

Policy and Procedure	Date Issued	Policy Number	Page 1
Milwaukee County Behavioral Health Division	06/14/2000	CARS - 107	
Community Access to Recovery Services	Date Revised	Subject:	
	04/28/2015	Death Reporting	

**1. POLICY:**

**PURPOSE:** To be informed of and monitor client deaths in Community Access to Recovery Services (CARS) programs, both BHD Day Treatment and Provider Network agencies, for purposes of ongoing quality assurance and performance improvement.

**POLICY:** The Behavioral Health Division (BHD) Community Access to Recovery Services (CARS) shall be informed in writing and by phone contact of any death of a client in service in Community Access to Recovery Services BHD Day Treatment and Provider Network agencies within 24 hours of discovery of death, on the first business day following the death.

**2. PROCEDURE:**

Programs are to notify BHD Community Access to Recovery Services, care of CARS Quality Assurance Department of any death of a client in service within 24 hours of discovery of the death, on the first business day following the death.

A. **BHD-Provider Network agencies** are to complete and submit the following forms:

1. Notification of Death Form to CARS Quality Assurance Department, within 24 hours of discovery of death, or on the first business day following the death. The form is to be completed in Provider Connect/Avatar, or the PDF fillable copy can be downloaded and completed electronically at <http://county.milwaukee.gov/forms.htm>.
  - Form must be completely filled out. (See example at <http://county.milwaukee.gov/forms.htm>)
2. In the case of a death believed to be caused by suicide, psychotropic medication or physical restraint/seclusion, programs having the regulatory reporting requirement to notify the State should report the death to the Division of Quality Assurance, Wisconsin Department of Health and Family Services, within 24 hours of the death (see Client/Patient Death Determination Form DSL-2470). A copy of the completed form should be forwarded to CARS Quality Assurance Department.
3. A Copy of Coroner/Medical Examiner's report to CARS Quality Assurance Department when available.
4. Other Notifications: each BHD Provider Network Agency will notify the Service Manager for the designated service area in the event a death occurs in the agency.

B. **BHD Day Treatment** is to complete and submit the following forms:

1. Notification of Death Form to CARS Quality Assurance Department, within 24 hours of discovery of death, or on the first business day following the death. The form is to be completed in Avatar, or the PDF fillable copy can be downloaded and completed electronically at <http://county.milwaukee.gov/forms.htm>.
  - Form must be completely filled out. (See example at <http://county.milwaukee.gov/forms.htm>)
2. Incident/Risk Management Report (MCBHD Form 4310-latest draft) should be sent to Quality Management and a copy should be forwarded to CARS Quality Assurance Department.

3. In the case of a death believed to be caused by suicide, psychotropic medication or physical restraint/seclusion, programs having the regulatory reporting requirement to notify the State should report the death to the Division of Quality Assurance, Wisconsin Department of Health and Family Services, within 24 hours of the death (see Client/Patient Death Determination Form DSL-2470). The Standard of Practice for BHD Day Treatment has been to complete this form and notify the State on all deaths that occur in the BHD Day Treatment program. A copy of the Client/Patient Death Determination Form DSL-2470 should be forwarded to the BHD CARS Quality Assurance Department.
4. Other Notifications: BHD Day Treatment will notify the Community Access to Recovery Services Director, the Manager of Medical Records, the Service Manager for the designated service area, and the Behavioral Health Division Administrator, in the event a death occurs in the respective program.

### **C. Quality Assurance Process**

1. CARS Provider Network agencies are to have a quality/risk management process in place for internal review of client deaths. Following the death of a client, the agency is to complete their internal review and submit a brief written summary of findings. This summary may include: treatment and service delivery at time of death, evaluation of those services, and recommendations for changes in services or treatment. This summary is to be sent to BHD CARS Quality Assurance Department.
2. BHD Day Treatment is subject to the existing BHD Quality/Risk Management policy and procedure governing critical incident review.
3. CARS, through Program Service Managers, will review the reports of client deaths and forward problematic cases to the BHD Critical Incident Committee.
4. CARS reserve the right to explore all reports of client deaths.

Attachment 1: Notification of Death Form

Reviewed & Approved by:   
**Jennifer Wittwer, Associate Director**  
**Community Access to Recovery Services**

### NOTIFICATION OF DEATH

Program: CCS  CRS  TCM  CSP  CBRF  MH Day Tx  MH OP   
RSC  AODA Residential  AODA Day Tx  AODA Outpatient  RSS Services

Consumer: \_\_\_\_\_ MR/Client #: \_\_\_\_\_

Gender: Male  Female  Transgender  Date of Birth: \_\_\_\_\_ Age at Death: \_\_\_\_\_

Agency RU#: \_\_\_\_\_ Agency Name: \_\_\_\_\_

Agency Admission Date: \_\_\_\_\_ Agency Contact & Phone #: \_\_\_\_\_

Date of Death (If Known): \_\_\_\_\_ Date of Agency's Discovery of Death: \_\_\_\_\_

Cause of Death (If Known): Natural  Suicide  Homicide  Accident  Unknown  Accidental Overdose   
Other  \_\_\_\_\_

I. Circumstances of Death (location, anticipated/unanticipated): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe Actions Taken: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Notifications Made:  Coroner / Medical Examiner  
 Sheriff / Police  
 State of WI DHSS Client/Patient Death Determination  
**(Please attach copy of completed form)**

#### II. Current Behavioral Health Condition / Treatment

A. Psychological/Substance Use Disorder Diagnosis: \_\_\_\_\_  
\_\_\_\_\_

Medical Diagnosis: \_\_\_\_\_  
\_\_\_\_\_

List of **Current** Medications (attach additional forms if needed): \_\_\_\_\_  
\_\_\_\_\_

Medication Changes within the Last Seven Days? Yes  No   
If Yes, Please Explain Changes: \_\_\_\_\_  
\_\_\_\_\_

Last Medical appointment: \_\_\_\_\_  
Date of Last Hospitalization: \_\_\_\_\_ Type: Psychiatric  Medical  Substance Abuse

B. Current Service Delivery: Daily  Weekly  Monthly   
Date and Context of Last Contact: \_\_\_\_\_  
\_\_\_\_\_

Describe any Psychosocial Stressors/ Significant Changes in Client's Behavioral Health in the Last Month based on Observed or Reported Symptoms and Behaviors: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. Any Evidence that Client was Having Suicidal Thoughts in the Last Month? Yes  No

If Yes, Please Explain: \_\_\_\_\_  
\_\_\_\_\_

Any Evidence that Client was Having Homicidal Thoughts in the Last Month? Yes  No

If Yes, Please Explain: \_\_\_\_\_  
\_\_\_\_\_

Risk behaviors (Include self-harm, suicide, dangerousness to self and/or others, substance abuse, antisocial, criminal): \_\_\_\_\_  
\_\_\_\_\_

**III. Other Factors**

A. Self care / Community Living Problems (Include safety, nutrition, judgment, vulnerability): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Name of Staff Reporting

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Clinical Supervisor

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*For Community Access to Recovery Services use only:*

Service Manager

**Impression:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Recommendations:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CARS Service Manager** \_\_\_\_\_ **Date** \_\_\_\_\_  
*Signature*

QA Staff

**Medical Examiner's Report Received?** Yes  No  N/A

**Medical Examiner's Cause of Death:** Natural  Suicide  Homicide  Accident  Unknown  Accidental Overdose   
Other  \_\_\_\_\_