Request for Inclusion or Revision to an Administrative Directive

Connecticut Department of Correction

CN 1301
REV 02/06/15

Administrative Directive Number: **8.10**	Title: **Quality Assurance and Improvement**

☒ I recommend the following inclusion or revision to the above referenced Administrative Directive (provide detailed explanation):

In accordance with Section 5-E of Administrative Directive 8.10; Quality Assurance and Improvement. DOC Health Services Unit must conduct a review in the event of an inmate death or other serious clinical event as determined by the Director of Health and Addiction Services in order to determine if a pattern of symptoms exist, which if identified during the course of treatment, might have resulted in earlier diagnosis and intervention, and to examine events immediately surrounding each death or other serious clinical event to determine if appropriate interventions were applied.

Presently there is no standardized format for documenting the findings of such review. As a result, I recommend the adoption of A.D. 8.10 Attachment-A as a newly created 2 page form to address this need. The form will be completed by both the incident reviewer and the Medical Director and will become part of the investigation file.

☒ **See attached documents**

ORIGINATOR

Name: [redacted]	Title: [redacted]	Date: 2/25/15
Signature: [redacted]	Facility/Unit: [redacted]	

UNIT/DISTRICT/DIVISION RECOMMENDATIONS

Approved	Denied		
☒	☐	Unit Administrator's signature: Kathleen F. Maurer	Date: 3/2/15
☐	☐	District Administrator's signature: (only needed if originating from facility)	Date:
☒	☐	Division Administrator's signature: [illegible]	Date: 3/25/15

COMMISSIONER'S DECISION

This request is: ☒ **APPROVED** ☐ **DENIED** Effective date of request: as practicable

☒ The language/provisions of this inclusion/revision shall be effective as of: _____ and subsequently added to the Administrative Directive at the next update.

☐ This inclusion/revision shall be added to the Administrative Directive prior to: _____

☐ This inclusion/revision shall be added immediately to the Administrative Directive.

Commissioner's signature:	Date: 4/2/15

Critical Medical Incident Case Review

Connecticut Department of Correction

AD 8.10-Att. A/1
REV 2/25/15

SD Case #:	**Inmate Number:**		**Inmate Name:**
Event Date:	**Event Time:**		**Event Location:**
Last DOC Location:	**DOB:**	**Sex:**	**Incarceration Date:**
Medical Score:	**Mental Health Score:**		**SA Score:**
Chart Received Date: **Time:**			
Reason for Death:		**Type of Death:**	

Prior Medical History:

Case Description:

Summary/ Conclusions:

Critical Medical Incident Case Review

Connecticut Department of Correction

AD 8.10-Att. A/2
REV 2/25/15

SD Case #:	Inmate Number:	Inmate Name:

Contributing Factors

Type	Impact	Description	Recommended Action

Reviewer:	Date:
Medical Director:	Date: