

DEPARTMENT OF MENTAL HEALTH  
CRITICAL INCIDENT REVIEW PROTOCOL

In any instance in which a critical incident, as defined below, occurs involving any individual in the care and custody of the Commissioner of the Department of Mental Health, or any individual being served in any program or facility funded directly or indirectly by the Department, including designated agencies, specialized services agencies, and designated hospitals, the event shall be examined or reviewed in accordance with the protocol set forth below.

A critical incident is defined and described in the *Critical Incident Reporting Requirements Manual* and includes actual or suspected abuse or neglect, prohibited practices, criminal acts, medical emergencies, serious injury, missing persons, deaths (natural, untimely, or suspicious), suicides, suicide attempts, potential for media involvement, and/or any significant event involving a staff member, provider, or worker.

When any staff member from DMH is informed of or learns of a critical incident, the following steps shall be taken:

1. Consult with the DMH Quality Unit regarding the incident.
2. The DMH Quality Unit will check for a Critical Incident Report (CIR).
3. If there is not a CIR on file, DMH Quality will work with applicable staff to determine if one is required.
4. DMH Quality will follow up with the agency to ask for a CIR, if necessary.
5. The DMH Quality Unit will share the CIR with leadership of the appropriate population and discuss if any follow up is needed.
6. If follow up is required, DMH Quality will assign staff to inquire with the agency.
7. A discussion with the person who completed the CIR and/or additional agency staff shall be conducted, if applicable.
8. The DMH Quality team will communicate any information learned from the discussion with agency staff and work with DMH leadership to determine if a critical incident review is indicated.
9. If a critical incident review is indicated, DMH recommends that the agency conduct a systematic and comprehensive assessment of factors contributing to the event, as applicable to the specific incident. Focus on systems and processes, not individual performance. The following elements should be included in the agency's internal review:
  - a. All relevant records shall be reviewed, which include:
    - i. the incident report
    - ii. the treatment plan/service plan/discharge plan
    - iii. any investigation report(s) completed by the provider or agency
    - iv. any reports provided by regulating authorities where applicable
    - v. any progress or other notes
  - b. A timeline of events shall be established regarding the events leading up

- to, and, if applicable, after the incident.
  - c. Interviews or discussions with relevant participants, which may include, but are not limited to:
    - i. the person who completed the incident report
    - ii. the individual's case manager, if applicable
    - iii. other witnesses to the incident
    - iv. agency staff responsible for quality and oversight of critical incidents
    - v. other persons who have or might have relevant information
  - d. Identification of contributing factors and root causes of the event.
  - e. A determination of steps the agency will take to limit the likelihood of a similar event occurring in the future.
10. A written summary of the agency's internal critical incident review process and recommendations for any further action or practice change shall be submitted to the DMH Quality Unit. This should not include details of the incident or related findings.

DMH may determine that an on-site inspection or visit is indicated, which may include:

- a. Observation of the site of the incident
- b. Interviews of staff and witnesses
- c. Review of records, treatment plans, policies, written reports, summaries of findings etc.

A summary report shall be completed by the DMH Quality Unit and submitted to the Commissioner of Mental Health.