VOLUME 1: GOVERNANCE AND ADMINISTRATION	Effective Date: 08/2008
CHAPTER 29	Revision Date: 10/2015
1.29.2 DEATH REPORTING AND REVIEW PROGRAM PROCEDURE	Attachments: Yes ☒ No ☐

I. PROCEDURE OVERVIEW

This procedure defines the process for California Correctional Health Care Services (CCHCS) to report and review all patient deaths within the custody of the California Department of Corrections and Rehabilitation (CDCR) and establishes and maintains the processes for the headquarters Death Review Committee (DRC) in compliance with Inmate Medical Services Policies and Procedures, Volume 1, Chapter 29.1, Death Reporting and Review Program Policy.

II. DEFINITIONS

Administrative Review: A comprehensive health record review of the clinical care preceding and surrounding a patient's death to identify areas in need of improvement and includes a review of level of care, health care services operations, emergency response actions, and correctional operations when applicable.

Expected Death: A medically anticipated death which is related to the natural course of a patient's illness or underlying condition.

Expedited Review: A priority report completed within specific timeframes, based on information available at the time of the review.

Extreme Departure: Care given that may cause injury or expose patients to some substantial risk of injury or harm which no other reasonable and competent provider would provide under the same or similar circumstances.

Not Preventable Death: A death that could not have been prevented or significantly delayed despite identified opportunities for improvement in the medical care or systemic issues.

Possibly Preventable Death: A death wherein opportunities for clinical intervention or significant lapses related to care delivery have been identified that may have prevented or significantly delayed the patient's death.

Preventable Death: A death wherein opportunities for clinical intervention or significant lapses related to care delivery have been identified that would have prevented or significantly delayed the patient's death.

Unexpected Death: Any unanticipated death which is not related to the natural course of a patient's illness or underlying condition.

III. RESPONSIBILITIES

A. The Deputy Director (DD), Medical Services, and the DD, Nursing Services, have joint overall responsibility for compliance with this procedure and are responsible for appointing and/or modifying the membership, and overseeing its operation.

1. The DD, Medical Services, shall appoint the medical Co-Chairperson of the DRC.
2. The DD, Nursing Services, shall appoint the nursing Co-Chairperson of the DRC.

3. The administrative Co-Chairperson shall be a manager in the Death Reporting and Review Committee, or designee.
4. The DD, Mental Health Program, and the DD, Division of Adult Institutions (DAI), shall appoint respective representatives to the DRC.
5. The DD, Quality Management (QM), shall appoint a non-voting representative to the DRC.

B. At least one of the DRC clinical Co-Chairpersons shall preside at all committee meetings, facilitate the clinical discussion, and govern meeting procedures.

C. The DRC administrative Co-Chairperson shall be responsible for scheduling all committee meetings and ensuring all motions, voting, and actions are taken in accordance with accepted procedure and current applicable CCHCS policies and procedures.

D. Each institution's Chief Executive Officer (CEO) shall establish and maintain local operating procedures to ensure compliance with this procedure and associated policies.

E. The Death Review Unit (DRU) shall be responsible for the coordination of the health record materials and assignment of headquarters staff death reviewers to complete the Death Review Summary (DRS). The DRU shall schedule the completed DRS on the DRC agenda, support the DRC session, and manage any proposed action items, including those from the suicide case review which pertain to health care providers or nurses.

IV. PROCEDURE

A. Death Reporting from Institution

Daily Reporting to Headquarters

1. All in-custody patient deaths shall be reported on a CDCR 7229-A, Initial Inmate Death Report, and in the case of a suicide, on a CDCR 7229-B, Initial Inmate Suicide Report. All deaths shall be reported, regardless of whether the death occurred:
   a. On institution grounds
   b. In a fire camp
   c. At a contracted facility
   d. While out-to-court and housed in a county facility
   e. In an outside hospital
   f. In a skilled nursing facility or other long-term care facility
2. Patient deaths are not required to be reported from:
   a. Sacramento Central Office (SACCO)
   b. Western Interstate Conference Compact (WICC)
   c. Parole, including medical parole
   d. Compassionate release
3. The CDCR 7229-A shall be completed by the Chief Medical Executive (CME) or designee. The CDCR 7229-B shall be completed by the Chief of Mental Health or designee. All sections of the form shall be completed legibly.
4. The CDCR 7229-A or B shall be transmitted to the DRU at headquarters as early as practical, but no later than 1200 hours on the next business day following the patient death. The CDCR 7229-A or B shall be scanned and e-mailed to the DRU at DeathReviewUnit@cdcr.ca.gov.
   a. The CDCR 7229-A or B shall also be forwarded to institution staff in accordance with the most current CDCR policy and procedures as defined in the CDCR Department Operations Manual.

b. The CEO shall establish a procedure to ensure the appropriate leadership staff at the institution are notified of a patient death.

