1.2.10 Mortality Review and Reporting

(a) Policy

California Correctional Health Care Services (CCHCS) shall maintain a Mortality Review and Reporting process to complete an independent review of every death of individuals in the custody of the California Department of Corrections and Rehabilitation (CDCR), in an effort to promote a safe, high quality health care system.

(b) Applicability

This policy applies to all deaths occurring while in the custody of CDCR. In addition to the review conducted under this section, each death classified as a suicide or suspected suicide shall also receive a Suicide Case Review, pursuant to the current Mental Health Services Delivery System Program Guide..

(c) Purpose

To utilize mortality data to mitigate patient harm within the correctional system and to identify opportunities for improvement related to patient safety, quality of health care services, and patient outcomes.

(d) Responsibility

(1) Statewide

(A) CDCR and CCHCS leadership, at all levels of the organization, within the scope of their authority, shall ensure administrative, custodial and clinical systems are in place, and appropriate tools, training, technical assistance and levels of resources are available to ensure the mortality review and reporting process is sustainably implemented.

(B) Headquarters (HQ) and regional executive representatives shall meet at least annually to review and discuss morbidity and mortality trends. Representatives shall ensure progress is made on current initiatives related to reducing avoidable mortality and morbidity, and inform new priorities to improve health care processes and patient outcomes and quality of services delivered, which shall be coordinated by the Patient Safety Program.

(C) Designated Medical Services Division (MSD) support staff shall comply with all federal and state reporting requirements. MSD support staff is responsible for entering mortality review findings into the electronic Health Care Incident Reporting (eHCIR) system and producing daily and weekly mortality reports and an annual report that complies with Department of Justice reporting requirements.

(2) Regional

Regional Health Care Executives have overall responsibility for ensuring implementation of this policy at the subset of institutions within an assigned region.

(3) Institutional

(A) The Chief Executive Officer (CEO) has overall responsibility for ensuring implementation of this policy at the assigned institution.

(B) The institution is responsible for patient safety oversight as described in the Health Care Department Operations Manual (HCDOM), Section 1.2.7, Institution Patient Safety Program.

(e) Procedure

(1) Daily Mortality Reporting from Institutions to Headquarters

(A) No later than 1200 hours on the next business day following the patient’s death, all in-custody patient deaths shall be entered in the health record on the Initial Inmate Death Record and in addition, for a death by suicide, an Initial Inmate Suicide Report shall be completed, pursuant to the current Mental Health Services Delivery System Program Guide .

(B) All deaths shall be reported, regardless of whether the death occurred:

1. Within an institution
2. Within a fire camp
3. Within a contracted facility
4. While out-to-court and housed in a county facility
5. Within an outside hospital or other medical facility setting
6. Within a skilled nursing facility or other long-term care facility
7. Within a re-entry facility, if not paroled
8. While in transit

(C) Patient deaths are not required to be reported from:

1. Sacramento Central Office
2. Western Interstate Conference Compact

3. Parole, including medical parole
4. Compassionate release
5. County offenders being housed with CDCR

(2) Collecting Clinical Records for Review

(A) Institution Staff

Within five calendar days of the date of death, institution health records staff shall complete the scanning of any paper documents into the health record, when applicable, including but not limited to outside community documents related to emergency medical response and hospitalization.

(B) Medical Services Division Support Staff

1. Within five calendar days of the date of death, MSD support staff shall:
   a) Contact the coroner's office in the county where the death occurred to determine whether an autopsy will be conducted and request the final report when available. Final reports shall be distributed to the institution, HQ Health Information Management (HIM), and the Mental Health Program within seven calendar days of receipt. Reports shall be scanned into the health record by HQ HIM staff upon receipt.
   b) Obtain the CDCR 837-A, B, and C, Crime/Incident Reports, from the Strategic Offender Management System or request the reports from custody representatives at the institution where the death occurred.
   c) Request CDCR 602 HC, Health Care Grievances, and responses for the six months prior to the date of death.
2. If CDCR or CCHCS documents above are not received within five calendar days, MSD support staff shall notify the appropriate health care or custody staff to request assistance with document acquisition.

(3) Institution Mortality Review

Within fourteen calendar days of the date of death, the institution CEO, or designee(s), shall complete a multidisciplinary review of the significant events leading to the patient's death. The review shall focus on identifying opportunities for improvement. Identified opportunities for improvement shall be submitted to MSD support staff at mortalityreview@cdcr.ca.gov for inclusion in the final mortality review at the discretion of the HQ mortality reviewers.

(4) Headquarters Mortality Case Review

(A) Each death shall be assigned to a CCHCS HQ or regional nurse reviewer and physician consultant reviewer.

1. The nurse reviewer shall be a Nurse Consultant Program Review (NCPR) Registered Nurse, assigned by the Deputy Director (DD), Nursing Services, or designee.
2. The physician consultant reviewer shall be a board-certified physician, assigned by the DD, Medical Services, or designee.

(B) Initial training for all mortality case reviewers shall occur prior to starting mortality review responsibilities. Training shall be in accordance with the most current community standards for mortality review. Ongoing training shall be provided on an as-needed basis and periodically throughout the calendar year.

(C) The nurse and physician consultant reviewers shall complete the mortality review using the most current electronic form or data entry program. Working in coordination with the physician consultant reviewer, the nurse reviewer shall review any of the deceased patient's clinical records, which are relevant to the history of the patient's cause of death. This will include, at a minimum, records up to six months prior to the death; however, reviewers may include older records if necessary or relevant to determine the trajectory of the terminal event. Relevant records may include, but are not limited to:

1. Initial Inmate Death Record and Initial Inmate Suicide Report, if applicable.
2. Progress notes, diagnostic results, and other clinical information.
3. Records from an outside hospital or other medical facility.
4. CDCR Incident Report.
5. Emergency response records.
6. Autopsy reports.
7. CDCR 602 HCs and subsequent responses.

