VIRGINIA DEPARTMENT OF HEALTH

ADULT FATALITY REVIEW IN VIRGINIA COMMUNITIES: TEAM PROTOCOL AND RESOURCE MANUAL

Office of the Chief Medical Examiner | 2015

Adapted from

Virginia's Family and Intimate Partner Violence Fatality Review
Team Protocol and Resource Manual

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Part I: Establishing a Team

Local and regional adult fatality review teams (AFRTs) are formed through voluntary efforts by individuals and agencies involved in the care and protection of elder and incapacitated adults. A number of persons may initiate the establishment of an AFRT, but a successful team requires cooperation and participation among multiple stakeholders. Beginning with a **team organizer**, this person takes the lead in identifying potential team members and convening early meetings. By law, the team organizer may be a representative from "any local or regional law-enforcement agency, department of social services, emergency medical services agency, attorney for the Commonwealth's office, community services board, or official with the Adult Protective Unit." An initial group of committed stakeholders identified by the team organizer make up the **core team**, which acts as a planning and implementation or steering committee. Core team members identify additional team members and move the team building process forward. Best practice suggests starting with a core group and then expanding to a **full team** as the process gains focus, approval and momentum. The full team is comprised of a multidisciplinary group of individuals and agency representatives who can commit to regular meetings and participate fully in the case review process.

There are several key dimensions or building blocks to consider in establishing the makeup and mission of the Team. Each is covered in more detail below.

- Determining jurisdiction
- Identifying team members
- Writing a mission statement
- Acquiring government endorsement
- Establishing policies and procedures
- Training on fatality review

There are as many ways to proceed through the steps of forming an AFRT as there are communities in Virginia. Using the wisdom and experience of the core team, each community has the flexibility to determine the best process in forming their team. This manual provides

insights and best practices from fatality review professionals and guidance in meeting statutory requirements for local and regional AFRTs in Virginia.

Resource 1: Establishing an Adult Fatality Review Team in Virginia: A Roadmap

Determining Jurisdiction

Any county or city, or combination of counties and/or cities, can implement an AFRT and review adult deaths that occur within the geographic boundaries of those localities. To determine the jurisdiction of the team, the organizer and core team members should consider the size and location of their community, the resources available for fatality review activities, and the number of deaths occurring there which are eligible for review. In addition, consider the degree of overlap and collaboration in service provision across locality boundaries and how this might support or challenge a multijurisdictional team approach to case review.

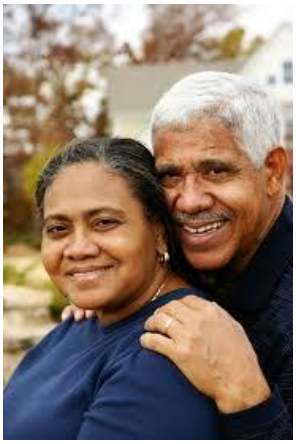
Identifying Team Members

The team organizer will begin the process of identifying potential team members and continue recruitment with the assistance and input of the core team. Potential stakeholders include agencies involved in the care and protection of adult populations or who are involved in the investigation of adult fatalities. The team organizer may represent one of the following local or regional entities:

- Adult Protective Services unit
- Commonwealth's attorney's office
- Community services board
- Department of social services
- Emergency medical services agency
- Law enforcement agency

Virginia law provides suggestions for team membership. There is no minimum or maximum team size. Teams in different communities vary in composition, size and structure. The most important factor in team membership is that all agencies and professions in your community reflecting the key stakeholders in adult health, safety and protection are at the table for review. Consider recruiting team members from the above agencies and from the following organizations:

- Advocacy or service organizations for the elderly and/or disabled
- Agency on aging or other department representing the interests of the elderly and/or disabled
- Centers for independent living
- Chief Medical Examiner's Office
- Funeral services providers
- Health care professionals specializing in geriatric care or care of incapacitated adults
- Health Department



- Human services agencies
- Judges
- Long-term care ombudsmen
- Long-term care providers
- Mental health agency
- Representatives of the local bar

Team organizers should ensure the team will have the capacity to identify fatalities for review, collect and interpret case facts relating to each agency's involvement in the case, and ultimately to facilitate policy and procedural change. In addition to having a good representation of local or regional service agencies at the table, the person who will represent that agency in regular team activities should be selected carefully. Team members should be multidisciplinary and diverse with respect to ethnicity, race, and gender. Ideal team members are seasoned, mature professionals with a solid background in issues relating to adult abuse, neglect and exploitation. Consider the following attributes of the model fatality review team member:

