Manitoba Families

# Agency Service Coordination Manual

## 6.3 Reviewing a Suspicious Death or Serious Injury

### Background

Each year, several Community Living disABILITY Services (CLDS) participants die due to natural causes or after a lengthy illness. In many instances, there are no concerns related to the care they received prior to their death. This process does NOT apply to these situations.

In the case of a suspicious death (defined as a death where there is a questionable cause, unusual circumstances or concern about service delivery) or a serious injury (defined as a life threatening injury due to an accident or unusual circumstances), a review may be required in order to understand the services in place at the time and what, if any, actions should be taken to improve service delivery and prevent similar events in the future.

This procedure describes roles and responsibilities for agency and department staff in the event of a suspicious death or a serious injury throughout the Service Coordination Pilot Project.

### Process

#### I. Initial Report

- The agency designate will immediately report all deaths and serious injuries to the Service and Support Navigator (SSN) and/or Community Service Worker (CSW), appropriate regional CLDS Program Manager, as well as the parent(s), guardian(s) or Substitute Decision Maker (SDM) of the individual where applicable.
    - For participants with the Public Guardian and Trustee (PGT) appointed as their SDM, the CSW will report the death or serious injury to the PGT.
- Where there is a questionable cause or concern, the Program Manager will immediately initiate the internal department protocol for reviewing a suspicious death or serious injury.
- The SSN or CSW and/or Program Manager will follow up with the agency designate for additional information details, including, but not limited to:
    - known circumstances of the death or injury (date, time, place, unusual circumstances);
    - any suspicious or concerning issues;
    - summary of service provider involvement;
    - persons contacted by the service provider (e.g., parents, SDM, police, Vulnerable Persons' Commissioner's Office, other service providers);

- other persons involved to-date (e.g., police, Chief Medical Examiner); and/or
- any other action taken.

- It is recognized that time is of the essence and not all information is available immediately. Forwarding information after the initial report is expected.

**II. Review by Executive Director**

- Upon receipt of the report of death or serious injury, the Executive Director of Disability Programs and Specialized Services (DPSS) will determine the need for an internal review of the services that were in place for the individual.
- This review could be separate from other reviews which may be required by legislation or regulations.
- The purpose of a review may be:
  - to document the sequence of events surrounding the individual's death;
  - to identify any issues or concerns (e.g., policy or regulatory) regarding care and support;
  - to identify and secure all records/files regarding the case;
  - to document what action was taken by any funded service provider and the department upon the individual's death or serious injury; and/or
  - to make any immediate or future recommendations regarding actions to be taken by any funded service provider of the department.
- Where it has been determined that a review is required, an appropriate lead reviewer from the department will be appointed and may request further assistance or expertise as required (e.g., The Protection Team, Residential Care Licensing).
- While the review will be conducted by department staff, participation and cooperation of the agency designate and other service provider staff will be required.

**III. Review Process**

- After receiving the basic information regarding the serious injury or death, the reviewer will meet with the agency designate and/or other service provider staff as appropriate to discuss their general knowledge of the circumstances surrounding the incident.
- The reviewer will request, secure and review all relevant files/records related to the individual, both from the department and funded service provider(s). Electronic files may also be included at the discretion of the reviewer.

- The reviewer will conduct thorough, in-person interviews with all relevant department and service provider staff, and others as appropriate.
- Findings from the record review and interviews will be documented in a report and examined from a system perspective. The draft report will be shared with the appropriate region and managing service provider to verify factual information prior to internal review, finalization and distribution to department leadership.
- The final report will contain recommendations that may be specific to one service provider, regional in nature or have provincial impact.
- In response to the report's recommendations, regional department staff will develop an action plan in collaboration with the managing service provider for review with department leadership.

## Standards

- The agency designate must immediately report the suspicious death or serious injury to the SSN or CSW, CLDS Program Manager, and parent/guardian/SDM, where applicable.
    a. For participants with the PGT appointed as their SDM, the CSW will inform the PGT of the death or serious injury.
- Where there is questionable cause or concern, the CLDS Program Manager will initiate the internal department protocol for reviewing a suspicious death immediately or within one working day upon receipt of the report. The SSN or CSW will begin gathering additional information from the agency designate immediately.
- The Executive Director of DPSS will determine the need for an internal review within seven working days of receiving report of the suspicious death or serious injury.
- The first draft of the report must be completed within two months of the start date and is reviewed for factual information. Following feedback, the second draft must be completed within one week and is shared with Civil Legal Services. The report is finalized within one week of receiving legal comments.
- Upon completion of the report, an action plan will be developed for review with executive department staff within two weeks of completion of the report.

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# 6.3 Reviewing a Suspicious Death or Serious Injury
# Appendix A: Roles and Responsibilities for Reviews of Suspicious Death or Serious Injury

| Responsibility | Action | Time-Frame |
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| Agency Designate | Reports death/serious injury to CLDS SSN and CLDS program manager | Immediately or within 24 hours |
| CLDS Program Manager | Reports death/serious injury to CLDS program specialist, regional director, community area director | Immediately or within 24 hours |
| Agency Designate | Ensures parent(s), guardian(s) and/or Substitute Decision Maker have been informed | Immediately |
| CLDS Service and Support Navigator (SSN) or Community Service Worker (CSW) | Gathers information from agency designate<br><br>Informs PGT if applicable | Immediately |
| CLDS Program Specialist | Reports death/injury Executive Director of Regional Social Services (RSS), Executive Director of Disability Programs and Specialized Services (DPSS), and Assistant Deputy Minister (ADM) of Community Service Delivery | Immediately |
| CLDS Program Specialist | Share information with relevant Program/prepare Briefing note or advisory note (if required by ADM) | Immediately |
| Executive Director of DPSS | Determines need for review, advises ED of RSS and appoints lead reviewer (if required) | Within 7 days |
| Reviewer | Prepares first draft of report | Within two months of being appointed |
| Reviewer | Shares draft report with region and managing service provider for factual review<br>Prepares second draft and shares with Civil Legal Services (if required) | After comments, within one week |

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| Reviewer | Prepares final report and provides to ED of DPSS | Within one week after receiving legal comments |
| Executive Director of DPSS | Shares report with ED of Wpg or RNS and ADM of CSD. | Immediately |
| DPSS | Files report | Immediately |
| ADM | Distributes report | Within seven days |
| Region and Managing Service Provider | Develops plan to address recommendations and review with ED of RSS | 14 days |
| Executive Director of RSS | Shares plan with ED of DPSS and ADM | Within seven days |

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