**U.S. Department of Justice**
Civil Rights Division

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DJ 168-80-24

*Special Litigation Section*
*950 Pennsylvania Ave, NW*
*Washington DC 20530*

April 3, 2020

**VIA EMAIL**

Allyson K. Tysinger, Esq.
Braden Curtis, Esq.
Assistant Attorneys General
Office of the Attorney General
Commonwealth of Virginia
202 North 9th Street
Richmond, Virginia 23219

Re: United States v. Virginia, No.: 3:12cv59; Review of deaths in FY17 of DBHDS service recipients.

Dear Ms. Tysinger and Mr. Curtis:

Attached is a final report providing a review of deaths of DBHDS service recipients in FY 2017. The purpose of the review was to assess the completeness and quality of Virginia's mortality data, analyze mortality patterns, and identify recommendations to improve Virginia's mortality review process. The foundation of this review is the Settlement Agreement's requirements that the Commonwealth conduct mortality reviews for unexplained or unexpected deaths of service recipients and that the Commonwealth's mortality review team "collect and analyze mortality data to identify trends, patterns, and problems . . . and develop and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable." Agreement § V.C.5.

This review was conducted at our direction by consultants from the Center for Developmental Disabilities Evaluation and Research (CDDER) of the Eunice Kennedy Shriver Center at the University of Massachusetts Medical School. CDDER has over 40 years of experience in providing research and program development to improve the lives of individuals with developmental disabilities and is considered a national leader in the field. CDDER and its director have particular expertise developing systems for identifying and monitoring risk and providing mortality analysis and incident data review to support quality management systems.

We appreciate the Commonwealth's assistance in making information for the review available to us and our consultants, and in providing additional data and clarification where

needed as a result of the parties' discussions regarding a draft of the report. One of the purposes of this review was to test the completeness of the system's data, and accordingly, when CDDER identified other individuals who died during FY 2017, the Commonwealth worked to determine whether those individuals had been receiving state-provided services at the time of their deaths. This is an important issue, as it has implications for whether the Commonwealth should have known about these deaths. As you know, it took significant time to resolve this issue in particular instances.

Another issue, which we know is of particular interest among stakeholders, is comparing mortality rates of individuals at the training centers to the mortality rates of individuals who have been discharged from training centers. We explored conducting such an analysis but determined, after serious consideration with our consultants, that it was not feasible to compare these mortality rates. Because the number of individuals remaining in the training centers is small, even slight changes in mortalities could lead to significant fluctuations in mortality rates, which would distort the analysis. Nevertheless, the report has important implications for DBHDS as it continues to serve individuals both in training centers and in the community.

We look forward to discussing CDDER's findings, assessments, and recommendations in the report with you and to working with the Commonwealth as it continues to improve the quality of its services and its mortality review process.

Sincerely,

/s *Jessica Polansky*

Jessica Polansky
Trial Attorney
Special Litigation Section

cc: Donald J. Fletcher, Independent Reviewer