SELECTING THE RIGHT TEAM MEMBERS	
Able to commit to meetings	Reliable member participation is a hallmark for building trust among team members. Meeting times should be consistent and agency representatives should commit, in writing, to regular attendance before joining the team.
Non-defensive	An open-minded, non-defensive approach to case review promotes the free flow of information and creates an atmosphere for team members to analyze and question agency policy, procedure and response.
Experienced on the front line	First-hand experience with adult populations will provide an educated but critical eye toward the availability, consistency and effectiveness of agency services.
Able to influence agency policy	A team member's ability to implement agency changes based on recommendations from the team's case review, or to approach the decision makers who can, is critical for making needed changes recommended by fatality review teams.

Once the team organizer and/or core team have identified potential team members, a letter of invitation can introduce stakeholders to the concept of fatality review and outline their requested participation. Once several stakeholders have been identified, the team organizer can convene a meeting of prospective team members to share additional information about the process of forming an AFRT. If your team has drafted a mission statement or protocol (described below) or has proposed meeting times and locations, include this information for prospective team members.

A meeting of prospective team members can include a more detailed discussion of the mission and structure of the AFRT, the status of team formation, and plans for further development of the team and its processes. Invitees should be provided with the details of the formal Memoranda of Agreement (MOA) which members will be asked to sign before joining the team. This agreement can vary, but should include:

- Agency endorsement of the adult fatality review process and the team mission statement.
- Agency designation of a representative(s) to the team.
- Agency agreement to fully participate in the case review process through regular attendance at meetings and provision of case-specific documentation.
- Agency understanding of the rights and responsibilities regarding confidentiality, including applicable state law. Confidentiality agreements are generally executed with individual members in addition to a Memorandum of Agreement.

Resource 2: Letter of Invitation
Resource 3: Memorandum of Agreement
Resource 4: Interagency Cooperation/Confidentiality Agreement

Writing a Mission Statement

Mission statements clarify the team's purpose and communicate that purpose to outside agencies and organizations. They serve an especially important role in the early formation of the team. The team's mission statement is the foundation for seeking government endorsement, helps in recruiting additional team members, and defines its purpose for the community.

Because a mission statement helps to garner buy-in, teams should submit for review a draft of their mission statement to stakeholders or governmental officials who are critical to the successful establishment of the team. Vetting the mission statement with these key officials gives a team outside feedback and can help to streamline the formal approval process. Regional teams should vet the mission statement with each jurisdiction represented on the team.

Mission statements are not static. Indeed, they are likely to change over time as the team evolves. Teams should revisit their mission statement periodically to be sure it is consistent with the work and goals of the team.

Resource 5: Sample Mission Statements

Acquiring Government Endorsement

Before beginning case reviews, newly formed AFRTs should obtain a governmental resolution from their local city or county government. Government endorsement reinforces the importance of the team's mission and provides the team with local authority to begin reviews. Additionally, government endorsement can be a useful tool in continuing to develop community buy-in and recruiting team members. Most importantly, government endorsement closes the loop on community accountability in responding to adult deaths. An endorsement of the team is good support when it comes time to share recommendations and catalyze change in the community.

The core team should have a clear understanding of the political landscape of their community. Potential areas of support and resistance should be discussed prior to seeking endorsement. A plan tailored to your community will have the best success moving forward. Strategies for building support for government endorsement might include one or more letters of support from key government officials or agencies, or educational presentations given at community or governmental agencies. Once the team has support from local officials, the process of securing a formal endorsement might involve making contact with your city or county manager and submitting an agenda item for discussion and action at their City Council or Board meeting. Be sure to vet your draft resolution with stakeholders prior to formal submission. A multijurisdictional team should seek separate endorsements from each relevant locality represented on the team.

