

**STATE OF CONNECTICUT  
DEPARTMENT OF MENTAL RETARDATION**

**Procedure No. I.D.PR.001**

**Issue Date:** March 15, 2002

**Subject:** Mortality Reporting: Reporting Deaths  
of Individuals

**Effective Date:** March 15, 2002

**Designated Area of Responsibility:** Quality Enhancement

**A. Purpose**

The purpose of this procedure is to ensure that deaths of all individuals who are served by the DMR are reported and documented.

**B. Applicability**

This procedure shall apply to all individuals who are clients of the department, who are monitored in the department's mainframe database, and/or who live in a DMR licensed facility.

**C. Definitions**

1. Direct or Oversight Responsibility for medical care: means all individuals who lived in DMR operated, funded, or licensed homes or facilities, who were placed in long-term-care facilities by the department, or who receive supported living services and do not independently manage their own medical regimens.
2. Do Not Resuscitate Order (DNR): A medical order to withhold cardiopulmonary resuscitation is known as a "*do not resuscitate*" or "*no code*" order.
3. Individual: for this procedure, means any person registered with the department and monitored in the department's mainframe database including children registered with the DMR in the Birth-to-Three System and adults registered through the OBRA system. It also includes a non-Connecticut resident who received services in a DMR operated, funded, and/or licensed facility or program.
4. OBRA-87: 1987 Omnibus Reconciliation Act that names the Department of Mental Retardation as lead agency for people with mental retardation and related conditions (e.g., seizure disorders, cerebral palsy, vision and hearing disabilities, etc.)
5. Sudden and/or Unexpected Death (SUD):
  - Death that was not expected or anticipated according to any previously known terminal medical diagnosis;

- Death that was the result of an accident (car accident, fall, choking, etc.), even if the person had a known terminal condition;
- Death that was due to a suspected/alleged homicide or suicide;
- Death suspected or alleged to be due to abuse or neglect.

#### **D. Implementation**

1. The death of every individual shall be immediately reported to the individual's family, the DMR regional or training school director or designee and regional health service director (See Attachment A).
2. Each DMR funded private agency shall develop and implement a procedure that identifies the responsible parties and details agency/region specific processes.
3. If the person's death was sudden and/or unexpected, DMR Procedures 1-D-PR-002, Sudden/Unexpected Deaths of Individual, 1-D-PR-003, Reporting A Death to the Office of the Chief Medical Examiner, and 1-D-PR-004, Autopsies, shall be followed.
4. On the first working day following an individual's death, the DMR case manager or other assigned staff shall telephone or fax a report of the death to the DMR special protections coordinator in central office, using the DMR Death Report Form (See Attachment B). A copy of the Death Report Form shall be sent to the regional health service director.
5. The special protections coordinator shall immediately notify the department's nurse investigator (NI) of the death of individuals for whom the department bears direct or oversight responsibility for medical care. The nurse investigator shall take the following actions:
  - a. Conduct a *Medical Desk Review* to determine the need for further review or investigation. This shall involve a review of the individual's health characteristics and circumstances surrounding the death through telephone contact with appropriate parties (e.g., DMR health service directors, staff) and a review of preliminary documents (DMR death report, death certificate, and as applicable, documentation of a Do No Resuscitate order, autopsy results and hospice documentation).
  - b. If no further review is needed, the NI will document the rationale and refer for mortality review.
  - c. If further review is indicated, the NI will request two copies of specific records (see attachment A). One copy shall be hand delivered to the DMR Hartford or Cheshire office within five working days and the other copy shall

be sent to the individual's case manager for inclusion in the mortality review packet.

- d. Following a review of the documents, the NI will document actions taken and rationale for those actions, as follows:
  - 1) Referral to the abuse/neglect system if abuse or neglect is suspected according to DMR Abuse/Neglect policy and procedures
  - 2) Referral for expedited mortality review if system deficiencies are identified or suspected
  - 3) Referral for routine mortality review as defined in DMR procedure I-D-PR-005, Mortality Review
6. The Regional Mortality Review Committee chairperson as defined in DMR procedure I-D-PR-005, shall be notified on the first working day following the death of an individual for whom the department bears direct or oversight responsibility for medical care.
7. For those cases requiring mortality review, the regional health service director shall provide the person's family and/or guardian with information regarding the review process and shall provide contact names and numbers for obtaining further information and/or discuss any concerns regarding the death.
8. The DMR special protections coordinator shall send a weekly report of all deaths to the DMR Commissioner, Deputy Commissioner, Director of Health and Clinical Services, Director of Quality Assurance and to the Office of Protection and Advocacy.

#### **E. References**

1. Rules, Regulations and Policy – External
  - a. Executive Order No. 25, issued by John G. Rowland, Governor, February 8, 2002
2. Rules, Regulations, Policy or Instructions – DMR
  - a. DMR Policy I-D-PO-001, Mortality Reporting and Review
  - b. DMR Procedure I-D-PR-002, Sudden/Unexpected Deaths of Individuals
  - c. DMR Procedure I-D-PR-003, Reporting a Death to the Office of the Chief Medical Examiner
  - d. DMR Procedure I-D-PR-004, Autopsies
  - e. DMR Procedure I-D-PR-005, Mortality Review
3. **Attachments:**
  - a. Attachment A: [Client Death: DMR Responsibilities Checklist](#)
  - b. Attachment B: [DMR Death Report Form](#)