1995	814	17	2%
1994	Unavailable	27	Unavailable
1993	Unavailable	15	Unavailable
1992	Unavailable	13	Unavailable
1991	Unavailable	36	Unavailable

- Results presented in Table 10 indicate the number of MRDD deaths between 2000 and 2005 (range 25 to 36), as well as data that could be gathered for years 1995-1999.
- It appears that deaths have historically represented 1.5% to 2% of the total MRDDA client population annually for years 2000 through 2005 (N=184).
- IMIU policies were first instituted in 1999. These policies mandated the reporting of all MRDDA consumer deaths and are still in existence.

[5] MCIS.
[6] MRDDA Death Listing from 1991- Sorted by Date

- **AGE AND MORTALITY**

Table 12 and Figure 4 below illustrate the number of deaths by age range for each year reviewed. The correlation between age and mortality shows the expected trend, with mortality increasing as the population served by MRDDA ages.

Figure 4

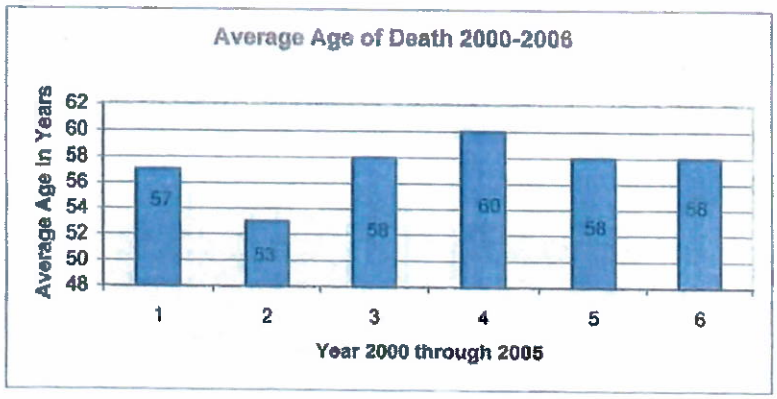


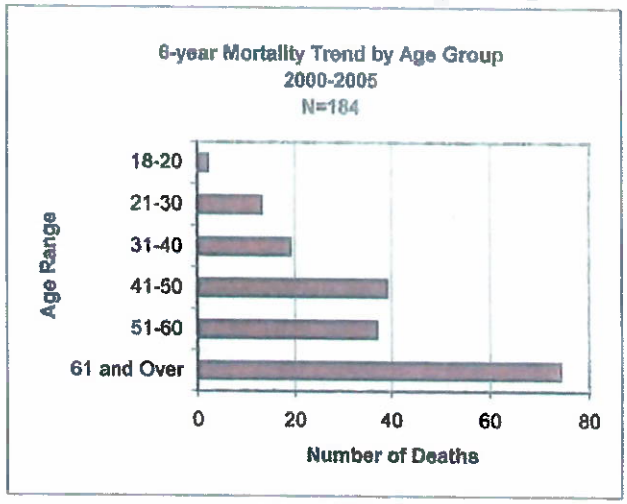
Table 12: Age and Mortality by Calendar Years 2000-2005

Age	2000 N=25	2001 N=32	2002 N=26	2003 N=31	2004 N=36	2005 N=34	Total N=184
18-20	0	0	0	2	0	0	2
21-30	2	4	1	4	1	1	13
31-40	5	6	3	0	4	1	19
41-50	4	5	7	6	7	10	39
51-60	2	5	3	7	10	10	37
60+	12	12	12	12	14	12	74

The largest number of deaths were of persons 61 years of age and older for each calendar year reviewed. Of the 184 deaths from 2000-2005, 74 or, 40% were 61 years of age or older; 37 or, 20% were ages 51-60; 39, or 21% were ages 41-50; 19, or 10% were ages 31-40; 13, or 7% were between 21-and 20; and 2, or less than 1% of the deaths were of individuals 18-20 years.

Overall, the relationship between mortality and age continued to show the expected trend of mortality increasing with age for the combined calendar years. After the age of 50 years, the death rate increases dramatically, in line with overall population trends.

Figure 5: Number of Deaths by Age Range



Life Expectancy in the District of Columbia
An Overview

According to the National Vital Statistic Report, 2002, life expectancy is a comparative measure of longevity often used to gauge the overall health of a population. Life expectancy is the average number of years remaining to be lived by those surviving to that age on the basis of a given set of age-specific death rates. However, life expectancy at birth represents the average number of years that a group of infants would live if the infants were to experience throughout life the age-specific mortality rates in a given period (Anderson et al., NCHS, 2002). Life expectancy at birth is strongly influenced by infant and child mortality. On the average, life expectancy at birth for the United States was 76.9 years in 2000, an increase of 0.2 years from 1999 (Minin et al., NCHS, 2002). Despite no increase in life expectancy between 1998 and 1999, the general trend observed in U.S. life expectancy has been upward throughout the 20th century (Anderson et al., NCHS, 1999).

There are marked differences in life expectancy at birth by race and gender for the total population of the U.S., with females tending to live longer than males and whites living longer than black/African Americans. For the U.S. in 2000, life expectancy for females was 79.5 years, while life expectancy for males was 74.1 years. Therefore females, on the average, lived 5.4 years longer than males. In 2000, life expectancy for whites was 77.4 years compared with the life expectancy for black/African Americans that was 71.7 years, a difference of 5.7 years between the white and black/African American populations.

Among the four major race-gender groups (Table 4), white females continued to have the highest life expectancy at birth (80.0 years), followed by black/African American females (74.9 years), white males (74.8 years), and black/African American males (68.2 years). Between 1999 and 2000, life expectancy increased 0.4 year for black/African American males from 67.8 years in 1999 to 68.2 in 2000. Black/African American males experience annual increases in 1990-1992 and 1994-2000 (NCHS, 2002). Life expectancy for black/ African American females climbed from 74.7 years in 1999 to 74.9 years in 2000, an increase of 0.2 year. From 1999 to 2000, life expectancy for white males increased 0.2 year from 74.6 years to 74.8 years. White female life expectancy increased during the same period by 0.1 year from 79.9 years to 80.0 years. Overall, the largest gain in life expectancy between 1980 and 2000 was for black/African American males (4.4 years).

The most current life tables published by the United States National Center for Health Statistics (NCHS) for the District of Columbia are for the average lifetime in years, 1989-1991. Therefore, from 1989-1991, the average three-year life expectancy at birth for the residents of the District of Columbia was 68.0 years, which was ranked 51 among the states. Nonetheless, the District of Columbia followed the general pattern of the United States females tend to live longer than males and whites live longer than black/ African Americans. For the District, the average life expectancy for females was 74.2 years or 12.2 years longer than males whose life expectancy averaged 62.0 years from 1989-1991. There are also similar differences in life expectancy at birth by race. Whites (76.1 years), on the average, lived 11.7 years longer than black/African Americans (64.4 years).

- **MORTALITY AND RESIDENCE**

The mortality and residential information in this section is provided to offer an overview of the type of residential settings of 184 decedents lived in at time of death.

Table 14: Residential Facilities

Facility Type N=184	2000 N=25	2001 N=32	2002 N=26	2003 N=31	2004 N=36	2005 N=34
Intermediate Care (ICF)	15	10	10	17	20	13
Nursing Home	1	10	5	6	9	11
Natural Home	4	5	2	2	2	5
Community Residential (CRF)	1	2	4	0	1	5
Other (Specialized home care,	4	5	5	6	4	0

As indicated in Table 14, of the 184 decedents, more resided in Intermediate Care Facilities (ICF/MR) than other residential facilities (85, or 46%) from 2000 through 2005. Forty-two decedents (23%) resided in nursing home facilities, 20, or 11% lived in their natural homes, thirteen, or 7% lived in Community Residential Facilities (CRF), and twenty-four, or 13% lived in Specialized Home Care (foster homes), supervised apartments or other settings.

- Of the 2000 decedents (N=25), 15 decedents lived in ICF/MR facilities. Twelve decedents resided in Ward Seven; one in Wards One and Four respectively, and one in Maryland. One decedent lived in a nursing home facility located in Ward Eight; four decedents lived in their natural homes three of which were located in Ward Four and one Ward Six. One decedent lived in a community residential facility in Ward Four; and two decedents lived in supervised apartments, one in Ward One and Four respectively. Two decedents lived in unidentified facilities both of which were located in Ward Four.
- Of the 2001 decedents (N=32), 10 lived in ICF/MR facilities. Five resided in Ward Four, two in Ward Seven, and one in Wards One and Eight respectively. Ten decedents also resided in nursing homes located, three of which were located in Ward Seven, three in Maryland, two in Ward Six, and one in Wards One and Eight respectively. Five decedents lived in their natural homes two of which were located in Ward Eight, one in Wards One and Four respectively, and one in Maryland. Two decedents lived in supervised apartments both of which were located in Maryland, one lived in specialized home care (Foster care) located in Ward Seven, and two lived in hospitals located in Wards One and Eight.
- Of the 2002 decedents (N=26), 10 lived in ICF/MR facilities. Four resided in Ward Seven, two in Ward Four, one in Wards One, Two, and Five respectively, and one was lived in Maryland. Five decedents resided in nursing homes, two in Ward Six, one in Ward Seven and two in Maryland. Two decedents lived in their natural homes located in Ward Four. Four decedents resided in Community Residential Facilities (CRF), one in Wards Four, Six and Seven respectively, and one in Maryland. Finally, two decedents lived in supervised apartments both of

Table 15: An Overview of Ward Data by Calendar Year (2000-2005) N=184

Year	Ward 1 N=14	Ward 2 N=4	Ward 3 N=1	Ward 4 N=30	Ward 5 N=10	Ward 6 N=14	Ward 7 N=62	Ward 8 N=16	Other States N=33	
2000 N=25	2	0	0	8	0	1	12	1	MD	1
									VA	0
									Other	0
2001 N=32	6	0	0	6	0	2	7	5	MD	6
									VA	0
									Other	0
2002 N=26	1	1	0	5	1	4	6	0	MD	7
									VA	0
									Other	1
2003 N=31	3	1	1	3	3	1	8	2	MD	7
									VA	0
									Other	2
2004 N=36	1	1	0	4	4	1	15	5	MD	3
									VA	2
									Other	0
2005 N=34	1	1	0	4	2	5	14	3	MD	3
									VA	1
									Other	0

LEVEL OF DISABILITY AND MORTALITY (CALENDAR YEARS 2004-2005)

Mental Retardation is not necessarily associated with an increased premature death rate. However, certain key disabilities can be used to accurately predict life expectancy in individuals with cerebral palsy and mental retardation. These include: (1) presence and severity of mental retardation, (2) inability to speak intelligible words, (3) inability to recognize voices, (4) inability to interact with peers, (5) severity of physical disability, (6) use of tube feeding, (7) incontinence, and (8) presence and severity of seizures.[10]

Individuals with severe to profound cognitive impairment, in addition to age, race and gender, experience a decreased life expectancy related to the underlying etiology or additional complicating disorders. Neurologic dysfunction resulting in immobility, significant oral motor dis-coordination, dysphasia, and aspiration confers a greater risk of premature death than mental retardation itself. When significant neurologic dysfunction is associated with other organ system anomalies, an individual's life expectancy is shortened further. The degrees of severity reflect the level of intellectual (cognitive) impairment:

- Mild Mental Retardation - IQ level 50-55 to approximately 70
- Moderate Retardation - IQ level 35-40 to 50-55
- Severe Mental Retardation - IQ level 20-25 to 35-40
- Profound Mental Retardation - IQ level below 20-25

[10] Life expectancy for children with cerebral palsy and mental retardation: Implications for life care planning; Richard T. Katz; Neurorehabilitation, Issue: Volume 18, number3/2003, pages 251-270.

- Of the 16 decedents classified as severely retarded, nine had mobility limitations, one had a feeding impairment, one had both risk factors, and six had none of the identified risk factors.

- Of the 14 decedents classified as moderately retarded, six had mobility limitations, two had feeding impairments, and six had none of the identified risk factors. Lastly, of the 12 decedents classified as mildly retarded, three had mobility limitations[12], three had feeding impairments and four decedents had none of the identified risk factors.

Table 16. Level of Disability and Risk Factors for calendar years 2004-2005

Level of Disability					Risk Factors							
Total N=70	N=36	N=34	Percentage of Population		No Risk Factors Identified		Mobility Limitations		Feeding Impairments		Both Risk Factors	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
Mild	5	4	13%	12%	1	3	2	1	2	1	0	1
Moderate	7	7	20%	21%	3	3	3	3	1	1	0	0
Severe	6	10	17%	29%	2	4	4	5	0	1	0	1
Profound	18	13	50%	38%	3	2	14	10	8	4	7	3

As highlighted in Tables 16 and 17, in line with expected trends, the relationship between level of mental retardation and mortality shows that persons with the most significant disabilities and health care needs (severe and profound, N=47 or, 67%) had a higher rate of mortality during the 2004 and 2005 calendar years. Overall, 48 decedents or 68%, had at least one of the identified risk factors associated with increased mortality. In addition, forty (57%) of the decedents were male, and thirty (43%) of the decedents were female.

[12] Mobility limitations include the use of adaptive equipment, and/or wheelchair dependent.

- **Manner of Death 2000-2005**

Table 18 provides an overview of the manner of death for the 2000-2005 decedents.

Table 18: Manner of Death

Manner of Death	Number N=184						Total Number & Percentage	
	2000 N=25	2001 N=32	2002 N=26	2003 N=31	2004 N=36	2005 N=34		
Natural	24	28	24	30	34	32	172	94%
Accident	1	3	2	1	1	1	9	5%
Suicide								
Homicide								
Undetermined		1			1			.05%
Pending						1		

Table 19 below presents information on the leading causes of death for individuals served by MRDDA for calendar years 2000 through 2005.