Resource 6: Letter of Support from Governmental Official
Resource 7: Sample Power Point Presentation on Adult Fatality Review Teams
Resource 8: City Council Agenda Item Summary
Resource 9: County Endorsement/Resolution

Establishing Policies and Procedures

Team policies and procedures, referred to as the team protocol once completed, include guidelines for case review as well as overall team functioning. Some teams start drafting their protocol in the early stages of development, while others wait until the full team is formed. One advantage to establishing policies and procedures early is that they can help facilitate team development and organization by specifying leadership and decision making structures. Whichever you chose, the draft protocol should be reviewed and approved by the full team before it is finalized. Sample elements of a team protocol include:

- Member roles and titles
- Membership rules and responsibilities
- Building and maintaining team capacity
- Protecting confidentiality
- Case review process
- Developing findings and recommendations
- Preparing team reports
- Communicating findings to your community and following up on recommendations

Drafting protocols can be time consuming and sometimes derail the momentum of a developing team. To avoiding dragging out the process, consider creating a subcommittee of team members who can quickly draft a protocol based on examples from other teams. Bring the draft back to the larger group and focus on approval of concepts. Avoid wordsmithing. Remember that your protocol is not set in stone and should in fact be revisited regularly and updated as needed.

Resource 10: Sample Domestic Violence Fatality Review Team Protocol: Fairfax, Virginia
Resource 11: Confidentiality Agreement A
Resource 12: Confidentiality Agreement B
Resource 13: Agreement to Maintain Confidentiality

Training on Fatality Review

Early team organizers should familiarize themselves with the theory and practice of fatality review so they can better answer questions about the process from stakeholders as the team gathers support. Once the full team is convened, new team members will need to be oriented to these concepts before they can start case review. Below is an overview of the principles and processes that commonly characterize fatality review methodology. Complex topics such as confidentiality are covered in more detail in Part II, which will be available in October of 2015.

Principles

No-blame, no-shame. The goal of fatality review is to save lives and improve a community's coordination and response to adult abuse and neglect. To this end, multidisciplinary professionals carefully examine and analyze the circumstances of a death. Fatality review does not seek to assign blame to any agency or individual, nor does it seek to reinvestigate a case.

Confidentiality. Successful team review hinges on members honoring the rights and responsibilities of confidentiality. A detailed discussion of this topic will be covered in Part II.

Member participation. By its very nature, fatality review requires that all involved agencies gather, present and contextualize case-specific facts. The absence of relevant information can compromise the process and results of case review.

Consensus decision-making. Fatality review is truly a group effort where members together analyze cases and develop findings and recommendations. The decision-making model most consistent with this group process is the consensus model, which will be detailed in Part II.

Process

1. ***Case identification and selection*****.** In identifying and selecting appropriate cases to review, the Code of Virginia provides a broad framework that allows a review of any person 60 years or older, or any adult age 18 years or older who is incapacitated, who:

- Was the subject of an Adult Protective Services or law enforcement investigation; or

- Whose death was due to abuse, neglect, or exploitation or acts suggesting abuse neglect or exploitation; or
- Whose death came under the jurisdiction of or was investigated by the Office of the Chief Medical Examiner as occurring in any suspicious, unusual, or unnatural manner.

The law requires that teams review only closed cases where no further criminal investigations or prosecutions are pending, or where the Commonwealth consents to the commencement of such a review prior to the completion of the criminal investigation. It is advisable to discuss pending criminal cases with your Commonwealth's Attorney. Regional teams should check with the Commonwealth's Attorneys of all relevant jurisdictions. Any team member can recommend a case for review, but in general members of the team most closely involved with the case - usually the Medical Examiner's Office, Adult Protective Services, Commonwealth's Attorneys or law enforcement - are excellent resources in selecting cases that fit Virginia's legal criteria for review.

The number and types of cases reviewed depends on many factors, including the number of local adult abuse or neglect fatalities and the goals and capacity of the team. Be aware that some cases can be difficult to identify. Deaths related to abuse, neglect or exploitation of vulnerable adults or elders are by their very nature unknown, hidden or uncounted, or they can be disguised by disease, illness or disability. Some options for review include the following:

- Review as broad a range of cases as possible, perhaps by choosing a designated period of time (for example, the year 2014 or the five year period from 2010-2014) and reviewing all deaths that fit the statutory guidelines. This approach may give you a broad overview of death cases in your community that are known to the system which was designed to respond to problems of adult or elder abuse, neglect or exploitation.
- Conduct a focused review of a single category of deaths, such those involving self-neglect or those occurring in an institutional setting. Reviews of this type provide the team and the community with an understanding of the unique dynamics of deaths and can spotlight critical gaps and needs for enhanced response and intervention.

- Create and agree on a protocol under which any team member, or any colleague of a member of a team, may recommend cases for review. Teams in other states have used this approach to identify and review deaths that may not have come to the attention of an agency or organization while the person was alive, but whose death was reported as suspicious by an emergency services provider, a funeral service provider, or the decedent's family member.

