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DELAWARE HEALTH AND SOCIAL SERVICES

DHSS Policy Memorandum #65 **Effective: February 6, 2025**

DHSS Mortality Review Committee

I. PURPOSE:

The Department of Health and Social Services (DHSS) has established the DHSS Mortality Review Committee to identify any underlying systemic issues and any contributing or unexpected circumstances that may have played a role in the of deaths of individuals age 18 and over who received services in settings operated or funded by DHSS.

II. SCOPE:

This policy applies to death reviews of individuals 18 years of age and older who have died while receiving services in a hospital, facility, residential, home or community-based settings, or subsidized settings operated by or for any DHSS Division or funded by DHSS in a provider-managed residential facility.

III. POLICY:

It is the policy of DHSS that each Division investigate any deaths of individuals 18 years of age and older who have died while receiving services in a residential setting, facility, or hospital operated by or for a specific DHSS Division or funded by DHSS in a provider-managed residential facility. As part of the investigation, a determination shall be made as to any contributing or unexpected circumstances along with any emergent, critical, or chronic illness or situations that occurred in proximity or relative to the death. Documentation of each investigation and the results will be maintained by each Division. The Division will forward a summary report of each investigation to the DHSS Chief of Staff via email on a monthly basis.

The summary report provided to the Chief of Staff shall include facts as well as considerations of the case and any resulting issues, guided by the following:

- What factors or circumstances caused or contributed to the death,
- What responses and investigations resulted from the death and whether all necessary agencies were notified, responsive, and proactive in instituting corrective actions if applicable,
- Whether the services and intervention concerning the decedent were appropriate and adequate for their needs,
- Whether staff involved with the decedent were adequately prepared, trained, and supported to perform their duties correctly, and
- Whether the applicable statutes, regulations, policies, and procedures are adequate to serve the needs of the population within the service system. If not, determine what changes are needed.

The Chief of Staff may request an additional internal Departmental review of any individual death(s). The purpose of this review is to identify any underlying systemic issues that may have played a role in an individual's death, with the goal of preventing a similar outcome in the future. The DHSS Mortality Review Committee will be the body responsible for this task. Investigative reviews will be conducted to gather and analyze evidence about the deaths; to safeguard and improve health; to ensure the safety and welfare of service recipients; and to reduce the number of preventable deaths and to promote quality improvement

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efforts. Additional records and pertinent data may be requested of the Division to complete a Departmental review. This includes the right to interview employees involved in the case and any other individuals who have direct involvement in, or knowledge of the case, as appropriate.

The DHSS Mortality Review Committee shall be comprised of the following members:

- DHSS Chief of Staff (Committee Chair)
- Division of Public Health (DPH) Medical Director or DPH Designee
- Division of Medicaid and Medical Assistance (DMMA) Medical Director or DMMA Designee
- Division of Substance Abuse and Mental Health (DSAMH) Medical Director or DSAMH Designee
- Division of Child Support Services (DCSS) Designee
- Division of Developmental Disabilities Services (DDDS) Designee
- Division of Health Care Quality (DHCQ) Designee
- Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) Designee
- Division of Social Services (DSS) Designee
- Division for the Visually Impaired (DVI) Designee
- Office of the Secretary Administration (OSEC Admin) Designee

The DHSS Mortality Review Committee will be responsible for:

- Meeting to review, as scheduled, the death summary report and associated files from the respective Division, documenting any comments and/or concerns.
- Analyzing the causes and circumstances contributing to each death.
- Reviewing and evaluating services provided by public and private systems and assessing whether said providers had properly carried out their respective duties and responsibilities.
- Identifying strengths and weaknesses in the public and private agencies and/or programs based on the results of the reviews (both individual and in the aggregate) and making recommendations to the applicable Division Director(s) to implement systemic and/or specific changes to improve services or to rectify deficiencies. The recommendations may address, but are not limited to, proposing legislative or regulatory changes; revising or implementing policies or procedures; creating or modifying training for service providers; and enhancing coordination and communication among entities providing or monitoring services.
- Consulting the Division's Deputy Attorney General (DAG) when needed.
- Producing a report for each death reviewed once the review is completed which includes analysis of data (age, gender, manner of death), any systemic recommendations, and all committee recommendations. This report shall be disseminated to the DHSS Cabinet Secretary, and recommendations should be shared with the relevant division, including the Deputy Cabinet Secretary of that Division.

All members of the DHSS Mortality Committee shall exercise the fullest extent of their responsibility to protect the confidentiality of records and persons involved with death reviews in accordance with applicable laws and DHSS PM #5 Client Confidentiality. The DHSS Mortality Review Committee is a quality performance improvement initiative and work products generated by, presented to, or considered by the Committee are peer protected pursuant to 24 *Del. C.* §1768 and shall not be disclosed or released under any circumstances.

All Mortality Review Committee records shall be maintained in a secure manner by the Committee Chair or designee for a period of three (3) years and will thereafter be securely destroyed.

Any part of this policy which is in conflict with federal or state laws shall be null and void; all other parts shall remain operative.

IV. IMPLEMENTATION

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This Policy Memorandum supersedes previous versions of DHSS PM #65 and is effective upon signature of the Cabinet Secretary.

The Office of the Secretary will be responsible for maintaining this policy and any revisions.

Signed by:
Josette D. Manning, Esquire
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Josette D. Manning, Esq.
Cabinet Secretary

2/10/2025 | 5:13 PM EST

Date

The Department of Health and Social Services is committed to improving the quality of life of Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations.