South Carolina
Department of Disabilities
and Special Needs

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I. Introduction

The purpose of this document is to establish procedures to be followed in the event of a death of individuals participating in a Department of Disabilities and Special Needs (DDSN) operated Home and Community Based (HCB) Waiver as well as individuals receiving DDSN contracted residential or day supports regardless of funding source.

Staff should always remain aware of the feelings and emotions of families whose loved one is critically ill or has just passed away. All contact with the family should be made in a sensitive and respectful manner. Direct Service Provider or Case Management staff who have worked closely with the critically ill or deceased person and family are important in assisting the family and are generally the primary contact for the family.

Should a person's death become imminent due to accident or serious illness, and the person is residing in a DDSN operated or contracted residence, the physician or the DDSN Regional Center/Provider designee should inform the parents/next-of-kin of the critical nature of the accident or serious illness. The residential staff or Case Manager, along with the physician will maintain contact with the family during the period the person remains in danger. If the family or person

supported desires, a pastor or other religious person of their choice will be located to minister to the needs of the person and the family as quickly as possible.

II. Definitions

Allegation of Abuse, Neglect, or Exploitation (ANE) – A person has reason to believe that another person has been or is at risk for abuse, neglect, or exploitation.

Administrative Review – The final step of the incident management process that reviews the circumstances of the incident; weighs evidence of policy or procedural violations or employee misconduct, and creates corrective action plans. The Administrative Review is intended to mitigate risks and prevent future incidents, where possible.

Case Manager - A person selected by the participant to coordinate assessment, planning, care coordination, evaluation, and services to meet a service recipient's needs. The Case Manager provides advocacy and information about available resources to ensure choice, satisfaction, and quality.

Corrective Actions – Actions implemented to increase protection to persons from similar future incidents. Corrective actions can be implemented for a single person and/or related to an organizational change to prevent similar incidents to all persons served.

Critical Incident – A type of incident that has been determined to be a sufficiently serious indicator of risk that it requires an administrative review.

Expected Death (Natural Causes) – Primarily attributed to a terminal illness or an internal malfunction of the body not directly influenced by external forces. This includes a death that is medically determined, based on a death certificate and supporting documentation, to have resulted solely from a diagnosed degenerative condition or a death that occurs as the result of an undiagnosed condition resulting from an explained condition, such as the aging process.

Unexpected Death – An unexpected death is primarily attributed to an external unexpected force acting upon the person. Deaths attributed to events such as car accidents, falls, homicide, choking and suicides would be considered unexpected.

Unexplained Death – A death in which the cause of death noted on a person's death certificate is not supported by documentation found in the person's medical history and other documentation.

Incident Management - The response to an event, intended to ensure the adequate, appropriate, and effective protection and promotion of the health, safety, and rights for all people served.

III. Reporting the Death of Persons Supported within DDSN Regional Centers or by DDSN Contracted Service Providers

In order to provide quality assurance oversight, DDSN tracks relevant information on the deaths of all persons who reside in DDSN sponsored residential services, or whose death occurs at a DDSN Regional Center or provider location (e.g., day program) or while under the supervision of a DDSN Regional Center or board/provider staff person.

A. Deaths of Persons Receiving Residential Services in a Home Operated by or Contracted for Operation by DDSN

1. The physician or DDSN Regional Center/Provider ensures that the county coroner's office is immediately notified of all deaths unless the death occurred in a hospital or Hospice setting.

2. For deaths involving persons age 18 and above, the DDSN Regional Center/Provider designee will report the death to the South Carolina Law Enforcement Division (SLED) Special Victims/Vulnerable Adult Investigations Unit immediately using SLED's toll-free number: 1-866-200-6066.

3. For deaths involving persons age 17 and under, the DDSN Regional Center/Provider designee will report the death to the South Carolina Law Enforcement Division (SLED) Special Victims/Child Fatality Unit immediately using SLED's toll-free number: 1-866-200-6066. The death must also be reported to the SC DSS Out of Home Abuse and Neglect Investigation Unit (OHAN).

4. The Initial Report of Death Form located in the Death Reporting function of the Incident Management System, must be completed-within 24 hours. A report must be made to DDSN and SLED even if the person dies in a location other than his/her DDSN sponsored home (e.g., hospital). The report to DDSN must be submitted on the Incident Management System. For persons recently discharged from a DDSN residential service location, SLED must be contacted by the former DDSN residential provider if the death occurs within 30 days of the discharge date.