- **Leading Cause of Death (2000-2005)**

A review of the deceased MRDD population spanning calendar years 2000-2005 revealed that the majority of the decedents succumbed to disorders of the cardiovascular system (N=55 or, 30%). Hypertensive and Arteriosclerotic Cardiovascular Diseases dominated in this group. Disorders of the nervous system, responsible for the disabling illness, followed closely with 54 cases or, about 30%. Ailments of the gastrointestinal system (N=16 or, 9%) and Infectious Diseases (N=14 or, 8%) were the third and fourth causes of death respectively in this population.

Cancer was the fifth leading cause with eleven cases (6%), followed by six cases of Respiratory System Disorders representing three percent. Although only six deaths were due to disorders of the respiratory system, pneumonia and bronchopneumonia, whether or not associated with aspiration of gastric contents, were contributing factors in more than 20% of the cases (N=37).

GLOSSARY OF TERMS

Term	Definition
Age	The length of somebody's or something's existence: the length of time that somebody or something has existed, usually expressed in years
Autopsy Report	A detailed report is prepared consisting of the autopsy procedure, microscopic and laboratory findings, a list of diagnoses, and a summary of the case
Cause of Death	The underlying pathological condition or injury that initiates the chain of events which brings about the demise
CRF	Community Residential Facility for individuals diagnosed with an intellectual disability (MR)
Down Syndrome	One of the most common and readily identifiable chromosomal condition associated with mental retardation and is caused by a chromosomal abnormality
Gender	The sex of a person or organism (male or female), or of a whole category of people or organisms
Group Home	Group Homes for Mentally Retarded Persons are licensed facilities that range in size from four (4) to eight (8) customers
Hospice	A program or facilities that provide special care for people who are near the end of life and for their families
Hospital	An institution where people receive medical, surgical, or psychiatric treatment and nursing care
ICF/MR	A licensed residential facility, which is certified and funded through Title XIX (Medicaid) for consumers diagnosed with an intellectual disability (MR)
IMIU	Incident Management and Investigations Unit for DHS/MRDDA
Leading Cause of Death	The total number of deaths for all ages by cause of death (a percentage is attributed to each age group)
Level of Disability	Individuals with severe to profound cognitive impairment
Life Expectancy	The average expected length of life: the number of years that somebody can be expected to live, according to statistics
Manner of Death	Manner of death refers to the circumstantial events surrounding the death
Mental Retardation	The District of Columbia Code defines mental retardation as a significantly "sub average general intellectual level" determined in accordance with standard measurements as recorded in the Manual of Terminology and Classification in Mental Retardation, 1973

APPENDICES

B. Promulgate recommendations based on the findings of the reviews that support the development and implementation of new or improved services, practices, policies or procedures of the agencies and programs (public or private) that serve these DWs, and that will enhance the protection of the target population; and

C. By 30 April of each year, produce an annual report that provides information and statistical data obtained from the reviews of deaths that occurred during the previous calendar year. The annual report shall be submitted to the Mayor and made available to the public. The information to be contained in the report shall include, at a minimum:

1. Statistical data on all fatalities of DWs reviewed by the Committee, including numbers reviewed, demographic characteristics of the subjects, and causes and manners of death;
2. Analyses of the data generated by the reviews, to demonstrate the types of cases reviewed (which may include illustrative case vignettes without identifiers), similarities or patterns of factors causing or contributing to the deaths, and trends (both temporal and geographic); and
3. Recommendations which are generated from the reviews, including service enhancements, systemic improvements or reforms, and changes in laws, policies, procedures or practices that would better protect DWs, and could prevent future deaths.

V. COMPOSITION OF THE FATALITY REVIEW COMMITTEE

Members shall be appointed by the Mayor based on individual expertise in relevant disciplines and their familiarity with the laws, standards and services related to the protection of the health and welfare of these DWs. The Committee membership shall comprise:

A. Eight (8) public members from the community who are not employees of the Government of the District of Columbia. All efforts shall be made to ensure proportionate representation from each ward of the District;

B. Two (2) faculty members from Schools of Social Work from colleges/universities in the District of Columbia;

C. Two (2) physicians who practice in the District of Columbia with experience in the evaluation and treatment of persons with mental retardation or developmental disabilities;

D. *Ex officio* members shall include the directors or their designees from the following District government departments or agencies, or their successor programs:

VII. COMMITTEE COORDINATOR: ROLES AND RESPONSIBILITIES

The Committee Coordinator shall serve as the focal point for receiving case notifications and information, as well as for the appropriate dissemination of information to the Committee. Some of the responsibilities of the Coordinator, under the direction of the Committee Co-Chairs and with the assistance of Committee members, shall include:

A. Receive and log in all reports of fatalities;
B. Determine the type of case and review required;
C. Monitor each case to ensure that reviews are held in a timely manner and report due dates are met;
D. Gather, review and analyze data and information to plan reviews;
E. Interview the court monitor for the Pratt (Evans) class members, to assure input from the monitor into the review process;
F. Develop a summary for the Committee file;
G. Develop and manage case identification system which ensures confidentiality and anonymity of cases except as required by protocols;
H. Collect and distribute case data while preserving confidentiality;
I. Schedule and facilitate meetings of the Full Committee and Advisory Panel;
J. Notify appropriate Committee members and non-Committee members in a timely manner of fatality case review meetings;
K. At the conclusion of each review retrieve materials and file necessary data in secure location;
L. Manage information system (data collection, entry and analysis);
M. Develop final report for each case reviewed and manage dissemination of reports;
N. Facilitate communication among participating agencies;
O. Assist in the preparation of the Annual Report; and
P. Serve as the Committee liaison to other fatality review committees.

VIII. AGENCY LIAISONS: ROLES AND RESPONSIBILITIES

Each agency/program shall designate a Committee Liaison to work directly with the Coordinator. This person shall serve as the primary point of contact for that agency, and shall be responsible for facilitating the process of providing information from that agency for the review process. Some of the duties of the Liaisons shall include:

A. Provide timely and proper notification to the Committee of fatalities of DWs;
B. Search the records of the agency;
C. Provide requested documents, data and information to the Coordinator (which may include results of internal reviews);
D. Prepare the agency Committee member(s) for meetings of the Committee or Advisory Board; and
E. Provide follow-up information to the Coordinator as requested.

systemic concerns related to the community, service and medical care providers, government supervision and regulation, and applicable or needed laws, procedures and regulations.)

b. What responses and investigations resulted from the death? (This includes whether all necessary agencies were notified and responded, and whether any corrective actions were instituted.)

c. Were the services, interventions and investigations concerning the DW appropriate and adequate for his/her needs? (In other words, did the systems and agencies provide and plan effectively for the DW?)

d. Were the staff involved with the DW adequately prepared, trained and supported to perform their duties correctly?

e. Was there adequate communication and coordination among the various entities involved with the DW?

f. 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?

7. Based on the case discussion, the Committee shall formulate applicable recommendations as enumerated above in Sections III D and IV B and C(3), for further consideration and possible inclusion in the Annual Report.

B. Advisory Panel

1. An Advisory Panel shall be established for the purposes of addressing interagency and intergovernmental issues, especially those that concern coordination of service delivery to DWs, and implementing recommendations made by the Committee. This panel will be responsible for advising the Mayor on the ramifications of the recommendations, and at the Mayor's direction, developing implementation strategies for the recommendations. The Advisory Panel shall also monitor the response to and implementation of the recommendations, address problems or obstacles to implementation, and report this to the full Committee.
2. The Advisory Panel shall meet semi-annually. The Advisory Panel may convene *ad hoc* meetings of its own volition, or at the request of the Committee or the Mayor, whenever necessary to fulfill its duties.
3. The Advisory Panel shall comprise the directors of relevant District Departments, who shall serve *ex officio*. The Advisory Panel shall, at a minimum, include the following agencies:
   (a) Department of Human Services (DHS)
   (b) Office of the Chief Medical Examiner (OCME)
   (c) Department of Health (DOH)

3. OIC
4. OCME
5. MPD
6. OIG
7. OCC
8. DOH

Case notifications may be made by any other person or entity with knowledge of a death of a DW.

B. Case notification reports should include for the affected DW:
   1. Demographic data (name, age/date of birth, race, gender)
   2. Address
   3. Parents/guardians
   4. Circumstances of the death (date, time, location, activities or risk factors, witnesses or sources of information)
   5. Agencies investigating the death
   6. History of involvement of government agencies or contracted service providers

C. MPD, DHS (OIC and MRDDA), DOH and OIG shall provide the Committee with copies of all death reports resulting from any investigation that is conducted on DWs. OCME shall provide the Committee with copies of all autopsy reports resulting from autopsies and death investigations conducted on DWs. These reports shall be provided within five (5) days after they are completed.

XII. NOTIFICATION OF PARTICIPANTS

Notification shall be provided in writing to all review participants two (2) weeks prior to the review. Notification shall include sufficient information for the case to be researched, the record identified and reviewed and adequate information related to the nature of the agency's involvement collected for presentation during the review meeting. Any agreed upon information shall be provided to the Committee Coordinator prior to the review.

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

XIII. RECORDS

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

A. Initial Data Form;

remaining copies of the information distributed shall be shredded immediately after the review.

9. The final report from each review, describing the discussion, analysis of issues and recommendations, shall be prepared and included in the case record, which must be maintained in a secured file cabinet. These reports are not public documents and shall be maintained only in the Committee record. Persons who were involved with the family may review only the final report. Review may only occur in the Committee office and copying or faxing of these documents are not permitted.
10. All information contained in the Committee record identifying the DW, his/her family and any party or agency involved with the family at the time of or prior to the death shall be destroyed three (3) years after the Annual Report has been issued.
11. Committee and Review Team members shall not disclose any case-specific information about the death (including the surrounding circumstances) derived from the review process to the press or any other third party.
12. The Committee Annual Report represents the only public document for distribution by the Committee. These Reports shall not contain any identifying information related to the DWs or their families.

C. Methods for ensuring that all information identifying third persons such as witnesses, complainants and agency/institution/program staff or professionals involved with the family are protected against disclosure are:

1. The same procedures established for DWs and their families above shall be followed for these entities.
2. Access to primary documents will be limited to the staff of the Committee and the chair of the review meeting.
3. Initials only will identify third persons in materials for distribution.

XV. RECOMMENDATIONS

A. Draft recommendations shall be developed by the Committee Coordinator based on issues raised during the reviews.

B. Draft recommendations shall be distributed to Departments and members for review and comment. Recommendations are finalized based on the comments received, including discussion at meetings of the Full Committee.

C. Final recommendations are incorporated into the Annual Report, and are forwarded to the Mayor. Interim recommendations may be forwarded to the affected entities for expeditious implementation, at the approval of the Mayor or his/her designee.

D. Representatives from agencies, institutions and programs may be invited to Full Committee meetings to present their plans for or progress made towards implementation of recommendations.

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

Mayor's Order 2005-143
September 30, 2005

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

ORIGINATING AGENCY: Office of the Mayor

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

I. **RE-ESTABLISHMENT**

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

II. **PURPOSE**

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

2. A process by which fatality cases are screened and selected for review;

3. A method for ensuring that all information identifying District wards over the age of 18 years with mental retardation or a developmental disability, their families and others associated with the cases or the circumstances surrounding the deaths, including witnesses and complainants, is protected against undue disclosure. This is to ensure that steps are taken to protect the right to privacy of an individual and his or her family in conducting investigations, disseminating information to Committee members, reporting as required by the Mayor's Order, and maintaining case records for the Committee;

4. A method for gathering individual and cumulative data from the reviews;

5. A method for reviewing whether recommendations generated by the Committee are being implemented and identifying problems related to obstacles/barriers to implementation; and

6. A method for evaluating the work of the Committee that takes into account community responses to the deaths of District wards with mental retardation or a developmental disability.

b. On or about December 31st of each year, producing an annual report that provides information obtained from the reviews of deaths that occurred during the previous calendar year. The annual report shall be submitted to the Mayor and made available to the public. The information to be contained in the report shall include at a minimum:

1. Statistical data on all fatalities of District wards with mental retardation or a developmental disability reviewed by the Committee, including numbers reviewed, demographic characteristics of the subjects, and causes and manners of deaths;

2. Analyses of the data generated by the reviews, to demonstrate the types of cases reviewed (which may include illustrative case vignettes without identifying information), similarities or patterns of factors causing or contributing to the deaths, and trends (including temporal and geographic); and

3. Recommendations generated from the reviews, including service enhancements, systemic improvements or reforms, and changes in laws,

B. Two (2) physicians who practice in the District with experience in the evaluation and treatment of persons with mental retardation or developmental disabilities;

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

VI. **TERMS**

a. Public members appointed to the Committee shall serve for three (3) year terms, except that of the members first appointed, one-half shall be appointed for three (3) year terms and one-half for two (2) year terms. The date on which the first members are installed shall become the anniversary date for all subsequent appointments.

b. Members appointed to represent District government agencies shall serve only while employed in their official positions and shall serve at the pleasure of the Mayor.

c. A public member shall not serve more than two (2) consecutive full terms.

d. A member appointed to fill an unexpired term shall serve for the remainder of that term.

e. A member may hold over after the member's term expires until reappointed or replaced.

f. A public member may be excused from a meeting for an emergency reason. A public member who fails to attend three (3) consecutive meetings shall be deemed to be removed from the Committee, and a vacancy created. Such vacancies shall be filled by the Mayor as outlined in section V of this Mayor's Order.

g. A public member may be removed by the Mayor for personal misconduct, neglect of duty, conflict of interest violations, incompetence, or official misconduct. Prior to removal, the public member shall be given a copy of any charges and an opportunity to respond within 10 business days following receipt of the charges. Upon a review of the charges and the response, the Director of the Office of Boards and Commissions, Executive Office of the Mayor, shall refer the matter to

c. Case review meetings of the full Committee shall be held monthly, if there are cases for review. After procedures have been established and tested, the Committee may consider holding case review meetings every other month (bi-monthly), if practicable. The full Committee may also convene additional meetings as needed for additional case reviews, or for other specific purposes of the Committee, including the development of recommendations or preparation of the annual report.

d. The Committee shall conduct multi-disciplinary reviews of the events and circumstances surrounding the deaths of District wards over the age of 18 years with mental retardation or a developmental disability as defined in section II, above, in order to provide the data to fulfill the purposes and duties of the Committee as enumerated in sections II and III, respectively.

e. Case reviews will occur at the first Committee meeting after the Committee receives notification of the fatality, or at the first meeting after sufficient materials are received for conducting the review. The review may be preliminary, pending conclusion of the investigation and prosecution, or release by the prosecutor to conduct the review, at which time a comprehensive review shall be conducted.

f. The case review process shall include presentation of the case summary, followed by presentations of relevant information concerning the death by any agencies or persons involved with District wards over the age of 18 years with mental retardation or a developmental disability or investigating the event.

g. Following presentation of the facts, the Committee will discuss the case and any issues that it raises, guided by the following principles and questions:

1. What factors or circumstances caused or contributed to the death? (This may include consideration of social service delivery and coordination to District wards over the age of 18 years with mental retardation or a developmental disability and their families and compliance with, or development of, applicable or needed laws, procedures and regulations.)

