NEW YORK STATE OF OPPORTUNITY.

Office for People With Developmental Disabilities

Documentation for Death Investigations

December 2018

Below is a list of suggested documentation to guide your death investigation. Not all documents may be relevant to your investigation.

- OPWDD 149 – signed and dated by the investigator - mandatory
- Death certificate and/or autopsy (if performed) (this should be identified as the Source of Cause of Death in the Report of Death) – mandatory, but investigation should be submitted if death certificate/autopsy is still pending.
- Life Plan/CFA and relevant associated plans
- Written statements (expected for all death investigations)
- Site specific Plan of Protective Oversight
- Individual Plan of Protective Oversight
- Relevant policies (CPR, Emergency Care, Triage, Fall and Head Injury Protocols)
- Training records (CPR, Plan of Nursing Services, Medication Administration, individual specific plans)
- General notes, staff notes, progress notes, nursing notes, communication logs
- Medical record – last annual physical, hospital records, consultations relevant to cause of death
- Medication Administration Record
- Assignment sheets, sign in sheets
- Plan(s) of Nursing Service– as applicable. Documentation related to the plan, if required.
- Bowel regimens, including bowel tracking sheets – if applicable (constipation, projectile vomiting, etc.)
- Dining plans
- EMS report, 911 call transcript, ER/hospital report, ambulance report if relevant
- Behavior Support Plan if relevant
- DNR/DNI/MOLST orders if applicable
- Hospice/palliative care plans if applicable
- Medication Regimen review
- Diet orders and swallow evaluation if relevant