CHAPTER: 1100

Inmate Health Services

DEPARTMENT ORDER:

1105 – Inmate Mortality Review

OFFICE OF PRIMARY RESPONSIBILITY:

MS

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ACCESS

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Arizona Department of Corrections Rehabilitation and Reentry

Department Order Manual

David Shinn, Director

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PURPOSE

This Department Order establishes a quality assurance process pursuant to Arizona Revised Statute (A.R.S.) §36-2401, to review and evaluate the health 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 health and mental healthcare within the Department.

References to healthcare professionals (i.e., Medical Services and Mental Health Services) are referring to the Medical Services Contractor or their subcontractors unless otherwise stated.

APPLICABILITY

This Department Order is applicable to all inmate deaths, which include suicide, fetal death or fetal sentinel event beyond the first trimester, that occur while the inmate is in the care and custody of the Department. Executions are excluded from the Department Order.

PROCEDURES

1.0 CONFIDENTIALITY OF THE QUALITY REVIEW FINDINGS – 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 MORTALITY REVIEW/INMATE DEATH

2.1 Institution Review

2.1.1 The Contract Facility Health Administrator of the affected institution shall:

2.1.1.1 On the next business day of an inmate death, fetal death or fetal sentinel event beyond the first trimester, complete the Contract Health Administrator Questionnaire, Form 601-7, and forward to the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) Medical Program Monitor, and ADCRR Contract Monitor.

2.1.1.2 Within three business days of an inmate death, fetal death or fetal sentinel event beyond the first trimester, convene the Complex Mortality Review Committee (CMRC).

2.1.2 The CMRC shall:

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

2.1.2.2 Forward the completed Mortality Review – Case Abstract and Cover Sheet form with copies of all pertinent medical progress notes (Subjective, Objective, Assessment, Plan, Education (SOAPE) notes), Emergency Medical Services (EMS) notes (if utilized) and Incident Command System (ICS) Information Reports to the ADCRR Contract Monitor.

2.1.2.2.1 The ADCRR Contract Monitor shall forward a copy of the Mortality Review – Case Abstract and Cover Sheet form with copies of all pertinent information to the ADCRR Medical Program Monitor, and the ADCRR Medical Records Monitor or designee.

2.1.2.3 Include the following issues for review:

2.1.2.3.1 Suicides

2.1.2.3.2 Delayed diagnosis

2.1.2.3.3 Incorrect diagnosis

2.1.2.3.4 Delayed treatment causing or contributing to serious injury or death

2.1.2.3.5 Avoidable deaths

2.1.2.3.6 Deviations from "community standards" for healthcare

2.1.3 If the incident resulted in an ICS being initiated, the CMRC shall include the affected Warden, Deputy Warden and unit Chief of Security in the initial meeting.

2.1.3.1 In the case of suicide, the Regional Mental Health Director shall initiate a Psychological Autopsy Committee (PAC) within 14 calendar days of the event to review the case and prepare a Psychological Autopsy as outlined in 2.3 of this section.

2.1.4 Within three days of receipt of the Autopsy and Toxicology reports from the County Medical Examiner's office, the Contract Facility Health Administrator shall reconvene the Complex Mortality Review Committee (CMRC). The CMRC shall:

2.1.4.1 Review the Autopsy and Toxicology reports and complete a secondary review utilizing the Mortality Review – Case Abstract and Cover Sheet form, updating the facts and conclusions as appropriate.

2.1.4.1.1 The Site Medical Director shall consolidate the information, and prepare a final Mortality Review – Case Abstract and Cover Sheet form. The completed form shall be forwarded to the ADC Medical Program Monitor, and the ADC Medical Records Monitor or designee.

2.1.4.2 Forward the inmate record, including any medical records for suicide and private prison cases, to the ADCRR Medical Records Monitor or designee for preparation of the final mortality review.

2.2 Joint Mortality Review Committee – The Regional Medical Director shall convene a Joint Mortality Review Committee (JMRC) meeting to review all inmate deaths, which include suicides, fetal deaths or fetal sentinel event beyond the first trimester, within 10 calendar days upon receipt of the Autopsy and Toxicology report and all other outside medical records.

2.2.1 Issues for review may include those outlined in 2.1.2.3.1 through 2.1.2.3.6 of this section, the Autopsy and Toxicology reports and the final Mortality Review – Case Abstract and Cover Sheet form.

2.2.2 The JMRC shall:

2.2.2.1 Review the autopsy and toxicology report.

2.2.2.2 Review the appropriateness of healthcare provided.

2.2.2.3 Make recommendations concerning disciplinary actions, and policy or procedural changes, if any.

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

2.2.3 The Medical Director and the ADCRR Medical Program Monitor shall review the report with the Assistant Director for Medical Services, and recommend any corrective action plans, as required. The report shall be forwarded to the Deputy Director through the chain of command.

2.3 Psychological Autopsy – The Regional Mental Health Director shall ensure that a Psychological Autopsy is completed on all inmates who commit suicide, regardless of their mental health score.

2.3.1 Within 14 calendar days of the notification of an inmate's suicide, the Mental Health Lead shall convene a Psychological Autopsy Committee (PAC). The PAC shall:

2.3.1.1 Review the inmate's Medical/Mental Health record, including autopsy and toxicology reports.

2.3.1.2 Review any source of data (e.g., Information Reports, investigation reports, and any Department documents, etc.) relevant to the incident.

2.3.1.3 Make recommendations to the Mental Health Lead concerning disciplinary actions, policy or procedural changes, as necessary.

2.3.2 Within 30 calendar days of an inmate's suicide:

2.3.2.1 The assigned Psychologist shall compose an integrated report and send it to the Regional Mental Health Director, and the Medical Services Division.

2.3.2.2 The Regional Mental Health Director and the ADCRR Mental Health Director shall meet with the Criminal Investigations Unit investigator assigned to the case to discuss any relevant information that either party has received.

2.3.2.3 The Regional Mental Health Director shall consolidate the above information, and publish a final Psychological Autopsy Report.

2.3.3 The Regional Mental Health Director shall review the report with the Assistant Director for Medical Services and the ADCRR Mental Health Program Monitor, and recommend any corrective action plans, as required. The report shall be forwarded to the Deputy Director through the chain of command.

3.0 INMATE DEATH ADMINISTRATIVE INVESTIGATION – All incidents of inmate death, 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 Department Order #601, Administrative Investigations and Employee Discipline.

DEFINITIONS/GLOSSARY

Refer to the Glossary of Terms

FORMS LIST

1105-1, Mortality Review - Case Abstract and Cover Sheet
1105-3, Mortality Review Committee Final Report

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. §36-2403, Confidentiality; protection from discovery proceedings and subpoena; exceptions
A.R.S. §36-2404, Quality Assurance Review Committees