

**STATE OF CONNECTICUT
DEPARTMENT OF MENTAL RETARDATION**

Procedure No. I.D.PR.005
Subject: Mortality Review
Section: Quality Enhancement

Issue Date: March 15, 2002
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Revised: July 12, 2004

A. Purpose

The purpose of this procedure is to describe the mortality review process utilized by the DMR following the death of individuals served by the department. The mortality review process is designed to identify issues and concerns that may have compromised the medical, health, or overall care provided to individuals served by DMR and to trigger corrective action and reduce future risk.

B. Applicability

This procedure shall apply to all individuals for whom the department bears direct or oversight responsibility for medical care. This includes individuals living in programs operated, licensed, and/or funded by the department, including non-Connecticut residents living in such facilities. It also applies to individuals receiving supported living services, to individuals living in facilities licensed by the Department of Public Health if the department was involved with the placement decision, to individuals who died during participation in a DMR operated or funded day program and to individuals receiving respite services in a DMR operated or funded facility. This procedure shall also apply to individuals receiving individual supports as determined appropriate by the health service director.

C. Definitions

Commissioner: The Commissioner of the Department of Mental Retardation

Department: The Department of Mental Retardation (DMR).

Executive Director: The Executive Director of the Office of Protection and Advocacy for Persons with Disabilities (OPA)

Direct or oversight responsibility for medical care: The department bears direct or oversight responsibility for medical care for all individuals who live in DMR operated, funded, and/or licensed homes or facilities, who were placed in long-term-care facilities by the department, or who receive supported living services directly provided or funded by the department.

Individual: For this procedure, individual means a person for whom the department bears direct or oversight responsibility for medical care including non-Connecticut residents who receive services in DMR operated, licensed, and/or funded facilities or programs.

Independent Mortality Review Board (IMRB): A board appointed by the Commissioner to review events, overall care, quality of life issues, and medical care preceding an individual's death, to evaluate the quality of care and to make recommendations for needed improvement or training to enhance care and reduce risk. The composition of the board shall include the following members or their designees: DMR Director of Health and Clinical Services, DMR Director of Quality Assurance, DMR Director of Investigations, State Medical Examiner, a medical doctor appointed jointly by the Commissioner and the Executive Director of the Office of Protection and Advocacy, the Commissioner of Public Health, two individuals appointed by the Executive Director of the Office of Protection and Advocacy, and a Private Provider jointly appointed by the Commissioner and the Executive Director of Protection and Advocacy. The following non-voting staff may provide technical assistance and support to the IMRB, as determined necessary by the Chairperson: a regional health service director, regional case management director of supervisor, the Medical Director of the Southbury Training School, and the central office special protections coordinator.

Regional/STS Mortality Review Committee (RMRC): A committee appointed by the regional or STS director to review overall care, quality of life issues, and health care preceding an individual's death. The committee shall be chaired by the regional health service director or medical director and shall include at a minimum: Health Services/Nursing Director, Case Management Supervisor, Quality Improvement Director, a registered nurse who is not an employee of the department, and a person who will serve as a client advocate and who is not employed by the department. The Regional or STS Director may appoint the following staff as members of the RMRC or to serve in a technical assistance/support capacity: a residential manager and/or Assistant Regional Director, the regional abuse/neglect liaison, and a family representative.

Root Cause Analysis (RCA): a prescribed process that is always conducted by a team of individuals who are familiar with the incident under review, department policy and program requirements, and the RCA process itself.

D. Implementation

1. The death of any individual for whom the department bears direct or oversight responsibility for medical care shall undergo a mortality review by the Regional or STS Mortality Review Committee (RMRC).
2. The Independent Mortality Review Board (IMRB) shall conduct a review whenever
 - a. Determined necessary by the RMRC;
 - b. The Commissioner of DMR or the OPA Executive Director believes it is likely the death occurred because of abuse or neglect;
 - c. The review is part of the quality assurance audit process.

