



VOLUME 3: QUALITY MANAGEMENT	Effective Date: 8/08
CHAPTER 7: PATIENT SAFETY	Revision Date(s): 8/27/12
3.7.8: DEATH REPORTING AND REVIEW PROCEDURE	Attachments: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

I. DEATH REPORTING AND REVIEW GENERAL PROCESS:

- A. The objective of this procedure is to establish the process for California Correctional Health Care Services (CCHCS) to report and review all patient-inmate deaths within the jurisdiction of the California Department of Corrections and Rehabilitation (CDCR).
 - 1. The CCHCS Death Review Committee shall review all deaths within thirty (30) business days of the death.
 - a. The Death Review Committee shall submit an aggregate, executive report of all death reviews to the headquarter (HQ) and field executive leadership as designated by the CCHCS Statewide Chief Medical Executive (SCME) and the Statewide Chief Nurse Executive (SCNE).

II. RESPONSIBILITIES

The CCHCS SCME and the SCNE have joint overall responsibility for compliance with this procedure. The Statewide CME and the Statewide CNE will designate the Death Review Committee’s leadership and membership and oversee its operation.

The Institution’s Chief Executive Officer (CEO) is ultimately responsible for that institution’s compliance with this policy and procedure. The CEO shall establish specific mechanisms and responsibilities in the institution in order to carry out these responsibilities.

III. PROCEDURE DETAILS

A. Death Reporting – Institutions

- 1. Daily Reporting
 - a. Initial Inmate Death Report – CDCR Form 7229 shall be reported to the Death Review Unit via email at DeathReviewUnit@cdcr.ca.gov or fax to (916) 691-0659 as early as practical but no later than 1200 the following business day.
 - b. The CEO shall establish a procedure for the appropriate leadership staff at the institution and HQ to be noticed of an inmate death.

B. Document Submission

- 1. Within three business days, the Unit Health Record (UHR) shall be scanned and available within the electronic UHR (eUHR) to include the following.
 - a. UHR from six months prior to inmate death (non-suicide)
 - b. Entire UHR (suicide only or special request)
 - c. Institution and Community Inpatient Medical Records
 - d. Outpatient Housing Unit Medical Records

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2. Within five business days, the following documents, when applicable, are to be forwarded to the Death Review Unit via email DeathReviewUnit@cdcr.ca.gov or fax to (916) 691-0659.
 - a. Hospice Medical Records
 - b. Community Emergency Medical Services (EMS) generated documents
 - c. Emergency Care flow sheets (front and back)
 - d. CDCR Form 7219, Medical Report of Injury
 - e. CDCR Form 7362, Health Care Services Request
 - f. CDCR Form, 602 HC, Patient/Inmate Health Care Appeal
 - g. CDCR Forms 837 A, B & C, Crime/Incident Report

If the documents listed above are not submitted within the required time, the Death Review Unit shall notify the respective Chief Executive Officer, Chief Medical Executive, Chief Nursing Executive, Health Information Management Unit, or custody representatives requesting assistance with document acquisition.

C. Death Reporting – Headquarters

In addition to the following, the Death Review Unit shall comply with all state and federal reporting requirements.

1. Daily Death Report

The Death Review Unit shall compile a list of all reported deaths and forward to HQ and field executive leadership as well as designated external sources.

2. Weekly Death Report

The Death Review Unit will issue a weekly summary report of all deaths reported that week and forward to HQ and field executive leadership as well as designated external sources.

3. Monthly Death Report

- a. The Death Review Unit shall generate and forward an aggregate, executive report of all cases reviewed at the Death Review Committee the previous month to HQ and field executive leadership as well as designated external sources.
- b. The Death Review Unit shall generate and forward to the HQ CCHCS Executive Staff a monthly status report that will include at a minimum:
 - 1) Number of deaths that occurred during the reporting period
 - 2) Number of deaths reported late by the institutions
 - 3) Number of deaths per institution
 - 4) Number of cases that had been presented at the Death Review Committee
 - 5) Number of referrals generated by the Death Review Committee
 - 6) Number of case notifications forwarded to programs
 - 7) Number of confirmations acknowledging receipt/action of referrals/notifications by HQ programs/committees.
 - 8) Preventability/Improvement Matrix data

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- 9) Average number of days from date of death to presentation at the Death Review Committee
 - 10) Top Three Causes of Death
 - 11) Number of Closed Cases
4. Quarterly Death Report
The Death Review Unit shall generate an aggregate report containing all the data included in the Monthly Report.
 5. Annual Death Report
The Death Review Unit shall generate and forward an annual aggregate report.

