



House of Representatives

General Assembly

File No. 386

February Session, 2006

Substitute House Bill No. 5199

House of Representatives, April 5, 2006

The Committee on Public Health reported through REP. SAYERS of the 60th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING THE ESTABLISHMENT OF THE FATALITY REVIEW BOARD FOR PERSONS WITH DISABILITIES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective from passage*) (a) There is established a
2 Fatality Review Board for Persons with Disabilities. The fatality review
3 board shall investigate the circumstances surrounding the untimely
4 deaths of persons with disabilities, including the untimely deaths of all
5 clients under the care of the Department of Mental Retardation, that, in
6 the opinion of the director of the Office of Protection and Advocacy for
7 Persons with Disabilities warrant a full and independent investigation.
8 In addition, the fatality review board may investigate the
9 circumstances surrounding deaths as described in subsection (b) of
10 section 46a-11c of the general statutes. In order to facilitate a prompt
11 investigation of the circumstances surrounding the untimely death of a
12 client under the care of the Department of Mental Retardation, said
13 director may refer a particular case to the fatality review board prior to
14 the completion of a review conducted by the Independent Mortality

15 Review Board pursuant to the provisions of section 17a-210 of the 2006
16 supplement to the general statutes, as amended by this act.

17 (b) The Fatality Review Board for Persons with Disabilities shall
18 consist of the following six members: The director of the Office of
19 Protection and Advocacy for Persons with Disabilities, the Chief State's
20 Attorney or his designee and four members appointed by the
21 Governor, one of whom shall be a law enforcement professional with a
22 background in forensic investigations, one of whom shall be a mental
23 retardation professional and two of whom shall be medical
24 professionals. The Commissioner of Mental Retardation or the
25 commissioner's designee shall serve as a nonvoting liaison to the
26 fatality review board. The director of the Office of Protection and
27 Advocacy for Persons with Disabilities shall serve as chairperson of the
28 fatality review board and may assign agency staff and hire consultants
29 with expertise as necessary to assist the board in the completion of its
30 investigation.

31 (c) In accordance with the requirements set forth in section 46a-13a
32 of the general statutes, all relevant state, local or private agencies shall
33 cooperate and assist the fatality review board in the performance of its
34 statutory duties.

35 (d) On or before February 1, 2007, and annually thereafter, the
36 fatality review board shall report, in accordance with section 11-4a of
37 the general statutes, on its investigations to the Governor, and to the
38 joint standing committees of the General Assembly having cognizance
39 of matters relating to human services and public health.

40 Sec. 2. Section 17a-210 of the 2006 supplement to the general statutes
41 is repealed and the following is substituted in lieu thereof (*Effective*
42 *from passage*):

43 (a) There shall be a Department of Mental Retardation. The
44 Department of Mental Retardation, with the advice of a Council on
45 Mental Retardation, shall be responsible for the planning,
46 development and administration of complete, comprehensive and

47 integrated state-wide services for persons with mental retardation and
48 persons medically diagnosed as having Prader-Willi syndrome. The
49 Department of Mental Retardation shall be under the supervision of a
50 Commissioner of Mental Retardation, who shall be appointed by the
51 Governor in accordance with the provisions of sections 4-5 to 4-8,
52 inclusive. The Council on Mental Retardation may advise the
53 Governor on the appointment. The commissioner shall be a person
54 who has background, training, education or experience in
55 administering programs for the care, training, education, treatment
56 and custody of persons with mental retardation. The commissioner
57 shall be responsible, with the advice of the council, for: (1) Planning
58 and developing complete, comprehensive and integrated state-wide
59 services for persons with mental retardation; (2) the implementation
60 and where appropriate the funding of such services; and (3) the
61 coordination of the efforts of the Department of Mental Retardation
62 with those of other state departments and agencies, municipal
63 governments and private agencies concerned with and providing
64 services for persons with mental retardation. The commissioner shall
65 be responsible for the administration and operation of the state
66 training school, state mental retardation regions and all state-operated
67 community-based residential facilities established for the diagnosis,
68 care and training of persons with mental retardation. The
69 commissioner shall be responsible for establishing standards,
70 providing technical assistance and exercising the requisite supervision
71 of all state-supported residential, day and program support services
72 for persons with mental retardation and work activity programs
73 operated pursuant to section 17a-226. [The commissioner shall conduct
74 or monitor investigations into allegations of abuse and neglect and file
75 reports as requested by state agencies having statutory responsibility
76 for the conduct and oversight of such investigations. In the event of the
77 death of a person with mental retardation for whom the department
78 has direct or oversight responsibility for medical care, the
79 commissioner shall ensure that a comprehensive and timely review of
80 the events, overall care, quality of life issues and medical care
81 preceding such death is conducted by the department and shall, as

