Adult Correctional Health Division of Primary Health Department of Health Services Policy and Procedure	**HEALTH CARE SERVICES**	
	Policy Number	**01-08**
	Effective Date	**09-30-15**
	Revision Date	**05-23-23**
Title: **Review of In-Custody Deaths**	Functional Area: **Governance & Administration**	
Approved By: Executive Team		

Policy:

All deaths in custody are reviewed by Adult Correctional Health (ACH) to determine the appropriateness of care provided while incarcerated and to determine whether changes are needed (policies, protocols, training, or other actions) in a timely manner. The intent of in-custody death reviews is to improve care and prevent future harm, including death.

Deaths that occur outside the jails (i.e., en route or at the hospital) while still under the custody of the Sacramento Sherrif's Office (SSO) shall be considered an in-custody death for purposes of administrative and clinical mortality reviews.

Definitions & Timeframes

Type of Review	Definition	Timeframe
Administrative Review	Assessment of correctional and emergency response actions. This is conducted by ACH in conjunction with SSO Custody.	Within 10 days of death.
Clinical Mortality Review	Assessment of clinical care (medical/mental health) provided and the circumstances leading up to a death.	Within 30 days of death.
Mental Health Review	Assessment of mental health care provided and circumstances that may have contributed to death. Conducted by Medical Director, Mental Health (MH) Medical Director, MH Manager and/or psychologist or other qualified mental health professional in response to a suicide or when diagnosed with a Serious Mental Illness (SMI).	Within 30 days of all deaths by suicide or when diagnosed with SMI.
Quality Improvement Review	An independent chart review conducted by a Quality Improvement (QI) Registered Nurse (RN) of the overall care provided, including systemic operational issues.	Within 30 days of death.

Procedures:

A. Administrative Review

1. Following a death, and within 10 days, key ACH and SSO leadership jointly conduct an administrative review regarding the immediate circumstances of a death and identify any immediate actions that need to occur (e.g., fix faulty equipment, address communication issues, etc.).
2. The team is responsible for the following:
    a. Review of timeliness and appropriateness of emergency response by SSO Custody staff.
    b. Review of timeliness and appropriateness of emergency response by health care staff.
    c. Identification of communication, equipment, training, or other issues that negatively affected emergency response.
    d. Identification of immediate actions to be taken pending the clinical mortality review.
    e. Development of an initial corrective action plan to address communication, equipment, physical plant, operational procedures, and training issues.

B. Clinical Mortality Review

1. The Clinical Review Team, including the Medical Director conducts a clinical mortality review within 30 days of death. This includes in-custody deaths that occur onsite or offsite while still under the custody of the SSO.
2. The Clinical Review Team consists of the Medical Director, Nursing Director, MH Medical Director, MH Program Director, and/or other designated clinical staff as indicated. This review assists the Medical Director in drafting a thorough Clinical Mortality Review and forming a Corrective Action Plan when indicated (see Section F).
3. The Clinical Review Team assesses the clinical care provided or not provided and the conditions surrounding a patient's death. The Clinical Review Team is responsible for addressing the following:
    a. Appropriateness of health care provided.
    b. Effectiveness of relevant policies and procedures.
    c. Medical response at the time of death.
    d. Possible ACH medical or SSO Custody improvements to prevent future deaths.
4. The Medical Director compiles a preliminary Clinical Mortality Review based on the Medical Director's findings and the findings of the Clinical Review Team to provide a written summary of the patient's medical history, diagnosis, and treatment as noted in the medical record, as well as areas outlined above in B.3.a-d.
5. The Clinical Mortality Review is designated as preliminary until the autopsy or death certificate is received. Once received, the Clinical Mortality Review will be updated by the Medical Director to include findings of the autopsy/death certificate cause of death and designate as final.
    a. The toxicology and autopsy results are frequently not received until after the Clinical Mortality Review is due within 30 days.

b. The Medical Director is responsible for the timely completion of the Clinical Mortality Review consistent with policy.