D. The Death Reviewer

1. The Death Physician Reviewers shall be a Clinical Support Unit (CSU) Physician, designated by the CSU Deputy Medical Executive (DME).
2. The Death Nurse Reviewer shall be a Nurse Consultant Program Review (NCPR) Registered Nurse (RNs) designated by the Assistant Statewide Chief Nurse Executive.
3. The Physician/Nurse Reviewers cannot evaluate a case if they have provided care to the patient-inmate within the previous six months.
4. The Physician/Nurse Reviewers shall review all relevant documentation to complete a thorough, objective report of the health care provided to the patient-inmate. The summary shall be completed and approved by the appropriate DME/HQ CNE within ten (10) business days from the date of death.
5. Upon approval, summaries shall be submitted electronically to the Death Review Unit or via electronic entry in the Clinical Operations Review System data program.
6. The Death Review Unit will schedule the Physician/Nurse Reviewers to present the Death Review Summary at the Death Review Committee.

E. Death Review Summary Completion

1. CCHCS reviewers shall use the most recent edition of the Death Review Summary Template.
2. The reviewers shall complete the ICD 10 code section for the top three diagnoses listed as well as all cover page entry fields to the best of their knowledge.
3. CCHCS reviewer shall review a minimum of six months of the UHR and other appropriate documents (see section III.B.1-2) preceding the patient-inmate death to determine the appropriateness of clinical care related to the death; ascertain whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study. The review may extend further as an individual case may warrant.
4. Each Death Review Summary (Physician and Nurse) shall have:
 - a. Administrative review
 - b. Clinical review
 - c. A psychological autopsy will be performed by Mental Health Services if death is a suspected suicide. All suspected drug overdoses may be considered a suspected suicide and will include a Mental Health Services review.

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F. Death Review Committee

1. The Death Review Committee shall objectively discuss all reports and the listed findings in a fair, transparent and consistent manner and make referrals to the appropriate peer review committee and notifications to HQ programs/committees.
2. The Death Review Committee shall meet, at a minimum, on a bi-weekly basis for the purpose of conducting clinical death reviews to identify and improve professional practice and patient care by:
 - Evaluating the care provided to the patient-inmate contained in the Death Review Summary.
 - Evaluating the preventability of deaths with committee concurrence as Not Preventable, Possibly Preventable, or Preventable.
 - Identifying opportunities for improvement in the health care system.
 - Making recommendations for change to Clinical Care Guidelines.
 - Recommending statewide training or Continuing Medical Education (CME) programs on identified weaknesses.
 - Identifying and referring system issues to institution leadership and other HQ programs/committees as needed.
 - Identifying and referring deficiencies in clinical care of patient-inmates to the appropriate Peer Review bodies as indicated.
3. The Death Review Committee Chair(s) and voting members shall be composed of an interdisciplinary group designated by the CCHCS Statewide Chief Medical Executive (SCME) and the Statewide Chief Nursing Executive (SCNE) to include, at a minimum, Physician, Nursing, Allied Health, and Custody representatives. Mental Health, Dental, and institutional representatives may be considered.

IV. References

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

National Commission on Correctional Health Care (NCCHC) 2008 Standards for Health

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

Inmate Medical Services Policies and Procedures (IMSP&P) Volume 3, Chapter 7:

- 3.7.1 Patient Safety Program Policy
- 3.7.2 Adverse/Sentinel Event Review Policy
- 3.7.3 Death Reporting and Review Policy
- 3.7.4 Patient Safety Program Procedure: Patient Safety Committee
- 3.7.5 Patient Safety Program Procedure: Initial Triage/Assessment of Adverse/Sentinel Events
- 3.7.6 Patient Safety Program Procedure: Institution Response to an Adverse/Sentinel Event

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- 3.7.7 Patient Safety Program Procedure: Headquarters Adverse/Sentinel Event Committee

Mental Health Program Guides

The Federal Receiver's Analysis of Death Review (2006, 2007, 2008, 2009, 2010)