5. If the death was unexpected or unexplained, the DDSN Regional Center/Provider designee must call the DDSN Associate State Director of Operations or their designee immediately. Immediately means as soon as reasonably possible but, under no circumstances, to exceed two (2) hours following the death. The Death Reporting function on the Incident Management System must be completed within 24 hours.

6. If there is any reason to believe that abuse or neglect may have occurred, the provider will also need to complete a corresponding ANE Report on the Incident Management System.

7. All deaths in Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IID) and Community Residential Care Facilities (CRCF) must be reported in writing by the DDSN Regional Center/Provider designee to the Health Licensing Division of the South Carolina Department of Health and Environmental Control (DHEC) at the same time a report is made to DDSN.

8. An Administrative Review will be conducted for all deaths. **This review should never interfere with any outside investigation.** For ICF/IID and CRCF locations, the results of all Administrative Reviews must be submitted to DDSN and to DHEC, within five (5) calendar days of the death. For all other residential settings, the results of all Administrative Reviews must be submitted to DDSN within ten (10) business days of the death. The results of the review must be documented in the Report of Death-Final Report, located within the Incident Management System. The DDSN Regional Center/Provider designee will submit the final report.

Notification Procedures

For those persons living in a DDSN operated or contracted residential setting, the family/guardian or primary correspondent will be notified of the death by the method they have identified in the person's plan such as by phone, personal visit or by notifying their minister who would then notify the family. If the family has made no prior arrangements, the attending physician will inform the family of the death of their family member per the physician's death notification policy. The provider representative will seek permission for an autopsy at that time as indicated by law. When gathering information on the death of a DDSN consumer, care must be taken to respect the feelings of survivors. The provider representative should express condolences, indicate the importance of gathering key information for the benefit of other individuals with disabilities, and proceed to fill out the "Report of Death" by retrieving information from the participant and staff records. If family members are unwilling/unable to participate in filling out the report, this information will be documented. The staff person should then proceed with the form using information from other approved participant records.

Autopsy

An autopsy will be performed following the death of a person when requested by the coroner or SLED and should also be done when:

a) Death is an unexpected or unexplained outcome as determined by the attending physician and/or medical director, and/or Executive Director, or;

b) Requested by the family. (*Costs for an autopsy requested by the family, but not required by the Coroner or SLED, will be the financial responsibility of the family*).

If the circumstances of the death do not require an autopsy (i.e., not ordered by the Coroner's Office or SLED), but one is sought, the attending physician will seek permission from the next of kin or correspondent. If permission is denied, this objection will be honored, and the denial recorded in the chart by the requesting physician/medical director or DDSN Regional Center/Provider designee.

Disposition of Remains

The remains of the deceased will be released according to the wishes of the person as specified in a pre-need document or to the parents or other responsible relative or guardian of record. If no responsible person is known or if such person refuses to accept custody of the remains, the DDSN Regional Center/Provider designee will arrange for burial or other appropriate disposition of the remains.

If possible, persons should be buried in accordance with their documented preferences or, if none, in their home community. If no family member or relative can be located to help make arrangements for the burial in the home community, the DDSN Regional Center/Provider can arrange for the burial at an appropriate community or church cemetery. In these cases, burials will be the financial responsibility of the DDSN Regional Center or provider previously supporting the person after all other resources have been utilized.

Personal Funds

At the time of death, all funds conserved for the person are frozen, and no disbursements will be made without legal authority of the Probate Court. Should this pose a problem for families needing immediate access to the person's funds for funeral expenses, the DDSN Regional Center/Provider will co-operate with the family to assure the burial is handled in a reasonable manner in accordance with the family's wishes.

The DDSN Regional Center/Provider designee will file the Affidavit for Collection of Personal Property Pursuant to Small Estate Proceeding available on the judicial website https://www.sccourts.org/forms/ (Probate Court Form 420ES). The Probate Court will issue an order permitting payment to the proper persons.

B. Deaths of persons of any age, other than those living in a residential program operated by or contracted for operation by DDSN whose death occurs at a DDSN Regional Center or provider location (e.g., day program) or while under the supervision of a DDSN Regional Center or board/provider staff person (e.g., respite, employment).