2. What responses and investigations resulted from the death? (This includes whether all necessary agencies were notified and responded, and whether any corrective actions were instituted.)

1. By a special process server, at least 18 years of age, designated by the Committee from among the staff of the Committee or any office or organization designated by the Committee; provided, that the special process server is not directly involved in the investigation; or

2. If, after a reasonable attempt, personal service on a witness or witness' agent cannot be obtained, a special process server identified in paragraph (1) may serve a subpoena by registered or certified mail not less than eight (8) business days before the date the witness must appear or the documents must be produced.

3. If a witness who has been personally summoned neglects or refuses to obey the subpoena issued pursuant to this section, the Committee may apply to the Superior Court of the District of Columbia for an order compelling the witness so summoned to obey the subpoena.

XI. CASE REVIEW CRITERIA AND PROCEDURES

a. All deaths of District wards over the age of 18 years with mental retardation or a developmental disability shall be reviewed by the Committee.

b. Factors of particular concern for review include:

1. All violent or unexplained manners of death (i.e., homicide, suicide, accident or undetermined), which include all deaths caused by injuries, including:

A. Fractures;

B. Blunt trauma, including fractures;

C. Burns;

D. Asphyxia or drowning;

E. Poisoning or intoxication;

F. Gunshot wounds; or

G. Stabbing or cutting wounds;

5. Metropolitan Police Department (MPD);

6. Office of the Inspector General (OIG);

7. Office of the Attorney General (OAG);

8. Department of Health (DOH); and

9. Department of Mental Health (DMH).

b. Case notification reports should include for the affected District ward over the age of 18 years with mental retardation or a developmental disability:

1. Demographic data (name, age/date of birth, race, gender);

2. Address;

3. Parents/guardians;

4. Circumstances of the death (date, time, location, activities, risk factors, witnesses or sources of information);

5. Agencies investigating the death; and

6. History of the involvement of government agencies or contacted service providers.

c. MPD, DHS (OIC and MRDDA), DOH and OIG shall provide the Committee copies of all death reports resulting from any investigations that are conducted concerning District wards over the age of 18 years with mental retardation or a developmental disability. The OCME shall provide the Committee copies of all autopsy reports resulting from autopsies and death investigations conducted on District wards over the age of 18 years with mental retardation or a developmental disability. These reports shall be provided within five (5) days after they are completed.

XIII. NOTIFICATION OF PARTICIPANTS

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

d. Methods for ensuring that all information identifying third persons such as witnesses, complainants, agency, institution, or program staff or professionals involved with the family are protected against disclosure are:

1. The same procedures established for District wards over the age of 18 years with mental retardation or a developmental disability and their families above shall be followed for these entities.

2. Access to primary documents will be limited to the staff of the Committee and the chair of the review meeting.

3. Initials only will identify third persons in materials for distribution.

XVI. RECOMMENDATIONS

a. Draft recommendations shall be developed by the Committee Coordinator based on issues raised during the reviews.

b. Draft recommendations shall be distributed to agencies and members for review and comment. Recommendations shall be finalized based on the comments received, including discussion at meetings of the full Committee.

c. Final recommendations shall be incorporated into the annual report and forwarded to the Mayor. Interim recommendations may be forwarded to the affected entities for expeditious implementation, at the approval of the Committee.

d. Representatives of agencies, institutions and programs may be invited to full Committee meetings to present their plans for, or progress made towards, implementing the recommendations.

XVII. COMPENSATION

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

XVIII. ADMINISTRATION

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

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

Mayor's Order 2004-76
May 13, 2004

SUBJECT: Autopsies of Deceased Clients of the Mental Retardation And Developmental Disability Administration

ORIGINATING AGENCY: Office of the Mayor

By virtue of the authority vested in me as Mayor of the District of Columbia pursuant to section 422(2) of the District of Columbia Home Rule Act of 1973, as amended, approved December 24, 1973, Pub. L. No. 93-198, 87 Stat. 790, D.C. Official Code § 1-204.22 (2001 ed.), it is hereby **ORDERED**:

1. The Office of the Chief Medical Examiner (the "OCME"), in the exercise of its statutory authority under the Establishment of the Chief Medical Examiner Act of 2000, effective October 19, 2000 (D.C. Law 13-172; D.C. Official Code § 5-1401 *et seq.*) (2001), and subject to the legal restrictions and obligations imposed thereby, shall conduct autopsies upon the human remains of persons with mental retardation and developmental disabilities who receive services and support from the Mental Retardation and Developmental Disability Administration.

2. The OCME shall perform the autopsies required by paragraph 1 of this Order within 48 hours of receipt of the remains or as soon thereafter as practicable, assigning a priority to such autopsies consistent with the OCME's priorities established with respect to law-enforcement and public-health policies and procedures.

3. The OCME shall promptly forward the reports of autopsies conducted in accordance with paragraph 1 of this Order to the D.C. Mental Retardation and Developmental Disabilities Administration Fatality Review Committee established by Mayor's Order 2001-27 (Feb. 14, 2001).

Appendix D

Cause of Death of Cases Reviewed in 2005

2003

1.* ARDS due to Sepsis due to Aspiration Pneumonia
2. Pulmonary Thromboembolism due to Deep Venus Thrombosis of the Lower Extremities due to Immobility due to Cerebral Palsy and Recurrent Hospitalization for Pneumonia
3. Atherosclerotic Cardiovascular Disease
4. Hypertensive and Atherosclerotic Cardiovascular Disease
5. Pulmonary Postirradiation Fibromatosis following radiation therapy for treatment of breast cancer

2004

6. Seizure Disorder of Undetermined Etiology
7. Hypertensive and Atherosclerotic Cardiovascular Disease
8. Down Syndrome Complicated by Alzheimer's Dementia, Stroke, Pneumonia and Sepsis
9. Non-alcoholic Steatohepatitis due to Obesity
10. Congestive Heart Failure with Bronchopneumonia
11. Cerebellar Intracerebral Hemorrhage due to Hypertensive Cardiovascular Disease
12. Complications following replacement of decannulated gastronomy tub placed for the treatment of inaition
13. Sepsis due to Purulent Peritonitis due to Hemorrhagic Cystitis
14. Hypertensive and Atherosclerotic Cardiovascular Disease
15. Sudden Cardiac Death due to Mitral Valve Insufficiency
16. Acute Bronchopneumonia due to Hypertensive Cardiovascular Disease
17. Cardiogenic Shock due to acute Myocardial Infarction due to Atherosclerotic Cardiovascular Disease

2005

18. Carcinoma of the Esophagus, Metastic
19. Trisomy 21 (Down's Syndrome) and Anoxic Encephalopathy and the complications thereof
20. Bronchopneumonia due to Persistent Vegative State due to Cerebral Palsy with Spastic Quadriplegia
21. Acute Bronchopneumonia due to Chronic Bronchitis
22. Complications of Right Cerebral Hemisphere Hemorrhage due to Arteriosclerotic Cardiovascular Disease
23. Pulmonary Thromboembolism due to Congestive Heart Failure due to coronary Arteriosclerosis
24. Complications of Cerebral Palsy
25. Hypertensive Cardiovascular Disease

MRDD Fatality Review Committee Recommendations 2000 Through 2005

Appendix E

FRC Recommendation	Status
• **01.013** – a) The FRC recommends the need for improvement in case management records, b) and the need for a special budget for MRDDA Wards residing more than twenty (20) miles outside of the District, for special institutional needs.	a) Pending b) Implemented.
• **01.015** - a) The FRC recommends that MRDDA institute a form for medication/dosages to be placed in the front of each District Ward resident. b) The FRC also recommended that a policy be developed to mandate that each District Ward receive annual health and dental assessments	Implemented.
• **01.017** - The FRC recommends that the Quality Council (in the Health Regulations Administration of DOH) perform an exploration of what mechanism either exists or can be readily developed such that MRDDA can enforce better long- term documentation on their customers.	Pending Response.
• **01.108** - The FRC recommends for the Committee to develop protocols regarding closure of MRDDA FRC cases.	Implemented.
• **01.019** - The FRC recommends that a request be made to DHS General Counsel to provide any information regarding the District's policy on Do Not Resuscitate (DNR) order for MRDDA clients.	Implemented. See also Response to Recommendation 03-0147.1.
• **01.0172.1** - The FRC recommends that MRDDA develop a partnership with nursing facilities to ensure quality of care.	MRDDA has a comprehensive protocol that is activated for each consumer upon entering a nursing home. The consumer's residential placement is reviewed by the MRDDA Human Rights Advisory Committee to assure that consumers' rights are not violated prior to placement.
• **01.0172.2** - The FRC recommends that MRDDA oversee the placement of consumers in skilled nursing facilities with a medical professional review of coordination of care and the appropriateness of health care services delivered.	Implemented.
• **02.011** - The FRC recommends that the KOBA Institute [or current contract agency] change the section of the investigative report from Recommendations to Suggestions, thereby reserving the term "recommendations: for the action the Committee formally proposes to address systemic issues or deficiencies.	Pending Response.
• **02.012** - The FRC recommends that a viable policy on the refusal of treatment be developed, which takes into account the issue of competency and the provision of appropriate support, such as that client can make a good informed decision, and not avoid or he denied medical care for life threatening conditions.	Pending Response.

FRC Recommendation	Status
• **02.098** – Following review of this case, the Committee recommended the Quality Trust examine procedures for end-of-life care, including DNR orders and educate providers on appropriate procedures that will maintain the dignity of MRDDA clients.	Pending Response.
• **02.1120.2** – The FRC recommends that the Health Regulation Administration review the records of J.B. Johnson Nursing Home to determine the quality of care that this home provides to MRDDA clients. The committee makes this recommendation due to J.B. Johnson's failure in this case to follow-up on medical issues, identify critical client health care needs, and adequately document the course of care.	In Progress.
• **02.1331.1** - The Committee recommends that MRDDA explain the process and train the providers in the payment process for mental treatment for MRDDA customers, including Evans class members.	Implemented.
• **02.3693** - The FRC recommends that providers ensure and document that the direct care staff are both competent in and currently certified in first aid and CPR.	Implemented.
• **02.3710** - The Committee recommends that the Medical Assistance Administration increase its oversight of physicians to ensure necessary services are provided by physicians directly to MRDDA residents.	Recommendation Declined.
• **03.0080** - The FRC recommends that IMIU follow up on the deficiencies of the provider's performance as noted in Mortality Investigation	Recommendation Declined.
• **03.0100.1** - The FRC recommends that death investigations shall include an interview of the primary care physician when healthcare and communication issues are identified	The DHS/IMIU Contract Manager for the investigation contract has communicated this recommendation to the contractor. The contractor will be monitored for compliance.
• **03.0100.2** - The FRC recommends that MRDDA incorporate the integration of End of Life issues into consumers' person-centered plans as appropriate. MRDDA shall develop a training module on End of Life quality issues as part of the person-centered planning curriculum.	MRDDA's Training Division offers comprehensive End of life training to community stakeholders, including those who participate in consumer's IPS teams.
• **03.0100.3** - The FRC recommends that the Nursing Board promulgate regulations that establish acceptable ratios of LPN's to ICF-MR facilities.	The Nursing Board is currently in the process of revising and updating regulations related to the scope of practice for registered and practical nurses and will take into consideration the recommendation to address staffing patterns for nursing personnel in residential settings.
• **03.0100.4** - The FRC recommends providers ensure each consumer's quarterly medical review includes an assessment of prescribed medications. This must include a pharmacological review to determine whether the medications have any contra-indications with other medications, side effects, and/or food or dietary limitations that could impede the medication's effectiveness or, if taken in conjunction with the medication, could cause a consumer's diagnosis to worsen. The provider must ensure that the provider physician reviews, at least on a quarterly basis, the consumer's medication record for, but not limited to, medication errors, duplicate prescriptions, interactions and contra-indications.	In Progress.

FRC Recommendation	Status
• **03.0289.2** - The FRC recommends that MRDDA develop a plan for building provider capacity for alternative community residential placements in the least restrictive environment for individuals with mental retardation.	In Progress.
• **03.0289.3** – The Office of Corporation Counsel (OCC) and DHS General Counsel should conduct a legal review of the "affidavit of friend". The research is to address the validity of such documents, and the process in which one becomes an advocate to make medical decisions for MRDDA customers who are receiving services outside of the District of Columbia.	Response Received. Due to the length of this response from OCC it is available for review via written request to MRDDA FRC Committee.
• **03.0379.2** - The FRC recommends that MRDDA develop a general educational document highlighting healthcare coordination issues in serving MRDDA customers, to be distributed to the relevant healthcare community	Pending Response.
• **03.0459.1** – The Committee recommends that MRDDA send a letter to providers requiring that they develop an Emergency Medical Care Information Sheet to include: Medications: Clinical Diagnosis list; and Contacts for the purpose of obtaining consent to accompany consumers for rountine and emergency medical visits to be left with medical providers. This form should be regularly updated.	Pending Response.
• **04.0190** – The FRC recommends that MRDDA provide training on coordinated services and support for senior (elderly) MRDDA consumers	Implemented.
• **04.0432** - The FRC recommends that OCME investigators should be made aware of medications and other co-existing disorders by DHS/IMIU via the DHS/MRDDA Fatality Review Form	Pending Response.
• **04.0520** - The FRC recommends that MRDDA continue plans for training regarding risk factors and to use the Board of Nursing as experts and support on MRDDA's efforts.	Implemented.
• **04.0408** - The FRC recommends that all health care issues are incorporated in the ISP in a coordinated plan of care.	Implemented.
• **04.0408.1** - The FRC recommends that MRDDA follow up with the Providers Medical Passport System Review Form	Implemented.
• **04.0531** - The FRC recommends that IMIU investigation report (via Columbus)[1] includes a review of day programs that offer medical support during the day. MRDDA shall provide a list of all Medical Day providers to IMIU	Pending Response.
• **04.0531.1 – Initial Recommendation Dated 11/19/04** – The FRC recommends that this body report the practices of this provider to the Medical Board. **Revised Recommendation Dated 01/28/05** - This recommendation is being revised to read: The FRC recommends that MRDDA send a letter to VOCA regarding the practices of this physician with a carbon copy to the Medical Board and OIG.	Pending Response.

