STATE OF CONNECTICUT
BY HER EXCELLENCY
M. JODI RELL
GOVERNOR
EXECUTIVE ORDER NO. 42

WHEREAS, Governor John G. Rowland initially issued Executive Order No. 25 on February 8, 2002 concerning the matters herein;

WHEREAS, certain provisions of such Executive Order have become dated, including its reference to the Department of Mental Retardation and use of the term mental retardation;

WHEREAS, this Executive Order seeks to remedy such issues and make other minor modifications, through the repeal and replacement of Governor John G. Rowland's Executive Order No. 25 with the text herein;

WHEREAS, the Office of Protection and Advocacy for Persons with Disabilities (OPA) is an independent agency, designated as Connecticut's protection and advocacy system for persons with developmental disabilities and authorized to advocate for the rights of all Connecticut citizens with disabilities;

WHEREAS, the OPA is required to oversee the Connecticut Developmental Services abuse and neglect reporting andinvestigation system;

WHEREAS, the Department of Developmental Services (Department) is required to ensure the health, safety, andwelfare of persons with intellectual disabilities who are placed or treated under the direction of the Commissioner of Developmental Services (Commissioner); and

WHEREAS, the Department is required to coordinate and develop comprehensive statewide services for Connecticutcitizens with intellectual disabilities, who are eligible for the services of the Department.

NOW THEREFORE, I, M. Jodi Rell, Governor of the State of Connecticut, by virtue of the authority vested in me by the Constitution and Statutes of the State of Connecticut, do hereby ORDER and DIRECT:

1. The Department shall report all deaths of persons placed or treated under the direction of the Commissioner of Developmental Services to OPA whether or not abuse or neglect is suspected to have contributed to the client's death.
2. There shall be a standing Independent Mortality Review Board (IMRB). A majority of members of the IMRB shall not be employees of the Department. The chairman of the IMRB shall be appointed by the Commissioner in consultation with the Executive Director of OPA (Executive Director) and shall consist of the following members or their designees:
    - The Department's Director of Health and Clinical Services,
    - The Department's Director of Quality Management Services,

- The Department's Director of Investigations,
- The State Medical Examiner,
- A medical doctor appointed jointly by the Commissioner and the Executive Director,
- The Commissioner of Public Health,
- Two members appointed by the Executive Director, and
- A private provider representative jointly appointed by the Commissioner and Executive Director.

The IMRB shall review the medical care and other circumstances surrounding the deaths of all clients under the Department's care where either the Executive Director or the Commissioner believe it is likely the death occurred because of abuse or neglect or where the IMRB determines that a thorough review of the quality of care and other circumstances surrounding the death of an individual is warranted. The IMRB shall also conduct expedited reviews of cases pending before the existing regional mortality review committees at the request of the Executive Director or the Commissioner.
After concluding its review, the IMRB shall report its findings and recommendations to the appropriate entities while ensuring that the privacy rights of individuals, families, and staff are not jeopardized and that such reporting will not inhibit or compromise the need for prompt and truthful reporting of abuse, neglect, and other untoward incidents.

3. IMRB review shall not limit the OPA's exercise of its investigatory mandates under state and federal law.

4. The IMRB shall report to the Governor and the Co-Chairs of the Public Health Committee annually. Such reports shall reflect data, trends, analysis and recommendations.

5. In addition to the IMRB, there shall be a standing Fatality Review Board for Persons with Disabilities (the Fatality Review Board) to investigate the circumstances surrounding those untimely deaths which, in the opinion of the Executive Director, warrant a full and independent investigation. In order to facilitate a timely investigation, the Executive Director may refer a particular case to the Fatality Review Board before the IMRB completes its review.

6. The Fatality Review Board shall be chaired by the Executive Director and shall consist of the following members who are appointed by the Governor:
   - One law enforcement professional with a background in forensic investigations,
   - One Developmental Services professional,
   - The Chief State's Attorney or his designee,
   - Two medical professionals, and
   - One person with expertise in teaching forensic investigation techniques.

   The Commissioner of Developmental Services or his designee shall serve as a non-voting liaison to the Fatality Review Board.

7. The Department and OPA shall enter into a memorandum of understanding outlining the

manner in which information will be shared between the Fatality Review Board and the Department.

8. The Fatality Review Board shall report to the Governor and the Co-Chairs of the Public Health Committee annually.

9. The Department shall:
    - Continue to employ a nurse within the Division of Investigations to review all untimely client deaths in conjunction with the State Police,
    - Increase the frequency of unannounced visits to private and public facilities licensed by the Department, and
    - Require that all providers post their licensing inspection report either in hard copy within each facility or the Department post licensing inspection reports on the Department's website.

10. Governor John G. Rowland's Executive Order No. 25 is repealed in its entirety and replaced with the text hereof.

11. This Order shall take effect immediately.

Dated in Hartford, Connecticut, this 5th day of April 2010.

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M. Jodi Rell, Governor

By Her Excellency's Command:

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Susan Bysiewicz, Secretary of the State