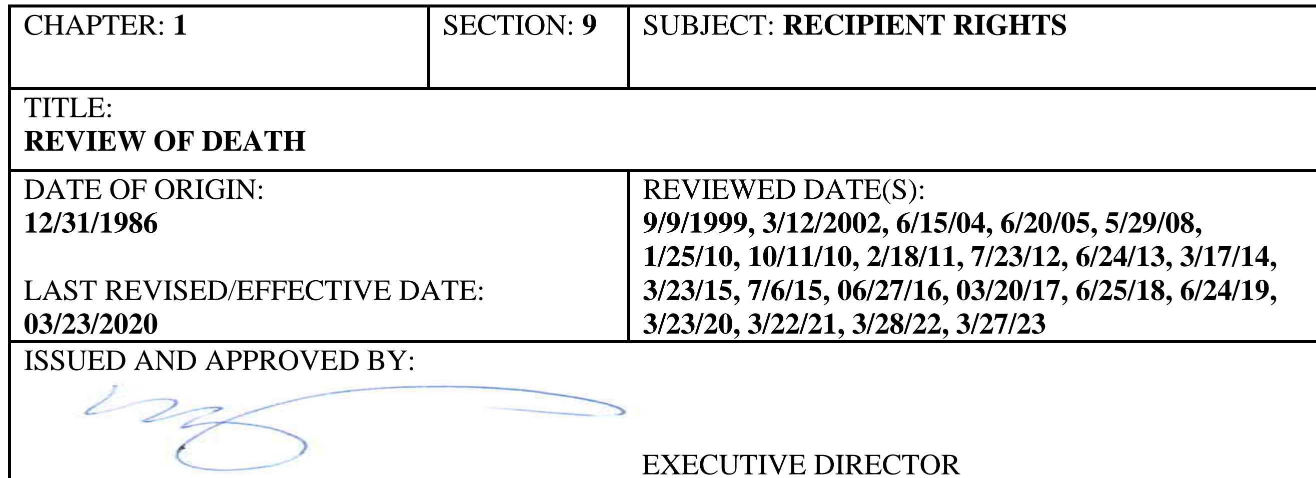
COMMUNITY MENTAL HEALTH OF OTTAWA COUNTY
RECIPIENT RIGHTS



CHAPTER: **1**	SECTION: **9**	SUBJECT: **RECIPIENT RIGHTS**
TITLE: **REVIEW OF DEATH**		
DATE OF ORIGIN: **12/31/1986** LAST REVISED/EFFECTIVE DATE: **03/23/2020**		REVIEWED DATE(S): **9/9/1999, 3/12/2002, 6/15/04, 6/20/05, 5/29/08, 1/25/10, 10/11/10, 2/18/11, 7/23/12, 6/24/13, 3/17/14, 3/23/15, 7/6/15, 06/27/16, 03/20/17, 6/25/18, 6/24/19, 3/23/20, 3/22/21, 3/28/22, 3/27/23**
ISSUED AND APPROVED BY:		EXECUTIVE DIRECTOR

I. PURPOSE:

To assure a timely, objective review of all unexpected deaths of consumers served by Community Mental Health of Ottawa County (CMHOC) to determine if the consumer's rights were protected and if appropriate services were provided.

II. APPLICATION:

All CMHOC staff and contract agency staff as specified by contract.

III. DEFINITIONS:

Unexpected Death: Includes those deaths that result from suicide, homicide, an undiagnosed condition, accidental, or were suspicious for possible abuse or neglect.

IV. POLICY:

It is the policy of CMHOC that deaths of consumers served by CMHOC will be reported and any unexplained/unexpected death will be reviewed by the Compliance Committee, Executive Director, and the Regional Entity, as needed. This review will be done in compliance with Section 748(9) of the Michigan Mental Health Code which states "the records, data, and knowledge collected for or by individuals or committees assigned a peer review function, including the review function under section 143a(1), are confidential, shall be used only for the purposes of peer review, are not public records, and are not subject to court subpoena."

V. PROCEDURE:

A. Deaths of consumers currently served by CMHOC, or those consumers who received an emergency service within the past thirty (30) days prior to death, will be reported to the Office of Recipient Rights and an Incident Report filed within one business day of becoming aware of the death. The Office of Recipient Rights will notify the CMHOC Executive Director and the Compliance Manager.

B. The Recipient Rights Office will request the Death Certificate and the Autopsy Report from the Medical Examiner's Office, if available.

C. The Case Manager/Supports Coordinator/Clinician will complete a "Report of Death" form and forward to the Office of Recipient Rights within three business days.

D. In cases of violent death by suicide, homicide, or accident; and in cases of unexplained death, the Compliance Manager will coordinate a review of the death.

E. The review will include a staff prescriber, the Office of Recipient Rights, the Compliance Manager, the appropriate clinical Program Supervisor, and other supervisors/clinical staff who were involved with the consumer.

F. The review will be initiated/conducted within thirty (30) days in which a "best judgment" determination will occur.

G. At the conclusion of the review process a report will be written jointly by the members of the review team. The report will include, but not necessarily be limited to, identifying data on the individual served, summary of the incident, information from the death certificate and the autopsy if applicable, and recommendations. After review, the Compliance Committee will forward the approved report to the Executive Director for review and signature.

H. The Executive Director will request action and follow-up on approved recommendations.

I. The report will then be forwarded to the Compliance Committee for review and assurance that policy was followed, and recommendations are completed.

J. CMHOC will report all consumer deaths to the Lakeshore Regional Entity, as required.

VI. ATTACHMENT:
None

VII. REFERENCE:
CMHOC Form #028 - Report of Death
LRE Review of Unexpected Death Report
Michigan Mental Health Code
CARF
MDHHS/CMHSP Contract Attachment C.6.5.1.1
MDHHS/CMHSP Contract Attachment C.6.1.1
MDHHS/CMHSP Contract Attachment C.6.8.1.1