CENTRAL OFFICE RESPONSIBILITIES, FUNCTIONS, REPORTS, AND FORMS

A. RESPONSIBILITIES AND FUNCTIONS

1. The Chief Clinical Advisor is ultimately responsible for the Mortality Review Program at central office.

2. It is the responsibility of the Central Office Mortality Review Coordinator to ensure that the requirements of the program are met and that the confidentiality of all documents is maintained.

3. The Central Office Mortality Review Coordinator is responsible for program development, mortality case review and evaluation, statistical analysis of data, preparation of quarterly and annual reports, and presentations to the Statewide QM Committee. Specific responsibilities of the Central Office Mortality Review Coordinator are to:

    a. Ensure, upon notification of an inmate death, that:

        (1) Any special cases are reported to the Chief Clinical Advisor, Health Services Director, and the Central Office Discipline Chiefs for Medical, Nursing, Dental, Pharmaceutical, as indicated by the information about the death.

        (2) The case shall be recorded on the mortality review database. A copy of the HSS-99 report may be used as the case log. The monthly HSS-99 report will be kept in the confidential file (by month) with the mortality review folders.

        (3) A mortality review file is established.

    b. Ensure, upon receipt of the institutional case packet, that:

        (1) The review is complete. Incomplete reviews shall be returned to the institution and/or a request will be sent to the institution for needed materials.

        (2) Institutional mortality review case findings are entered into the mortality review database and the original reviews are placed in confidential quality management files.

        (3) When all materials are submitted, the file is reviewed by the Chief Clinical Advisor for consideration of closure, and the case is closed following closure procedures (see Appendix F).

c. Ensure, for purposes of reporting and communicating findings, that:

(1) The biannual reports are prepared for the statewide Quality Management (QM) Committee, to include:

(a) Statistical information: patterns and trends.

(b) Recommendations made to the statewide QM Committee from institutional committees.

(c) Individual case information that has statewide implications.

(2) There is follow-up on statewide QM Committee directives or action items.

(3) The original mortality reviews are maintained at the central office in a confidential file until archived.

(4) Staff are advised of current procedures related to the mortality review process.

4. In cases of deaths due to suspected suicide, the FDC Chief of Mental Health Services will notify the Mental Health Director who shall:

a. Assign the completion of the psychological autopsy to a Regional Mental Health Director;

b. Ensure the psychological autopsy report is completed within 33 business days of the assignment to the Regional Mental Health Director.

c. Complete a review and closure summary, which will summarize the findings of the psychological autopsy and identify required training and/or corrective action as needed, within ten (10) business days of completion of the report by the Regional Mental Health Director;

d. Forward the signed psychological autopsy and signed closure summary to the FDC Chief of Mental Health Services;

e. The FDC Chief of Mental Health Services will review and, if no additional action is required, will sign and forward to the Central Office Mortality Review Coordinator.

f. If training and/or corrective action is indicated, ensure completion and provide the Central Office Mortality Review Coordinator an outline of the training and attendance sign-in sheet. The training and/or corrective action will be

completed within ten (10) business days of completion of the psychological autopsy by the Regional Mental Health Director.

g. A second mortality review will be conducted at the institution after all documents have been received at the institution. The completion of the DC4-508 and DC4-504 will be sent to the Central Office Mortality Review Coordinator.

5. It is the responsibility of the Chief Clinical Advisor to:

a. Approve closure of cases.

Upon review, if deficiencies are noted or questions arise, correspond with staff in the form of an Incomplete Institutional Review memo which the Central Office Mortality Review Coordinator will send. Responses will be reviewed by the Chief Clinical Advisor who will either direct the closure of the case, or the need for additional documentation.

b. Communicate special concerns to the statewide Quality Management Committee to include making and responding to recommendations, and presenting issues and concerns based on mortality review findings.

c. Act as a resource person for the Central Office Mortality Review Coordinator.

B. REPORTS

The biannual mortality review report to the statewide QM Committee is presented by the Chief Clinical Advisor and the Central Office Mortality Review Coordinator and will consist of:

1. The number of deaths for the reporting months related to major causes of death.

2. An ongoing comparison of mortality data for the year.

3. A mortality review statistics report with clinically significant findings of recommendations for improvements or other corrective action.

4. Any information on the review process or problems being encountered with the process that is appropriate for committee involvement.

C. CONFIDENTIALITY

All materials in the mortality review file are confidential.