NYS Office of Mental Retardation and Developmental Disabilities
Putting People First

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MEMORANDUM

TO: DDSO Directors
Executive Directors, Voluntary Agencies

FROM: Sheila McBain, Ph.D. Sheila M. McB
Deputy Commissioner
Division of Quality Management

DATE: July 9, 2009

SUBJECT: Reporting Deaths

SUPERCEDE: The following information supersedes that contained in the June 11th, 1999 memorandum from Richard Johnson

As part of the Office of Mental Retardation and Developmental Disabilities' (OMRDD) commitment to ensure quality services to people with developmental disabilities, all deaths of individuals receiving services from both state-operated and voluntary agency operated programs must be reported to the local Developmental Disabilities Services Office (DDSO) and to the Commission on Quality of Care and Advocacy for Persons with Disabilities (CQCAPD). Providers of services must submit the OMR 147 to the appropriate DDSO within 24 hours of the discovery of the death. The form QCC-100 must be submitted to the CQCAPD and the DDSO within three working days of the discovery of the death.

All deaths must be investigated. However, in every instance following the death of someone receiving services, those who were involved with the individual (e.g., staff, roommates, etc.) must feel supported and valued. It is important to acknowledge the feelings of staff and individuals receiving services and to consider their needs throughout the investigation process.

A death classified as "reportable" is a death due to natural and expected causes. In these cases a mortality review may substitute for a formal investigation. A mortality review is a process in which the care and treatment provided to the individual receiving services is examined with a focus on improving the quality of care provided to individuals during end of life events. Mortality review results must be reviewed by the Incident Review Committee.

A death classified as a "serious reportable" is a death due to circumstances unrelated to the natural course of an illness/disease or proper treatment in accordance with acceptable medical standards; an apparent homicide or suicide; or an unexplained or accidental death. Serious reportable deaths must be investigated according to the provider's policies and procedures for investigation of incidents.

In those instances wherein a provider does not have overall responsibility for the medical care of the individual receiving services, (a day service provider, a Family Support Services provider, an

Article 16 provider, an MSC provider, a respite service provider) an OMR 147 and a QCC 100 must be completed to the best of that provider's ability. Deaths must be reviewed to the extent possible; however, it is not necessary for the provider to intrude on a family's mourning in an effort to obtain information to complete the forms. For example, in such cases, it is not generally necessary to request that an autopsy report be provided.

Designated DDSO personnel are responsible for reviewing the submitted OMR 147s and QCC100s for thoroughness and in each case take any follow-up actions deemed necessary. Upon receipt, the DDSO is responsible for submitting a copy of the QCC 100 and the OMR 147 to OMRDD Office of Internal Affairs.

Thank you for your attention to this matter. If you have any questions, please contact the appropriate DDSO Incident Review Coordinator.

cc: Ms. Ritter
Mr. Chmura
Mr. Lind
Ms. Broderick
Ms. Ohoro
Mr. Smits
SCIR