SUBJECT: PATIENT DEATH INVESTIGATION PROCEDURES

I. PURPOSE

To provide procedures for investigations into patient deaths to assure that every death will be thoroughly investigated/evaluated and that appropriate corrective action will be taken where necessary.

II. AUTHORITY

Department of Mental Health Special Order 205.02, Welfare and Institutions Code Section 5328.8, Government Code Section 12525

III. POLICY

It is the policy of Coalinga State Hospital (CSH) to ensure all patient deaths are subjected to a preliminary death investigation with health professional input. "Unusual, suspicious, or unexpected" deaths shall receive an intensive investigation when circumstances of the death, or the findings of the preliminary review, warrant such action. The coroner's investigation, although conducted independently, shall provide input to the hospital's investigation.

All patients' deaths shall be subjected to a clinical review by medical staff; as an integral part of hospital performance improvement activities. To the extent possible, the medical staff review should include input from the persons responsible for the deceased.

IV. METHOD

The attached provides death investigation procedures and detailed instructions for implementation:

a. Death investigation Procedures (Attachment # 1).

b. Criteria for Extensive Investigation at Death Scene (Attachment # 2).

W. T. VOSS
Executive Director

ATTACHMENT #I

DEATH INVESTIGATION PROCEDURES

1. Staff attending or discovering an apparent death shall immediately initiate appropriate lifesaving activities and request the services of a physician and the hospital police.

2. A log, which will form the basis for the special incident report and a copy attached to the police report, shall be initiated by unit staff indicating the time, and circumstances of the death, the time of the request for the physician and hospital police officer and all subsequent activities until removal of the deceased from the unit (area).

3. The hospital police shall, upon arrival at the death scene, take temporary possession of the medical record. The hospital police officer shall insure that appropriate notations of the time of death have been made, and that all additions to the medical record shall be identified as being made post-death. The hospital police shall then supervise necessary additions or access to the medical record, notifying Health Information Management Department (HIMD) of location of record.

4. The hospital police officer will notify the coroner's office of each death.

5. Except for lifesaving purposes, the body of the deceased shall not be moved, nor the area around the body disturbed until authorized by the coroner and the hospital police's supervisor or Watch Commander.

6. If after consultation with the Coroner, and based upon the "criteria for intensive investigation at the death scene", it is decided no further investigation is needed at the scene, the hospital police officer shall complete the "Preliminary Death Investigation Report", (Form MH 1470). As soon as possible, the record shall be transferred to the HIMD, and a copy shall be placed in the police report.

7. The hospital police officer shall photograph the condition of the deceased and the immediate surrounding areas, secure physical evidence, and take necessary statements from hospital staff at the scene. The Senior Special Investigator/ Special Investigator (SSI/SI) may be contacted to respond to the hospital and take over the investigation at any time as determined by the Police Watch Commander, per criteria in Attachment 2.

8. If the coroner comes to the death scene, the hospital police and/ or the SSI/SI shall insure that the medical record is available for inspection by the coroner. Should the coroner require portions of the record for the coroner's files, the hospital police and/ or SSI/SI shall arrange duplication so the original can remain at the hospital. The hospital police officer and the SSI/SI shall provide other assistance to the coroner's investigation as needed.

   * It should be noted that Section 5328.8 of the Welfare and Institutions Code requires that the state hospital release appropriate information to the coroner when a patient dies "while hospitalized in a state hospital".

This pertains to all patients who die and are on record (i.e. have not been discharged). When a patient dies in a community hospital the Department is still responsible to make available appropriate information as defined in the code. If the coroner needs information from the community hospital, his office should deal with that hospital directly.

* Also note: Government Code Section 12525 requires law enforcement agencies or local correction facilities to report death of a person in custody, within 10 days, to the Attorney General. Death in Custody Reporting Form (BCIA 713) shall be used by Police Services personnel to comply with this mandate.

9. The hospital police officer shall remain at the death scene in those cases where further investigation is required until released by the coroner, the Police Watch Commander or the SSI/SI.

10. The SSI/SI, in conjunction with appropriate professional personnel, shall review the medical record of the deceased as soon as possible following the death. In order to facilitate the work of the Mortality Review Committee, professional staff groups as necessary, other treatment or administrative staff, and the HIMD shall respond to requests for duplicate records as quickly as possible. The HIMD Director shall make records easily and readily available, as necessary, while assuring the integrity of the original record until the case under investigation is closed.

11. The SSI/SI will conduct some level of review on all deaths of patients who are on state hospital records (i.e. have not been discharged). This can range from a mere review of documents to a thorough and intensive investigation which may include an inquiry into the cause of circumstances of deaths as required. The level of review is a matter of judgment depending on the circumstances of the death (see Attachment #2). When a patient dies in a community hospital a review by the SSI/SI is required for the purpose of assessing the steps taken and the care provided by state hospital staff prior to or during the transfer of a patient to the community hospital.

