STATE OF CONNECTICUT
DEPARTMENT OF MENTAL RETARDATION

Procedure No. I.D.PR.003 **Issue Date**: June 25, 2001

Subject: Reporting A Death to the Office of the Chief Medical Examiner **Effective Date**: June 25, 2001

Designated Area of Responsibility: Quality Enhancement **Revised: March 15, 2002**

A. Purpose

The purpose of this procedure is to ensure statewide consistency in reporting sudden and/or unexpected deaths of individuals to the Office of the Chief Medical Examiner (rather than to local medical examiners).

B. Applicability

This procedure shall apply to individuals served by programs licensed, operated and/or funded by the Department of Mental Retardation and for whom the department bears direct or oversight responsibility for medical care and includes people living in community living arrangements, community training homes, and those receiving supported living services. This procedure also applies to individuals whose deaths occurred during participation in a DMR operated or funded day program, or while receiving respite services in a DMR operated or licensed facility.

This procedure does not apply to individuals who live independently in their own or family homes or who have individual support agreements.

C. Definitions

1. Next-of-Kin: Per CGS 19a-570, next-of-kin means any member of the following classes of persons in order of priority listed: 1) spouse; 2) adult son or daughter of the person; 3) either parent of the person; 4) adult brother or sister of the person; 5) either grandparent of the person. (Guardianship ends upon the death of the individual.)

2. Sudden and/or Unexpected Death
   - Death that was not expected or anticipated as a result of any previously known terminal medical diagnosis (with or without a valid Do Not Resuscitate Order)
   - 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 for which there is an allegation of abuse or neglect.

D. Implementation

1. Each DMR region and training school shall develop and implement a procedure (i.e., Reporting a Death to the Office of the Chief Medical Examiner) that identifies the responsible parties and details agency and region specific processes.

2. Upon notification of the death of an individual who lives in a DMR licensed, operated, and/or funded program, the designated DMR manager shall ensure that the OCME is called. The OCME is available 24 hours a day, seven days a week and can be reached as follows:

    a. Within the Hartford area: 860-679-3980

    b. Outside the Hartford are: 1-800-842-8820 (This number is to be used solely for reporting a death.)

3. The person designated to contact the OCME shall be prepared to provide the following information and shall document the call on the attached form:

    a. Name and telephone number of the person reporting the death

    b. Name of the deceased

    c. Age, race and sex of the deceased

    d. Residence of the deceased

    e. Place of death

    f. Date and time death was pronounced

    g. Name, address, and telephone number of the deceased's usual attending physician

    h. Name and professional address or affiliation of the physician, nurse, or emergency medical technician who determined death.

    i. A brief summary of the medical background of the deceased and circumstances surrounding the death. Include all information that may have affected the individual's health status such as history of a recent fall or injury.

4. The person reporting the death to the OCME shall document the following information on the *Reporting Death to the Office of the Chief Medical Examiner*

Form (See Attachment A). The form shall be forwarded to the regional health service director on the next working day:

a. Date and time called;

b. Name of person at the OCME to whom death was reported and name of the medical examiner on call;

c. Case number assigned by the medical examiner on call;

d. Medical examiner's decision to accept or decline jurisdiction.

1) When the OCME accepts jurisdiction for a case, the OCME will make arrangements for transportation of the deceased, will perform the autopsy, and will subsequently issue the death certificate.

2) If the OCME declines jurisdiction, DMR procedure I-D-PR-004, Autopsies, shall be followed.

5. If the person reporting the death to the OCME is unable to talk directly with the medical examiner on call, determination of jurisdiction will be made as soon as possible by the OCME. DMR procedure I-D-PR-002, Sudden/Unexpected Death of Individuals, shall be followed.

6. The regional health service director shall request a copy of the autopsy results from the OCME for the DMR file and if requested by the deceased's next-of-kin, shall assist the family to obtain a copy of the autopsy results directly from the OCME.

E. References

1. Statute
   a. Connecticut General Statutes Chapter 368q, Sections 19a-400 – 19a-412 Connecticut General Statutes Section 20-101a, Pronouncement of Death by a Registered Nurse
2. Rules, Regulations and Policy – External
   a. OCME Guidelines for Connecticut Emergency Medical Services and Public Safety Personnel: Transportation of Deceased Bodies
3. Rules, Regulations and Policy - DMR
   a. DMR Policy, I-D-PO-001, Mortality Reporting and Review
   b. DMR Procedure I-D-PR-001, Mortality Reporting: Reporting the Death of an Individual
   c. DMR Procedure I-D-PR-002, Sudden/Unexpected Death of an Individual
   d. DMR Procedure I-D-PR-004, Autopsies
   e. DMR Procedure I-D-PR-005, Mortality Review
4. Attachments:
   a. DMR Reporting Deaths to the Office of the Chief Medical Examiner Form