How do I Report a Death or Serious Injury?

The Ombudsman's Office has Death Report and Serious Injury Report forms located on our website: https://mn.gov/omhdd/reporting-death-or-serious-injury/download-forms.jsp

Completed forms may be faxed to:
651-797-1950

If you do not have internet access, please call:

Toll free: **1-800-657-3506**
Voice: **651-757-1800**
MN Relay Service: **711**

It is recommended that you keep a copy of the completed form for your records.

What Does the Ombudsman do with Serious Injury Reports?

There are nine Regional Ombudsman and each receives and reviews the serious injuries in their region so they can take appropriate action. The Regional Ombudsman may:

- Obtain additional information
- Request a review by the MRS
- Refer the report to the appropriate licensing agency
- Suggest strategies to prevent similar injuries

Individualized Training

The Medical Review Coordinator can provide specialized training/presentations designed to improve client outcomes and reduce the risk of serious harm to clients. Training is developed using knowledge gained from reviews of deaths and serious injuries. Training also considers the sometimes unique or additional needs of people with disabilities. Training topics include: prevention of serious injuries, advocating for your client with health care providers, underlying medical conditions, occuring in people with disabilities and suicide prevention.

If your agency, organization or group is interested in individualized training, please contact the Medical Review Coordinator at **651-431-5202** or Toll Free: **1-800-657-3506**.

Contact Information

Mailing address:
Office of Ombudsman for Mental Health and Developmental Disabilities
121 7th Place East
Metro Square Building, Suite 420
Saint Paul, Minnesota 55101-2117

Fax: **651-797-1950**

Email: ombudsman.mhdd@state.mn.us

MINNESOTA

OFFICE OF OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

REPORTING DEATHS AND SERIOUS INJURIES

Revised July 2018

"Giving Voice to Those Seldom Heard"

What is Required When a Client Dies or Receives a Serious Injury?

It is required by law that an agency, facility or program report to the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD) the death or serious injury of a client. The report must be made within 24 hours of the death or serious injury.

The OMHDD maintains a database of these reports and reviews the collective data.

Definitions

Client means anyone receiving services or treatment for mental illness, developmental disability, chemical dependency or emotional disturbance from an agency, facility or program.

Facility or Program means a residential or non-residential program or an acute care inpatient facility providing services or treatment for the above disabilities.

Agency means the divisions, officials or employees of the Departments of Human Services, Health or Education, local school districts or county social service agencies who monitor, provide or regulate services or treatment to clients of the OMHDD.

What is a Serious Injury?

- Fracture
- Dislocation
- Internal injury
- Head injury with loss of consciousness
- Potential closed head injury or concussion (without loss of consciousness) requiring medical assessment
- Lacerations with nerve, tendon or muscle damage
- Extensive burn, second or third degree
- Extensive frostbite, second or third degree
- Eye injury
- Dental injury that causes avulsion of teeth
- Ingestion of poison or harmful substance
- Near drowning
- Heat exhaustion/sun stroke
- Complication of previous injury
- Complication of medical treatment
- Suicide attempt
- Any injury considered serious after assessment by a health care professional (includes SIB, med error and delay of treatment or complication of injury or treatment)

Death Review Results:

Information from the reviews is used to identify trends, problem areas and opportunities to improve care delivery systems. Improvements may be made through recommendations, education efforts and input into policy change to agencies, facilities or programs.

What Does the Ombudsman do with Death Reports?

The Medical Review Team receives each death report and determines the level of review necessary.

Some death reports are reviewed by the **Medical Review Subcommittee (MRS)**. The MRS consists of at least five members of the Ombudsman's Advisory Committee, who are selected by the Governor. Including at least three members who are physicians, one of whom is a psychiatrist.

The MRS:

- Meets on a regular basis.
- Reviews client deaths when there are questions about the treatment provided.
- May make recommendations to prevent occurrence of similar deaths.
- May identify system-wide problems.
- May provide consultation and offer advice for improving care delivery.
- May report to or request consultation with relevant licensing or regulatory agencies.
- May be asked to lend its expertise to specific issues raised by Ombudsman staff.

ADA Advisory

This document is available in alternative formats to individuals with disabilities by using the above contact information.