CHS In-Custody Death Review Process

Sean Henderson, MD
April 9, 2026

Roles and Responsibilities

- **Ensuring Accountability -** verify that all staff followed established protocols
- **Quality of Care -** audit clinical records and the emergency response to ensure treatment met the required healthcare standards, **and**
- **Systemic Improvement -** identify patterns or gaps in practices and policies to implement corrective changes that prevent future occurrences

Clinical Mortality Review

- **Timeline Reconstruction:** Within 14 days of the death, medical professionals (physicians, nursing directors, mental health representatives) evaluate the clinical care provided and review of emergency response.

- **Adherence to Protocol:** determine appropriateness of clinical care and whether policies and protocols were followed.

- **Gap Analysis:** look for "missed opportunities." Could an earlier intervention have changed the outcome?

Psychological Autopsy (Suicides Only)

- Must be completed within 6 months of a suicide. It is typically conducted by a Qualified Mental Health Professional (QMHP) who was not directly involved in the decedent's care to ensure objectivity.
- **Behavioral Tracking:** Review mental health and disciplinary records to see if the individual showed "red flags", i.e., history of self-harm, recent medication changes, missed appointments, court sentencing, and changes in housing.
- **Environmental Assessment:** examine the cell and the suicide method to see if the physical environment contributed.
- **Final Observations/Recommendations**

Death Review Committee

- **Multidisciplinary Meeting**: CHS executive leadership (Medical, Nursing, Mental Health), together with Office of Inspector General (OIG) representatives, Department of Justice (DOJ) monitors, custody representatives, and legal consultants

- **Review and Discussion of Findings**

- **Final Determination:** identify Corrective Action Plan(s) (CAPs)

- **Tracking:** CAPs must be tracked until completion

Questions
Thank you

CHS In-Custody Death Review Process

Sean Henderson, MD
April 9, 2026

Roles and Responsibilities

- **Ensuring Accountability -** verify that all staff followed established protocols
- **Quality of Care -** audit clinical records and the emergency response to ensure treatment met the required healthcare standards**, and**
- **Systemic Improvement -** identify patterns or gaps in practices and policies to implement corrective changes that prevent future occurrences

Clinical Mortality Review

- **Timeline Reconstruction:** Within 14 days of the death, medical professionals (physicians, nursing directors, mental health representatives) evaluate the clinical care provided and review of emergency response.

- **Adherence to Protocol:** determine appropriateness of clinical care and whether policies and protocols were followed.

- **Gap Analysis:** look for "missed opportunities." Could an earlier intervention have changed the outcome?

Psychological Autopsy (Suicides Only)

- Must be completed within 6 months of a suicide. It is typically conducted by a Qualified Mental Health Professional (QMHP) who was not directly involved in the decedent's care to ensure objectivity.
- **Behavioral Tracking:** Review mental health and disciplinary records to see if the individual showed "red flags", i.e., history of self-harm, recent medication changes, missed appointments, court sentencing, and changes in housing.
- **Environmental Assessment:** examine the cell and the suicide method to see if the physical environment contributed.
- **Final Observations/Recommendations**

Death Review Committee

- **Multidisciplinary Meeting**: CHS executive leadership (Medical, Nursing, Mental Health), together with Office of Inspector General (OIG) representatives, Department of Justice (DOJ) monitors, custody representatives, and legal consultants
- **Review and Discussion of Findings**
- **Final Determination:** identify Corrective Action Plan(s) (CAPs)
- **Tracking:** CAPs must be tracked until completion