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 Attachment
Section 5: Offender Health Care	Effective Date: May 1, 1998
Signature: /s/ Mike Ferriter, Director	Revised: 01/04/12

I. POLICY

The Department of Corrections facilities will establish reporting procedures to notify appropriate administrators, next of kin, and local authorities in the event of the death of an offender in Department custody.

II. APPLICABILITY

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

III. DEFINITIONS

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.

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.

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, or designee, will consult with the medical director and decide whether to request a post mortem examination; unattended deaths and suicides will require a post mortem examination.

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

B. Documentation and Incident Reports

1. Health care staff will complete comprehensive documentation as soon as possible, but no later than the end of the shift; documentation will include, at minimum:
   a. time of death;
   b. nature of death, i.e., accident, natural, suicide, or homicide;
   c. circumstances surrounding nature of death;
   d. treatment rendered (if any);
   e. persons notified of death; and
   f. whether an autopsy was requested.

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. Mortality Review

1. The medical director and/or the health services bureau chief, or designee, 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; and
      2) events immediately surrounding the death indicate if appropriate interventions occurred.

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 Department's Health Services administrator.

VI. REFERENCES

A. *46-4-122, MCA; 50-22-101, MCA; 53-1-203, MCA*
B. *National Commission on Correctional Health Care Standards, 2008*

VII. ATTACHMENT

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