B. Collecting Clinical Records for Review

1. Within five (5) calendar days of the date of death, the following documents, when applicable, shall be scanned into the patient's health record:
   a. Hospice health records
   b. Correctional Treatment Center records
   c. Outpatient Housing Unit records
   d. Community Emergency Medical Services generated documents
   e. CDCR 7464, Triage and Treatment Services Flow Sheet (front and back)
   f. CDC 7362, Health Care Services Request Form
   g. All outside facility records
   h. Any other pertinent information
2. Upon request, the DRU shall receive the CDCR 837-A, B, and C, Crime/Incident Report from the institution within five (5) calendar days of the date of request.

If the documents listed above are not received within five (5) calendar days from the date of death, the DRU shall notify the respective CEO, CME, Chief Nursing Executive (CNE), Health Information Management, or custody representatives to request assistance with document acquisition.

C. Initial Death Review Summary from the Institution

1. The institution CME and CNE, or their designee(s), shall submit an initial report to the headquarters DRU within five (5) calendar days of the date of death summarizing the health care provided to the deceased while in their institution.
2. The institution's initial DRS shall be a combined medical and nursing care review and shall include, at a minimum, the following information:
   a. Chronology of significant events leading to the patient death.
   b. Chronology of the emergency medical response, if applicable.
   c. Any identified lapses in health care including completion of a Physician Order for Life Sustaining Treatment and comfort care.
   d. Any identified system issues which may have contributed to the patient death.
   e. Recommendation for an expedited review, if necessary.

D. Death Review at Headquarters

1. For each death, there shall be an assigned physician and nurse reviewer.
   a. The physician death reviewer shall be a Clinical Support Unit (CSU) physician or other physician designated by the CSU Deputy Medical Executive (DME) or designee.
   b. The nurse death reviewer shall be a Nurse Consultant Program Review, Registered Nurse, designated by the DD, Nursing Services, or designee.
2. For each death classified as a suicide or suspected suicide, a suicide case reviewer shall be assigned by the DD, Mental Health Program or designee. In cases of potential overdose or unknown deaths, the suicide case review coordinator collects and reviews information in conjunction with the Suicide Prevention and Response Focused Improvement Team in order to determine if the death is a suspected suicide.

3. Extreme departures from the standard of care identified by the physician death reviewer that may pose a significant risk to patient care shall be immediately referred to the Medical Peer Review Committee (MPRC).
4. Extreme departures from the standard of nursing care identified by the nurse death reviewer shall be immediately referred to the Nursing Professional Practice Council (NPPC).
5. Extreme departures from the standard of mental health care identified by the suicide case reviewer shall be immediately referred to the Mental Health Peer Review Committee (MHPRC).
6. The physician, nurse, or mental health reviewer shall not evaluate a case if they have provided care to the patient within the six (6) months prior to the patient's death.

E. Death Review Summary Completion at Headquarters

1. The physician and nurse reviewers shall complete the DRS using the most current electronic form or data entry program. The physician death reviewer shall be responsible for the preliminary determination of preventability.
2. A focused report of the health care provided to the patient as it relates to the patient's death shall be completed on each patient death.
3. Focused reports shall be categorized as either:
   a. Level 1– 60-day Review:
      Generally applies, but is not limited to, deaths determined to be unexpected.
      1) A Level 1 clinical review shall be completed to determine the appropriateness of clinical care related to the death; to ascertain whether changes to policies, procedures, or processes are warranted; and to identify issues that require further study.
      2) The death reviewer shall focus on the following three (3) questions:
         - Could the medical response at the time of death been improved?
         - Was an earlier clinical intervention possible?
         - Independent of the cause of death, were there ways to improve patient care?
      3) The Level 1 clinical review shall be completed within 50 calendar days from the date of death based on the information available in the health record on the date of the review.
   b. Level 2 – 30-day Review:
      Generally applies, but is not limited to, deaths determined to be expected.
      1) A Level 2 clinical review, focusing on the relevant clinical aspects of the death and preceding treatment, shall be completed.
      2) The Level 2 clinical review, shall be completed within 20 calendar days from the date of death based on the information available in the health record on the date of the review.
4. Level 1 or 2 deaths may be expedited if requested by the institution or if extreme departures were referred to the MPRC, NPPC, or the MHPRC. An expedited clinical review shall be completed within 14 calendar days from the date of the death and shall be based on information available at the time of the review.
5. If a death reviewer cannot complete the focused report within any of the timeframes stated above, a late justification shall be submitted to the DRU. The late justification shall be submitted to the clinical Co-Chairs and shall be tracked by the DRU.