[1] The Columbus organization is a contractor with the District of Columbia. Department of Human Services. This organization conducts mortality investigations for deceased persons with mental retardation and developmental disabilities.

FRC Recommendation	Status
• **05-0657.1** - MRDDA should initiate and lead discussions with authorities, agencies and stakeholders regarding contractual arrangements with primary care physicians.	Pending

A copy of official responses to these recommendations is available upon request to the Office of the Chief Medical Examiner, Fatality Review Unit, Mental Retardation and Developmental Disabilities Fatality Review Committee.

This document was prepared by the Office of the Chief Medical Examiner,
Fatality Review Unit
Mental Retardation and Developmental Disabilities Fatality Review Committee
(202) 698-9000

District of Columbia

Mental Retardation and Developmental Disabilities

Fatality Review Committee

2004

Annual Report

Presented to

Anthony A. Williams
Mayor

Edward D. Reiskin
Deputy Mayor for Public Safety and Justice

Neil O. Albert
Deputy Mayor for Children, Youth, Families and Elders

April 2005

The Honorable Mayor Anthony A. Williams
Honorable Members of the Council of the District of Columbia

On behalf of the Mental Retardation and Developmental Disabilities (MRDD) Fatality Review Committee, I am pleased to present the 2004 Annual Report. During calendar year 2004, 36 persons with MRDD who were served by the Mental Retardation and Developmental Disabilities Administration died. Information in this report is specific to 26 cases that were reviewed by the Fatality Review Committee during the calendar year.

This report also presents recommendations that we believe will address and provide solutions to systemic issues as they relate to the service of this community, and will serve as an indicator to aid the District in providing superior services and coordination of care for this vulnerable population.

As we strive to improve the overall quality of care that persons with mental retardation and developmental disabilities receive in the District of Columbia, we also encourage the citizens to join us in our effort to make the District of Columbia the model for providing this service to the rest of the nation.

Sincerely,

Marie-Lydie Y. Pierre-Louis, MD
Chief Medical Examiner/MRDD FRC Co-Chair
Office of the Chief Medical Examiner

Dale E. Brown
Administrator, MRDDA
MRDD FRC Co-Chair

Introduction

This report is a summary of the work performed by the District of Columbia Mental Retardation and Developmental Disability (MRDD) Fatality Review Committee (hereinafter referred to as the Fatality Review Committee (FRC)). Information in this report is specific to decedents with MRDD who received services from MRDDA and were reviewed during the 12-month period between January 1, 2004 and December 31, 2004. The FRC was established in February 2001, under the authority of Mayor's Order 2001-27. The Order mandates that the FRC examine events that surround the deaths of District wards or residents 18 years of age and older with mental retardation and/or developmental disabilities.

The FRC is comprised of members who represent public and private community organizations from a broad range of disciplines that include health, mental retardation and mental health, social services, public safety, legal and law enforcement. These individuals come together as a collective body for the purpose of examining and evaluating relevant systemic issues associated with services and interventions provided to deceased persons with mental retardation and developmental disabilities (MRDD).

The scope of the fatality review includes the examination of relevant policies and statutes, independent investigative reports and reports of forensic autopsies conducted by the Office of the Chief Medical Examiner. This information highlights each deceased individual's social history including family and care giver relationships as well as living conditions prior to death; medical diagnosis and medical history; services provided; and cause and manner of death. These reviews examine compliance with regulations and recommendations by service providers, and may lead to the identification of systemic health care and service concerns. The FRC recommends systemic strategies to improve the quality of life for persons with MRDD under the care of the District's Mental Retardation and Developmental Disabilities Administration (hereinafter referred to as (MRDDA).

The District of Columbia Code defines mental retardation as a significantly subaverage general intellectual level determined in accordance with standard measurements as recorded in the Manual of Terminology and Classification in Mental Retardation, 1973.[1] MRDDA's eligibility criteria for identification of persons with mental retardation are as follows:

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

[1] District of Columbia, Official Code, 2001 Edition, Title 7, Section *§7-1301.03(19)*.

Table 1: District of Columbia MRDDA Population and Deaths 2001 to 2004.

Year	Population	Number of Deaths	Percentage
2004	1915	36	1.9%
2003	1790	31	1.7%
2002	1703	26	1.5%
2001	1547	32	2%

*Information on the total population for each of the four years was provided by MRDDA, MCIS (MRDDA Consumer Information System).

Table 1.1: Race of MRDD Population and Fatalities by Year

Race	2001		2002		2003		2004	
	Population N=1547	Deaths N=32	Population N=1703	Deaths N=26	Population N=1790	Deaths N=31	Population N=1915	Deaths N=36
Black	1163	24	1411	17	1467	23	1586	28
Caucasian	224	8	218	9	200	8	198	6
Other	*160	0	64	0	123	0	131	2

*In 2002, MRDDA implemented the MCIS 3.0. The previous versions of the system did not require the race, however, the new system required that race be documented. During the conversion of the system MRDDA was able to correctly identify the race for the 1,703 consumers on record at the end of 2002, and the number of consumers with the race marked as other in 2001 was significantly reduced.

Summary of Case Review Findings

The information contained in this section will cover the data and findings that resulted from cases reviewed over a four-year period, with a specific emphasis on those reviewed during calendar year 2004. The tables and graphs provide information related to those cases reviewed during 2004 (n=26). Data in these tables also clearly specifies the year of the death despite the fact that the review occurred during 2004.

At the close of 2004, there were 43 cases in which reviews remained pending. These cases spanned years from 2002 through 2004. Table 2 depicts the number of cases reviewed and the number of cases pending review for each of these years.

Table 2: FRC Cases Pending Review

Year	Number of Deaths By Year	Number of Cases Reviewed By Year	Number of Cases Pending Review
2004	36	13	23
2003	31	16	15
2002	26	19	7
2001	32	32	0
Total	**125**	**80**	**45**

*FRC review of these cases is pending completion of the Columbus Investigation reports.

Ward Data

Ward of residence refers to the decedent's residential address at the time of death. Addresses included natural homes, foster care, intermediate care facilities for persons with mental retardation, supervised apartments and nursing homes. During calendar year 2004, out of the 26 fatalities reviewed, the majority of the decedents were residing in the District at the time of their deaths (n = 19, or 73%). Seven decedents (27%) were residents of other states, five resided in Maryland, and two resided in Virginia.

Table 5: Ward/Jurisdiction of Residence At the Time of Death

District Ward/ Jurisdiction	Total Deaths Reviewed in 2004	Deaths By Calendar Year			
		2001	2002	2003	2004
One	3	2			1
Two	1			1	
Three	2		1		1
Four	2				2
Five	1			1	
Six	1			1	
Seven	5	1	1		3
Eight	4			1	3
Maryland	5	1		3	1
Virginia	2				2

Because of the backlog of fatality cases that are pending investigations from calendar years 2001 through 2003, it is difficult to evaluate mortality trends. However, the following observations were highlighted during the 2004 MRDD FRC case review meetings:

Decedents Residing in Out-of-State Facilities

- The decedents who resided outside the District were in the care of MRDDA and had been placed in numerous types of out-of-state facilities that included three nursing homes, two natural homes, one supervised apartment, and one group home.
- These decedents ages ranged from 23 to 76, with the majority being over the age of 50 (n = 5, or 71%).
- Consistent with the overall population, the majority of the Maryland and Virginia decedents were Black (n = 5, or 71%).

Abuse and Neglect

Abuse and neglect is defined as wrongful treatment of a customer that endangers his or her physical or emotional well-being, through the action or inaction of anyone, including, but not limited to, another customer, an employee, intern, volunteer, consultant, contractor, visitor, family member, guardian or stranger, whether or not the affected customer is, or appears to be, injured or harmed.[2]

Of the 26 cases reviewed in 2004, there was one (1) allegation of abuse that occurred within 6 months of death as reported by Incident Management Investigations Unit (hereinafter referred to as IMIU). The investigative report indicated that this case was not substantiated and the necessary corrective action, e.g., staff training on effective communication with non-verbal consumers, was taken. In one case, the circumstances leading to the death remain unclear.

Cause and Manner of Death

Pursuant to Mayor's Order 2004-76, "Autopsies of Deceased Clients of the Mental Retardation and Developmental Disability Administration",[3] autopsies must be performed on all persons with MRDD who die in the District of Columbia and received services and support from MRDDA. Of the 26 cases reviewed, 24 were autopsied; 1 was an external examination; and 1 was declined. [4]

The District's Office of the Chief Medical Examiner (OCME) accepted jurisdiction and performed autopsies on 18 (69%) of the 26 decedents whose cases were reviewed. Six (23%) of the autopsies were performed in out-of-state facilities, in one case (4%) an external examination was performed and in one case (4%) jurisdiction was declined. The autopsy rate for the District's MRDD cases reviewed in 2004 was 92%.

Table 7 presents information on the wide variety of neurologic conditions affecting the MRDD population including genetic defects, developmental malformations or diseases and their complications. In many cases more than one condition was present in the same individual.

---

[2] Department of Human Services Mental Retardation/Developmental Disabilities Administration, Policy and Procedure, Transmittal Letter No., Supersedes: Policy dated 10/1/2001, Manual Location, October 1, 2003

[3] Mayor's Order 2004-76, Autopsies of Deceased Clients of the Mental Retardation and Developmental Disabilities Administration, May 13, 2004.

[4] The previous Mayor's Order mandating autopsies of deceased clients of MRDDA expired before re-establishment of the mandate in Mayor's Order 2004-76. It was during the lapse period that the external examination was performed and, in one case, jurisdiction was declined pursuant to D.C. Official Code § 5-1401 et seq. (2001).

Manner of Death

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

Table 9: Manner of Death

Manner of Death	Number of Deaths	Percentage
Natural	23	88.5%
Accident	2	7.5%
Suicide	0	0
Homicide	0	0
Undetermined	1	4%
Total	**26**	**100%**

The results in Table 9 indicate that of the 26 deaths reviewed during 2004, the manner of death at autopsy was determined to be natural for 23 (88.5%) of the decedents, accidental for 2 (7.5%) of the deaths, and undetermined for 1 (4%) of the deaths.

C. Review and evaluate services provided by public and private systems which are responsible for protecting or providing services to DWs, and whether said entities have properly carried out their respective duties and responsibilities; and

D. Based on the results of the reviews (both individual and in aggregate), identify strengths and weaknesses in the governmental and private agencies and/or programs that serve these DWs, and thence make recommendations to the Mayor (and/or to these entities directly) to implement systemic changes to improve services or to rectify deficiencies. Such recommendations may address, but are not limited to, proposing statutes, policies or procedures (both new or amendments to existing ones); modifying training for those persons who provide services related to these DWs; enhancing coordination and communication among entities providing or monitoring services for DWs; and facilitating investigations of fatalities.

IV. FUNCTIONS

The Committee shall:

A. Within ninety (90) days of the date of the Mayor's Order establishing this committee, develop and issue procedures governing its overall operation. The procedures shall include, at a minimum, the following:

1. Methods by which deaths of District of Columbia wards (DWs) are identified and reported to ensure expeditious and excellent reviews;
2. A process by which fatality cases are screened and selected for review;
3. Methods for assembling a properly composed committee and conducting the reviews;
4. A method for ensuring that all information identifying DWs, their families and others associated with the case or the circumstances surrounding the death, including witnesses and complainants, is protected against disclosure. This is to ensure that steps are taken to protect an individual's right to privacy both in the conduct of the investigations, dissemination of information to Committee members, reporting as required by the Mayor's Order and maintenance of case records for the Committee;
5. A systematic method for gathering individual and cumulative data from the reviews;
6. A method for ensuring that information required for the reviews is made available timely for use by the Committee;
7. A method for reviewing whether recommendations generated by the Committee have been implemented and identifying problems related to obstacles/barriers to implementation; and
8. A method for evaluating the work of the Committee which also considers community responses to the deaths of DWs.

1. Department of Human Services (DHS):
    a. Mental Retardation and Developmental Disabilities Administration (MRDDA)
    b. Office of Inspections and Compliance (OIC)
    c. Rehabilitation Services Administration (RSA)
    d. Adult Protective Services (APS)
2. Office of the Chief Medical Examiner (OCME)
3. Department of Health (DOH)
    a. Health Regulation Administration (HRA)
    b. Medical Assistance Administration (MAA)
    c State Center for Health Statistics (SCHS)
    d. Bureau of Injury and Disability Prevention (BIDP)
4. Metropolitan Police Department (MPD), Criminal Investigations Division
5. Office of the Corporation Counsel (OCC)
6. Office of the Inspector General (OIG)
7. Commission on Mental Health Services (CMHS)
8. Fire Department and Emergency Medical Service, EMS Director

E. The following agencies may be included, should they agree to participate:
1. Office of the United States Attorney for the District of Columbia
2. Superior Court of the District of Columbia

The Chief Medical Examiner for the District and a social services professional who practices and/or teaches In the District with experience in the evaluation and provision of services to persons with mental retardation or developmental disability shall be appointed by the Mayor as **Co-Chairpersons** and shall serve at the pleasure of the Mayor.

