

**STATE OF CONNECTICUT
DEPARTMENT OF MENTAL RETARDATION**

Procedure No. I.D.PR.002

Issue Date: June 25, 2001

Subject: Sudden/Unexpected Deaths of Individuals

Effective Date: June 25, 2001

Designated Area of Responsibility: Quality Enhancement

Revised: March 15, 2002

A. Purpose

The purpose of this procedure is to ensure statewide consistency in the handling of sudden and/or unexpected deaths of individuals who receive supports and services from the department. Implementation of this procedure will assure that timely notification occurs, that essential information is obtained and/or secured as near to the time of death as possible, and that individuals who continue to live or work in a setting where another individual has died suddenly or unexpectedly, are safe and free from harm.

B. Applicability

This procedure shall apply to individuals served in residential programs licensed, operated and/or funded by the Department of Mental Retardation. This includes individuals living in campus facilities, community living arrangements, community training homes and individuals who receive supported living services.

This procedure also applies to individuals whose deaths occurred during participation in a DMR operated or funded day program, or while receiving respite services in a DMR operated or licensed facility.

It does not apply to individuals who live independently in their own or family homes or who have individual support agreements.

C. Definitions

1. Do Not Resuscitate Order: A medical order to withhold cardiopulmonary resuscitation is known as a “*do not resuscitate*” or “*no code*” order (DNR)
2. Next of Kin: Per CGS 19a-570, next-of-kin means any member of the following classes of persons in order of priority listed: 1) spouse; 2) adult son or daughter of the person; 3) either parent of the person; 4) adult brother or sister of the person; 5) either grandparent of the person. (Guardianship ends upon the death of the individual.)
3. Safety Assessment Monitor: a person designated by the regional director and/or the director of the DMR Division of Quality Assurance.
4. Safety Review: a review conducted by the “safety assessment monitor” within eight (8) hours of notification to DMR that a sudden/unexpected death has occurred.

5. Sudden and/or Unexpected Death (SUD)

- Death that was not expected or anticipated according to any previously known terminal medical diagnosis;
- Death that was the result of an accident (car accident, fall, choking, etc.), even if the person had a known terminal condition;
- Death that was due to a suspected/alleged homicide or suicide;
- Death suspected or alleged to be due to abuse or neglect.

D. Implementation

1. When an individual's death has been confirmed during normal business hours, the following shall occur:
 - a. The responsible agency or program shall immediately notify the individual's family and/or guardian, DMR regional health service director/STS medical director who shall notify the regional/STS director, abuse/neglect coordinator and the individual's case manager or case management supervisor.
 - b. The regional director or designee shall ensure that all applicable parties have been notified (i.e., individual's family/guardian, agency, DMR managers and all appropriate staff). When the death occurred in a DMR operated, funded and/or licensed program or facility, the regional director or designee shall ensure that:
 - 1) Police (state or local depending on jurisdiction) are notified immediately and that a preliminary investigation is conducted. If police fail to initiate or otherwise decline to conduct an investigation, the Regional Director or designee shall notify the DMR Director of Investigations or designee for assistance.
 - 2) The environment, documents and records are immediately secured. (i.e., the physical site where the death occurred, equipment and/or items associated with the death).
 - a. Securing the scene:
 - Take every reasonable effort to avoid altering or contaminating the scene prior to police arrival. (This shall not mean that care and assistance is withheld to the individual(s) in need.)

- Actions that should be taken include: taking pictures when possible; not allowing anyone to enter the room/area unless absolutely necessary; not disturbing anything in the room or area.
 - Police/law enforcement will assume authority as appropriate.
 - Further advice may be obtained from the DMR Director of Investigations.
- b. Securing documents and records:
- All pertinent records should be copied or secured to prevent loss or tampering. This shall include all client records (nurses notes, medication record, incident reports), house logs, and other pertinent facility documents.
 - A detailed description of events just prior to, during and immediately following the event shall be documented and a copy included with the secured documents.
- 3) A preliminary review is conducted as determined by the regional director.
- c. The regional director or designee shall notify the Commissioner or designee (after hours, central office on-call manager) of the death to jointly determine whether to initiate a safety review. The review by the *safety assessment monitor* shall:
- 1) Assess conditions at the location and determine if conditions exist that threaten the safety of any individual. This assessment process shall not interfere with the police or department investigations.
 - 2) Document the results on the *Immediate Safety Assessment & Monitoring Form* (See Attachment A).
 - 3) If issues identified are not immediately resolvable, the safety assessment monitor (e.g., through communication with community emergency personnel (911), DMR Regional Director and/or Private Agency Administrator, or other appropriate managers) shall initiate acquisition of additional resources to resolve the concern.
 - 4) The results of the safety assessment shall be immediately and directly communicated to the appropriate regional director who shall inform the Commissioner.