6. Each physician and nurse DRS shall include the following:
   a. Administrative Review:
      Includes the correctional and emergency response actions surrounding the death with the intent to identify areas where operations, policies, or procedures may be improved. The emergency response review shall include a timeline for the emergency response and considerations for compliance with emergency response policies and procedures.
   b. Clinical Mortality Review:
      The evaluation of the clinical care provided, and the circumstances leading to the death, with the intent of identifying areas of patient care or system policies and procedures that may be improved. The death reviewer shall categorize the identified areas of improvement by choosing the suitable taxonomy category (Refer to Attachment I).
7. In conducting the death review, the death reviewer shall evaluate the care provided to the patient as it may relate to the cause of death.
   a. The health record shall be reviewed for the six (6) months prior to the date of death to determine whether any care was relevant in the patient's death.
   b. If warranted, the reviewer may go back earlier than six (6) months if there is a relevant issue pertaining to the care provided and the patient's death.
   c. In addition to reviewing the health record, other relevant documents that may relate to the death shall also be reviewed, as the reviewer determines appropriate (e.g., emergency response documentation, custody movement documentation, CDCR 602 HC, Patient-Inmate Health Care Appeal).
   d. The death reviewer may contact the affected institution's health care staff for clarification on any aspect of the review.
8. If the death is a suspected suicide, a suicide case review shall be performed and foreseeability and preventability determined by the Mental Health Program consistent with current Mental Health Program policy. The final suicide case review shall be submitted to the DRU within 60 calendar days of the date of death for inclusion in the DRS and review by the DRC
9. Suspected drug overdoses may be considered a possible consequence of self-harm and shall include a Mental Health Program preliminary review to determine if the cause was suicide.
10. If a medical autopsy is completed after the DRC review, the DRS shall be amended by the assigned physician death reviewer with the information from the autopsy report and returned to the DRC for additional review, if necessary.

F. Death Review Summary Endorsement

1. The completed physician and nurse reviewer DRS shall be submitted electronically for review and endorsement by the designated Regional DME or CNE.
2. The Regional DME/CNE shall endorse or reject the DRS within three (3) calendar days of receipt.
3. Upon endorsement by the Regional DME/CNE, the DRS shall be submitted electronically to the DRU to forward to the institution(s) involved for review, and to schedule on the DRC agenda.
4. All Level 1 deaths shall be scheduled for review by the DRC within 60 calendar days of the death.

5. All Level 2 deaths shall be scheduled for review by the DRC within 30 calendar days of the death.

G. Institution Review

The DRU shall forward the endorsed DRS to the appropriate institution(s) for review by clinical leadership. Feedback, comments, or suggested changes shall be submitted to the DRU within five (5) calendar days of receipt of the DRS.

1. The DRU shall attach institution feedback, if received, to the DRS for consideration by the DRC. The DRU shall schedule the DRS, and the physician/nurse reviewers required to present the case at a DRC meeting.
2. If no institution feedback is received within five (5) calendar days, the DRU shall schedule the DRS, and the physician/nurse reviewers required to present the case at a DRC meeting.

