
Title 1	Northern Lakes Policies
Part 106	Supports and Services – NLCMH Provided and Contract
Subpart J	Mental Health Code Protected Recipient Rights
Policy No.	106.1036
Subject	Recipient Death – Autopsy Requests Reporting and Review (RR)

Applicability

Policy applies to all NLCMH activities, operations and sites and to all Workforce Members except members of the governing body. Policy also applies to any Network Provider and its employees, volunteers, or agents that has elected to adopt and adhere to NLCMH policies and procedures pertaining to Recipient Rights under the terms of its Participating Provider Agreement.

Policy

It is the policy of Northern Lakes CMH to conduct a timely review in the event of the death of any recipient. All Workforce Members and contract Workforce Members have a responsibility to report, on an agency approved Death Report form and according to procedures, any occurrence that results in the death of a recipient, whether expected or unexpected.

Procedures

1. The Workforce Member will immediately notify by oral report the Office of Recipient Rights (ORR) and the immediate supervisor of any death.
2. The assigned Northern Lakes CMH Workforce Member who was responsible for implementing the plan of services for the deceased recipient shall do the following:
 - a. Request an autopsy in the event that the death occurred in any of the following settings or circumstances:
 - While the recipient was receiving inpatient psychiatric services; or
 - If the recipient is or was recently receiving services in a residential program operated by or under contract with Northern Lakes CMH; or
 - When the death occurred at any other Northern Lakes CMH direct operated or contract service site; or
 - If the recipient was under the supervision of a Northern Lakes CMH Workforce Member at the time of death.

- b. Because time is critical, the senior Workforce Member present at the service site shall make a request to either the family member of the recipient and/or to the appropriate Medical Examiner that an autopsy be conducted. Family may be encouraged to pursue an autopsy, however this should be done with sensitivity to the family's cultural and belief systems, and honoring the family's preferences. When the death of a recipient occurs other than as described above, the assigned worker shall obtain the results of an autopsy, if and when available.
2. Within 24 hours of being notified of the death, the assigned Northern Lakes Workforce Member shall complete a Report of Recipient Death, obtain supervisor signature, and forward to the ORR and Director of Quality Improvement.
 3. If the death was unexpected, the assigned Northern Lakes CMH Workforce Member shall:
 - o request a copy of the death certificate
 - o request medical records seal the recipient's Northern Lakes CMH record and send to ORR
 4. Preliminary Reviews of Death
 - a. ORR Review of Death-Upon receiving the Report of Recipient Death the ORR shall conduct a prompt review of the circumstances surrounding a recipient's death. If a determination is made that there is an apparent or suspected violation of rights associated with the death, a Recipient Rights Investigation shall commence in accordance with Section 778 of the Michigan Mental Health Code. If this review identifies a possible Sentinel Event, the Director of Quality Improvement will be notified immediately.
 - b. Supervisor/Chief Operating Officer Review of Death - If a Chief Operating Officer makes a determination that the death may meet the criteria of a Sentinel Event as defined by Policy and Procedure IV-I-09, he/she will notify the Director of Quality Improvement immediately.
 - c. The Director of Quality Improvement will review all deaths in relation to Michigan Department of Community Health reporting requirements and ensure that summary reports are made consistent with the requirements specified in the MDCH contract.

Adoption Date: May 23, 2006

Review Dates:

Revision Dates:
August 31, 2010