6. Coroner's Office:
   a. The Coroner's office provides copies of the autopsy reports to the designated Jail Assistant Commander, SSO Custody, ACH Medical Director, and the designated ACH Quality Improvement Coordinator.
   b. The Coroner's office does not take jurisdiction over inmate deaths under the following conditions:
      1. The patient is under the care of an outside physician.
      2. The death is due to natural causes.
      3. The death occurred at an outside facility.
      4. When the physician agrees to attest to the cause of death so a death certificate can be completed.
7. The Clinical Mortality Review, Coroner's Report, and Corrective Action Plan (when applicable) are maintained in a protected electronic file for designated ACH staff only.
8. SSO Custody completes the "Custody" components of SSO's Death Binder as soon as possible and no later than 14 days for submission to the Medical Director.
   a. A SSO Medical Review is completed by the Medical Director for the SSO Death Binder, which consists of a brief, high-level information noting the medical record was reviewed and any actions taken if indicated.
   b. A copy is placed in the Death Binder and signed off by the Medical Director and Health Services Administrator.
9. The QI Coordinator instructs ACH Medical Records to mark the electronic medical record as "sensitive" and "deceased," which prevents changes. All access to a "sensitive" chart is tracked.
10. The QI Coordinator maintains the mortality review log, tracks receipt of death certificates, autopsy reports, and completion of the mortality review log. This individual also initiates the review meetings with custody leadership and/or internal team meetings when indicated.

C. Mental Health Review

1. A mental health review is performed on all deaths involving individuals diagnosed with Serious Mental Illness (SMI) and/or deaths by apparent suicide. The MH Medical Director or designee is responsible for conducting a clinical review of the care provided to the patient.
2. Mental Health Reviews are performed within 30 days of death.
3. For the mental health review of an inmate suicide, refer to ACH PP 02-05 Suicide Prevention Policy.
4. The MH Review Team consists of the MH Medical Director, MH Program Director, SSO Custody, and others as indicated.

D. Quality Improvement Review

1. The QI RN is responsible for conducting a health record review of all in-custody deaths within 30 days in the following areas with respect to policy and within licensure scope:
    a. Appropriateness and timeliness of health and mental health care provided.
    b. Effectiveness of relevant policies and procedures.
    c. Medical response at the time of death.
    d. Proposed questions for ACH leadership review regarding potential ACH and/or SSO Custody improvements to prevent future deaths or improve care.

E. **Mortality Review Meetings**

1. The Mortality Review Meeting consists of relevant members from the Clinical Review Team (see B.2.), the QI Director, and the Health Services Administrator.
2. The Mortality Review Meetings occur monthly to review the following:
    a. Feedback and questions on the preliminary or final Clinical Mortality Reviews completed since the previous Mortality Review Meeting.
    b. Feedback and questions from the QI health record review on in-custody deaths completed by the QI Nurse on recent in-custody deaths.
    c. All active Corrective Action Plans on in-custody deaths – including updates on action items and readiness for completion.
    d. Any needed corrective actions based on the preliminary Clinical Mortality Reviews completed since the last Mortality Review Meeting.
3. The following is then developed based on agreement of all attendees, including:
    a. Action items based on findings are assigned.
    b. Updates on the preliminary Clinical Mortality Reviews based on findings.
    c. Updates to all active Corrective Action Plans – including agreement on completion.
    d. Corrective Action Plans started and assigned for further development based on findings.

F. Corrective Actions

1. Following the development of a Clinical Mortality Review, ACH shall develop a Corrective Action Plan when indicated to improve the ACH health care system and reduce the risk of future adverse events and outcomes.
2. Mortality Corrective Action Plans will include:
    a. Identification of areas of concern.

b. Identification of root cause(s) or contributing factors.

c. Corrective action(s) to be taken.

d. Responsible individuals.

e. Timeframe for completion of action items.

f. Timeframes for follow-up.

g. Determination as to whether the issues have been corrected.

3. Designated members of the Clinical Review Team are responsible for communicating the results of investigations related to in-custody deaths and updates on corrective actions to QI and the Health Services Administrator until the Corrective Action Plans are completed.

G. Mortality Review Log

1. The designated QI Coordinator is responsible for maintaining a Mortality Review Log that tracks all in-custody deaths.
2. The Mortality Review Log shall contain the following information:

a. Patient name and identification number.

b. Date of death.

c. Age at time of death.

d. Date of the Administrative Review.

e. Date of the Preliminary Clinical Mortality Review.

f. Date of the Final Clinical Mortality Review.

g. Cause of death (i.e., hanging, respiratory failure).

h. Manner of death (i.e., natural, suicide, homicide, accident).

i. Date of Mental Health Review completed by mental health, if applicable.

j. Date of receipt of the death certificate.

References:

ACH PP 02-05 Suicide Prevention Program

National Commission on Correctional Health Care, Standards for Health Services in Jails (2018). *J-A-09 Procedure in the Event of an Inmate Death*

Title 15 Minimum Standards for Local Detention Facilities (October 1, 2019) *Section 1046 Death in Custody*

California Government Code, Section 27491, 12525 (Coroner role of deaths in custody; reporting to Attorney General). Items pertinent to these codes are reflected in SSO Operations Orders.

Attachments:

N/A

Contact:

Medical Director

QI Coordinator
Nursing Director
MH Medical Director
MH Manager