



VOLUME 3: QUALITY MANAGEMENT	Effective Date: 8/08
CHAPTER 7: PATIENT SAFETY	Revision Date(s): 6/1/12
3.7.3: DEATH REPORTING AND REVIEW POLICY	Attachments: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

I. POLICY

This policy applies to all patients within the jurisdiction of the California Department of Corrections and Rehabilitation (CDCR). The California Correctional Health Care Services (CCHCS) shall conduct a death review of every in-custody inmate death.

The Headquarters' CCHCS Death Review Committee shall conduct an appropriate review, make all appropriate findings supported by that review and determine appropriate actions based on the findings, and forward their results to the institution clinical leadership and the appropriate Headquarters (HQ) programs and/or committees. The CCHCS Death Review will be conducted by a multidisciplinary Headquarters' CCHCS Death Review Committee. All deaths shall be reviewed by the CCHCS Death Review Committee within 30 business days of the date of death.

Each Death Review shall:

- Comply with any and all state and federal reporting requirements;
- Conduct a thorough review of the Electronic Unit Health Record (eUHR) and any other relevant supporting documentation of the inmate death;
- Include an objective and comprehensive clinical review of the health care provided;
- Identify lapses in care that may be related to the cause of death;
- Identify degree of preventability of death as one of the following: not preventable, possibly preventable, or preventable; and
- Create a single Death Review Summary in each case, incorporating input from all involved clinical disciplines into one unitary report that sets forth all the Committee's findings and any recommendations

This policy replaces Inmate Medical Services Policy and Procedure (IMSP&P) Volume 1, Chapter 7, Death Reporting and Review Policy in its entirety.

II. PURPOSE

The intent of this policy is to reduce the occurrence of preventable deaths by:

- Evaluating and assessing the overall quality of health care provided;
- Informing the institution Chief Executive Officer (CEO) of the Death Review Committee findings for dissemination to appropriate staff;
- Identifying opportunities for improvement and best practices;
- Identifying lapses in care that may be related to the cause of death;
- Identifying and recommending changes to clinical guidelines, policies or procedures;

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- Gauging opportunities for improvement or the need for immediate action at the institution;
- Noticing the appropriate peer review body of any professional practice issues; and
- Noticing appropriate HQ programs and/or committees as indicated of identified systemic vulnerabilities

III. RESPONSIBILITIES

The CCHCS Statewide Chief Medical Executive (SCME) and the Statewide Chief Nurse Executive (SCNE) have joint overall responsibility for compliance with this policy. The SCME and the SCNE will designate the Headquarters' CCHCS Death Review Committee's leadership and membership and oversee its operation.

The institution's CEO is ultimately responsible for that institution's compliance with this policy. The CEO shall establish specific mechanisms and responsibilities in the institution in order to carry out these responsibilities.

IV. REFERENCES

Federal Death in Custody Reporting Act of 2000 (PL 106-297)

National Commission on Correctional Health Care, Standard P-A-10, Procedure in the Event of an Inmate Death

California Code of Regulations, Title 15, Section 3365

Department Operations Manual, Article 7, Subsection 51070.1 through 51070.20

California Government Code Section 12525

California Penal Code Sections 5058 and 5021