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I. VIRGINIA § 32.1-283.6; enacted 07/01/2015

§ 32.1-283.6. Local and regional adult fatality review teams established; membership; authority; confidentiality; immunity.

A. Upon the initiative of 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 Services Unit established pursuant to § 51.5-148, local or regional adult fatality review teams may be established for the purpose of conducting contemporaneous reviews of local adult deaths in order to develop interventions and strategies for prevention specific to the locality or region. For the purposes of this section, the team may review the death of any person age 60 years or older, or any adult age 18 years or older who is incapacitated, who resides in the Commonwealth and who is in need of temporary or emergency protective services (i) who was the subject of an adult protective services or law-enforcement investigation; (ii) whose death was due to abuse, neglect, or exploitation or acts suggesting abuse, neglect, or exploitation; or (iii) 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, pursuant to § 32.1-283. Each team shall establish rules and procedures to govern the review process. Agencies may share information but shall be bound by confidentiality and execute a sworn statement to honor the confidentiality of the information they share. A violation of this subsection is punishable as a Class 3 misdemeanor. The Office of the Chief Medical Examiner shall develop a model protocol for the development and implementation of local or regional adult fatality review teams and such model protocol shall include relevant procedures for conducting reviews of adult fatalities.

B. Local and regional teams may be composed of the following persons from the localities represented on a particular board or their designees: a medical examiner appointed pursuant to § 32.1-282, a local adult protective services official, a local social services official, a director of the relevant local or district health department, an executive director of the local area agency on aging or other department representing the interests of the elderly or disabled, a chief law-enforcement officer, the attorney for the Commonwealth, an executive director of the local community services board or other local mental health agency, a local judge, and such additional
persons as may be appointed to serve by the chair of the local or regional team. The chair shall be elected from among the designated membership. The additional members appointed by the chair may include, but are not restricted to, representatives of local human services agencies, local health care professionals specializing in geriatric care or care of incapacitated adults, local emergency medical services personnel, local long-term care providers, representatives of local advocacy or service organizations for elderly or disabled populations, experts in forensic medicine and pathology, local funeral services providers, local centers for independent living, local long-term care ombudsmen, and representatives of the local bar.

C. Each local or regional team shall establish operating procedures to govern the review process prior to conducting the first adult fatality review. The review of a death shall be delayed until any criminal investigations connected with the death are completed or the Commonwealth consents to the commencement of such review prior to the completion of the criminal investigation.

D. All information and records obtained or created regarding a review of a fatality shall be confidential and shall be excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 9 of §2.2-3705.5. All such information and records shall be used by the team only in the exercise of its proper purpose and function and shall not be disclosed. Such information and records shall not be subject to subpoena, subpoena duces tecum, discovery, or introduction into evidence when obtained through such other sources solely because the information and records were presented to the team during the fatality review. No person who participated in the review and no member of the team shall be required to make any statement as to what transpired during the review or what information was collected during the review. Upon the conclusion of the fatality review, all information and records concerning the victim and family shall be returned to the originating agency or destroyed. However, the findings of the team may be disclosed or published in statistical or other form that does not identify any individuals. The portions of meetings in which individual cases are discussed by the team shall be closed pursuant to subdivision A 21 of § 2.2-3711. All team members, persons attending closed team meetings, and persons presenting information and records on specific fatalities to the team during closed meetings shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific death. A violation of this subsection is punishable as a Class 3 misdemeanor.
Members of teams, as well as their agents and employees, shall be immune from civil liability for any act or omission made in connection with participation in an adult fatality review team review, unless such act or omission was the result of gross negligence or willful misconduct. Any organization, institution, or person furnishing information, data, testimony, reports, or records to review teams as part of such review shall be immune from civil liability for any act or omission in furnishing such information, unless such act or omission was the result of gross negligence or willful misconduct.

II. MISSION STATEMENT

The Metro Richmond Adult Fatality Review Team (MRAFRT) in accordance with Virginia §32.1-283.6 has been established to examine the circumstances of fatal events involving any person aged 60 years or older, or any adult aged 18 years or older, who was incapacitated at the time of the fatal event, who resided in the Richmond metro area (the City of Richmond and the counties of Chesterfield and Henrico) and/or who was in need of temporary or emergency protective services. The mission of MRAFRT is to better understand and thus prevent deaths due to abuse, neglect, or exploitation or other means as defined in Virginia §32.1-283.6 by constructively examining the fatal circumstances and making recommendations based on our reviews.

III. MEMBERSHIP

The Metro Richmond Adult Fatality Review Team shall consist of the following structure:

a) **Core Group**: The core group members shall be reflective of all jurisdictions in the metro Richmond area (City of Richmond and counties of Chesterfield and Henrico) and represent the following areas: local human services agencies, local emergency medical services, local long-term care ombudsmen, community services boards, law enforcement agencies, VA Center on Aging, and Commonwealth’s Attorney’s Offices. Core group members must be willing to commit to meeting attendance, serving in a leadership role, and a willingness to accept new ideas. Group members shall be involved in the following tasks (1) development and revision of policies and procedures; (2) case type selection; and (3) the determination of meeting structure.
b) **Co-Chairs:** Two core group members, representing two of the four present jurisdictions, who shall be asked to serve as co-chairs, are required to commit to a term of two (2) years, adhering to a plan of succession. Their role shall be to facilitate the fatality review team meetings, provide all administrative functions, and ensure compliance with regard to the founding statute and the policies and procedures set forth in these operating guidelines.

c) **Data Recorder:** The Data Recorder is a member of the core team and selected by the co-chairs to record all relevant data required by the MRAFRT and any additional data collection determined by the team to be relevant to the case review process. The Data Recorder has the responsibility of storing the data collected as well as the modification and maintenance of all data collection instruments. Additionally, the Data Recorder shall be responsible for the storage of said collection.