VI. TERMS

Public members of the Committee shall serve for 3-year terms except that of the members first appointed under the Mayor's Order establishing this Committee, one-third shall be appointed for 3-year terms, one-third for 2-year terms and one-third for I -year terms. The date the first members are installed shall become the anniversary date for all subsequent appointments.

A. A member appointed to fill an un-expired term shall serve for the remainder of that term. Members may continue to serve until re-appointed or replaced. Members may serve not more than two consecutive full terms;

B. Each member representing a public agency, shall be designated by the director of that department, and shall serve at the pleasure of the Mayor; and

C. *Ex officio* members shall serve at the pleasure of the Mayor.

IX. TEAM STRUCTURES

The Committee shall convene as the full Committee and as an Advisory Panel.

A. Full Committee

1. A minimum of two-thirds of the members shall be present to constitute a quorum. Meetings of the full Committee will be for the purposes of:
    a. conducting case reviews, or assessing additional data from prior cases that have since become available;
    b. consideration of recommendations arising from available case reviews;
    c. preparation of the annual report; and
    d. any other business necessary for the Committee to operate or fulfill its duties.

2. Case review meetings of the full Committee shall be held monthly, if there are cases for review. (After procedures have been established and tested, the Committee may consider holding case review meetings bimonthly, if practicable.) The full Committee may also convene monthly or *ad hoc* meetings as needed for additional case reviews, or for other specific purposes of the Committee, e.g.- development of recommendations or preparation of the Annual Report.
3. The Committee shall conduct multi-disciplinary reviews of the events and circumstances surrounding the deaths of DWs as defined in Section II, in order to provide the data to fulfill the Purposes and Duties of the Committee as enumerated in Sections II and III, respectively.
4. Case reviews will occur at the next Committee meeting after the Committee receives notification of the fatality, or at the first meeting after sufficient materials are received for conducting the review. 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 to conduct the review, at which time a comprehensive review shall be conducted.
5. The case review process shall include presentation of the case summary, followed by presentations of relevant information concerning the death by any agencies or persons involved with the DW, or investigating the event.
6. Following presentation of the facts, the Committee will discuss the case and any issues that it raises, guided by the following principles and questions:
    a. What factors or circumstances caused or contributed to the death? (This may include consideration of

(c) Office of the Corporation Counsel (OCC)
(d) Metropolitan Police Department (MPD)
(e) Office of the Inspector General (OIG)

4. The Panel may also include the following agencies, should they agree to participate:
(a) Office of the United States Attorney for the District of Columbia
(b) District of Columbia Superior Court

X. CASE REVIEW CRITERIA AND PROCEDURES

A. All deaths of DWs older than 18 years of age will be reviewed by the Committee. (Note: Deaths of DWs who are 18 years of age or less will be reviewed by the Child Fatality Review Committee.)

B. Factors of particular concern for review include:
1. All violent or unexplained manners of death (i.e.- homicide, suicide, accident or undetermined), which include all deaths caused by injuries, including but not limited to:
   a. blunt trauma, including fractures
   b. burns
   c. asphyxia or drowning
   d. poisoning or intoxication
   e. gunshot wounds
   f. stabbing or cutting wounds
2. Abuse, either physical or sexual
3. Neglect, including medical and custodial
4. Malnourishment or dehydration
5. Circumstances or events deemed suspicious

C. The Committee may, at its discretion, review groups of sudden, unexpected or unexplained deaths of DWs to examine aggregate data in order to address specific issues or trends.

D. DWs who live in facilities outside the District, or who die outside the District, will be subject to review by the Committee, and will be included in the Annual Report, both for statistical analysis and recommendations. The Committee members shall serve as liaisons to their counterparts in outside jurisdictions for the purpose of gathering information and obtaining documents (e.g.-police or autopsy reports) to complete the review.

XI. CASE NOTIFICATION PROCEDURES

A. District agencies and service providers contracted by the District to serve DWs shall provide written notification to the Committee within 24 hours of any death of a DW, or within 24 hours of becoming aware of such a death. The sources of case notifications will include but not be limited to:
1. MRDDA
2. Contracted service providers (e.g.-group home staff)

B. Final Report; and
C. Death Certificate.

XIV. CONFIDENTIALITY

A. A key tenet of the Committee is the necessity for keeping confidential all information obtained by, presented to and considered by the Committee. Any information gathered in preparation for or divulged during Committee reviews may not be disclosed for purposes other than those outlined in this Mayor's Order. All participants in the Committee proceedings shall be required to sign a confidentiality statement during all Committee case review meetings and in general meetings where any specific case is discussed. Case specific information distributed during the meeting shall be collected at the end of each review. Any required participant who is not willing to sign a confidentiality statement or abide by the confidentiality requirements shall not be allowed to participate in case review meetings.

B. Confidentiality Protocols

Methods for ensuring that all information identifying DWs and their families is protected against disclosure are:

1. The Committee Coordinator shall be designated as the individual responsible for receiving and protecting all records
2. During the notification and case selection process, every case will be assigned a number identifier and a record established. The full name of the DW and family shall be maintained in the case record at all times during the review planning process.
3. All case records shall be maintained in a locked file cabinet at all times unless in use by the Committee Coordinator or other designated staff of the Committee.
4. All records from other agencies/programs shall be obtained by or delivered directly to the Committee Coordinator. Once the necessary documents from the various member agencies/programs related to service delivery or interventions provided to the DW are received, they shall be maintained in the case record only.
5. A case summary shall be prepared for each case and stapled to the left inside cover of the file folder, for use by the Coordinator and chair of the review meeting.
6. No further duplication of documents is permitted.
7. Any documents distributed during the review shall only identify the DW by the Committee case number identifier.
8. Upon completion of the review of a case, all documents/information distributed shall be returned to the Committee Coordinator or other designated Committee staff. One (1) copy shall be maintained in the case record, along with a copy of the list of review participants, confidentiality statements for each review participant and the agenda. The

E. The Advisory Panel will address interagency and intergovernmental issues relating to implementation of recommendations, and will advise the Mayor or his/her designee regarding such concerns.

XVI. COMPENSATION

Committee members shall serve without compensation.

XVII. ADMINISTRATION

Appropriate administrative support, facilities and resources to ensure the effective operation of the Committee and the implementation of the requirements of The Mayor's Order establishing this committee shall be provided under the direction of the Office of the Chief Medical Examiner. Expenses shall be obligated against funds designated for this purpose by the Department of Human Services or the Executive Office of the Mayor.

All agencies of the District of Columbia government that were involved with the DW shall cooperate with the Committee and provide timely access to information necessary to carry out its duties, subject to the applicable District and Federal statutes and regulations governing privacy, dissemination and confidentiality of information.

XVIII. EFFECTIVE DATE

This Order shall become effective immediately.

ANTHONY A. WILLIAMS
MAYOR

ATTEST:
BEVERLY D. RIVERS
SECRETARY OF THE DISTRICT OF COLUMBIA

(5) "Community-based services" means non-residential specialized or generic services for the evaluation, care and habilitation of mentally retarded persons, in a community setting, directed toward the intellectual, social, personal, physical, emotional or economic development of a mentally retarded person. Such services shall include, but not be limited to, diagnosis, evaluation, treatment, day care, training, education, sheltered employment, recreation, counseling of the mentally retarded person and his or her family, protective and other social and socio-legal services, information and referral, and transportation to assure delivery of services to persons of all ages who are mentally retarded.

(5A) "Competent" means to have the mental capacity to appreciate the nature and implications of a decision to enter a facility, choose between or among alternatives presented, and communicate the choice in an unambiguous manner.

(6) "Comprehensive evaluation" means an assessment of a person with mental retardation by persons with special training and experience in the diagnosis and habilitation of persons with mental retardation, which includes a sequence of observations and examinations intended to determine the person's strengths, developmental needs, and need for services. The initial comprehensive evaluation shall include, but not be limited to, a physical examination that includes the person's medical history; an educational evaluation, vocational evaluation, or both; a psychological evaluation, including an evaluation of cognitive and adaptive functioning levels; a social evaluation; and a dental examination.

(7) "Council" means the Council of the District of Columbia.

(8) "Court" means the Superior Court of the District of Columbia.

(8A) "Crime of violence" has the same meaning as in § 23-1331(4).

(8B) "Customer" means a person admitted to or committed to a facility pursuant to subchapter III of this chapter for habilitation or care.

(9) "Department of Human Services" means the Department of Human Services of the District of Columbia.

(10) "Director" means the administrative head of a facility, or community-based service and includes superintendents.

(11) "District" means the District of Columbia government.

(11A) "DSM-IV" means the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

(11B) "DSM-IV "V' Codes" means "V" codes as defined in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

(12) "Education" means a systematic process of training, instruction and habilitation to facilitate the intellectual, physical, social and emotional development of a mentally retarded person.

(13) "Facility" means a public or private residence, or part thereof, which is licensed by the District as a skilled or intermediate care facility or a community residential facility (as defined in D.C. Regulation 74-15, as amended) and also includes any supervised group residence for mentally retarded persons under 18 years of age. For persons committed or for whom commitment may be sought under § 7-1304.06a, the term "facility" may include a physically secure facility or a staff-

(18) "Mental retardation advocate" means a member of the group of advocates created pursuant to § 7-1304.13.

(19) "Mental retardation" or "mentally retarded" means a substantial limitation in capacity that manifests before 18 years of age and is characterized by significantly subaverage intellectual functioning, existing concurrently with 2 or more significant limitations in adaptive functioning.

(19A) "MRDDA" means the Mental Retardation and Developmental Disabilities Administration of the District of Columbia, Department of Human Services.

(20) "Normalization principle" means the principle of aiding mentally retarded persons to obtain a lifestyle as close to normal as possible, making available to them patterns and conditions of everyday life which are as close as possible to the patterns of mainstream society.

(21) "Qualified mental retardation professional" means:

(A) A psychologist with at least a master's degree from an accredited program and with specialized training or 1 year of experience in mental retardation; or

(B) A physician licensed by the Commission on Licensure to Practice the Healing Arts to practice medicine in the District and with specialized training in mental retardation or with 1 year of experience in treating the mentally retarded; or

(C) An educator with a degree in education from an accredited program and with specialized training or 1 year of experience in working with mentally retarded persons; or

(D) A social worker with:

(i) A master's degree from a school of social work accredited by the Council on Social Work Education (New York, New York), and with specialized training in mental retardation or with 1 year of experience in working with mentally retarded persons; or

(ii) With a bachelor's degree from an undergraduate social work program accredited by the Council on Social Work Education who is currently working and continues to work under the supervision of a social worker as defined in sub-subparagraph (i) of this subparagraph, and who has specialized training in mental retardation or 1 year of experience in working with mentally retarded persons; or

(E) A rehabilitation counselor who is certified by the Commission on Rehabilitation Counselor Certification (Chicago, Illinois) and who has specialized training in mental retardation or 1 year of experience in working with mentally retarded persons; or

(F) A physical or occupational therapist with a bachelor's degree from an accredited program in physical or occupational therapy and who has specialized training or 1 year of experience in working with mentally retarded persons; or

(G) A therapeutic recreation specialist who is a graduate of an accredited program and who has specialized training or 1 year of experience in working with mentally retarded persons.

(22) "Resident of the District of Columbia" means a person who maintains his or her principal place of abode in the District of Columbia, including a person with mental retardation who would be a resident of the District of Columbia if the person had not been placed in an out-of-state facility by the District. A person with mental retardation who is under 21 years of age shall be deemed to be

D.C. Code § 7-1301.03

LEGISLATIVE HISTORY OF LAW 2-137. --See note to § 7-1301.02.

LEGISLATIVE HISTORY OF LAW 10-253. --See note to § 7-1301.02.

LEGISLATIVE HISTORY OF LAW 11-52. --See note to § 7-1301.02.

LEGISLATIVE HISTORY OF LAW 14-199. --Law 14-199, the "Civil Commitment of Citizens with Mental Retardation Amendment Act of 2002," was introduced in Council and assigned Bill No. 14-616. The Bill was adopted on first and second readings on June 4, 2002 and July 2, 2002, respectively. Signed by the Mayor on July 17, 2002, it was assigned Act No. 14-432 and transmitted to Congress for its review. D.C. Law 14-199 became effective on October 17, 2002.

ANALYSIS
Construction
Guardian

CONSTRUCTION.

When construing D.C. Code 7-1301.03(1), as it applies to a person who is only mildly retarded, the inclusion of the words "at least moderately mentally retarded" in the definition of "admission" was an oversight by the City Council, and as such, voluntary admissions are available to mentally retarded persons regardless of their degree of retardation. *In re Bicksler, App. D.C., 501 A.2d 1 (1985).*

GUARDIAN.