3. The Independent Mortality Review Board (IMRB) shall assume immediate jurisdiction and conduct an expedited review when determined necessary by the Commissioner or Executive Director, the Director of Quality Assurance, and/or the Director of Health & Clinical Services.
4. The Regional Mortality Review Committee process is as follows:
 - a. Each region and training school shall have a mortality review committee that reviews events preceding each death, which includes health care, overall care and quality of life issues. The health service director or the training school medical director shall chair the committee.
 - b. Case management supervisors shall be responsible for ensuring that case managers obtain and provide the RCMC with the required documentation in a timely fashion as detailed on the DMR Mortality Review form (See Attachment A)
 - c. The chairperson may assign responsibilities as needed to committee members.
 - d. Appropriate representatives directly involved with the care of the deceased individual may coordinate the presentation to the committee.
 - e. The RMRC shall detail its findings, recommendations and actions on the DMR Mortality Review form (See Attachment A) following the review and shall send it to the Independent Mortality Review Board (IMRB) within 90 days of the death. This report shall include:
 - i) Supporting documentation such as a copy of death certificate, relevant information from the individual's files, an autopsy report where applicable, and other relevant information such as that listed on the DMR Mortality Review form; and
 - ii) Documentation of the committee's decision as to whether the case was closed at the local level or whether a review by the IMRB is required.
 - f. If the RMRC determines that immediate referral to outside agencies for further investigation is warranted, the chairperson shall notify the central office director of health and clinical services to ensure appropriate tracking and follow-up of such actions.
 - g. The RMRC shall automatically refer a case for IMRB review whenever any of the following criteria are met:
 - i) The case involved an allegation of abuse or neglect.

- ii) The Office of the Chief Medical Examiner or local medical examiner accepted jurisdiction.
 - iii) An autopsy was performed.
 - iv) The individual's death was sudden and unexpected (e.g., the person was found dead or died shortly after admission to a hospital, or other similar situations).
 - v) The cause of the death was unexpected and unrelated to a previously diagnosed medical condition (e.g., the person was hospitalized for a known condition but the cause of death was unrelated to the admission diagnosis).
 - vi) The RMRC findings and/or recommendations were significant and may have statewide significance.
 - vii) The RMRC is "unsure" of whether to refer the case to IMRB.
- h. If the RMRC is unable to complete its review and issue a report within 90 days, the committee chairperson shall notify the IMRB chairperson prior to the due date with an explanation of the reason for the delay.
 - i. The regional health service director shall inform the deceased's next-of-kin and/or legal guardian upon completion of the regional review and shall review RMRC findings and recommendations with family members as requested. A copy of the notification letter shall be placed in the individual's mortality review file.
 - i. When an individual residing out of state dies, the region of nexus shall request that the state in which the individual died, conduct an investigation and submit findings to the IMRB. If no such investigation occurs, the IMRB may secure an independent investigation.
5. The IMRB shall operate at the statewide level. The function of the board is to:
- a. Provide an independent review by qualified professional unrelated to the deceased person's region of nexus including physicians, nurses, advocates and other disciplines and agencies;
 - b. Ensure that reviews by local mortality review committees fully evaluate health care, overall care, and quality of life issues, and make recommendations and identify corrective actions as appropriate;
 - c. Recommend an independent investigation of any death if deemed necessary;