82 requested, provide information and assistance to the Independent
83 Mortality Review Board established by Executive Order No. 25 of
84 Governor John G. Rowland. The commissioner shall report to the
85 board and the board shall review any death: (A) Involving an
86 allegation of abuse or neglect; (B) for which the Office of Chief Medical
87 Examiner or local medical examiner has accepted jurisdiction; (C) in
88 which an autopsy was performed; (D) which was sudden and
89 unexpected; or (E) in which the commissioner's review raises questions
90 about the appropriateness of care.] The commissioner shall stimulate
91 research by public and private agencies, institutions of higher learning
92 and hospitals, in the interest of the elimination and amelioration of
93 retardation and care and training of persons with mental retardation.

94 (b) The commissioner shall conduct or monitor investigations into
95 allegations of abuse and neglect and file reports as requested by state
96 agencies having statutory responsibility for the conduct and oversight
97 of such investigations. In the event of the death of a person with
98 mental retardation for whom the department has direct or oversight
99 responsibility for medical care, the commissioner shall: (1) Promptly
100 report such death to the Office of Protection and Advocacy for Persons
101 with Disabilities, and (2) ensure that a comprehensive and timely
102 review of the events, overall care, quality of life issues and medical
103 care preceding such death is conducted by the department and shall,
104 as requested, provide information and assistance to the Independent
105 Mortality Review Board established by Executive Order No. 25 of
106 Governor John G. Rowland and on and after the effective date of this
107 section, to the Fatality Review Board for Persons with Disabilities,
108 established pursuant to section 1 of this act. The commissioner shall
109 report to the board and the board shall review any death: (A)
110 Involving an allegation of abuse or neglect; (B) for which the Office of
111 Chief Medical Examiner or local medical examiner has accepted
112 jurisdiction; (C) in which an autopsy was performed; (D) which was
113 sudden and unexpected; or (E) in which the commissioner's review
114 raises questions about the appropriateness of care.

115 [(b)] (c) The commissioner shall be responsible for the development

116 of criteria as to the eligibility of any person with mental retardation for
117 residential care in any public or state-supported private institution
118 and, after considering the recommendation of a properly designated
119 diagnostic agency, may assign such person to a public or state-
120 supported private institution. The commissioner may transfer such
121 persons from one such institution to another when necessary and
122 desirable for their welfare, provided such person and such person's
123 parent, conservator, guardian or other legal representative receive
124 written notice of their right to object to such transfer at least ten days
125 prior to the proposed transfer of such person from any such institution
126 or facility. Such prior notice shall not be required when transfers are
127 made between residential units within the training school or a state
128 mental retardation region or when necessary to avoid a serious and
129 immediate threat to the life or physical or mental health of such person
130 or others residing in such institution or facility. The notice required by
131 this subsection shall notify the recipient of his or her right to object to
132 such transfer, except in the case of an emergency transfer as provided
133 in this subsection, and shall include the name, address and telephone
134 number of the Office of Protection and Advocacy for Persons with
135 Disabilities. In the event of an emergency transfer, the notice required
136 by this subsection shall notify the recipient of his or her right to
137 request a hearing in accordance with subsection [(c)] (d) of this section
138 and shall be given within ten days following the emergency transfer.
139 In the event of an objection to the proposed transfer, the commissioner
140 shall conduct a hearing in accordance with subsection [(c)] (d) of this
141 section and the transfer shall be stayed pending final disposition of the
142 hearing, provided no such hearing shall be required if the
143 commissioner withdraws such proposed transfer.

144 [(c)] (d) Any person with mental retardation who is eighteen years
145 of age or older and who resides at any institution or facility operated
146 by the Department of Mental Retardation, or the parent, guardian,
147 conservator or other legal representative of any person with mental
148 retardation who resides at any such institution or facility, may object to
149 any transfer of such person from one institution or facility to another
150 for any reason other than a medical reason or an emergency, or may

151 request such a transfer. In the event of any such objection or request,
152 the commissioner shall conduct a hearing on such proposed transfer,
153 provided no such hearing shall be required if the commissioner
154 withdraws such proposed transfer. In any such transfer hearing, the
155 proponent of a transfer shall have the burden of showing, by clear and
156 convincing evidence, that the proposed transfer is in the best interest
157 of the resident being considered for transfer and that the facility and
158 programs to which transfer is proposed (1) are safe and effectively
159 supervised and monitored, and (2) provide a greater opportunity for
160 personal development than the resident's present setting. Such hearing
161 shall be conducted in accordance with the provisions of chapter 54.

