STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE

Policy No. DOC 4.5.34	Subject: **OFFENDER DEATH**	
Chapter 4: FACILITY/PROGRAM SERVICES		Page 1 of 3 and Attachments
Section 5: Clinical Services		Effective Date: May 1, 1998
Department Director Signature: /s/ Brian Gootkin		Revised: 4/19/2021
Medical Director Signature: /s/ Dr. Paul Rees		
Clinical Services Division Administrator: /s/ Connie Winner		

I. POLICY

The Department of Corrections will conduct a thorough review of all deaths in their custody in an effort to improve care and prevent future deaths

II. APPLICABILITY

The secure care facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Administrative Review – An assessment of correctional and emergency response actions surrounding an inmate's death. Its purpose is to identify areas where facility operations, policies, and procedures can be improved

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Clinical Mortality Review – An assessment of the clinical care provided and the circumstances leading up to a death. Its purpose is to identify areas of patient care or system policies and procedures that can be improved.

Death – When an individual has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brainstem. A determination of death must be made by a physician or coroner in accordance with accepted medical standards pursuant to *50-22-101, MCA.*

Facility Health Services Administrator – The health authority or nursing supervisor responsible for the facility's offender health care services.

Investigations Bureau – The bureau that oversees investigations for the Department.

Mortality Review – A process of evaluating the cause of death and the events preceding and following the event to ascertain if any area could be improved.

Psychological Autopsy – A written reconstruction of an individual's life with an emphasis on mental health factors that may have contributed to the individual's death. It is usually conducted by a psychologist or other qualified mental health professional. These are also referred to as a psychological reconstruction or postmortem.

IV. DEPARTMENT DIRECTIVES

A. Notifications

1. Within 8 hours of an offender death, the nurse or staff in charge must notify the facility health services administrator, or designee, the appropriate physician, and the facility administrator, or designee.

2. In the event of offender death, the facility administrator, or designee, must notify the Department medical director, the Investigations Bureau chief, and appropriate law enforcement officials.

3. The facility administrator will immediately notify the Department director by phone of offender deaths.

B. Documentation and Incident Reports

1. A log is maintained by health care staff and will be updated as soon as possible, but no later than the end of shit, log will include, at minimum:
   a. patient name or identification number;
   b. age at time of death;
   c. date of death
   d. date of clinical mortality review;
   e. date of administrative review;
   f. cause of death, i.e., hanging, respiratory failure;
   g. nature of death, i.e., accident, natural, suicide or homicide;
   h. date pertinent findings of review(s) shared with staff; and
   i. date of psychological autopsy, if applicable

2. All staff who witnessed the death will complete incident reports as soon as possible, but no later than the end of the shift.

C. Release of Information

1. Department employees must not release information concerning offender death to outside media, all information releases will comply with *DOC Policy 1.1.8, Media Relations*.

D. Report of Offender Death and Health Record

1. Within 24 hours or the next business day, the facility health services bureau chief, or designee, will complete and forward the *Death in Custody: Inmate Death Report* form to the warden, Department director, the Health Services administrator, and the Investigations Bureau chief.

2. The facility health services bureau chief, or designee, will ensure that all health record entries are complete, and that the original offender health record is kept in a locked cabinet on-site.

E. Death Reviews

1. The medical director and/or the health services bureau chief, or designee must conduct a clinical mortality review and will:
   a. coordinate a multi-disciplinary mortality review within 30-60 working days of an adult or youth offender's death using the *Mortality Case Review* form;
   b. notify all the necessary disciplines involved, i.e., legal, medical, mental health, and custody staff, that the review will be conducted to determine the following:
      1) there was a pattern of symptoms that may have precipitated an earlier diagnosis and intervention;
      2) events immediately surrounding the death indicate if appropriate interventions occurred; and
      3) treating staff are informed of pertinent findings of the review.

2. An administrative review is conducted with custody staff and treating staff are informed of pertinent findings of the review.

3. Facility administrators, or designees will consult with the medical director and decide whether to request a postmortem examination and if deemed necessary:
   a. The postmortem examination is performed within 30 days; and
   b. Medical treating staff are informed of pertinent findings of the review.

4. Psychological Autopsies must be performed on all deaths by suicide within 30 days.

F. Review by Medical Examiner/Coroner

1. The medical examiner or coroner will review all offender deaths and subsequent reports.

V. CLOSING

Questions concerning this policy should be directed to the Clinical Services Division Administrator

VI. REFERENCES

A. *46-4-122, MCA; 50-22-101, MCA; 53-1-203, MCA*
B. *P-A-09; National Commission on Correctional Health Care Standards, 2018*
C. *MH-A-10; National Commission on Correctional Mental Health Services in Correctional Facilities, 2015*
D. *Y-A-10; National Commission on Correctional Health Services in Juvenile Detention and Confinement Facilities, 2015*

VII. ATTACHMENT

Death in Custody: Inmate Death Report	PDF
Mortality Case Review	PDF