H. Death Review Committee

1. The purpose of the DRC is to deliberate on the information presented in the DRS, the institution feedback and, when applicable, the mental health suicide case review.
2. The DRC shall objectively discuss all reports and the listed findings in a fair, transparent, and consistent manner; make referrals to the appropriate peer review committees; vote on preventability; determine causes of death; and provide notifications to headquarters programs/committees.
3. Membership, Voting, and Appointment
   a. The DRC clinical Co-Chair(s) and committee members shall be an interdisciplinary group including physicians, nurses, a psychiatrist or psychologist from the Mental Health Program, and a DAI representative. Dental Services and other institutional representatives may be included as needed. The Administrative Co-Chair and QM representative shall be included as non-voting members.
   b. The DRC shall consist of a minimum of eight (8) voting members consisting of at least:
      - Three (3) physician representatives from Medical Services
      - Three (3) representatives from Nursing Services
      - One (1) representative from the Mental Health Program (Votes only if the death was a suicide)
      - One (1) representative from DAI (Votes only on preventability if the death had custody involvement)
   c. A quorum is met when a minimum of 50 percent of the voting members are in attendance, either in person or telephonically. A quorum must include at least two (2) Medical Services and two (2) Nursing Services voting members. The DRC shall not take action on any agenda item without a quorum. In the case of a split vote, one of the clinical Co-Chairs shall be the deciding vote.
   d. In the absence of a quorum, the DRC clinical Co-Chairs may recess the meeting to restore the quorum, set a time for a continuation of the meeting, or adjourn.
   e. The maximum term for a voting or non-voting member to serve on the DRC is 24 months. Exceptions to this rule may be granted by the DD, Medical Services; DD, Nursing Services; DD, Mental Health Program; DD, DAI; and the DD, QM, for their respective members.

f. After serving a maximum of 24 months, a period of six (6) months must pass during which he/she does not serve on the DRC before the member is eligible to return as a voting member of the committee.

4. Conflict of Interest
   a. A voting DRC member or designee must abstain from reviewing, discussing, or voting on any death case if he/she provided direct care to the deceased patient within the six (6) months prior to the patient's death.
   b. A voting DRC member or designee must abstain from making decisions on peer review referrals if the provider or nurse in question is under his/her direct supervision.
   c. A DRC member or designee shall not participate in any decision under the breach of professional clinical peer review process if he/she has a personal conflict of interest.
      1) A personal conflict is defined as a professional, financial, or other obligation/interest that is likely to limit the member's ability to participate impartially in DRC decision-making.
      2) Any potential and actual conflicts of interest shall be disclosed by the member or designee prior to participating in decision-making.
      3) DRC members or other stakeholders may raise potential conflicts of interest concerning DRC members to the DRC clinical chairpersons who shall decide the matter.
5. Committee Meeting
   a. The DRC shall meet as often as needed to perform its duties on time, but no less than monthly.
   b. Except for the vote to determine preventability, meetings shall be conducted informally using a consensus approach. If a consensus cannot be reached, the clinical Co-Chair may resolve the issue by using the procedures according to *Meeting Procedures: Parliamentary Law and Rules of Order for the 21st Century* (Lochrie); however, technical failures to follow such rules shall not invalidate action taken at such a meeting.
   c. The proceedings and records of the DRC shall be confidential and protected from discovery to the extent permitted by law.
6. Basis of Decision

   The DRC shall take into consideration the information presented in the submitted death reviews and determine the appropriate response. Responses include, but are not limited to:
   a. Identifying and referring deficiencies in clinical care of patients to appropriate peer review bodies as indicated. Referrals to peer review bodies shall be determined by a consensus of the voting members of the same discipline as the affected provider or nurse only.
   b. Voting on categories of preventability to include:
      1) Not preventable
      2) Possibly preventable
      3) Preventable

      The category of preventability shall be determined by a majority vote of the clinical DRC members. The DAI representative shall only vote on preventability

if the death had custody involvement. Where the committee vote differs from the recommendation of the original death reviewer, the minutes shall reflect the reasoning for the change.

c. Determining the primary, secondary, and tertiary causes of death. Causes of death shall be determined by a consensus of the physician voting members present. The Mental Health Program representative shall be included in the vote if the death was a suicide.
d. Identifying opportunities for improvement in the health care policies.
e. Making recommendations for change to interdisciplinary care guides, protocols, and procedures.
f. Making recommendations to other headquarters committees and/or programs.
g. Recommending statewide training or continuing education programs on identified weaknesses.
h. Identifying and referring system issues to institution leadership and the headquarters QM programs/committees as needed.
i. Utilizing the DRC taxonomy to categorize the areas in need of improvement.
j. Submitting death cases which have been determined to be sentinel events to the Patient Safety Program.

