GEORGIA DEPARTMENT OF CORRECTIONS **Standard Operating Procedures**		
Policy Name: Death Notification, Critical Incident Notification, and Investigation		
Policy Number: 508.03	**Effective Date:** 7/13/2020	**Page Number:** 1 of 6
Authority: Commissioner	**Originating Division:** Health Services Division (Mental Health)	**Access Listing:** Level I: All Access

I. Introduction and Summary:

It is the policy of the Georgia Department of Corrections (GDC) to conduct a clinical investigation of a death or Critical Incident. Specifically, a clinical investigation may be conducted in the event an offender commits suicide, homicide, or engages in behavior that constitutes a Critical Incident or one that potentially puts the offender at risk to either their health or the health of others, or if an offender receiving mental health services dies of unusual circumstances.

II. Authority:

A. Ga. Comp. R. & Regs. 125-2-4-.20 Death and Interment;

B. O.C.G.A. § 31-7-133;

C. GDC Standard Operating Procedures (SOPs): 208.03, Death of an Offender and 507.04.67, Offender Death and Mortality Reviews;

D. ACA Standards: 2-CO-4E-01, 5-ACI-6C-16 (ref. 4-4425), 5-ACI-6D-02 (ref. 4-4410 Mandatory), 4-ALDF-4D-23, and 4-ACRS-7D-15; and

E. NCCHC Standards.

III. Definitions:

A. **Critical Incident** - Any actual or alleged event or situation that creates a significant risk of loss of life.

B. **Communicable Disease** - An infectious disease transmittable by direct contact with an infected individual, the individual's discharges or by indirect means.

C. **Serious Self-Injury** - An intentional injury to one's self requiring transfer to an infirmary and/or community hospital setting, for treatment beyond first aid.

D. **Unusual Death** - Any unanticipated loss of life that is not due to a natural death or disease and is not the clear result of a suicide.

E. **Clinical Peer Review** - An assessment by a Clinical Peer Review team of the clinical care provided and the circumstances leading up to a death. Its purpose is to identify areas of patient care or system policies and procedures that can be improved.

F. **Psychological Autopsy** - A written reconstruction of an offender's mental health status with an emphasis on factors that led up to and may have contributed to the individual's death. It is usually conducted by a psychologist or other qualified mental health professional.

IV. Statement of Policy and Applicable Procedures:

A. Notification of Death or Critical Incident:

1. The Mental Health Unit Manager will notify the State Mental Health Program Supervisor/designee as soon as possible after the death or Critical Incident involving offenders receiving mental health services.

2. For Critical Incidents involving non-mental health offenders, a mental health referral may be initiated.

3. For any unusual deaths of offenders receiving mental health services and/or for any offender (Level 1 - 6) who commits suicide, a Psychological Autopsy or review of the circumstances surrounding the death shall occur.

4. The Mental Health Unit Manager/designee will provide a copy of the offender's mental health records to the State Mental Health Program Supervisor/designee for administrative review and coordination of the psychiatric/psychological autopsy or review.

5. The Health Services Administrator (HSA) will be contacted to provide the medical record to the State Mental Health Program Supervisor/designee for administrative review and coordination of the psychiatric/psychological autopsy or review, and

6. The death notification procedures stated in SOP 507.04.67, Offender Death and Mortality Reviews, will be followed for all offenders receiving mental health services and for all completed suicides.

B. Clinical Peer Review Process:

1. A Clinical Peer Review process will examine suicides, unusual deaths and Critical Incidents of offenders receiving mental health services.

2. Clinical Peer Review, which is confidential and non-discoverable per O.C.G.A. § 31-7-133, will be conducted in an open and honest manner with contributions encouraged from all staff involved in the clinical care of the deceased offender in order to:

   a. Improve the quality of care; and

   b. Help prevent unnecessary loss of life due to injury or suicide.

3. Critical Incidents will be reviewed in order to ascertain institutional compliance with the Standard Operating Procedures.

4. The Clinical Peer Review Team will be comprised of the Mental Health Unit Manager, Clinical Director, and those involved in the direct care of the deceased offender.

5. The team may also include a mental health nurse, a Multifunctional Correctional Officer (MFCO), and other clinical staff as needed and appropriate.

6. In the event of an offender's death or Critical Incident, Attachment 1, Form M03-01-01 (Offender Death Notification Form) or Attachment 2, Form M03-01-02 (Offender Critical Incident Notification Form) will be completed by the Mental Health Unit Manager within one (1) week; and

7. The Mental Health Unit Manager/designee will forward the form to the State Mental Health Program Director/designee and the facility Warden.

C. Central Office Clinical Peer Review Team:

1. The Statewide Medical Director, Statewide Mental Health Director and Chief Psychiatrist/designee will establish a Clinical Peer Review team whose function will be:

   a. To conduct an in-depth clinical analysis of all suicide cases, and

   b. Any unusual Critical Incidents determined to be clinically significant by the Statewide Mental Health Director.

2. The Statewide Medical Director, Statewide Mental Health Director, and Chief Psychiatrist/designee will determine the exact composition of the Clinical Peer Review team which will depend on the nature of the incident to be reviewed.

3. The focus of the Clinical Peer Review will be to:

   a. Identify what happened in the case under review;

   b. Identify what can be learned to help prevent future incidents;

   c. Identify areas of patient care that can be improved; and

   d. Identify system policies and procedures that can be improved.

4. The Clinical Peer Review team will carefully review the quality of care provided in the particular case.

5. The review will involve a thorough investigation and group discussion of each Critical Incident or offender suicide.

6. The Clinical Peer Review discussion will cover the psychological state of any offender(s):

    a. Involved in the Critical Incident;

    b. The offender who committed suicide, or

    c. The history and the procedures followed by the facility's mental health staff.

7. The Clinical Peer Review team will interview other appropriate staff members and offenders, and review written reports prepared by other staff relative to the incident.

8. Any additional information relative to a particular case will be fully explored.

9. Meetings of the Central Office Clinical Peer Review Team will be scheduled within ten (10) working days and occur within thirty (30) days after the incident.

10. A designated team member will take the responsibility for making sure that the institutional record, mental health treatment record and medical record are available to the team at the time of the review.

11. The team will be advised in advance of the date, time and place of the review meetings.

12. At the conclusion of the review, the chairperson of the team will make a written confidential report to the Statewide Medical Director and Statewide Mental Health Director of their findings and make recommendations to improve the quality of care, and

13. Appropriate recommendations will be utilized as the basis for local and statewide in-service trainings.

V. Attachments:

Attachment 1: Offender Death Notification Form (M03-01-01)
Attachment 2: Offender Critical Incident Notification Form (M03-01-02)

VI. Record Retention of Forms Relevant to this Policy:

Upon completion, Attachments 1 & 2, shall be placed in the offender's mental health file. At the end of the offender's need for mental health services and/or sentence, the mental health file shall be placed within the offender's health record and retained for ten (10) years.