The term "guardian", as used in the definition of respite care under D.C. Code § 7-1301.03(23), does not include a government entity such as the Department of Human Services, even if it acts as a provider of care to a mentally retarded person given the emphasis in the legislative history on maintaining family ties with a mentally retarded person. *In re Williams, App. D.C., 471 A.2d 263 (1984).*

21. Acute bronchopneumonia due to Hypertensive and Atherosclerotic Cardiovascular Disease.
22.* Hydranencephaly and its sequelae due to Perinatal event of undetermined etiology
23. Hypertensive and Arteriosclerotic Cardiovascular Disease
24. Intracerebral Hemorrhage due to Hypertensive Cardiovascular and Cerebrovascular Disease
25. Ischemic Heart Disease
26. Sepsis due to Endocarditis due to Disseminated infection from decubitis ulcers due to Limited mobility due to Complications of end stage renal disease due to Hypertensive and Arteriosclerotic Cardiovascular disease; Other significant conditions: Obesity

FRC Recommendation	Official Response
• **02.015** – The FRC referred this case to the Quality Council.	Pending Response. **Note:** due to the disbanding of the Quality Council MRDDA will request the FRC to review this recommendation and determine whether it should be reissued, considered resolved, or rescinded.
• **02.021b** - The FRC recommends that MRDDA conduct appropriate documentation and supervision [training] to meet the standards of the case management system.	Implemented.
• **02.021b** - The Committee recommends that some guidelines be put in place at the residential facilities for the care of customer who for whatever reason are not able to participate in their day program.	Existing ICF/MR regulations, Medicaid Provider agreements and contracts contain standards that govern activities that should be made available to consumers who remain home from day programs due to illness or other reasons. Planned activities are also identified in the ISP to ensure that consumers are participating in their day programs or receiving active treatment when they are not in attendance.
• **02.024** – The FRC recommended that the Quality Council review the medical records of this customer, and make recommendations to the committee.	Pending Response.
• **02.374.3** – The FRC recommends that Adult Protective Service provide education to MRDDA staff and service providers on APS reporting requirements.	Implemented
• **02.0279.1, 03-0147l** - The FRC recommends that the Office of the Corporation Counsel (OCC) conduct a comprehensive assessment of the issue of DNR orders for MRDDA clients. OCC may assemble a working group as needed to accomplish this task.	Completed. **Summary Response:** The Office of the Attorney General for the District completed an in-depth review and determined that Do Not Resuscitate orders cannot be issued or authorized by the District or any of its agents.
• **02.028** - The Committee recommended that nursing and group homes should be staffed at adequate levels with properly trained personnel. The staff should monitor and document the care of MRDDA client and their adherence to internal quality assurance protocols on a routine basis. Group and nursing homes that do not have internal quality assurance measures should establish them. MRDDA should monitor compliance with these standards and report poor care and irregularities to the Health Regulation Administration.	Implemented.
• **02.0374.1** - The FRC recommends that MRDDA develop policies regarding coordination of care in acute care facilities including a process for reporting issues related to quality of care.	DHS currently has a protocol to address reporting issues related to quality of care, however, DHS has no jurisdiction or authority over acute care facilities. A protocol will be developed addressing MRDDA's response when customers are admitted to an acute care facility.
• **02.0374.2** - The FRC recommends that MRDDA develop procedures to address coordination of hospital discharge planning, pain management and follow up of end of life care.	Pending Response.
• **02.0569** - The FRC recommends that MRDDA review issues related to transportation of MRDDA clients, including incident reporting and the existence of and follow up to hospital discharge planning.	Pending Response. **Note:** Recommendation first issue – 04/29/03; Re-issued to MRDDA 02/23/05.

FRC Recommendation	Official Response
• 03.0122 - The FRC recommends that MRDDA ensure that the oversight of clinical reviews and coordination of health care services on medically fragile individuals is conducted by the appropriate health care professionals. This will require that MRDDA assign adequate numbers of staff.	MRDDA is currently realigning its Clinical Services Division to meet the requirements of its Comprehensive Health Care Plan. The Plan required that MRDDA and community providers oversee clinical reviews and coordinate health care services for all consumers served.
• 03.0187.1 - The FRC recommends that DOH (MAA and HRA) and the OIG (MFCU) investigate the Washington Nursing Facility for concerns of neglect and failure to provide appropriate care, possibly causing or contributing to the deaths of patients.	**MAA Response:** "The responsibility for investigation of deaths rests with the HRA. The MAA will coordinate with HRA regarding the quality of services rendered by providers who are reimbursed by DC Medicaid. If concerns are found related to the provision of care, or neglect then the fatality is cited and fined depending upon the deficiency. The case will also be referred to the OIG and MPD if needed". **Declined by HRA** **Pending Response from OIG.**
• 03.0219, 03.0080.2 - The FRC recommends that ICF-MR's shall ensure that the appropriate clinical professionals (including but not limited to: nurses, speech pathologists, occupational therapists, nutritionists, and physical therapists) are required to monitor mealtime protocols, physical management (such as safe feeding and appropriate positioning), dysphagia issues, and aspiration, or high-risk individuals requiring specialized services. This monitoring plan must be incorporated in the ISP	Implemented.
• 03.0219.2 - The FRC recommends that provider agencies follow the DC Code and health regulations process when conducting intra-provider discharging and transferring of consumers, and should include coordination with case managers, appropriate advance notice to the entity receiving the consumer, and a transition plan that includes health care coordination, specific individualized support that the consumer may need, and training that the receiving entity's staff may need to ensure a comprehensive transition for consumer and staff needs	Implemented.
• 03.0278.1 - The FRC recommends that MRDDA develop a policy that requires providers to identify health risk factors, coordination of care issues, and implement strategies to address and mitigate the risks identified into the Individual Service Plan (ISP).	Response Pending.
• 03.0289.1 - The FRC recommends that for MRDDA customers placed outside of the District, a formal reporting protocol should be established between the Department of Human Services, Incident Management and Investigations Unit and the regulatory entity in the jurisdictions of the placements.	Implemented.

FRC Recommendation	Official Response
• 04.0531.2 - The FRC recommends that MRDDA send a reminder to the provider community regarding MRDDA's Medical Care Protocols.	Pending Response

District of Columbia

Mental Retardation and Developmental Disabilities

Fatality Review Committee

Annual Report

2001, 2002 and 2003

Presented to

Government of the District of Columbia
Anthony A. Williams
Mayor

Robert C. Bobb
City Administrator/Acting Deputy Mayor for Public Safety and Justice

Neil O. Albert
Deputy Mayor for Children, Youth, Families and Elders

October 2004

The Honorable Mayor Anthony A. Williams
Honorable Members of the Council of the District of Columbia

On behalf of the Mental Retardation and Developmental Disability Fatality Review Committee, we are pleased to present the Annual Report covering statistical data and recommendations resulting from fatality reviews held during calendar years 2001 through 2003.

This report presents recommendations we believe address and provide solutions to systemic issues as they relate to services provided to this community. It will serve as an indicator to aid the District in providing superior services and coordination of care for this vulnerable population.

As we strive to improve the overall quality of care that residents who are developmentally disabled receive in the District of Columbia, we encourage citizens to join us in our efforts to make the District of Columbia the model for the rest of the nation in providing this service

Sincerely,

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

Dale Brown
Administrator, MRDDA
MRDD FRC Co-Chair

Introduction

This report is a composite summary of work of the District of Columbia Mental Retardation and Developmental Disability (MRDD) Fatality Review Committee for the calendar years 2001, 2002 and 2003. The MRDD Fatality Review Committee was established in February 2001, by Mayor's Order 2001-27, (herein referred to as the Order). The Order mandates that the Committee, referred to as the Fatality Review Committee (FRC), examine events that surround the deaths of District wards or residents 18 years of age and older with mental retardation and/or developmental disabilities. See Appendix A for the full text of the Order.

The Mental Retardation and Developmental Disabilities Administration (MRDDA) facilitates services and resources for persons with mental retardation and/or developmental disabilities in the District of Columbia. Mental retardation is defined as a condition of substantial limitation in capacity that manifests before 18 years of age and is characterized by "significantly subaverage general intellectual level" existing concurrently with two (2) or more significant limitations in adaptive functioning. See Appendix B for relevant DC Law.

The FRC is comprised of members who represent public and private community organizations from a broad range of disciplines to include health, mental retardation and mental health, social services, public safety, legal and law enforcement. These individuals come together as a collective body for the purpose of examining and evaluating relevant facts associated with services and interventions provided to deceased persons with mental retardation and developmental disabilities (MRDD).

During the fatality case reviews, the FRC examines an independent investigative report and a report of a forensic autopsy conducted by the Office of the Chief Medical Examiner. The reports highlight each deceased individual's social history including family and care giver's relationships with the deceased, and living conditions prior to death; medical diagnosis and medical history; services provided; and cause and manner of death. These fatality reviews examine compliance with regulations and recommendations by service providers, and may lead to identification of systemic health care and service concerns. The FRC recommends strategies to promote comprehensive health care and improve the quality of life for persons with MRDD.

This report is organized as follows: (1) Duties of the committee; (2) Demographic characteristics of deceased persons with MRDD; (3) Place of death; (4) Residence at time of death; (5) Cause and Manner of death; and (6) Highlights and a Look Forward.

Demographic Characteristics of Deceased Persons with MRDD

The total number of persons with MRDD served by MRDDA in the District of Columbia for the calendar years 2001, 2002 and 2003 were 1547, 1703 and 1790 respectively.

Table 1 presents the number of deaths from the population with MRDD reviewed by FRC.

Table 1 District of Columbia MRDDA Population* and Number of Deaths by Year

Year	Population	Number of Deaths	Percentage
2001	1547	32	2%
2002	1703	26	1.5%
2003	1790	31	1.7%

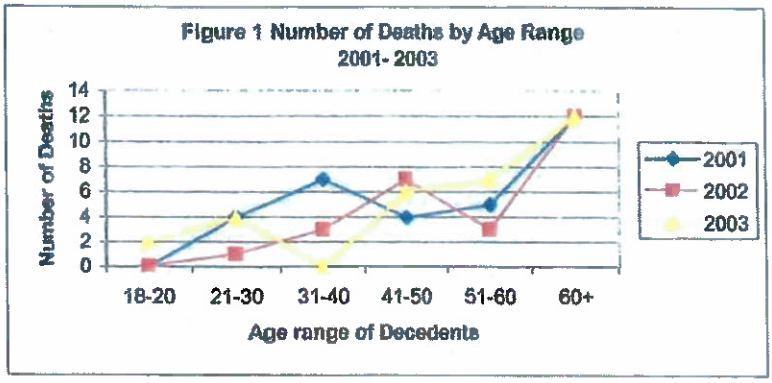
*Information on the total population for each of the three years was provided by MRDDA.

Results presented in Table 1 indicate that between 1.5 to 2 percent of the MRDD population died during the three-year period.

Age

Figure 1 presents information on the number of deaths by age groups for the three-year period.

Figure 1 Number of Deaths by Age Range



Race

Table 4 presents information on the MRDD population and deaths reviewed by race.

Table 4 Race of MRDD Population and Fatalities Reviewed by Year

Race	2001		2002		2003	
	Population N=1547	Deaths N=32	Population N=1703	Deaths N=26	Population N=1790	Deaths N=31
Black	1163	24	1411	17	1467	23
Caucasian	224	8	218	9	200	8
Other	160	0	64	0	123	0

The results presented in Table 4 indicated that deaths by race were consistent with the overall MRDD population.

Place of Death

Place of death included hospitals, nursing homes, hospice, and specialized home care, i.e., foster homes and other types of residential placement. Table 5 presents the place of death for the 89 individuals whose cases were reviewed during the three-year period.

Table 5 Place of Death

Place of Death	2001 N=32	2002 N=26	2003 N=31
Hospital	22	16	25
Nursing Home	6	6	5
Hospice	0	2	1
Residential	4	0	0
Other, e.g., specialized home care and foster homes	0	2	0

The information in Table 5 indicates that during the review period, almost all MRDD individuals died in hospitals (70%), and nursing homes (19%).

Cause and Manner of Death

Pursuant to Public Law 1435 for calendar years 2001, 2002 and 2003; and Mayor's Order 2004-76, "Autopsies of Deceased Clients of the Mental Retardation and Developmental Disability Administration", of May 13, 2004, an autopsy must be performed on all persons with MRDD who die in the District of Columbia and receive services and support from the Mental Retardation and Developmental Disability Administration.

Of the 89 cases reviewed, 83 individuals were autopsied during this review period. They presented with a wide variety of neurologic conditions including genetic defects; developmental malformations or diseases; sequellae of prenatal or perinatal brain insults, infectious diseases, degenerative brain diseases; and complications of atherosclerotic cardiovascular disease. In one case the symptoms resulted from head trauma. See Table 7.

Table 7 Primary Neurologic Conditions

Primary Neurologic Disorder	Consumers Affected
Mental Retardation, not otherwise specified	38
Hypoxic Encephalopathy/Cerebal palsy	19
Down's Syndrome	7
Alzheimer's disease	5
Porencephaly	3
Microcephaly	2
Cri du Chat Syndrome	2
Schizophrenia	2
Atherosclerotic Cerebrovascular Disease	2
Complications of Leptomeningitis	1
Klippel-Feil Syndrome	1
Seizure Disorder/Brain trauma	1
Head Trauma	1

Cause of Death

Cause of death is defined as the natural underlying pathological condition or injury that initiates the chain of events which will bring about the demise. The majority of the deaths in the MRDD population for calendar years 2001 through 2003 were due to medical conditions as listed in Table 8 below.

Manner of Death

The manner of death refers to the circumstantial events surrounding the death. The manner of death, as determined by the forensic pathologist, is an opinion based on the known facts concerning the circumstances leading up to and surrounding the death, in conjunction with the findings at autopsy and the laboratory tests.[2]

Of the 89 deaths reviewed during 2001-2003, the manner of death was determined as natural for seventy-nine individuals. Six deaths were determined to have been accidental. Of these, 3 cases were related to traffic accidents, 1 case was due to a fall, and 2 cases were due to choking on solid food. In one case, manner of death was undetermined. Information on three cases was unavailable pending out-of-state requests for death information.

[2] V.I.D. DiMais Forensic Pathology 2nd Edition, 2001

Appendices

Mental Retardation Developmental Disabilities Review Committee

By virtue of the authority vested in me as Mayor of the District of Columbia pursuant to section 422(2) of the District of Columbia Home Rule Act of 1973, as amended, 87 Stat. 790. Pub. L.No.93-198, D.C. Code1-242(2)(1999 Repl.), it is hereby ORDERED that 2001-27:

I. ESTABLISHMENT

There is hereby established in the government of the District of Columbia the District of Columbia Mental Retardation and Developmental Disabilities Administration Fatality Review Committee (herein referred to as the Committee)

II. PURPOSE

The District of Columbia MRDDA Fatality Review Committee shall examine events and circumstances surrounding the deaths of District wards or residents in the District with mental retardation, developmental disability or other disabling condition (ODC) in an effort to reduce the number of preventable deaths; assist the District in gaining Empirical evidence into fatalities occurring within the community; Provide a mechanism for the District government and community to become actively involved in reducing the factors that negatively impact the health, safety and welfare of the target population; and promote improved and integrated public and private systems serving District residents.

