County of San Bernardino
Department of Behavioral Health

Investigating and Reporting Death of a DBH Client

Effective Date 08/88
Revision Date 02/24/2012

Allan Rawland, Director

Purpose

To establish procedures for investigating and reporting the death of a Department of Behavioral Health (DBH) client.

Procedure

Upon receiving notification of the death of a DBH client, the following procedure will be followed:

1	A DBH Clinic Supervisor/Contract Agency or designee will complete the Unusual Occurrence/Incident Report form (QM053).
2	The Clinic Supervisor or designee will fax the completed Unusual Occurrence/Incident Report within 24 hours to the following: • DBH Director • Medical Director • Appropriate Deputy Director • Appropriate Program Manager • Chief Compliance Officer
3	**In the case of unusual deaths such as homicides, accidents or suicide:** • DBH Clinic Supervisor/Contract Agency designee shall immediately notify: o DBH Director o Deputy Director o Program Manager o Chief Compliance Officer • The Chief Compliance Officer will be required to notify County Risk Management and complete Incident Report Form 15-13866-000. The Clinic Supervisor or designee will: A. Document the following information in the client's chart: 1. Name of Client 2. Date of Birth 3. Where case was opened 4. Date case was opened 5. Date consumer was last seen 6. Treating Physician 7. Medications, if any 8. Location of death 9. Cause of death 10. Contact person and phone number

Continued on next page

Investigating and Reporting Death of a DBH Client, Continued

Procedure (continued)

3	B. Audit the client's chart for completeness C. Close the chart in SIMON D. Complete the Discharge Summary E. Send the chart to Medical Records.
4	Medical Records will request the client's official death certificate. Upon receiving the official death certificate, the Medical Records Supervisor will send the chart to the Medical Director for review.
5	The Medical Director will assign a Physician, not related to the case, to perform a review of all records pertaining to the client and the assigned physician will submit a report of the findings, using the Quality Assurance Review of Unexpected Deaths form. This will include, but may not be limited to: • Client medical records • Coroner's report • Autopsy report (when available) • Any special incident reports • Appropriate employee interviews (as needed) • Policy report
6	Upon reviewing all the information, the Medical Director will decide if a quality of care issue exists. If there appears to be a quality of care issue, the case will be presented to the Medication Monitoring Committee for review. In selected cases, a Root Cause Analysis Team will also be assembled to review the circumstances of the death and compile a psychological autopsy profile to determine the root cause (if any) of the death and make recommendations for system improvement.
7	The Medical Director or designee will present the findings of the Medication Monitoring Committee to the Quality Management Executive Committee. A copy of the report of the findings will be sent to: • DBH Director • Assistant Director • Chief Compliance Officer
8	Upon reviewing the information, the Director's Office will determine whether the event should be reported to the Department's Safety Coordinator, County Risk Management and the Chief Administrative Officer.
9	Debriefing for affected staff, clients and family will be arranged through the **Access Unit. Call (909) 381-2420 during normal business hours, or toll free (888) 743-1478 after hours.**

Continued on next page

Investigating and Reporting Death of a DBH Client, Continued

Alcohol and Drug Services

If the client is receiving services through an Alcohol and Drug Services (ADS) residential facility; in addition to the above steps, the following procedures must be followed
whether the death takes place in a licensed facility or not:

1	DBH Clinic Supervisor/Contract Agency or designee will report the death telephonically within one (1) working day to the Alcohol and Drug Program (ADP) Compliance Branch (PCB) of the Licensing and Certification Division (LCD) at (877) 685-8333.
2	The DBH Clinic Supervisor/Contract Agency designee will follow up with a written report within seven (7) days using the ADP C-6B Incident/Injury/Death Report Form; by sending a facsimile (fax) to (916)445-5084 or by mailing to: Department of Alcohol & Drug Programs Program Compliance Branch 1700 K Street, Second Floor Sacramento, CA 95811-4037
	Important Note: If a report to local authorities exists that contains the information cited below, a copy of such report will suffice for the written report required by ADP. Events reported shall include: (1) Death of any cause (2) Information provided shall include the following: a. Client's name, age, sex, and date of admission. b. Date, time, and nature of event. c. Attending physician's name, findings, and treatment if any.

References

ADP Bulletin No. 11-15
California Code of Regulations (CCR), Title 9, Chapter 5, Sections 10561(b), 10561(b)(1), and 10561(b)(2).

Related Policy

DBH Standard Practice Manual

- COM0939 Root Cause Analysis
- SFT7017: How to Report and Incident