CHAPTER: 1100

Inmate Health Services

DEPARTMENT ORDER:

1105 – Inmate Mortality Review

OFFICE OF PRIMARY RESPONSIBILITY:

MS

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ACCESS

☐ **Contains Restricted Section(s)**

Arizona Department of Corrections Rehabilitation and Reentry

Department Order Manual

David Shinn, Director

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EXPECTED PRACTICES

American Correctional Association (ACA) Expected Practices: 5-ACI-6A-36, 5-ACI-6C-03 (M), 5-ACI-6C-16, and 5-ACI-6D-02 (M)

PURPOSE

This Department Order establishes a quality assurance process pursuant to Arizona Revised Statute (A.R.S.) §36-2401, 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., Medical Services and Mental Health Services) are referring to the Contract Healthcare Provider (CHP) or their subcontractors unless otherwise stated.

APPLICABILITY

This Department Order 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 the Department Order.

PROCEDURES

1.0 CONFIDENTIALITY OF THE QUALITY REVIEW FINDINGS – The principle of confidentiality applies to inmate Medical Records and information about inmate medical status in accordance with Department Order #1101, Inmate Access to Healthcare. {5-ACI-6C-03 (M)}

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 Department Order #1101, Inmate Access to Healthcare. {5-ACI-6D-02 (M)}

2.1 The Department Order and Medical Services Technical Manual chapters 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 Department Order #601, Administrative Investigations and Employee Discipline.

3.2 Institution Review - Authorities having jurisdiction are promptly notified of an inmate's death. Procedures specify and govern the actions to be taken in the event of the death of an inmate. {5-ACI-6C-16}

3.2.1 The Contract Healthcare Provider (CHP) of the institution 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 CHP Questionnaire, Form 1105-10, and forward to the CHP Regional Medical Director and the Department's Medical Records Monitor or designee.

3.2.1.2 Convene the Complex Mortality Review Committee (CMRC).

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 medical 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 Include the following issues for review:

3.2.2.3.1 Suicides

3.2.2.3.2 Delayed diagnosis

3.2.2.3.3 Incorrect diagnosis

3.2.2.3.4 Delayed treatment causing or contributing to serious injury or death

3.2.2.3.5 Avoidable deaths

3.2.2.3.6 Deviations from "community standards" for healthcare

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

3.3 Psychological Autopsy

3.3.1 The CHP Regional Mental Health Director shall ensure that a Psychological Autopsy is completed on all inmates who commit suicide regardless of their mental health score. The Psychological Autopsy is completed utilizing the Psychological Autopsy, Form 1105-9. This is a retrospective reconstruction of the inmate's life with an emphasis on the risk factors that may have contributed to the inmate's death. {5-ACI-6A-36}

3.3.2 Within 14 calendar days of the notification of an inmate's suicide, the CHP Regional Mental Health Director shall:

3.3.2.1 Convene a Psychological Autopsy Committee (PAC). The PAC shall:

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

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

3.3.2.1.3 Make recommendations concerning corrective actions policy or procedural changes as necessary.

3.3.2.2 Assign a CHP Psychologist to complete a Psychological Autopsy.

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

3.3.3.1 The assigned Psychologist shall compose an integrated report utilizing the Psychological Autopsy form and send it to the CHP Regional Mental Health Director and the Department's Mental Health Director or designee.

3.3.3.2 The CHP Regional Mental Health Director and the Department's Mental Health Director or designee shall meet with the Criminal Investigations Unit investigator assigned to the case to discuss any relevant information that either party has received.

3.3.3.3 The CHP Regional Mental Health Director shall consolidate the necessary information and create a revised Psychological Autopsy Report if necessary.

3.4 Joint Mortality Review Committee – The Department's Medical Director or designee shall convene a Joint Mortality Review Committee (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.

3.4.1 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 shall be reviewed.

3.4.2 The JMRC shall:

3.4.2.1 Review the appropriateness of healthcare provided.

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

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

3.4.3 The CHP Regional Medical Director and the Department's Medical Director or designee 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 respective Deputy Director through the chain of command.

3.5 Within three business days of receipt of the Autopsy and Toxicology reports from the County Medical Examiner's office, the CHP shall reconvene the Complex Mortality Review Committee (CMRC). The CMRC only needs to reconvene if the Autopsy and Toxicology Report was not available during the JMRC mortality review that took place within 30 calendar days of the inmate's death.

3.5.1 The CMRC shall 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.

3.5.1.1 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.

3.6 Within 10 business days of receipt of the Autopsy and Toxicology reports from the County Medical Examiner's office:

3.6.1 A final independent clinical mortality review will be completed by the Department's Medical Director or designee. This review only needs to be completed if the Autopsy and Toxicology Report was not available during the JMRC mortality review that took place within 30 calendar days of the inmate's death.

3.6.2 The Department's Medical Director or designee shall convene another JMRC, if needed, as the result of the mortality review.

3.6.3 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.

DEFINITIONS/GLOSSARY

Refer to the Glossary of Terms for the following:

- Complex Mortality Review Committee (CMRC)
- Contract Facility Health Administrator
- Joint Mortality Review Committee (JMRC)
- Psychological Autopsy Committee
- Unexpected Death

FORMS LIST

1105-1, Mortality Review - Case Abstract and Cover Sheet
1105-3, Mortality Review Committee Report
1105-9, Psychological Autopsy
1105-10, Contract Health Administrator Questionnaire

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