1. DDSN Regional Center/Provider designee will report the death to DDSN using the Death Reporting function of the Incident Management System within 24 hours.

2. If the death was unexpected or unexplained, the DDSN Regional Center/Provider designee must call the DDSN Associate State Director of Operations or their designee immediately. Immediately means as soon as reasonably possible but, under no circumstances, to exceed two (2) hours following the death. The Death Reporting function on the Incident Management System must be completed within 24 hours.

3. If there is any reason to believe that abuse or neglect may have occurred, the provider will also need to complete a corresponding ANE Report on the Incident Management System.

4. The physician or DSDN Regional Center/Provider designee shall notify the county coroner's office immediately of all deaths unless the death occurred in a hospital setting.

5. An Administrative Review will be conducted of all child deaths. **This review should never interfere with any outside investigation.** Results of all Administrative Reviews must be submitted to DDSN and to DHEC, as applicable, within ten (10) working days of the death. The results of the review must be documented in the Report of Death-Final Report, located within the Death Reporting function of the Incident Management System. The DDSN Regional Center/Provider designee will submit the final report.

IV. Reporting the Death of Persons enrolled in a DDSN operated HCB Waiver who do not meet the criteria listed previously

In order to provide quality assurance oversight, DDSN tracks relevant information on the deaths of all persons enrolled in a DDSN operated HCB Waiver. When the death that does not meet the criteria in A or B above, the Waiver Case Manager is responsible for reporting to DDSN.

1. Waiver Case Managers will report the death to DDSN using the Death Reporting function on the Incident Management System within 24 hours of their notification of the fatality.

2. If there is any reason to believe that abuse or neglect may have occurred, the provider will also need to complete a corresponding ANE Report on the Incident Management System.

3. An Administrative Review will be conducted for all deaths. **This review should never interfere with any outside investigation**. The Waiver Case Manager must complete the initial and final death reports as completely as possible, noting any suspected cause of death and whether an autopsy has been requested. The results of the review must be documented in the Report of Death-Final Report, located within the Death Reporting function of the Incident Management System. The Waiver Case Manager will submit the final report within ten (10) working days of the initial notification of the death.

V. Mortality Reviews

Providers are responsible for completing all required documentation to close out service authorizations, disenroll from Waiver services, and terminate billing. In addition, providers are expected to promptly comply with any requests for information from the Vulnerable Adult Fatality Committee or from the SLED Vulnerable Adult Investigations Unit. DDSN will participate in the Vulnerable Adult Fatalities Review Committee and the Children's Fatalities Review Committee to improve service quality and to develop and implement measures to prevent future deaths from similar causes from occurring if at all possible.

Through the DDSN Regional Center/Provider Risk Management Committee, a Mortality Review Process should evaluate information gathered during the reporting process to identify the following:

1. Immediate and secondary causes of death;

2. If the deaths were:

    a. Expected due to a known terminal illness;
    b. Associated with a known chronic illness;
    c. A sudden, unexpected death;
    d. Due to unknown cause;
    e. Due to an accident and, if so, the type of accident;
    f. Due to self-inflicted injury or illness (e.g., suicide, serious self-injurious behavior);
    g. Due to suspicious or unusual circumstances; and
    h. Due to suspected or alleged neglect, abuse, or criminal activity.

3. Findings from any outside investigation (as available/applicable) such as SLED, law enforcement etc.

4. Any trends and/or patterns in the deaths reported.

5. Immediate and longer-term circumstances and events that contributed to or were associated with deaths.

6. Actions that may eliminate or lessen the likelihood of circumstances and events that contribute to or are associated with the causes related to specific deaths.

Barry D. Malphrus
Vice Chairman

Stephanie M. Rawlinson
Chairman

Related Directives or Laws:

Child Protection Reform Act, S.C. Code Ann. § 20-7-480, et seq.
Omnibus Adult Protection Act, S.C. Code Ann. § 45-35-35, et seq.

200-02-DD: Financial Management of Personal Funds
200-12-DD: Management of Funds for Individuals Participating in Community Residential Programs
535-07-DD Obtaining Consent for Individuals Regarding Health Care – Making Health Care Decisions
Administrative Agency Standards