III. Duties

A. Expeditiously review deaths of residents living in group homes, foster homes, nursing homes or any other health care entity licensed by and located in the District of Columbia;

B. Identify the causes and circumstances contributing to deaths of District wards (DW) or residents with mental retardation, developmental disability or ODC;

C. Identify and evaluate services to ensure that all systems, public and private, which are responsible for protecting or providing services to DW or the District's population with mental retardation or a developmental disability or ODC are accountable;

D. Develop and monitor plans for the implementation of recommendations for systemic changes within the various governmental and private agencies and/or programs interfacing with DW or residents with mental retardation, developmental disability, or ODC; and

E. Develop and monitor plans for 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 maltreatment.

IV FUNCTIONS

The Committee shall:

V. COMPOSITION OF THE FATALITY REVIEW COMMITTEE

The members, as designated hereunder, shall be appointed by the Mayor based on individual expertise in relevant disciplines and their familiarity with the laws, standards and services related to the protection of the health and welfare of DW or residents with mental retardation, developmental disability, or ODC in the District of Columbia.

A. Eight (8) public members from the community who are not employees of the Government of the District of Columbia. All efforts shall be made to ensure proportionate representation from each ward of the District;

B. Two (2) faculty members from Schools of Social Work from colleges/Universities in the District of Columbia;

C. Two (2) physicians who practice in the District of Columbia with experience in the evaluation and treatment of mentally retarded, developmentally disabled or ODC persons;

D. Ex officio members shall include the department head or designee thereof from following agencies/institutions/committees or its successor programs:
   1. Department of Human Services (DHS):
      a. Mental Retardation and Developmental Disabilities Administration (MRDDA)
      b. Adult Protective Services (APS)
      c. Rehabilitative Services Administration (RSA)
      d. Office of Inspections and Compliance)OIC)
   2. Office of the Chief Medical Examiners (OCME)
   3. Department of Health (DOH)
      a. Medical Assistance Administration (MAA)
      b. State Center for Health Statistics (SCHS)
   c. Health Regulation Administration (HRA)
   d. Bureau of Injury and Disability Prevention (BIDP)
   4. Metropolitan Police Department, Criminal Investigations Division (MPD)
   5. Office of the Corporation Counsel (OCC) [Office of the Attorney General]
   6. Office of the Inspector General (OIG)
   7. Commission [Department] on Mental Health (DMH)
   8. Fire Department & Emergency Medical Services, EMS Director

E. The following agencies may be included, should they agree to participate:
   1. Office of the United States Attorney for the District of Columbia
   2. Superior Court of the District of Columbia

The Chief Medical Examiner for the District and a social service professional who practices and/or teaches in the District with experience in the evaluation and provision of services to persons with mental retardation or developmental disability shall be appointed by the Mayor as Co-Chairpersons and shall serve at the pleasure of the Mayor.

VIII. AGENCY LIAISONS: ROLES AND RESPONSIBILITIES

Each agency/program shall designate a Community Liaison to work directly with the Coordinator. This person shall serve as the primary point of contact for the agency, and shall be responsible for facilitating the process of providing information fro that agency for the review process. Some of the duties of the Liaisons shall include:

A. Provide timely and proper notification to the Committee of fatalities of DW's.
B. Search the records of the Agency;
C. Provide requested documents, data and information to the Coordinator (which may include results of internal reviews);
D. Prepare the agency Committee member(s) for meetings of the Committee or Advisory Board; and
E. Provide follow-up information to the Coordinator as requested

IX. TEAM STRUCTURES

The Committee shall convene as the full Committee and as an Advisory Panel.

A. Full Committee

1. A minimum of two-thirds of the members shall be present to constitute a quorum. Meetings of the full Committee will be for the purpose of:
   a. Conducting case reviews, or assessing additional data from prior cases that have since become available;
   b. Consideration of recommendations arising from available case reviews;
   c. Preparation of the annual report;
   d. Any other business necessary for the Committee to operate or fulfill its duties.

2. Case review meetings of the full Committee shall be held monthly, if there are cases for review. After procedures have been established, reviewedand tested the Committee may consider holding care review meetings bimonthly, if practicable.). The full Committee may also convene monthly or ad hoc meetings as needed for additional case reviews, or for other specific purposes of the committee, e.g., development of recommendations, preparation of the Annual Report.
3. The Committee shall conduct multi-disciplinary reviews of the events and circumstances surrounding the deaths of DW's as defined in Section II, in order to provide the data to fulfill the Purposes and Duties of the Committee as enumerated in Sections II and III, respectively.
4. Case reviews will occur at the next Committee meeting after the Committee receives notification of the fatality, or at the first meeting after sufficient materials are received for conducting the review. 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 to conduct the review, at which time a comprehensive shall be conducted.

(d)Office of the Corporation Counsel (OCC)
(e)Metropolitan Police Department (MPD)
(f)Office of the Inspector General (OIG)

4. The Panel may also include the following agencies, should they agree to participate:
(a) Office of the US Attorney for the District of Columbia
(b) District of Columbia Superior Court.

X CASE REVIEW CRITERIA AND PROCEDURES

A. All deaths of DWs older than 18 years of age will be reviewed by the Committee. (Note: Deaths of DWs who are 18 years of age or less will be reviewed by the Child Fatality Review Committee.)

B. Factors of particular concern for review include:

1. All violent or unexpected manners of death (I.e.g, homicide, suicide, accident, underdetermined), which include all deaths caused by injuries, including but not limited to:

(a) blunt trauma, including fractures
(b) burns
(c) asphyxia or drowning
(d) poisoning or intoxication
(e) gunshot wounds
(f) Abuse, either physical or sexual
(g) Neglect, including medical and custodial
(h) Malnourishment or dehydration
(1) Circumstance or events deemed suspicious

C. The Committee may, at its discretion, review groups of sudden, unexpected or unexplained deaths of DWs to examine aggregate data in order to address specific issues or trends.

D. DWs who live in facilities outside the District, or who die outside the District, will be subject to review by the Committee, and will be included in the Annual Report, both for statistical analysis and recommendations. The Committee members shall serve as liaisons to their counter parts in outside jurisdictions for the purpose of gathering information and obtaining documents (e.g., police or autopsy reports) to complete the review.

XI. CASE NOTIFICATION PROCEDURES

A. District agencies and service providers contracted by the District to serve DWs shall provide written notification to the Committee within 24 hours of any death of a DW, or within 24 hours of becoming aware of such a death. The sources of case notifications will include but not limited to:

1. MRDDA
2. Contracted service providers (e.g., group home staff)
3. OIC

XIV. CONFIDENTIALITY

A. A key tenet of the Committee is the necessity for keeping confidential all information obtained by, presented to and considered by the Committee. Any information gathered in preparation for or divulged during Committee reviews may not be disclosed for purposes other than those outlined in this Mayor's Order. All participants in the Committee proceedings shall be required to sign a confidentiality statement during all Committee case review meetings and in general meetings where any specific case is discussed. Case specific information distributed during the meeting shall be collected at the end of each review. Any required participant who is not willing to sign a confidentiality statement or abide by the confidentiality requirements shall not be allowed to participate in case review meetings.

B. Confidentiality Protocols

Methods for ensuring that all information identifying DWs and their families is protected against disclosure are:

1. The Committee Coordinator shall be designated as the individual responsible for receiving and protecting all records.
2. During the notification and case selection process, every case will be assigned a number identifier and a record established. The full name of the DW and family shall be maintained in the case records at all times during the review planning process.
3. All case records shall be maintained in a locked file cabinet at all times unless in use by the Committee Coordinator or other designated staff of the Committee
4. All records from other agencies/programs shall be obtained by or delivered directly to the committee Coordinator. Once the necessary documents from the various member agencies/programs related to service delivery or interventions provided to the DW are received, they shall be maintained in the case record only.
5. A case summary shall be prepared for each case and stapled to the left side cover of the file folder, for use by the Coordinator and chair of the review meeting.
6. No further duplication of documents is permitted.
7. Any documents distributed during the review shall only identify the DW by the Committee case number identifier.
8. Upon completion of the review of a case, all documents/information distributed shall be returned to the Committee Coordinator or other designated Committee Staff. One (1) copy shall be maintained in the case record, along with a copy of the list of review participants, confidentiality statements for each review participant and the agenda. The remaining copies of the information distributed shall be shredded immediately after the review.
9. The final report from each review, describing the discussion, analysis of issues and recommendations, shall be prepared and included in the case record, which must be maintained in a secured file cabinet. These report are not public documents and shall be maintained only in the Committee record. Persons where were involved with the family may review only the final report. Review may only occur in the Committee office and copying or faxing of these documents is not permitted.

Examiner. Expenses shall be obligated against funds designated for the purpose by the Department of Human Services or the Executive Office f the Mayor.

All agencies of the District of Columbia government that were involved with the DW shall cooperate with the Committee and provide timely access to information necessary to carry out its duties, subject to the applicable District and Federal statutes and regulations governing privacy, dissemination and confidentiality of information.

XVIII. EFFECTIVE DATE

This Order shall become effective immediately.

(5) "Community-based services" means non-residential specialized or generic services for the evaluation, care and habilitation of mentally retarded persons, in a community setting, directed toward the intellectual, social, personal, physical, emotional or economic development of a mentally retarded person. Such services shall include, but not be limited to, diagnosis, evaluation, treatment, day care, training, education, sheltered employment, recreation, counseling of the mentally retarded person and his or her family, protective and other social and socio-legal services, information and referral, and transportation to assure delivery of services to persons of all ages who are mentally retarded.

(5A) "Competent" means to have the mental capacity to appreciate the nature and implications of a decision to enter a facility, choose between or among alternatives presented, and communicate the choice in an unambiguous manner.

(6) "Comprehensive evaluation" means an assessment of a person with mental retardation by persons with special training and experience in the diagnosis and habilitation of persons with mental retardation, which includes a sequence of observations and examinations intended to determine the person's strengths, developmental needs, and need for services. The initial comprehensive evaluation shall include, but not be limited to, a physical examination that includes the person's medical history; an educational evaluation, vocational evaluation, or both; a psychological evaluation, including an evaluation of cognitive and adaptive functioning levels; a social evaluation; and a dental examination.

(7) "Council" means the Council of the District of Columbia.

(8) "Court" means the Superior Court of the District of Columbia.

(8A) "Crime of violence" has the same meaning as in § 23-1331(4).

(8B) "Customer" means a person admitted to or committed to a facility pursuant to subchapter III of this chapter for habilitation or care.

(9) "Department of Human Services" means the Department of Human Services of the District of Columbia.

(10) "Director" means the administrative head of a facility, or community-based service and includes superintendents.

(11) "District" means the District of Columbia government.

(11A) "DSM-IV" means the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

(11B) "DSM-IV "V' Codes" means "V" codes as defined in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

(12) "Education" means a systematic process of training, instruction and habilitation to facilitate the intellectual, physical, social and emotional development of a mentally retarded person.

(13) "Facility" means a public or private residence, or part thereof, which is licensed by the District as a skilled or intermediate care facility or a community residential facility (as defined in D.C. Regulation 74-15, as amended) and also includes any supervised group residence for mentally retarded persons under 18 years of age. For persons committed or for whom commitment may be sought under § 7-1304.06a, the term "facility" may include a physically secure facility or a staff-

(18) "Mental retardation advocate" means a member of the group of advocates created pursuant to § 7-1304.13.

(19) "Mental retardation" or "mentally retarded" means a substantial limitation in capacity that manifests before 18 years of age and is characterized by significantly subaverage intellectual functioning, existing concurrently with 2 or more significant limitations in adaptive functioning.

(19A) "MRDDA" means the Mental Retardation and Developmental Disabilities Administration of the District of Columbia, Department of Human Services.

(20) "Normalization principle" means the principle of aiding mentally retarded persons to obtain a lifestyle as close to normal as possible, making available to them patterns and conditions of everyday life which are as close as possible to the patterns of mainstream society.

(21) "Qualified mental retardation professional" means:

(A) A psychologist with at least a master's degree from an accredited program and with specialized training or 1 year of experience in mental retardation; or

(B) A physician licensed by the Commission on Licensure to Practice the Healing Arts to practice medicine in the District and with specialized training in mental retardation or with 1 year of experience in treating the mentally retarded; or

(C) An educator with a degree in education from an accredited program and with specialized training or 1 year of experience in working with mentally retarded persons; or

(D) A social worker with:

(i) A master's degree from a school of social work accredited by the Council on Social Work Education (New York, New York), and with specialized training in mental retardation or with 1 year of experience in working with mentally retarded persons; or

(ii) With a bachelor's degree from an undergraduate social work program accredited by the Council on Social Work Education who is currently working and continues to work under the supervision of a social worker as defined in sub-subparagraph (i) of this subparagraph, and who has specialized training in mental retardation or 1 year of experience in working with mentally retarded persons; or

(E) A rehabilitation counselor who is certified by the Commission on Rehabilitation Counselor Certification (Chicago, Illinois) and who has specialized training in mental retardation or 1 year of experience in working with mentally retarded persons; or

(F) A physical or occupational therapist with a bachelor's degree from an accredited program in physical or occupational therapy and who has specialized training or 1 year of experience in working with mentally retarded persons; or

(G) A therapeutic recreation specialist who is a graduate of an accredited program and who has specialized training or 1 year of experience in working with mentally retarded persons.

(22) "Resident of the District of Columbia" means a person who maintains his or her principal place of abode in the District of Columbia, including a person with mental retardation who would be a resident of the District of Columbia if the person had not been placed in an out-of-state facility by the District. A person with mental retardation who is under 21 years of age shall be deemed to be

LEGISLATIVE HISTORY OF LAW 2-137. --See note to § 7-1301.02.

LEGISLATIVE HISTORY OF LAW 10-253. --See note to § 7-1301.02.

LEGISLATIVE HISTORY OF LAW 11-52. --See note to § 7-1301.02.

