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## County to Contract with NCCHC for Historical Review of Fatalities at the Jail

*County Also Seeking Legislative Creation of Review Team for Individual Deaths*

**PITTSBURGH –** County Executive Rich Fitzgerald today announced that after several weeks of research into best practices throughout the country, the administration is moving forward to contract with National Commission on Correctional Health Care (NCCHC) Resources to conduct a historical review of fatalities at the Allegheny County Jail.

NCCHC recommends a three-pronged approach to every inmate death, regardless of cause. It includes an administrative review, a clinical mortality review, and, in the event of a suicide, a psychological autopsy. Currently, the jail administration conducts an internal review following each incident at the jail, including deaths. Additionally, the matter is also turned over to Allegheny County Police Department's Internal Affairs Unit for an independent investigation. The Allegheny County Office of the Medical Examiner (ACOME) also takes jurisdiction and undertakes a death investigation to determine cause and manner. The NCCHC analysis would be another independent and holistic review of incidents over a longer time period and would identify what went right, what went wrong, what could be done better, and what, if any, policies and procedures need to change based on the results of that longer-term look at incidents.

"NCCHC has significant experience in this sort of review and analysis and is the same agency that was previously engaged by the county to review and make recommendations relative to suicide prevention efforts at the jail that have been helpful and effective," said Fitzgerald. "NCCHC will bring in a multi-disciplinary team of physicians, behavioral health experts, and correctional policy and security experts to review the history of deaths that occurred at the jail. I have directed the administration and jail administration to cooperate fully with this review and to provide the NCCHC team data and records and participate in first-person interviews. Once the team completes its independent assessment, the members will summarize strengths and weaknesses and will also identify opportunities for further exploration or improvement."

NCCHC's origins date to the early 1970s, when an American Medical Association study of jails found inadequate, disorganized health services and a lack of national standards. In collaboration with other organizations, the AMA established a program that in 1983 became an independent, 501(c)(3) nonprofit organization: National Commission on Correctional Health Care (NCCHC).

"It's more important than ever that there be confidence in these reviews and while NCCHC will look at these fatalities historically, there must also be something in place moving forward," said Fitzgerald. "Allegheny County isn't the only county experiencing an increase in fatalities at its jails and a process for review would benefit all of those facilities and communities. I've spoken with members of the General Assembly about introducing legislation that would establish similar review teams to what was created nearly 15 years ago to review the fatality or near fatalities of children."

Those early conversations have also included the Courts and the Medical Examiner's Office about what a review committee may look like. The team would be charged with reviewing fatalities at the jail. In addition to the provisions of the review, the state legislation could also provide authority and jurisdiction for the team members, govern the confidentiality of the information and provide protections for team members from liability while also providing that the proceedings, deliberations and records of

the team are privileged and confidential and not subject to discovery, subpoena or introduction into evidence in any civil or criminal action.

These provisions are similar to the process put together to review the fatality or near fatality of a child under suspicious circumstances in Act 33 of 2008. Similar legislation was enacted later that same year in Act 87 of 2008. It called for the public health review of deaths of all children under the age of 21. These protections have allowed for the open sharing of information for quality improvement and have helped counties improve agency and community protections without the threat of liability.

The County Manager's Office is currently working with NCCHC Resources on a scope of work for consulting and technical assistance. NCCHC would provide an independent historical assessment. The agency could also help the jail and partners set up ongoing fatality incident reviews to support ongoing quality improvement if the legislature provides the legal and policy infrastructure to do so effectively.

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