d) **Team Organizer:** The Team Organizer orientates new members and maintains membership retention and Affidavits of Confidentiality. The Team Organizer modifies and updates the operating guidelines, capturing policy issues as they arise, and relevant forms other than data collection instructions. The Team Organizer is responsible for coordinating meeting logistics. The team organizer will assist the Data Recorder in their absence and also may take on other responsibilities that arise per the core team’s request.

e) **Team Members:** All above positions are considered team members. Each team member, with the sole exception of the co-chairs, shall commit a term of membership that is one (1) year in duration and is subject to his or her employment status. All team members shall sign an Affidavit of Confidentiality when joining the MRAFRT. Team members should be consistent in their attendance and have the ability to collect and provide information from their agency at meeting. Team members may represent (but are not limited to) the following: local health care professionals specializing in geriatric care or care of incapacitated adults, local long-term care providers, representatives of local advocacy or service organizations for elderly or disabled populations, experts in forensic medicine and pathology, local funeral services providers, local centers for independent living. Each member is responsible for presenting the team with information from their agency’s records as well represent their profession.

f) **Guests:** This includes individuals or representatives of agencies who may, on a case-to-case basis, be invited to participate on specific reviews if determined to have information that may be pertinent to the case. Notification should be provided to a co-chair prior to the meeting, with the understanding that one of the co-chairs will reach out to the guest as a means of providing orientating information.
IV. CONFIDENTIALITY AND COMMUNICATIONS

- Team records are exempt from the Virginia Freedom of Information Act, and cannot otherwise be disclosed or subpoenaed. No team member or participant shall be required to make any statement as to what transpired during the review or what information was collected during the review.

- Team members and participants providing information, as well as their agents and employees, are immune from civil liability for any act or omission made in connection with participation in family violence fatality review, unless such act or omission was the result of gross negligence or willful misconduct.

- Team members, other than the co-chairs, should not consent to media interviews concerning the MRAFRT without the knowledge and agreement of the core team.

- HIPPA: Death review team members that are covered entities (i.e. healthcare agencies, healthcare providers) can disclose protected health information during the death review meetings without violating the Privacy Rule. Data released during the meeting shall be relevant and specific to the purposes of the death review.

- At the beginning of each case review, each team member in attendance shall sign a statement of confidentiality.

- The co-chairs and/or data recorder shall be the custodians of any confidential document(s) produced by the fatality review team during the review and shall ensure that they are promptly destroyed or returned to the presenting agency or department upon the completion of recommendations for each predetermined group of cases reviewed.

- The co-chairs and/or data recorder shall see that all documents, including data collection tools concerning the review are secured at all times until the documents are destroyed or returned to the presenting department or agency.

- Any violation of the Code of Virginia regarding confidentiality during reviews shall be subject to investigation and prosecution via criminal justice process. Any member found to be in violation of confidential agreements is subject to disbarment from future participation on the MRAFRT.
• VAWA: Domestic and Sexual Violence Agencies: if a person is deceased, information about a victim may be released. If a person is not deceased and services were provided to the person with Office on Violence Against Women funding, the information should be protected (42 U.S.C. 13925(b)(2)).

V. CASE REVIEW PROCEDURES

a.) Case Selection: A case can be reviewed if it meets the following criteria:

1.) The death of any persons aged 60 or older or any adult age 18 years or older, who was incapacitated at the time of the fatal event, who resided in the Commonwealth, and/or who was in need of temporary or emergency protective services and/or one of the following named below:

   i. Who was the subject of an adult protective services or law enforcement investigation
   ii. Whose death was due to abuse, neglect, or exploitation or acts of suggested abuse, neglect, or exploitation
   iii. 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

2.) Incapacitated person is defined, in accordance with 22 VAC 30-100-10, as the following:
   “Any adult who is impaired by reason of mental illness, intellectual disability, physical illness or disability, advanced age or other causes to the extent that the adult lacks sufficient understanding or capacity to make, communicate or carry out reasonable decisions concerning his or her well-being. This definition is for the purpose of establishing an adult's eligibility for adult protective services and such adult may or may not have been found incapacitated through court procedures.”

3.) The fatal event occurred within one of the following jurisdictions:
   • Chesterfield County
   • Henrico County
   • Richmond City
4.) All criminal investigations, prosecutions and appeals connected with the fatal event are completed.

5.) Based on above information, the core team will determine the types of cases that the team will review and any additional parameters.

b.) Notification and Information Collection: It is a procedure of the MRAFRT that once a case is selected for review, the co-chairs will mail or provide in person a confidential case notification form to all team members at least 30 days prior to the scheduled case review meeting. Notification shall be placed in a sealed envelope marked “confidential.” Upon receipt, team members shall gather all information relevant to his or her agency involvement or non-involvement in the case. Each member should be prepared to present their agency information at the upcoming meeting in an organized and chronological manner. More specifically, team members are requested to identify and review all pertinent records and compile all relevant information of their respective agency’s involvement with the case. If a team member is unable to attend the case review meeting, reports or other documents related to the review should be forwarded to the co-chairs, prior to the review. At the conclusion of each case review, the co-chair(s) and/or data recorder shall collect all case review records in a method that ensures no documents remain in circulation.

VI. RECOMMENDATIONS

The MRAFRT reviews the circumstances that led up to adult fatalities in the Metro Richmond area in an effort to identify indicators, patterns, and trends. After a predetermined group of cases are reviewed, a report will be generated. This report will consist of data complied via review as well as specific written recommendations aimed at strengthening policies, practices and broad-based prevention strategies.