

**STATE OF CONNECTICUT
DEPARTMENT OF MENTAL RETARDATION**

Policy No. I.D.PO.001

Issue Date: March 15, 2002

Subject: Mortality Reporting and Review

Effective Date: March 15, 2002

Designated Area of Responsibility: Quality Enhancement

A. Policy Statement

The Department of Mental Retardation has a responsibility to the citizens it serves to ensure quality services including health care. One way to ensure quality is to receive timely notification of the death of every individual served by the department and to review the care provided for these individuals served prior to their deaths.

Deaths of all people served by the department shall be reported and documented as detailed in DMR procedure # I-D-PR-001, Mortality Reporting: Reporting Deaths of Individuals.

Deaths of all individuals for whom the department bears direct or oversight responsibility for medical care shall be subject to mortality review as one means of monitoring and evaluating the quality of health care and overall care provided to individuals served by the department. Mortality reviews shall also include a review of the quality of life issues and mission principles such as dignity and respect. The review process as delineated in DMR Procedure #I-D-PR-005 shall identify issues and concerns that may have compromised the medical, health or overall care provided to individuals in order to trigger corrective actions and reduce future risk.

Autopsies shall be pursued as outlined in DMR Procedures # I-D-PR-003, Reporting Deaths to the Office of the Chief Medical Examiner and #I-D-PR-004, Autopsies.

Deaths in which abuse or neglect is suspected shall be reported for investigation as indicated in the DMR Policy 2, Abuse and Neglect.

B. Applicability

This policy shall apply to all individuals who are served by the department and who are registered in the department's mainframe database (CAMRIS) including children in the Birth-to-Three System and adults registered with the department due to the 1987 Omnibus Reconciliation Act (OBRA) requirements.

C. References

1. Statutes
 - a. CGS 7-62-56, "Death Certificates"
 - b. CGS 7-15h, "Abuse of Elderly Persons"

- c. CGS 18-38a, “Abuse of Children”
 - d. CGS 19-17b, “Peer Review”
 - e. CGS 19a-405-413, “Medicolegal Investigations”
 - f. CGS 19a-406 (b), 19a-413, “Autopsy
 - g. CGS 19a-458, “Abuse of Persons who are Mentally Retarded”
 - h. CGS 53-73a, “Crimes”
2. Rules, Regulations and Policy – External
- a. [Executive Order No. 25, issued by John G. Rowland, Governor, February 8, 2002](#)
3. Rules, Regulations and Policy – DMR
- a. DMR Policy 2, Abuse Neglect
 - b. DMR 1-D-PR-001, Mortality Reporting: Reporting Deaths of Individuals
 - c. DMR 1-D-PR-002, Sudden/Unexpected Deaths
 - d. DMR 1-D-PR-003, Reporting a Death to the Office of the Chief Medical Examiner
 - e. DMR 1-D-PR-004, Autopsies
 - f. DMR 1-D-PR-005, Mortality Review