- d. Review the findings and recommendations of abuse/neglect allegations relevant to the individual's care and make additional recommendations as needed;
 - e. Identify incidents that require a more comprehensive review utilizing root cause analysis and review the findings and recommendations of completed; root cause analyses in order to recommend practice changes or enhancement that can reduce future risk;
 - f. Identify issues specific to a region, training school, or facility that require training, different treatment strategies, or administrative oversight, and make recommendations as needed;
 - g. Identify systemic issues that require statewide action(s) such as training, administrative actions, and other similar responses;
 - h. Refer issues and concerns to other state agencies for investigation as needed;
 - i. Submit case reviews and recommendations to the Commissioner within 30 days of the board's review using the IMRB review form (See Attachment B);
 - j. Send findings and recommendations to the regional health service director who shall notify families and/or guardians that the IMRB has been conducted (a copy of the notification letter shall be placed in the individual's mortality review file) and shall share results as requested;
 - k. Recommend issues for policy, procedure, directive or advisory development and implementation;
 - l. Issue reports to the Governor and Co-Chairs of the Legislative Public Health Committee at least annually that identify trends, results of analyses, and recommendations for system enhancements.
6. The IMRB shall meet at least quarterly or more frequently as necessary.
 7. The IMRB shall review all cases identified by local committees as requiring a statewide review and shall review at least 10% of those cases closed at the local level by regional/STS mortality review committees. The board shall document these reviews including its findings and recommendations on the DMR Independent Mortality Review Board Review Form.
 8. When the IMRB and/or the Commissioner deems that corrective actions is necessary, the regional or training school director or private agency executive director shall be responsible for creating a plan to implement those actions in a timely fashion. This plan may include but is not limited to the following:
 - a. professional education;

- b. increased resources;
 - c. facility and equipment improvements
 - d. new or revised policies and procedures;
 - e. corrective actions specific to the event, facility or program;
 - f. staff training or re-training.
9. The IMRB shall review the implementation of corrective action plans and follow-up on other recommendations made by the board including results of investigation done by other departments and/or agencies. The board shall document its review and any subsequent action(s) as necessary, on the IMRB review form.
 10. The IMRB shall provide feedback to local mortality review committees regarding outcomes of board recommended actions or corrective action plans.
 11. The Regional Mortality Review Committees and the Independent Mortality Review Board shall ensure that deliberations and all reports generated from such committees, including findings and recommendations obtained from any completed root cause analyses, do not jeopardize the privacy rights of individuals and families and that any reporting does not inhibit or compromise the need for prompt and truthful reporting of abuse, neglect and other untoward incidents. Therefore, all reports of the regional and statewide review committees shall be confidential as per section 19a-17b of the Connecticut General Statutes. The central office director of health and clinical services, director of legal and government affairs and the Commissioner shall evaluate each request for release of mortality review records.
 12. The DMR director of health and clinical services shall collect and analyze mortality statistics in each region and training school. These data, in conjunction with the mortality reviews, may be reviewed by the IMRB to provide the basis for further quality assurance initiatives.

E. References

1. Statutes
 - CGS 7-62-65, "Death Certificates"
 - CGS 18-38a, "Abuse of Children"
 - CGS 19-17b, "Peer Review"
 - CGS 19a-405-413, "Medicolegal Investigations"
 - CGS 19a-406(b), 19a-413, "Autopsy"
 - CGS 19a-458, Abuse of Persons who are Mentally Retarded
 - CGS 53-70-73a, "Crimes"
2. Rules, Regulations and Policy – External
 - Executive Order No. 25, issued by John G. Rowland, Governor, February 8, 2002

3. Rules, Regulations and Policy or Instructions – DMR
 - DMR Abuse Neglect policy and procedures
 - DMR Policy #I-D-PO-001, Mortality Reporting and Review
 - DMR Procedure #I-D_PR-001, Mortality Reporting: Reporting Deaths of Individuals
 - DMR Procedure #I-D-PR-002, Sudden/Unexpected Deaths
 - DMR Procedure #I-D-PR-003, Reporting Deaths to the Office of the Chief Medical Examiner
 - DMR Procedure #I-D-PR-004, Autopsies
 - DMR Medical Advisory #87-2 (Revised May 1989) “Withholding Cardiopulmonary Resuscitation of Terminally Ill DMR Clients

F. Attachments:

- Attachment A: DMR Mortality Review (Revised 3/02)
- Attachment B: IMRB Review Forms