- d. The regional health service director or designee shall notify the Office of the Chief Medical Examiner (OCME) and shall document the call on the OCME form (see Procedure I-D-PR-003, Notifying the Office of the Chief Medical Examiner). The health service director shall maintain the form for inclusion in the person's mortality review file.
- e. If the OCME declines the case, the regional health service director or designee shall pursue consent for autopsy from the next of kin or responsible party and shall assist with arrangements if consent is obtained.
- f. The DMR case manager or other assigned staff shall notify the DMR special protections coordinator on the first working day following the death via telephone and/or fax, utilizing the DMR Death Report. A copy of the report shall be sent to the regional health service director.
- g. The special protections coordinator shall immediately notify the department's nurse investigator (NI) of the individual's death. The NI shall take the following actions:
 - 1) Conduct a *Medical Desk Review* to determine the need for further review or investigation. This shall involve a review of the individual's health characteristics and circumstances surrounding the death to determine the need for further review through telephone contact with appropriate parties (e.g., DMR health service directors, staff) and a review of preliminary documents (DMR death report, death certificate, and as applicable, DNR documentation, autopsy results and hospice documentation).
 - 2) If no further review is needed, the NI will document the rationale and refer for mortality review.
 - 3) If further review is indicated, the NI will request two copies of specific records (See Attachment B). One shall be hand delivered to DMR Hartford or Cheshire office within five working day and the other copy set shall be sent to the individual's case manager for inclusion in the mortality review packet.
 - 4) Following a review of the documents, the NI will document the actions taken and rationale for those actions, as follows:
 - a) Referral to the abuse/neglect system if abuse or neglect is suspected according to DMR Abuse/Neglect policy and procedures
 - b) Referral for expedited mortality review if system deficiencies are identified or suspected;

- c) Referral for routine mortality review as defined in DMR procedure I-D-PR-005, Mortality Review.
 - h. In the case of a death in which abuse or neglect is alleged, the DMR Abuse/Neglect procedures shall be followed.
- 2. If the death occurs after normal business hours, the following shall occur:
 - a. Once the death has been confirmed, the responsible agency or program shall immediately notify the individual's family and/or guardian and the DMR region using the regional on-call system
 - b. The regional on-call manager shall immediately notify the DMR Regional Director, the central office on-call manager, the regional health service director and other appropriate individuals.
 - c. Follow steps *1b through 1h above*
 - d. The regional on-call manager shall notify the abuse/neglect liaison, the individual's case manager or case management supervisor and as appropriate, the lead investigator, on the next working day. If the lead investigator is not available, the Director of Investigations shall be notified.
- 3. In the case of the death of a child (person under age 18), the Special Protections Coordinator shall notify the Office of the Child Advocate immediately upon notification by the region.

D. References

- 1. Rules, Regulations and Policy – DMR
 - a. DMR Policy I-D-PO-1, Mortality Reporting and Review Policy
 - b. DMR Procedure I-D-PR-001, Mortality Reporting: Reporting Deaths of DMR Clients
 - c. DMR Procedure I-D-PR-003, Reporting Deaths to the Office of the Chief Medical Examiner
 - d. DMR Procedure I-D-PR-004, Autopsies
 - e. DMR Procedure I-D-005, Mortality Review
- 2. Attachments:
 - a. Attachment A: [Immediate Safety Assessment & Monitoring Form](#)
 - b. Attachment B: Nurse Investigator Administrative Review Checklist
 - c. Attachment C: [Client Death: DMR Responsibilities Checklist](#)