DEPARTMENT OF CORRECTIONS

Policy Number: 500.220
Title: Health Services Death Review
Effective Date: 8/18/20

PURPOSE: To provide the department with a review regarding the health management of an offender/resident to assess for preventable mortality and morbidity, including recommendations for improvement.

APPLICABILITY: All facilities and office of special investigations (OSI)

DEFINITION:
Confidential – defined as per Minn. Stat. §145.64, subd. 1, for the purposes of this policy.

PROCEDURES:

A. The Minnesota department of corrections (DOC) conducts a nursing, mental health, and medical death review on offenders/residents who die while incarcerated in a department facility.

B. The office of special investigations (OSI) forensic pathology specialist sends one copy of the medical record to the DOC medical director (see Policy 203.230, "Death of an Offender").

C. Preliminary reviews
   1. The DOC director of nursing must conduct a preliminary review within 30 days of an offender's/resident's death. The review must focus on nursing practices and other nursing administration issues.
      a) The director of nursing must provide a report to the DOC medical director for inclusion in the medical director's formal report.
      b) If the director of nursing determines that DOC policies or nursing practices may have been violated, the director of nursing authorizes an investigation into alleged violations.

   2. The DOC medical director must conduct a preliminary medical review within 30 days of an offender's/resident's death and determine if any remedial actions must occur immediately. The preliminary medical review must consist of the preliminary formal written report (see section E.1, below) with the following modifications/additions:
      a) Clinical diagnosis (based on the medical director's opinion pending committee review;
      b) Anatomical diagnosis (if available, e.g. a preliminary autopsy report): and
      c) Recommendations for immediate correction action, if necessary.

C. Medical death review committee
   1. The DOC medical director convenes an offender/resident death review within 90 days (or when necessary records are available) following an offender/resident death. The committee includes:
      a) The regional medical director of the contracted vendor;
      b) One or more licensed physicians from the community (in person/by phone) with expertise in the most appropriate clinical area, if indicated;
      c) The DOC director of nursing;

d) A physician from the contract vendor's providers;
e) The DOC director of behavioral health;
f) The director of psychiatry of the contracted vendor;
g) The clinical pharmacist of the contracted vendor;
h) The pharmacist liaison of the contracted vendor's pharmacy;
i) In cases of suicide or unanticipated death, an OSI representative; and/or
j) Other ad hoc members as indicated.

2. The DOC medical director ensures that copies of the medical record, incident reports, and other pertinent information are available for review by the offender/resident death review committee prior to the meeting.

3. The offender/resident death review committee meeting follows the agenda outlined below.
   a) Presentation of the case:
      (1) Past medical and mental health history;
      (2) Presentation of recent illness and clinical course;
      (3) Medications;
      (4) Procedures;
      (5) Laboratory results;
      (6) Nursing review; and
      (7) OSI findings (for suicide or unanticipated death).
   b) Clinical diagnosis;
   c) Anatomical diagnosis;
   d) Case discussion; and
   e) Summary and recommendations.

D. Formal Report
1. The DOC medical director completes a formal written report of the offender/resident death review. The report must be marked "confidential" and formatted as follows.
   a) Case summary:
      (1) Past medical and mental health history;
      (2) Presentation of recent illness and clinical course;
      (3) Medications;
      (4) Procedures;
      (5) Laboratory results;
      (6) Nursing review; and
      (7) OSI findings (for suicide or unanticipated death).
   b) Clinical diagnosis;
   c) Anatomical diagnosis;
   d) Case discussion;
   e) Conclusions;
   f) Recommendations for remedial action; and
   g) Program for re-evaluation of remedial actions in ninety days.

2. After review of the report by the medical death review committee, the DOC medical director forwards the written report of the death review to the health services director and the deputy commissioner of the facilities division. The health services director retains documentation of the completion of the death review.

E. Corrective action

1. The health services director maintains a tracking log of all corrective actions recommended in the report. The tracking log indicates the recommendation for corrective action, the person responsible for completing the corrective action, the action taken, and the date completed.

2. The health services director or designee reviews the report and shares appropriate information with individuals involved in treating the offender/resident for purposes of quality improvement.

3. Any individual having violated policy is subject to appropriate corrective or disciplinary measures.

INTERNAL CONTROLS:

A. Documentation of completion of a death review is retained in central office health services.

B. Corrective actions are tracked and the health services director retains the tracking log in the central office.

ACA STANDARDS: ACA Standards 4-4425, 1-ABC-4E-41, 2-CO-4E-01

REFERENCES: Minn. Stat. §§ 145.61 subd. 5; 145.64
Policy 203.230, "Death of an Offender"
Policy 106.210, "Providing Access to and Protecting Government Data "
Policy 500.190, "Health Care Data Practices"
Policy 500.011, "Health Services Review and Assessment"
Policy 600.210, "Review of Complaints, Incidents, and Deaths"

REPLACES: Policy 500.220, "Medical Death Review," 8/21/18.
All facility policies, memos, or other communications whether verbal, written, or transmitted by electronic means regarding this topic.

ATTACHMENTS: None

APPROVALS:
Deputy Commissioner, Community Services
Deputy Commissioner, Facility Services
Assistant Commissioner, Operations Support
Assistant Commissioner, Criminal Justice Policy, Research, and Performance