    Inquiries shall be conducted in a professional manner in order to avoid feelings of harassment or intimidation on the part of persons who may be the subject of the inquiry. The SSI/SI shall seek advice and assistance from the Medical Director, Mortality Review Committee, and/ or professional staff departments, as appropriate, whenever inquiries lead to questions of professional Special Order No. 205.02 medical/ clinical practice. The SSI/SI can provide these persons with information discovered in the course of inquiries, which is required to facilitate Committee response to the Executive Director. Disclosure of information will conform to the parameters of Government Code Section 6254(b) & (f).

12. The SSI/SI shall issue a report to the Executive Director and the Chief of Police on each death case as soon as possible. The report is to include all findings of the investigation and conclusions-of-fact. The Chief of Police will determine if any criminal filings with the District Attorney are warranted, and then will review his decision with the Executive Director.

Prior to the taking of any action on the basis of investigative reports, including punitive actions or referrals to professional licensing boards; the Executive Director will request review of the investigator's report by a person, or committee of persons of good standing in each of the professions of the persons who may be objects of such action.

13. The Executive Director will have final investigative reports reviewed and commented on by the facility's Medical Director or medical staff member designated as Medical Director to insure all treatment issues and clinical practices were adequately addressed. The Executive Director will transmit the investigation report and relevant supporting materials to the Department's Deputy Director, with a memorandum specifying any action taken.

14. A medical review of all patient deaths by medical staff is required. This shall be done in accord with the following:

A. A standing Mortality Review Committee will be nominated by the medical staff and approved/ appointed by the Executive Director:

1. It shall be minimally composed of three physicians, with a Registered Nurse and a Pharmacist as consultants. Additional members from the same or other disciplines are discretionary.

   These standing Mortality Review Committee members shall serve for specified terms to assure continuity: 1 year, staggered 6 month terms, or such method as the Executive Director determines to be appropriate for that facility.

2. There should be a chairperson of this Mortality Review Committee who shall call meetings within the time specified to insure that the duties of the Committee are carried out in a timely manner, and who shall have the right to call in special consultants as needed, with approval of the Executive Director.

B. The Mortality Review Committee shall have the following functions:

1. To perform a medical/clinical review of each deceased client's medical record and other documents relevant to circumstances of death as soon as Special Order No. 205.02 possible and not more than 15 calendar days after all of the records are available. The Medical Director, or medical staff member so designated, shall perform an immediate review of the death within 72 hours.

2. To identify and record any inconsistencies, irregularities, or deficiencies of medical/ clinical practice.

3. To meet with the patient's ID team as part of the information gathering process.

4. To report findings and conclusions to the Executive Director and SSI/ SI, including negative findings and recommendations of areas, subjects, or incidents which will improve the facility's medical care and professional education program.

All findings and conclusions of the Mortality Review Committee shall be provided to the Executive Director.

5. To refer findings of irregularities or deficiencies of medical/clinical professional practice to the appropriate professional staff group (ref. P.M. 21-77, 42977) for review and recommendation to the Executive Director.

6. To act as medical/ clinical consultants to the Executive Director and/ or SSI/ SI. The Executive Director shall insure that adequate time away from other duties is provided for Committee members so that the Mortality Review Committee (and professional staff group, as necessary) can perform its functions, and shall insure that conflicts of interest do not arise.

C. The Executive Director shall refer particularly difficult, questionable, or internally controversial cases to the Deputy Director, Long Term Care Services, where referrals will be made to the Mortality Review Committee or appropriate professional staff group or another state hospital.

ATTACHMENT #2

CRITERIA FOR EXTENSIVE INVESTIGATION AT THE DEATH SCENE

The hospital police officer who first responded to the scene may request the presence of the Senior Special Investigator/ Senior Investigator (SSI/SI) in any of the following situations:

1. Cause of death is "unusual, unexpected or suspicious", including: °

    a. Known or suspected suicide.

    b. Known or suspected homicide.

    c. Deaths resulting in whole or in part from accident or injury

    d. Deaths occurring under violent, sudden, or questionable circumstances, such as deaths due to: drowning, poisoning, fire, hanging, gunshot, cutting, exposure, starvation, alcoholism, rape, drug addiction, strangulation, aspiration, abortion, contagious disease, or occupational disease.

    e. Deaths in operating rooms or when a patient has not fully recovered from an anesthetic.

    f. Any other death where cause is unclear.

2. Responding physician has reservations about the cause of death or questions about circumstances surrounding death.

3. Coroner decides to investigate scene of the death.

4. Staff members or relatives present at the scene of the death raise questions.

5. Initial evaluation of death scene identifies irregularities.

° Adapted from Section 27491 of the Government Code and Section 10250 of the Health and Safety Code of California (defining coroner responsibilities).