2. ***Case notification and information request.*** Team members are notified in writing of case selection. For privacy purposes and to assure the confidentiality of the review, many teams recommend that notification be made by U.S. mail or hand-delivered. Some teams opt to provide information on the next case to be reviewed at the end of a case review meeting. In this case, team members leave the meeting with information on the case to be reviewed and have time to prepare case information before the next meeting. Case specific information should not be communicated via e-mail unless steps are taken to encrypt the message. Team members should be provided with critical case identifiers such as the names of the victim and any alleged perpetrators (including aliases), birth dates, date of death, as well as a brief description of the fatal event.

3. ***Collection of case facts*****.** Case review involves the careful examination of events that led to fatal adult abuse or neglect. It begins with the collection of case facts gathered from all relevant community agencies and organizations, such as:

- Demographic information for the victim and perpetrator (e.g., age, gender, race, employment status, education and income level)
- Location of the fatal event
- Relationship of the parties involved in the fatal event
- Cause of death
- Risk factors and findings related to abuse, neglect or exploitation

- Community services requested, received or refused by the victim or perpetrator

Well-researched case facts enable the team to create a comprehensive picture of the fatal event and gain an understanding of gaps and problems in the system of response and/or services. Members are responsible for gathering all pertinent facts, documents and background information from their respective agencies. Their efforts in this regard will either support or undermine a successful case review.

Key Sources of Information:

- Adult protective services records
- Autopsy/Medical Examiner reports
- Health care information:
    - Emergency medical services records
    - Home health care provider records
    - Hospital records, including visits to emergency departments, nursing homes, assisted living facilities, or rehabilitation facilities
    - Medical/dental records, including photographs, diagrams if available
    - Medical provider interviews or records (particularly those regarding missed appointments, lack of follow-up from caregivers or patient, etc.)
    - Mental health records
- Law enforcement reports (all incident and investigative reports, call histories, 911 recordings)
- Prosecution records
- Witness/neighbor/family member interviews

Other Sources of Information:

- Animal control reports

- Banking records, ATM records
- Court files (all cases including criminal, civil, family and juvenile)
- Court advocate records
- Domestic violence/shelter service records
- Employment records
- Eyewitness reports from neighbors, lawn care companies, mail carriers, and other delivery persons
- Faith community interviews
- Family history genograms (including history of abuse, neglect or exploitation)
- Financial reports from savings and investment accounts
- Funeral Service provider records
- Guardian records
- Housing/landlord records (including maintenance records, neighbor complaints)
- Insurance policies
- Military records
- National Crime Information Center (NCIC) or criminal history records
- Newspaper articles/media accounts
- Security guard interviews
- Service records from other communities
- Social services records
- Suicide intervention reports
- Victim advocate records
- Weapons records

In addition to providing an agency's case-specific facts, members are expected to provide the team with a contextual understanding of this data. They are responsible for interpreting for the team, as thoroughly as possible, the actions of their agency or organization. Without this information, a team cannot create or effectively analyze a complete picture of the fatality.

4. *Organizing case facts.*

Compiling case facts. Once case facts are collected by members from their respective agencies, this information is compiled and organized. Teams can do this prior to the first case review meeting or during the meeting. Either method is acceptable and depends on the energy and staffing of the team. Generally, the compilation of case information prior to the team meeting requires a designated recorder or coordinator. S/he gathers, organizes and sometimes summarizes case information so it is ready when the team comes together at the case review meeting.

If case facts are not compiled prior to the team meeting, this task is done during the case review meeting by either a volunteer or designated recorder. A designated recorder is not necessary but makes data compilation and reporting more organized and efficient. It also allows other team members to focus on case discussion and synthesis rather than on taking notes.

Creating a case timeline. Timelines are an effective way of organizing case facts from various agencies and organizations. A timeline is a summarized listing of events leading up to a fatality. It describes each discrete event in a simple format identifying the date, agency and incident. An example of how a timeline is organized is as follows:

Date	Agency	Event(s)	Other
11/23/05	Emergency Room	Brought to the ER by daughter after a fall. Evaluated as "moderate to maximally dependent."	
12/01/05	Nursing Home	Discharged from nursing home following surgical recovery, complaint made by NH staff to APS out of concern for quality of care given at home.	
12/11/05, 12/25/05, 12/26/05, 01/18/06, and 02/14/06	Adult Protective Services	Home visits by APS attempted; no one answered door and APS was unable to reach anyone by phone. Unable to assess/investigate complaint; case closed.	