(D) The nurse reviewer shall document any findings that are discovered during the review and include relevant opportunities for improvement received from the institution. Findings/opportunities for improvement may be added or modified by the physician consultant reviewer, in collaboration with the nurse reviewer.

(E) If at any time during the review process, the reviewer identifies circumstances or processes that may represent an immediate patient safety issue, the nurse or the physician consultant reviewer shall submit an eHCIR using the process defined in the current HCDOM, Section 1.2.6, Statewide Patient Safety Program, and the HCDOM, Section 1.2.7, Institution Patient Safety Program.

(F) In cases where the cause of death is unknown, including in potential drug overdose cases, assigned mortality case reviewers shall work in collaboration with mental health case reviewers who are assigned to conduct reviews pursuant to the current Mental Health Services Delivery System Program Guide, to collect and share information, and consult with each other to determine if the cause of death could have been the result of suicide. For deaths by suicide or suspected suicide, assigned mortality case reviewers and suicide case reviewers assigned pursuant to the current Mental Health Services Delivery System Program Guide, shall collaborate during the mortality and suicide case review processes, including timely sharing of initial information and findings and coordinating on reviews, as necessary. Final mortality reports for suicide deaths and final suicide reports completed by mental health shall be distributed to both disciplines.

(G) For each death classified as a homicide or suspected homicide, if clarification is needed regarding custodial or security elements, a Department of Adult Institutions (DAI) staff shall be consulted.

(H) The preliminary mortality reports shall be completed by the nurse and physician consultant reviewers within 60 calendar days of the date of death, absent a showing of good cause for an extention, in which case an extention may be granted by the DD, Medical Services, or designee.

(5) Regional and Institution Review

(A) The preliminary mortality reports shall be submitted electronically to relevant regional and institution physician and nurse executives.

(B) Regional and institution physician and nurse executives shall collaborate on the review of the report and shall accept or reject the mortality report within five calendar days of receipt.

(C) If rejected, MSD support staff shall facilitate any edits and necessary clarification with the nurse and physician consultant reviewers. Revised reports shall be re-submitted to the regional and institution physician and nurse executives for review and disposition. Regional and institution physician and nurse executives shall collaborate on the revised report and shall accept or reject the mortality review within five calendar days of receipt. The mortality review is considered final once the regional and institution physician and nurse executives have accepted the report.

(D) Amended Mortality Reports

A final mortality report may be amended if new information that is material and relevant to the mortality review is obtained subsequent to the report being finalized. The amended report shall be approved by the relevant regional and institution physician and nurse executives.

(6) Mortality Report Distribution

(A) Finalized original and amended mortality reports shall be distributed to the following stakeholders:

1. The relevant institution and regional executives responsible for the patient's health care prior to death. If multiple institutions were involved with the health care of the patient during the period of review and there are findings from that time period, a report shall be submitted to the leadership of each institution and region that were involved.
2. Statewide Patient Safety Program via the eHCIR system.
3. DAI and institution Warden, if related to a drug overdose, suicide, homicide, or other deaths where a potential custody-related opportunity for improvement was identified.

(7) Conflict of Interest

(A) A physician or nurse shall not participate in any decision under the breach of professional clinical peer review process if the individual has a personal conflict of interest.

(B) A personal conflict is a professional, financial, or other obligation/interest that is likely to limit the reviewer's ability to participate impartially in decision-making.

(C) The physician or nurse shall disclose any potential and actual conflicts of interest prior to participating in decision-making.

(8) Confidentiality

(A) It is critical that the records of the mortality review process be maintained as confidential and not be made available to unauthorized persons or organizations.

(B) All staff participating in the mortality review process discussed in this procedure shall adhere to these provisions regarding confidentiality.

(C) The mortality review process is intended for improvements in the quality of patient care and shall be maintained as confidential and protected from discovery to the extent permitted by law.

(f) References

- Federal Death in Custody Reporting Act of 2000 (Public Law 106-297)
- California Government Code, Title 2, Division 3, Part 2, Chapter 6, Article 2, Section 12525
- California Penal Code, Part 3, Title 7, Chapter 1, Section 5021
- National Commission on Correctional Health Care, Standards for Health Services in Prisons (2016)
- National Commission on Correctional Health Care, Standard P-A-10, Procedure in the Event of an Inmate Death
- California Department of Corrections and Rehabilitation, Department Operations Manual, Article 7, Sections 51070.1 through 51070.20
- California Department of Corrections and Rehabilitation, Mental Health Services Delivery System Program Guide, Chapter 10, Suicide Prevention and Response, Section E, Suicide Reporting, and Section F, Suicide Death Review
- Health Care Department Operations Manual, Chapter 1, Article 2, Section 1.2.1, Complete Care Oversight Team Committee
- Health Care Department Operations Manual, Chapter 1, Article 2, Section 1.2.3, Quality Management Program Overview
- Health Care Department Operations Manual, Chapter 1, Article 2, Section 1.2.4, Quality Management Program, Statewide Governance
- Health Care Department Operations Manual, Chapter 1, Article 2, Section 1.2.5, Quality Management Program, Institution
- Health Care Department Operations Manual, Chapter 1, Article 2, Section 1.2.6, Statewide Patient Safety Program
- Health Care Department Operations Manual, Chapter 1, Article 2, Section 1.2.7, Institution Patient Safety Program
- Health Care Department Operations Manual, Chapter 1, Article 2, Section 1.2.15, Utilization Management Program
- The Federal Receiver's Analysis of Death Reviews (2006-2016)

Revision History
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