

FY 2013 MORTALITY REVIEW ANNUAL REPORT

A total of four Preliminary Mortality Review Meetings were conducted from July 1, 2012 through June 30, 2013. Meetings were held on September 18, 2012, January 10, 2013, March 5, 2013 and May 7, 2013. The fiscal year 2013 statistics include:

A total of 40 deaths were reviewed, including 37 adults and 3 children.

There were 10 deaths that listed Cerebral Palsy as at least one of the reasons for death. Of those, the most commonly noted accessory reasons were Aspiration Pneumonia and Respiratory Arrest.

In one case a death was caused by Status Epilepticus subsequent to continuous and ongoing seizures.

In the 2013 fiscal year, mental retardation (intellectual disability) and autism were not identified as a cause of death.

The ages of the children were age 8, age 9, and age 16.

The ages of the adults were:

18-29	7
30-39	5
40-49	8
50-59	9
60-69	7
70-79	1

24 Adults had guardians, 13 individuals were competent, and the 3 children were minors.

All 40 deaths reviewed were "Expected".

20 individuals were inpatients at hospitals at the time of death.

4 deaths occurred as individuals were receiving hospice services.

11 deaths occurred while an individual was in his home, visiting a relative or in a group home.

4 deaths occurred while individuals were receiving care in a hospital emergency room. This was confirmed by individual death certificates.

1 death occurred while an individual was residing in a nursing home shortly after the consumer left a hospice facility.

Of the forty deaths reviewed, three had unusual circumstances. None of those circumstances impacted the decision that the deaths were expected.

None of these deaths were referred to the Community Mortality Review Committee as none of the deaths reviewed met the criteria.

Additional Mortality Review Reporting Topics:

1. There have been no new revisions of mortality review related forms or policy during the 2012-2013 FY. Mortality Review Policy 3018 was effective February 28, 2012.
2. There has been no development of new Provider or Division policy to address systemic issues discovered during the review process as no systemic issues were identified.
3. There has been no training related to mortality reviews, either at the provider or statewide level during the 2012-2013 FY.
4. No new recommendations regarding best practices or risk-prevention practices have been developed during the 2012-2013 FY. The Preliminary Mortality Review Team has made no recommendations for development or modification of provider policies.
5. No statewide alerts were issued during the 2012-2013 FY.

Settings	#of Persons
Hospital Inpatient	20
Hospice, home or facility	4
Home, own, or relative	11
Home, neighbor	0
Emergency Room	4
Long Term Care Setting	1
Motor Vehicle Accident	0

LEGAL STATUS	# of Persons
Competent	13
Guardian	24
Minor	3

DESIGNATION	# of Persons
Expected	40
Unexpected	0

AGE	# of Persons
1-5	0
6-10	2
11-15	0
16-17	1
18-29	7
30-39	5
40-49	8
50-59	9
60-69	7
70-79	1

NOTEWORTHY CAUSE OF DEATH	# of Persons
Cerebral Palsy	10
Down Syndrome	0
Mental Retardation	0
Seizure	0
Epilepsy	1
Autism	0