CHAPTER: 1100

Inmate Health Services

DEPARTMENT ORDER:

1105 – Inmate Mortality Review

OFFICE OF PRIMARY RESPONSIBILITY:

HS

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Arizona Department of Corrections Rehabilitation and Reentry

Department Order Manual

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PURPOSE

This Department Order (DO) establishes a quality assurance process pursuant to Arizona Revised Statute (A.R.S), Title 36 Chapter 25, Health Care Quality, A.R.S. §§ 36-2401 through 36-2403, to review and evaluate the medical and mental healthcare provided to inmates who are in the custody of the Department. The Department has developed this instruction to reduce the morbidity and mortality in the delivery of medical and mental healthcare within the Department.

References to healthcare professionals (i.e., Healthcare Services and Mental Health Services) are referring to the Contract Healthcare Provider (CHP) or their subcontractors unless otherwise stated.

APPLICABILITY

This DO is applicable to all inmate deaths, which include suicides, fetal deaths or fetal sentinel events beyond the first trimester, that occur while the inmate is in the care and custody of the Department. Executions are excluded from this DO.

PROCEDURES

1.0 CONFIDENTIALITY OF THE QUALITY REVIEW FINDINGS – Inmate medical records and information about inmate medical status are confidential. (See DO #1101, Inmate Access to Health Care)

1.1 All records, reports, databases, and meetings are protected by patient confidentiality and are to be held in strict confidence. All review reports shall be stamped "*DO NOT COPY – PEER/UTILIZATION REVIEW COMMITTEE (URC) REVIEW" and shall not be subject to disclosure.

2.0 INTERNAL REVIEW AND QUALITY ASSURANCE - A system of documented internal review shall be developed and implemented by the health authority in accordance with DO #1101, Inmate Access to Health Care.

2.1 The DO and the Medical and Dental Services Technical Manual (MDSTM), chapter P-A-09.01 pertaining to mortality reviews shall be reviewed for consistency.

3.0 MORTALITY REVIEW/INMATE DEATH

3.1 Inmate Death Administrative Investigation – All incidents of inmate deaths and any fetal death or fetal sentinel event beyond the first trimester, regardless of circumstances or cause, shall be referred for investigation as outlined in DO #601, Internal Affairs Investigations and Employee Discipline.

3.2 Institution Review - Authorities having jurisdiction are promptly notified of an inmate's death.

3.2.1 The Contract Healthcare Provider (CHP) Facility Health Administrator or designee shall within seven business days of an inmate death, fetal death, or fetal sentinel event beyond the first trimester:

3.2.1.1 Complete the Contract Health Administrator Questionnaire, Form 1105-10, or approved equivalent, and forward to the CHP Regional Medical Director or designee and the Department's Medical Records Monitor or designee.

3.2.1.2 Convene the Complex Mortality Review Committee (CMRC), which is a complex-level review.

3.2.1.2.1 The CMRC shall consist of the CHP Facility Health Administrator, Site Medical Director, Director of Nursing, Mental Health staff, Department's Healthcare Coordinator, Internal Affairs, Warden or designee that conducts a mortality review at the prison complex where the mortality took place.

3.2.1.2.2 The CMRC shall include the Warden, Deputy Warden, and the unit Chief of Security in the initial meeting.

3.2.2 The CMRC shall:

3.2.2.1 Complete the Mortality Review – Case Abstract and Cover Sheet, Form 1105-1.

3.2.2.2 Forward the completed Mortality Review – Case Abstract and Cover Sheet form with copies of all pertinent health records, Emergency Medical Services (EMS) notes (if utilized) and Incident Command System (ICS) Information Reports to the Department's Medical Director or designee, CHP Regional Medical Director, and the Department's Medical Records Monitor or designee.

3.2.2.3 The CMRC shall be conducted in accordance with the MDSTM, chapter P-A-09.01, Inmate Mortality.

3.3 Joint Mortality Review Committee (JMRC) – The Department's Medical Director or designee shall convene a monthly JMRC meeting to review all inmate deaths which include suicides, fetal deaths, or fetal sentinel events beyond the first trimester within 30 calendar days of the mortality. The JMRC is a comprehensive, statewide level review that prioritizes and implements correction action plans which may have statewide implications.

3.3.1 Issues for review may include suicides, delayed diagnosis, incorrect diagnosis, delayed treatment causing or contributing to serious injury or death, avoidable deaths, and deviations from "community standards" for healthcare. In addition, the Autopsy and Toxicology reports (if available), the Psychological Autopsy report (if applicable), and the Mortality Review – Case Abstract and Cover Sheet, Form 1105-1, shall be reviewed.

