JUVENILE COURT HEALTH SERVICES

Subject:	Original Issue Date:	Policy #
PROCEDURE IN THE EVENT OF A YOUTH DEATH	4/22/85	**C-113**
	Supersedes: 2/8/2019	Effective Date: 5/18/2021

Departments Consulted:	Approved By:	Approved by:
Probation Department DHS Risk Management	(Signature on File) Health Services Administrator (Signature on File) Nursing Director	(Signature on File) Medical Director

PURPOSE

To describe the review process in the event of a youth's death.

POLICY

An interdisciplinary death review shall be conducted within 30 days of the youth's death. Components of the review will include the following: clinical mortality, administrative, and a psychological autopsy in the case of suicide.

PROCEDURE

Internal Procedures and Procedures Involving Probation Department and Partner Agencies

1. Upon receipt of the notification of a youth's death, JCHS Risk Manager completes a claim within the University Health Consortium (UHC) Safety Intelligence system.
2. Appropriate interdepartmental reporting is performed upon receipt of the notification of a youth's death.
3. An Executive Case Review is conducted by the following team members: Medical Director, Nursing Director, Mental Health Director, Probation Bureau Chief(s)/Director(s) and Risk Management (DHS and Probation) within 3 business days of the death.
4. Ancillary Departmental (laboratory, dental, radiology, pharmacy, etc.) review of the case will occur within 5 days of the death.
5. A preliminary Death Report with analysis of contributing factors and recommended corrective actions will be generated within 10 days of the death.
6. Executive review of the preliminary Death Report with approval of corrective actions will be performed within 14 days by the relevant Department Heads. This review will be reported to the JCHS QI Committee.
7. The JCHS QI Committee will oversee the audits of all corrective actions to ensure compliance.
8. A Mortality Review conference will be held within 28 days.
9. A Final Death Report will be completed by the 28th day.

10. Amendments to the Final Death Report may be made as needed (e.g., autopsy findings). Any new information that results in further corrective actions will be submitted for approval by the Executive case review team.
11. In the event of a suicide, a psychological autopsy will be conducted in collaboration with the Department of Mental Health – Juvenile Justice Mental Health Program regarding any factors that may have contributed to the death of the youth.

External Procedures

1. JCHS Risk Manager will notify Ambulatory Care Network (ACN) Risk Management Office of the event within 3 business days.
2. JCHS Risk Manager will write up the full review (as described above) and oversee development of a Corrective Action Plan to submit to the Risk Management Office. The Corrective Action Plan must be submitted within 45 days of the event.
3. If appropriate, JCHS Risk Manager will notify the County's Third-party Administrator of the event so that they may prepare for any potential litigation or other legal proceedings.

AUTHORITY

California Code of Regulations, Title 15, Article 4, Section 1341

REFERENCE

NCCHC Standard Y-A-10

REVIEW DATES

January 30, 2012; March 15, 2013; March 8, 2018; February 8, 2019; May 18, 2021