As shown in the example above, timelines refer to agency involvement and do not identify the names of individual service providers. Timeline chronology can begin with the fatal event and work backwards, or begin with the earliest contact and work forward to the time of death. Timelines may be created prior to or during the team's case review meeting(s). The last column is generally completed with the collective input of all members, and may include additional information, opportunities for intervention, recommendations or comments.

Some fatality review teams use a program such as PowerPoint to create a timeline during the case review meeting(s). A member/recorder makes timeline entries on a computer that projects the entries on a screen. This way, all team members can easily view and discuss the timeline.

5. ***Collecting and documenting case data.*** The team's findings may be disclosed or published in statistical or other form that does not identify individuals. To facilitate the collection and organization of statistical data gleaned from the case review process, a form or spreadsheet

should be used with each case to collect and document common factors such as demographics, event circumstances and risk factors. Data collection and documentation is described further below, and will be covered in more detail in Part III of the AFRT Protocol.

6. ***Team discussion, analysis, and documentation.*** Once the team has presented, reconciled, and compiled all case facts, the collective work of discussing and analyzing the case begins. There are multiple elements involved in the case review process. All are critical. Not all teams use the same terminology for this process, nor do they all use the same data collection or analysis methods. Likewise, there is no prescribed order to these functions; they are often done simultaneously and/or throughout the entire case review process.

A. ***Case Facts***

Discussion and analysis. Fatality review is truly a multidisciplinary process. Case information from a wide range of disciplines is brought to the table for discussion and analysis. Equally important is the coming together of the service providers themselves. This joining of information and stakeholders creates the most comprehensive picture possible of the life and death of an abuse or neglect victim. Through this process, teams have the unique opportunity to examine the complexities of adult abuse and neglect and of their system response. As mentioned earlier, the sharing of multidisciplinary information and perspectives is critical to effective case review and systems assessment.

A team member is responsible for bringing their agency's information to the table, for understanding that information, and for being able to contextualize that information for other team members—for example, by explaining his/her agency's policies and procedures, professional guidelines, resource limitations, etc. It is through this multidisciplinary education and discussion that team members are able to better understand the realities and identify strengths and gaps in how their community addresses adult abuse and neglect.

Documentation. Teams should complete some kind of comprehensive data collection form. This form captures detailed information about the victim and perpetrator, about the fatal event and about relevant case histories. It serves as a critical baseline for the team's quantitative case review reporting. We recommend that this form be as specific and closed-ended as possible, especially for a newer team less familiar with the case review process. This encourages the collection and reporting of case information that is more easily adapted to the next, and more complex, level(s) of case review, which is systems assessment.

Data collection forms and procedures are not static and may evolve over time. We encourage teams to periodically review and revise their processes and forms. This may be especially valuable for multijurisdictional teams, where existing protocols for response to vulnerable adults and reporting may vary among jurisdictions.

B. *System assessment.*

Discussion and analysis. This is often the most complex and critical level of case review. After all the facts and circumstances have been presented, the team synthesizes and analyzes this information. This process, which is the heart of multidisciplinary review, is detailed in Part II of the AFRT Protocol Manual. As individuals and as a team, members apply critical thinking to the system responses identified in the case. This is not necessarily a separate step of case review. It may be happening on an individual or team basis throughout the entire review process.

Experienced teams report that this level of analysis improves and becomes easier with time, especially if the team has an effective, systematic method of case review in place.

Documentation. Like the case facts data collection form, the systems assessment data collection form serves multiple functions. It encourages discussion and analysis at the systems level. It also serves as a record-keeping and data collection tool which can help streamline the findings and recommendations process where individual case review information is tabulated

and analyzed. New teams may resist filling out forms. But experienced teams have found that these documents encourage higher-level critical thinking and make their work easier when they begin developing findings and recommendations.

Case review will be different for every team but shares many basic elements. Using the descriptions and experiences of other teams, an AFRT will find the process and the data collection tools that work for them. We recommend that teams familiarize themselves with the case review guidelines as well as the protocols and reports of other teams.

Fatality review is a complex process and a team's work will grow more efficient and sophisticated over time. As with other aspects of AFRT functioning, we recommend that teams network with and learn from other death review teams whenever possible.