I. Final Death Review Summary

1. The DRS shall be considered final once the DRC has heard the case and has determined no further information is needed or expected (e.g., an autopsy) in order to make determinations regarding the preventability category or action items.
2. The DRU shall share the final DRS with the institution leadership. If multiple institutions were involved with the health care of the patient during the time period of review, a report shall be submitted to the institution leadership of each institution.
3. The institution leadership shall take any necessary action on recommended action items in the final DRS.

J. Death Review Reporting - Headquarters

The DRU shall comply with all state and federal reporting requirements. In addition, the DRU is responsible for completion of the following:

1. Daily Death Report
   The DRU shall compile a list of all reported deaths and forward the list to headquarters, institutional executive leadership, and designated external stakeholders.
2. Weekly Death Report
   The DRU shall issue a weekly summary report on the last business day of the week, of all deaths reported that week, and forward the report to headquarters, institutional executive leadership, and designated external stakeholders.
3. Monthly Death Report
   By the last business day of each month, the DRU shall issue a monthly summary report to designated stakeholders of all deaths reported during the month.
4. Quarterly Death Report
   The DRU shall generate an aggregate, executive report of all cases reviewed at the DRC during the previous quarter to headquarters, executive leadership, and designated external stakeholders. Quarterly reports shall be generated based on a calendar year. The quarterly status report shall include, at a minimum, the following:
   a. Number of deaths that occurred during the reporting period

b. Number of deaths reported late by the institutions
c. Number of deaths per institution
d. Number of cases presented at the DRC
e. Number of referrals generated by the DRC
f. Number of case notifications forwarded to programs
g. Preventability/Improvement Matrix data
h. Average number of days from date of death to presentation at the DRC
i. Top three (3) causes of death
j. Number of closed cases

5. Annual Death Report
   a. The DRU shall generate an annual, aggregate report for executive management which shall include comparison, analysis, and trending of the previous year's data and identification of opportunites for improving the process.
   b. The DRU shall comply with annual reporting requirements to the Department of Justice.

V. REFERENCES

- Federal Death in Custody Reporting Act of 2000 (Public Law 106-297)
- California Government Code, Title 2, Division 3, Part 2, Chapter 6, Article 2, Section 12525
- California Penal Code, Part 3, Title 7, Chapter 1, Section 5021
- California Penal Code, Part 3, Title 7, Chapter 2, Section 5058
- California Code of Regulations, Title 15, Section 3365
- California Department of Corrections and Rehabilitation, Department Operations Manual, Article 7, Section 51070.1 through 51070.20
- National Commission on Correctional Health Care, Standards for Health Services in Prisons (2008)
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 4, Chapter 12:
  - 12.1 Emergency Medical Response System Policy
  - 12.2 Emergency Medical Response System Procedure
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures Volume 3, Chapter 7:
  - 3.7.1 Patient Safety Program Policy
  - 3.7.2 Adverse/Sentinel Event Review Policy
  - 3.7.4 Patient Safety Program Procedure: Patient Safety Committee
  - 3.7.5 Patient Safety Program Procedure: Initial Triage/Assessment of Adverse/Sentinel Events
  - 3.7.6 Patient Safety Program Procedure: Institution Response to an Adverse/Sentinel Event
  - 3.7.7 Patient Safety Program Procedure: Headquarters Adverse/Sentinel Event Committee
- California Department of Corrections and Rehabilitation, Mental Health Services Delivery System Program Guide, Chapter 10, Suicide Prevention and Response, Section E, Suicide Reporting, and Section F, Suicide Death Review

- The Federal Receiver's Analysis of Death Reviews (2006, 2007, 2008, 2009, 2010, 2011, 2012)
- *Meeting Procedures: Parliamentary Law and Rules of Order for the 21st Century* (Lochrie)

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
ATTACHMENT I
Taxonomy

1. Coordination/Continuity of Care	
1.1 Communication/Hand-offs	
a	Effective communication
b	Lack of communication between health care worker and patient
c	Diagnostic results
d	Between CDCR health care disciplines
e	Failure to refer to higher level of care
f	CDCR inter-facility transfer of medically complex patient
g	Transition of care to outside health care facility, county jail, or contracted prison
h	Transition of care from outside health care facility, county jail, or contracted prison
i	Transferred to ER/outside hospital without AD/POLST
j	Lack of medical records transferred with the patient
k	Inadequate communication for specialty consult
l	Healthcare staff did not follow patient's wishes on AD/POLST
1.2 Documentation	
a	Illegible
b	Inadequate/Incomplete
c	Inappropriate
d	Falsification
e	Conflicting timelines on emergency medical response
f	Missing Provider progress note
g	Missing on call note
h	Legacy charting
i	Use of wrong document/chart
j	No AD/POLST on file
k	Medical record not in chronological order
l	Delay in availability
1.3 Scheduling/Follow-up	
a	Appointment occurring outside of timelines
b	Failure to schedule PCP appointment within timeframes
c	Failure to schedule follow – up appointment
d	Failure to schedule diagnostic services after ordering
e	Failure to schedule specialty services appointment within timeframes