3.3.2 The JMRC shall:

3.3.2.1 Consist of Department and CHP personnel deemed necessary to review the mortality of a patient.

3.3.2.2 Review the appropriateness of healthcare provided.

3.3.2.3 Make recommendations concerning corrective actions, and policy or procedural changes, if any.

3.3.2.4 Publish a JMRC report utilizing the Mortality Review Committee Report, Form 1105-3.

3.3.3 The CHP Regional Medical Director, the Department's Medical Director or designee, and the Assistant Director for Healthcare Services shall review the JMRC report and prioritize errors found for root cause analysis, including any preventable adverse events or near misses.

3.3.3.1 Errors found will be prioritized for root cause analysis and will result in the development of an effective and sustainable statewide plan, which will be implemented within one month of the death.

3.4 If Autopsy and Toxicology reports were not available during the JMRC review, the CMRC shall reconvene within three business days of the receipt of the reports from the County Medical Examiner's office to review the reports.

3.4.1 The CHP Facility Health Administrator shall review the Autopsy and Toxicology reports and complete a secondary review utilizing the Mortality Review – Case Abstract and Cover Sheet, Form 1105-1, updating the facts and conclusions as appropriate.

3.4.1.1 The completed form shall be forwarded to the Department's Medical Director or designee, the CHP Regional Medical Director, and the Department's Medical Records Monitor or designee.

3.4.1.2 The site will review the Medical Examiner's report to determine if any Continuous Quality Improvement action or staff notice needs to take place.

3.4.2 The Mortality Review Committee Report is marked "final" and is completed by the Department's Medical Director or designee based on the review of the Autopsy and Toxicology report.

4.0 CUSTODY MORTALITY AND ATTEMPTED SUICIDE REVIEWS - Custody Mortality and Attempted Suicide Reviews shall be conducted for all inmate deaths or incidents of attempted suicide.

4.1 The scope of the review shall be to identify if there are any significant health care or custody errors, including any preventable adverse events or near misses.

4.2 The Complex Warden shall obtain, catalog, and forward to the Security Operations Administrator the required documents within three business days.

4.2.1 The Complex Warden or Deputy Warden of Operations shall:

4.2.1.1 Conduct the preliminary review of the incident. This shall focus on the review and compliance with security practices leading to the discovery and the response to the incident.

4.2.1.2 Submit in writing the preliminary findings during their review to the Security Operations Administrator.

4.3 The Security Operations Administrator or designee shall schedule and convene a second level review.

4.3.1 The Security Review panel shall be comprised of the following members to include the Security Operations Administrator, Deputy Assistant Director for Prison Operations, Calculation, Records and Population Management Deputy Administrator, and the Complex Warden of the incident location.

4.3.2 The scope of the review shall identify if there are any security lapses in custody staff performing their required custodial responsibilities which may have had an adverse contributory impact to the incident.

4.4 Upon the completion of the Custody Mortality Review, the Security Operations Administrator shall generate a report of the committee findings.

4.5 The Department's Medical Director or designee shall be notified of the completion of the custody mortality review or attempted suicide review.

4.5.1 A joint review shall be scheduled by the Medical Director or designee with the Security Operations Administrator to discuss the medical and custody review findings.

4.5.2 The Medical Director or designee shall document the review findings and any recommended changes or corrective action if warranted.

4.6 The Assistant Director for Prison Operations and/or the Assistant Director for Healthcare Services shall implement sustainable operational changes for any lapses that have been identified during the review process within 30 calendar days.

DEFINITIONS/GLOSSARY

Refer to the Glossary of Terms for the following:

- Complex Mortality Review Committee (CMRC)
- Contract Healthcare Provider (CHP) Facility Health Administrator
- Joint Mortality Review Committee (JMRC)
- Unexpected Death

FORMS LIST

1105-1, Mortality Review - Case Abstract and Cover Sheet
1105-3, Mortality Review Committee Report
1105-10, Contract Health Administrator Questionnaire

OTHER REFERENCES

Medical and Dental Services Technical Manual (MDSTM)

AUTHORITY

A.R.S. § 36-441, Healthcare Utilization Committees; Immunity; Exception; Definition
A.R.S. § 36-445, Review of Certain Medical Practices
A.R.S. § 36-2401, Definitions

A.R.S. § 36-2402, Quality Assurance Activities; Sharing of Quality Assurance Information; Immunity
A.R.S. § 36-2403, Confidentiality; Protection from Discovery Proceedings and Subpoena; Exceptions