LEGISLATIVE HISTORY OF LAW 14-199. --Law 14-199, the "Civil Commitment of Citizens with Mental Retardation Amendment Act of 2002," was introduced in Council and assigned Bill No. 14-616. The Bill was adopted on first and second readings on June 4, 2002 and July 2, 2002, respectively. Signed by the Mayor on July 17, 2002, it was assigned Act No. 14-432 and transmitted to Congress for its review. D.C. Law 14-199 became effective on October 17, 2002.

ANALYSIS
Construction
Guardian

CONSTRUCTION.

When construing D.C. Code 7-1301.03(1), as it applies to a person who is only mildly retarded, the inclusion of the words "at least moderately mentally retarded" in the definition of "admission" was an oversight by the City Council, and as such, voluntary admissions are available to mentally retarded persons regardless of their degree of retardation. *In re Bicksler, App. D.C., 501 A.2d 1 (1985).*

GUARDIAN.

The term "guardian", as used in the definition of respite care under D.C. Code § 7-1301.03(23), does not include a government entity such as the Department of Human Services, even if it acts as a provider of care to a mentally retarded person given the emphasis in the legislative history on maintaining family ties with a mentally retarded person. *In re Williams, App. D.C., 471 A.2d 263 (1984).*

4. EFFECTIVE DATE: This Order shall be effective nunc pro tunc to May 7, 2004.

ANTHONY A. WILLIAMS
MAYOR

ATTEST: _____
SHERRYL HOBBS NEWMAN
SECRETARY OF THE DISTRICT OF COLUMBIA

16. *Complications of small Bowel Obstruction due to Fibrous Adhesions Following remote Laparotomy for Appendectomy
17. Porencephaly and its sequelae

18. Acute peritonitis due to perforation of duodenum by migrated gastrostomy feeding tube placed for treatment of porencephaly

19. Acute Bronchopneumonia due to Atherosclerotic Cardiovascular Disease

20. Hypertensive and Arteriosclerotic Cardiovascular Disease/Diabetes Mellitus

21. Complications of Aspiration Pneumonia due to Cerebral Aqueduct Stenosis with hydrocephalus due to probable old leptomeningitis

22. *Fluvoxamine Intoxication

23. Pyelonephritis due to prolonged immobility following resection of ruptured esophageal segment due to esophageo-gastric junction scarring after naso-gastric intubation for treatment of small bowel obstruction after surgical repair of perforated pyloric peptic ulcer

24. *Pneumonia/Chronic Obstructive Pulmonary Disease

25. Methicillin resistant staphylococcus aureus sepsis following cholecystectomy, complicating Microcephaly due to infantile Meningoencephalitis

26. Complications of intestinal Obstruction of undetermined etiology

27. Choking with airway obstruction by sausage due to paranoid Schizophrenia

28. Seizure disorder due to global hypoxic-ischemic encephalomalacia, etiology unknown.

29. Hypoxic Encephalopathy due to dislodgement of Tracheostomy tube placed for treatment of pneumonia complicating Trisomy 21

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

18. Recurrent Bronchopneumonia complicating Pulmonary Emphysema

19. Acquired Immunodeficiency Syndrome

20. Cerebral Palsy and Seizure Disorder of Undetermined Etiology

21. Bronchopneumonia due to Hypertensive Cardiovascular Disease

22. Cri Du Chat Syndrome

23. Gastrointestinal Hemorrhage due to Duodenal Ulcer

24. Hypertensive and Valvular Cardiovascular Disease

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

19. Hypertensive and Atherosclerotic Cardiovascular Disease

20. *Down's Syndrome

21. Acute Bronchopneumonia due to Immobility due to Congestive Heart Failure due to Hypertensive Cardiovascular Disease/Polymyalgia Rheumatica, Rheumatoid Arthritis

22. Seizure Disorder due to remote Blunt Impact Head Trauma

23. Hyperosmolar Coma Due to Diabetes Mellitus

24. Pulmonary Thromboembolism due to Deep Venous Thrombosis of the lower extremities due to reduced mobility due to hospitalization for Pneumonia due to Cerebral Palsy and Mental Retardation, etiologies unknown.

25. *Atherosclerotic Cardiovascular Disease

26. Metastatic Gastric Cancer

27. Septic Complication Following repair of Incarcerated Inguinal Hernia

28. Pulmonary Postirradiation Fibromatosis Following Radiation Therapy for the Treatment of Breast Cancer

29. Hypoxic-Ischemic Encephalopathy with Cortical Laminar Necrosis due to Presumed Birth Hypoxia-Ischemia, undetermined etiology

30. *Adult Respiratory Distress Syndrome due to Sepsis due to Aspiration Pneumonia/ Cri Du Chat Syndrome

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

• The FRC recommends that MRDDA oversee the placement of consumers in skilled nursing facilities with a medical professional review of coordination of care and the appropriateness of health care services delivered.	MRDDA has a comprehensive protocol that is activated for each consumer upon entering a nursing home. The protocol includes close medical, clinical and case management oversight and interaction with the nursing home staff.
• The FRC recommends that the KOBA Institute [or current contract agency] change the section of the investigative report from Recommendations to Suggestions, thereby reserving the term "recommendations: for the action the Committee formally proposes to address systemic issues or deficiencies.	Pending an Official Response: The KOBA Institute's emergency contract with the District to do investigations into the deaths of MRDDA customers has expired. The current contractor is the Columbus Organization. DHS and MRDDA will not adopt this recommendation due to their requirements of court supervision in the case. The court requires that "...investigations will result in written reports which include findings and recommendations".
• The FRC recommends that a viable policy on the refusal of treatment be developed, which takes into account the issue of competency and the provision of appropriate support, such as that client can make a good informed decision, and not avoid or be denied medical care for life threatening conditions.	Pending an Official Response: The "Surrogate Decision Making for Medical Care Act of 2002" has been drafted and submitted to the City Council for consideration and action. This legislation addresses issues of competency, standards and procedures to determine whether a customer can give "informed consent" to authorize or to refuse medical treatment. In those cases where the customer is unable to provide such consent, an independent panel will have the authority to determine whether substituted consent can be provided on behalf of the consumer. Once the legislation receives final approval by District officials and counsel, it will be submitted to the Council of the District of Columbia for legislative action.
• The FRC recommends that MRDDA conduct appropriate documentation and supervision [training] to meet the standards of the case management system.	MRDDA's Bureau of Case Management developed and implemented new performance standards for the Case Management System. These new performance standards are the measures by which case managers are rated in job performance. The standards measure case management tasks for completeness and accuracy. The Performance Standards provide supervisors with appropriate tool to measure and assess the case manager's performance of their specific duties, i.e., completing the required number of consumer visits, appropriate use of available tools, reporting requirements, etc.
• The Committee recommends that some guidelines be put in place at the residential facilities for the care of customer who for whatever reason are no able to participate in their day program.	Existing ICF/MR regulations, Medicaid Provider agreements and contracts contain standards that govern activities that should

	be made available to consumers who remain home from day programs due to illness or other reasons. Planned activities are also identified in the ISP to ensure that consumers are participating in their day programs or receiving active treatment when they are not in attendance.
• The FRC recommends that the Office of the Corporation Counsel (OCC) conduct a comprehensive assessment of the issue of DNR orders for MRDDA clients. OCC may assemble a working group as needed to accomplish this task.	The Office of the Attorney General for the District completed an in-depth review and determined that Do Not Resuscitate orders cannot be issued or authorized by the District or any of its agents.
• The Committee recommended that nursing and group home should be staffed at adequate levels with properly trained personnel. The staff should monitor and document the care of MRDDA client and their adherence to internal quality assurance protocols on a routine basis. Group and nursing homes that do not have internal quality assurance measures should establish them. MRDDA should monitor compliance with these standards and report poor care and irregularities to the Health Regulation Administration.	Federal and local regulations provide specific staff-to-consumer ratios for residential and day providers. These regulations also contain requirements for initial and periodic ongoing training for staff that provide support to consumers. Nursing and group homes are required by regulation to monitor care, keep clinical notes, document medication administration, and all other supports provided to consumers. These regulations hold the "Governing Body" of group and nursing homes responsible for upholding quality standards, and HRA, the enforcement arm for these groups, can and does enforce these regulations. MRDDA monitors group homes for performance and compliance with policy and standards, offers technical assistance when necessary, follows up on incidents and alert findings and refers to HRA for enforcement when other efforts are unsuccessful.
• The FRC recommends that MRDDA develop policies regarding coordination of care in acute care facilities including a process for reporting issues related to quality of care.	DHS currently has a protocol to address reporting issues related to quality of care, however, DHS has no jurisdiction or authority over acute care facilities. A protocol will be developed addressing MRDDA's response when customers are admitted to an acute care facility.
• The FRC recommends that MRDDA develop procedures to address coordination of hospital discharge planning, pain management and follow up of end of life care.	Pending an Official Response: MRDDA has developed a Comprehensive Health Care Plan that includes partnerships with the Departments of Health and Mental Health and community-based contracting partners as well. The Plan is the overall vehicle for providing coordinated medical support and care for MRDDA's consumers, and the Coordination of Care Policy is being developed to closely fit within the context of the Plan.

• The FRC recommends that IMIU follow up on the deficiencies of the provider's performance as noted in Mortality Investigation	The DHS/IMIU issued dispositions to Providers to ensure concerns are addressed. MRDDA has a process to conduct "Mortality Reviews" with residential providers who support MRDDA consumers that have expired. The Mortality Review Committee members include staff from the IMIU unit, MRDDA Clinical Services Division, Bureau of Case Management, and the Quality Assurance Unit. As soon as the mortality investigation is received for any deceased MRDDA consumer, IMIU staff contact the residential provider to schedule a Mortality Review Committee meeting. An established agenda is followed, and dispositions, corrective actions and recommendations are shared with Provider units of DHS and/or MRDDA as appropriate.
• The FRC recommends that death investigations shall include an interview of the primary care physician when healthcare and communication issues are identified	The DHS/IMIU Contract Manager for the investigation contract has communicated this recommendation to the contractor. The contractor will be monitored for compliance.
• The FRC recommends that MRDDA incorporate the integration of End of Life issues into consumers' person-centered plans as appropriate. MRDDA shall develop a training module on End of Life quality issues as part of the person-centered planning curriculum.	MRDDA's Training Division offers comprehensive End of life training to community stakeholders, including those who participate in consumer's IPS teams.
• The FRC recommends that the Nursing Board promulgate regulations that establish acceptable ratios of LPN's to ICF-MR facilities.	The Nursing Board is currently in the process of revising and updating regulations related to the scope of practice for registered and practical nurses and will take into consideration the recommendation to address staffing patterns for nursing personnel in residential settings.
• The FRC recommends providers ensure each consumer's quarterly medical review includes an assessment of prescribed medications. This must include a pharmacological review to determine whether the medications have any contra-indications with other medications, side effects, and/or food or dietary limitations that could impede the medication's effectiveness or, if taken in conjunction with the medication, could cause a consumer's diagnosis to worsen. The provider must ensure that the provider physician reviews, at least on a quarterly basis, the consumer's medication record for, but not limited to, medication errors, duplicate prescriptions, interactions and contra-indications.	This recommendation is under consideration by MRDDA. The major outcome for the Comprehensive Health Care Plan is to provide appropriate, timely medical supports to MRDDA consumers. As each consumer's health risk management plan is individually developed, monitoring intervals by clinical and medical staff are built in. Health interventions will be based on the findings of the scheduled monitoring by health professionals.
• The FRC recommends that MRDDA ensure that the oversight of clinical reviews and coordination of health care services on medically fragile individuals is conducted by the appropriate health care professionals. This will require that MRDDA assign adequate numbers of staff.	MRDDA is currently realigning its Clinical Services Division to meet the requirements of its Comprehensive Health Care Plan. The Plan required that MRDDA and community providers oversee clinical

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Mental Health

NEUROLOGY SERVICE AT SAINT ELIZABETHS HOSPITAL
SMITH CENTER RM 509
WASHINGTON, DC 20032

TEL (202) 645-5722
FAX (202) 645-5751

September 24, 2004

Dr. Marie Pierre-Louis
Acting Chief,
District Of Columbia Office of the Chief Medical Examiner

Dear Dr. Pierre-Louis:

Thank you for asking me to review the draft of the MRDDA Annual Report. As you know, I am sometimes called upon to evaluate MRDDA patients in my role as Director of the Neurology Service for the Department of Mental Health. We also see patients with similar neurological disorders in the DMH. Many of these patients have severe, and often incapacitating, neurological disorders which in turn predispose them to major medical complications and place them at increased risk of death from these complications. For example, patients with advanced Alzheimer's disease, major CNS infarctions, severe congenital brain disorders such as porencephaly or microcephaly, hypoxic encephalopathies, and other severe CNS disorders, are well known to be at heightened risk for developing aspiration pneumonia. Thus, it does not surprise me at all that the most prevalent cause of death between 2001-2003 in the MRDDA population was respiratory ailments. Many of the other illnesses that you mention in section III of your report are likewise medical conditions to which this population is especially susceptible. Moreover, because of impairment in their inability to communicate or obviously manifest their symptoms, which can be profound, these patients may not come to medical attention as quickly as one might hope -- despite being under the supervision of caregivers. This in turn further increases the likelihood of their demise before corrective medical action can be implemented or have a beneficial effect. In addition, the MRDDA patient population is at risk for the same kinds of common medical conditions that one sees in the general population, for example cardiovascular disease and cancer, which I note are also well represented as causes of death in Table 10.

I would suggest a minor change in Table 9 (Primary Neurologic Disorders), specifically to change the column heading "Cause of Death" to "Neurological Condition" since these conditions are not the actual or direct cause of death, but are predisposing conditions in most instances.

In summary, your findings for the 2001-2003 are not surprising to me, and would seem compatible with the heightened risk for certain medical complications that one expects to see in the MRDDA population.

Thank you for asking for my opinion, and please feel free to contact me if you have any further questions.

Sincerely,

Steven S. Wolf, M.D., Director, Neurology Service
St. Elizabeths Hospital, DC Department of Mental Health