162 ~~[(d)]~~ (e) Any person, or the parent, guardian, conservator or other
163 legal representative of such person, may request a hearing for any final
164 determination by the department that denies such person eligibility for
165 programs and services of the department. A request for a hearing shall
166 be made in writing to the commissioner. Such hearing shall be
167 conducted in accordance with the provisions of chapter 54.

168 ~~[(e)]~~ (f) Any person with mental retardation, or the parent, guardian,
169 conservator or other legal representative of such person, may request a
170 hearing to contest the priority assignment made by the department for
171 persons seeking residential placement, residential services or
172 residential support. A request for hearing shall be made, in writing, to
173 the commissioner. Such hearing shall be conducted in accordance with
174 the provisions of chapter 54.

175 ~~[(f)]~~ (g) Any person with mental retardation or the parent, guardian,
176 conservator or other legal representative of such person, may object to
177 (1) a proposed approval by the department of a program for such
178 person that includes the use of behavior-modifying medications or
179 aversive procedures, or (2) a proposed determination of the
180 department that community placement is inappropriate for such
181 person placed under the direction of the commissioner. The
182 department shall provide written notice of any such proposed
183 approval or determination to the person, or to the parent, guardian,

184 conservator or other legal representative of such person, at least ten
 185 days prior to making such approval or determination. In the event of
 186 an objection to such proposed approval or determination, the
 187 commissioner shall conduct a hearing in accordance with the
 188 provisions of chapter 54, provided no such hearing shall be required if
 189 the commissioner withdraws such proposed approval or
 190 determination.

191 Sec. 3. Subsection (d) of section 17a-451 of the 2006 supplement to
 192 the general statutes is repealed and the following is substituted in lieu
 193 thereof (*Effective from passage*):

194 (d) The commissioner shall coordinate the community programs
 195 receiving state funds with programs of state-operated facilities for the
 196 treatment of persons with psychiatric disabilities or persons with
 197 substance abuse disabilities, or both. In the event of the death of a
 198 person with psychiatric disabilities or a person with substance abuse
 199 disabilities, or both, for whom the department has direct or oversight
 200 responsibility for medical care and treatment because such person is
 201 receiving inpatient treatment at a state-operated or state-funded
 202 hospital, the commissioner shall promptly report such death to the
 203 director of the Office of Protection and Advocacy for Persons with
 204 Disabilities.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage</i>	New section
Sec. 2	<i>from passage</i>	17a-210
Sec. 3	<i>from passage</i>	17a-451(d)

Statement of Legislative Commissioners:

In Subsec. (a) of section 1, "Fatality Review Board" has been redesignated as the "Fatality Review Board for Persons with Disabilities" to distinguish this board from other state entities that review fatalities. In Subsec. (b) of section 2, the phrase "and on and after the effective date of this section, to the Fatality Review Board for Persons with Disabilities, established pursuant to section 1 of this act"

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 07 \$	FY 08 \$
Departments of Mental Retardation and Mental Health & Addiction Services; and the Office of Protection & Advocacy for Persons with Disabilities	GF - None	None	None

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill codifies the Fatality Review Board for Persons with Disabilities, as established in Executive Order #25 (February 2002), and the reporting of deaths of people under the Department of Mental Retardation's care to the Office of Protection and Advocacy for Persons with Disabilities. The bill implements current practice and will not result in any fiscal impact. The bill also creates an additional reporting requirement for the Department of Mental Health and Addiction Services. This requirement will not result in any additional cost for the department.

The Out Years

There is no fiscal impact in the out years.

OLR Bill Analysis
sHB 5199***AN ACT CONCERNING THE ESTABLISHMENT OF THE FATALITY REVIEW BOARD FOR PERSONS WITH DISABILITIES.*****SUMMARY:**

This bill codifies, with changes, the Fatality Review Board (FRB) for Persons with Disabilities, which was created by Executive Order 25 in February 2002. The six-member board must investigate the circumstances surrounding untimely deaths of persons with disabilities, including all untimely deaths of people under the Department of Mental Retardation's (DMR) care, when the director of the Office of Protection and Advocacy for Persons with Disabilities (OPA) determines it is necessary.

The FRB must report on its investigations by February 1, 2007, and annually thereafter, to the governor and the Human Services and Public Health committees. Executive Order 25 requires annual reports to the governor and Public Health committees (see BACKGROUND).

The bill also requires the commissioner of the Department of Mental Health and Addiction Service (DMHAS) to promptly report deaths of individuals with psychiatric or substance abuse disabilities to OPA in certain circumstances.

