

GEORGIA DEPARTMENT OF JUVENILE JUSTICE	Transmittal # 12-17	Policy # 8.6
Applicability: {x} All DJJ Staff {x} Administration { } Community Services {x} Secure Facilities	Related Standards & References: NCCHC 2011: Y-A-10	
Chapter 8: SAFETY, SECURITY AND CONTROL	Effective Date: 11/1/12 Scheduled Review Date: 11/1/14 APPROVED:	
Subject: FATALITY REVIEW IN SECURE FACILITIES		
Attachments: None.		

I. POLICY:

The Department of Juvenile Justice shall thoroughly review the cases of all youth who become deceased while placed in a secure facility.

II. DEFINITIONS:

Administrative Review: An assessment of correctional and emergency response actions surrounding a juvenile’s death used to identify areas where facility operations, policies, and procedures can be improved.

Clinical Mortality Review: An assessment of the clinical care provided and the circumstances leading up to a youth’s death. Its purpose is to identify areas of patient care or system policies and procedures that can be improved.

Fatality of a Youth: Any youth who resides in a secure facility and has become deceased by any means.

Psychological Autopsy: A written reconstruction of an individual’s life with an emphasis on factors that may have contributed to the death.

III. PROCEDURES:

Directive 14-06
July 1st, 2014

A. ~~The Commissioner will appoint a Fatality Review Committee (“Committee”) as soon as practicable but no later than 5 business days following the death of a youth, even if complete autopsy results are not yet available. The Commissioner will appoint the chair of the Fatality Review Committee, with the Commissioner serving as an ex-officio member. The Committee will not interfere with or take the place of any ongoing investigation.~~

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The Commissioner will appoint a Fatality Review Committee (“Committee”) as soon as practicable but no later than 5 business days following the death of a youth, even if complete autopsy results are not yet available. The Commissioner will appoint the chair of the Fatality Review Committee, with the Commissioner serving as an ex-officio member. If the death was due to suicide, the Commissioner will appoint the Director of the Office of Behavioral Health Services to chair the Fatality Review Committee. The Committee will not interfere with or take the place of any ongoing investigation.

- B. A fatality review consists of an administrative review, a clinical mortality review and a psychological autopsy (if death is by suicide).
- C. Administrative Review
1. The Fatality Review Committee will administratively review all deaths within 30 days of occurrence.
 2. Within 10 business days of the Committee review, the chair of the Administrative Fatality Review Committee will review with the Commissioner or designee the findings and recommendations for where facility operations, policies, and procedures can be improved.
- D. Clinical Mortality Review
1. A clinical mortality review will be completed for all youth fatalities. The clinical mortality will be completed by the Director of Medical Services.
 2. The Fatality Review Committee will review the following:
 - Areas for improvement in the medical response;
 - The possibility of an earlier intervention;
 - Ways to improve patient care, if the cause of death was independent;
 - A review of the incident and facility procedures used;
 - Training received by involved staff;
 - Pertinent medical and mental health services or reports involving the juvenile; and
 - Recommendations for changes to policy, training, physical plant, medical or mental health services, and operational procedures.
 3. For expected deaths, a modified review process that focuses on the relevant clinical aspects of the death and preceding treatment may be followed.
 4. When multiple deaths occur at a facility, an assessment will be completed to determine whether any patterns require further study.

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5. When a medical autopsy is completed after the clinical mortality review is completed, the clinical review is appended with information from the autopsy report.
6. The Director of Medical Services will provide the treating staff with the findings of the clinical mortality and administrative reviews.
7. Corrective actions identified through the mortality review process will be implemented and monitored through the facility's Behavioral Health and Medical Services quality assurance processes.

E. Psychological Autopsy:

1. A psychologist or psychiatrist will conduct all psychological autopsies.
2. A psychological autopsy will be completed in addition to the clinical mortality review and the administrative fatality review for all deaths by suicide.
3. The Fatality Review Committee will determine if a death, other than by suicide, should receive a psychological autopsy.

IV. LOCAL OPERATING PROCEDURES REQUIRED: NO