2. Clinical Management	
2.1 Diagnosis	
a	Delay in diagnosis- Institution
b	Delay in diagnosis- County jail/Contracted prison
c	Delay in diagnosis- Specialty care provider
d	No diagnosis
e	Inappropriate diagnosis
f	Wrong diagnosis
2.2 Treatment	
a	Failure to recognize, evaluate and manage important symptoms and signs
b	Lack of Primary Care Model
c	Inappropriate treatment
d	Failure to identify and/or react to abnormal test results
e	Failure to follow Clinical Guidelines
f	Delayed treatment
g	Failure to monitor
h	Failure to follow Specialist recommendations when indicated
2.3 Procedure	
a	Not Performed
b	Delayed
c	Incomplete
d	Wrong patient
e	Wrong process
f	Wrong body part/side
g	Surgical or procedural complication
2.4 Screening/Preventative	
a	Not Performed When Indicated
b	Delayed
c	Incomplete
d	Wrong patient
e	Wrong process

3. Medications	
3.1 Missing/Delayed dose	
a	Prescribing
b	Dispensing (Pharmacy)
c	Administering (Single Dose)
3.2 Wrong Patient	
a	Prescribing
b	Dispensing (Pharmacy)
c	Administering (Single Dose)
3.3 Wrong Route	
a	Prescribing
b	Dispensing (Pharmacy)
c	Administering (Single Dose)
3.4 Wrong Medication/Dosing	
a	Prescribing
b	Dispensing (Pharmacy)
c	Administering (Single Dose)
3.5 Failure to recognize and avoid known drug interactions	

4. Miscellaneous	
4.1 Medical Device/Equipment malfunction	
4.2 Patient accident	
a	Patient delay/refusal of care
4.3 Patient self-harm	
a	Suicide attempt
b	Completed suicide
c	Other non-lethal self-harm
4.4 Credentialing	
4.5 Unusual Occurrences	
a	Physical/sexual assault
b	Electric shock
c	Wrong gas/toxic substance
d	Burn/fire/explosion
e	Poison
4.6	Undefined/Unknown event- An undefined event or series of events that led to patient harm or death.
4.7	Practicing outside of scope (may apply to LVNs, RNs, midlevel practitioners, dentists, or physicians)
4.8	Failure to adequately supervise a midlevel practitioner
4.9	Failure to be readily available for consultation
4.10	Administrative failure to provide for appropriate supervision

5. Near-Miss	
5.1	An event or situation that could have resulted in an adverse/sentinel event, but did not, either by chance or through timely intervention.

6. Emergency Medical Care	
6.1	Naloxone (Narcan)- inappropriate administration
6.2	AED- Not used, used inappropriately, or not available
6.3	Emergency Medical Equipment- Not used, used inappropriately, or not available
6.4	Healthcare staff practicing emergency medical response outside of scope
6.5	Delay or failure in emergency response- custody
6.6	Delay or failure in emergency response- medical

7. Transportation	
7.1	Inappropriate mode for condition of patient (state car vs. ambulance)
7.2	Medication not transferred with patient

8. Nursing Encounter	
8.1	7362 processing outside of timelines
8.2	FTF assessment outside of required timeline
8.3	Inadequate or lack of FTF assessment
8.4	Failure to refer to higher level of licensure
8.5	Use of inappropriate protocol
8.6	Lack of appropriate plan
8.7	Inappropriate intervention

9. Utilization Management	
9.1 Outside Healthcare Facility	
a	Inappropriate management of patient's condition
b	Inappropriate end-of-life management
c	Premature or inappropriate discharge
d	Overutilization of medical services (futility care)
e	Delay in access
9.2 Specialty Care Provider	
a	Inadequate assessment
b	Inappropriate recommendations