EFFECTIVE DATE: Upon passage

FATALITY REVIEW BOARD (FRB)***Membership***

The bill constitutes the FRB with the following six members: (1) the OPA director; (2) the chief state's attorney; (3) and four members the governor appoints, one law enforcement professional with a forensic investigations background, one mental retardation professional, and two medical professionals.

The DMR commissioner or his designee serves as a nonvoting liaison to the FRB. The OPA director chairs the FRB and can assign agency staff and hire experts to help the board investigate.

Executive Order 25 already requires this composition and respective roles for agency heads.

Authority to Investigate When Abuse or Neglect Suspected

In addition to its mandate to review referrals from OPA, the bill allows the FRB to investigate deaths of people for whom DMR has direct oversight responsibility for medical care and whose deaths DMR believed were caused by abuse or neglect.

Current law requires the DMR commissioner to notify OPA within 24 hours when these deaths occur, and OPA generally must investigate them to determine whether abuse or neglect occurred. Its investigations follow protocols it establishes in consultation with the DMR commissioner.

DMR Mandate to Report Certain Deaths

The bill requires DMR, whenever someone for whom it has direct or oversight responsibility for medical care dies, to report the death promptly to OPA, regardless of whether abuse or neglect is suspected. Executive Order 25 directs DMR to make these reports but imposes no timeliness requirement.

Referrals to FRB Before Independent Mortality Review Board Completes Investigation

To facilitate prompt investigations of untimely deaths, the bill allows the OPA director to refer cases to the FRB before the Independent Mortality Review Board (IMRB), also established in Executive Order 25 (see BACKGROUND), finishes its review of medical care and other circumstances surrounding DMR client deaths. This authority already exists in the executive order.

The IMRB investigates deaths when either the DMR commissioner or OPA director believes the deaths were caused by abuse and neglect

or when it determines that a thorough review of the care quality and other circumstances surrounding the death is warranted.

The IMRB has not been codified but part of its charge has.

Obligation to Assist With Investigations

The bill requires all relevant state, local, or private agencies to cooperate and assist the FRB in performing its duties, in accordance with the law that requires them to cooperate with OPA in its investigations, including releasing client records with the client's consent.

By law, DMR must provide information and assistance to the IMRB, when asked. The bill requires DMR to do this for the FRB.

DMHAS Reporting

The bill requires the DMHAS commissioner to promptly report to OPA the death of anyone (1) who has a psychiatric disability, substance abuse disability, or both and (2) for whom DMHAS has direct or oversight responsibility for medical care and treatment because he is receiving inpatient treatment at a state-operated or -funded hospital.

BACKGROUND

Executive Order 25

In February 2002, Governor Rowland issued Executive Order No. 25, largely in response to a number of untimely deaths of DMR clients living in community living arrangements. The order required DMR to report to OPA all deaths of persons it placed or treated under the commissioner's direction, regardless of whether abuse or neglect was suspected.

It also established an Independent Mortality Review Board to review the medical care and other circumstances surrounding these deaths when either the DMR commissioner or OPA director believed the deaths were caused by abuse or neglect, or by its own review. By law, the board must review any death involving an allegation of abuse

or neglect, among other things.

Finally, it created a Fatality Review Board for Persons with Disabilities to investigate deaths that, in the OPA director's opinion, warranted a full and independent investigation, which could include individuals with other disabilities besides mental retardation.

PA 03-146, the result of a Legislative Program Review and Investigations Committee study, built on the executive order, creating additional requirements for the DMR commissioner when people for whom DMR had direct or oversight responsibility for medical care died. It also directed the OPA director, when allegations were made that the deaths could have been due to abuse or neglect, to determine whether such abuse or neglect occurred, unless a court ordered otherwise.

PA 04-12 (1) established a 24-hour deadline for the DMR commissioner to report to OPA deaths of anyone placed or treated under his direction and (2) shortened from five calendar days to 72 hours the time within which mandated reporters of suspected abuse or neglect of persons with mental retardations had to report to OPA.

Effect of Statutes on Executive Orders

In 1986, the attorney general issued a formal opinion in response to a series of questions about executive orders. One question was whether the legislature could amend or repeal an executive order. In his response, Attorney General Lieberman wrote that an act that the legislature passed that explicitly referred to the executive order and stating that it modified that order would alter it. He added that even if the executive order was not specifically cited, a "more recent and more specific legislative enactment dealing with the same subject matter would take precedence over an earlier executive order."

COMMITTEE ACTION

Human Services Committee

Joint Favorable Change of Reference

Yea 13 Nay 3 (03/14/2006)

Public Health Committee

Joint Favorable

Yea 26 Nay 0 (03/20/2006)