DEPARTMENT OF CORRECTIONS
MONTANA WOMEN'S PRISON
OPERATIONAL PROCEDURE

Procedure No. MWP 4.5.34 | Subject: **INMATE DEATH**	
Reference: DOC Policy No. 4.5.34	Page 1 of 3 & 2 Attachments
Effective Date: September 1, 2020	
Signature: /s/ Jennie Hansen / Warden	

I. PURPOSE

The Montana Women's Prison has established reporting procedures to notify appropriate administrators, next of kin, and local authorities in the event of the death of an inmate in Department custody.

II. 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 or 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.

III. PROCEDURES

A. General Requirements

1. Within 8 hours of an inmate death, the nurse, Lieutenant or designee in charge must notify the MWP Health Services Manager, or designee, **and** the MWP Warden or designee.

2. The Warden or designee will notify the Director, Investigations Bureau Chief, appropriate law enforcement officials and the DOC Medical Director.

3. The Warden, or designee, will consult with the DOC Medical Director and decide whether to request a postmortem examination; unattended deaths and suicides will

require a postmortem examination.

4. Within 24 hours, the Religious Activities Specialist will contact the deceased inmate's emergency contact.

B. Documentation and Incident Reports

1. Health care staff will complete the *Death in Custody: Inmate Death Report* (Attachment A) as soon as possible, but no later than the end of the shift and forward the form to the Warden, Department Director, the Health Services Administrator and the Investigations Bureau Chief.

2. The MWP Health Services Manager, or designee, will ensure that all health record entries are complete, and that the original inmate health record is kept in a locked cabinet on-site.

3. 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 inmate death to outside media, all information releases will comply with DOC Policy 1.1.8, Media Relations.

D. 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 inmate'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.

E. Review by Medical Examiner/ Coroner

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

IV. CLOSING

Questions concerning this procedure should be directed to the Warden or designee.

V. REFERENCES

A. 46-4-122, MCA; 50-22-101, MCA; 53-1-203, MCA

B. National Commission on Correctional Health Care Standards, 2008

VI. ATTACHMENTS

Death in Custody: Inmate Death Report	Attachment A
Mortality Case Review	Attachment B

State of Montana
DEPARTMENT OF CORRECTIONS
DEATH IN CUSTODY: INMATE DEATH REPORT

State: _____

1. **What was the inmate's name?**

_____ _____ ___
(Last) (First) MI

2. **On what date did the inmate die?**

_____ _____ _____
(Month) (Day) (Year)

3. **What was the name and location of the correctional facility involved?**

_____

4. **What was the inmate's date of birth?**

_____ _____ _____
(Month) (Day) (Year)

5. **What was the inmate's sex?**

Male 01☐ Female 02☐

6. **What was the inmate's race/ethnic origin?**

01 ☐ White (not of Hispanic origin)
02 ☐ Black or African American (not of Hispanic origin)
03 ☐ Hispanic or Latino
04 ☐ American Indian/Alaskan Native (not of Hispanic origin)
05 ☐ Asian (not of Hispanic origin)
06 ☐ Native Hawaiian or Other Pacific Islander (not of Hispanic origin)
07 ☐ Two or more races (not of Hispanic origin)
Additional categories in your information system –
08 ☐ Specify _____
09 ☐ Not known

7. **On what date had the inmate been admitted to one of your correctional facilities?**

_____ _____ _____
(Month) (Day) (Year)

8. **Since admissions, did the inmate ever stay overnight in a mental health observation unit or an outside mental health facility?**

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

9. **Where did the inmate die?**

01 ☐ In general housing in the facility or on prison grounds
02 ☐ In segregation unit
03 ☐ In special medical unit/infirmary within your facility
04 ☐ In special mental health services unit within your facility
05 ☐ In medical center outside your facility
06 ☐ In mental health center outside your facility
07 ☐ While in transit
08 ☐ Elsewhere
Specify _____

10. **Are the results of a medical examiner's or coroner's evaluation (such as an autopsy, post-mortem exam, or review of medical records) available in order to establish an official cause of death?**

01 ☐ Yes – ***Complete items 11 through 15.***

02 ☐ Evaluation complete, results are pending ***– Skip remaining items; you will be contacted later for those data.***

03 ☐ No such evaluation is planned – ***Complete 11 through 15.***

Name of deceased Inmate: _____ _____ _____
(Last) (First) (MI)

11. **What was the cause of death?**

01 ☐ Illness (Excludes AIDS – related deaths) Specify illness: _____
02 ☐ Acquired Immune Deficiency Syndrome (AIDS)
03 ☐ Accidental alcohol/drug intoxication Specify type: _____
04 ☐ Accidental injury to self – Describe events: _____
05 ☐ Accidental injury by other (e.g. vehicular accidents during transport) – Describe events: _____
06 ☐ Suicide (e.g. hanging, knife/cutting instrument, intentional drug overdose) – Describe events: _____
_____
07 ☐ Homicide committed by other inmate(s)
08 ☐ Homicide incidental to use of force by staff – Describe events: _____
_____
09 ☐ Other causes – Specify causes: _____
_____

12. **Was the cause of death the result of a pre-existing medical condition or did the inmate develop the condition after admission?**

01 ☐ Pre-existing medical condition
02 ☐ Inmate developed condition after admission
03 ☐ Could not be determined
04 ☐ Not applicable – cause of death was accidental injury, intoxication, suicide, or homicide.

13. **Had the inmate been receiving treatment for the medical condition after admission to your correctional facilities?** *Exclude emergency care provided at time of death.*

Yes	No	Don't know	
01☐	07☐	08☐	Evaluated by Physician/ medical staff
02☐	07☐	08☐	Had diagnostic tests (e.g., x-rays, MRI)
03☐	07☐	08☐	Received medications
04☐	07☐	08☐	Received treatment/care other than medications
05☐	07☐	08☐	Had surgery
06☐	07☐	08☐	Confined in special medical unit

09☐ Not applicable cause of death was accidental injury, intoxication, suicide, or homicide

14. **When did the incident (e.g., accident, suicide, or homicide) causing the inmate's death occur?**

01☐ Morning (6 a.m. to noon)
02☐ Afternoon (noon to 6 p.m.)
03☐ Evening (6 p.m. to midnight)
04☐ Overnight (midnight to 6 a.m.)
09☐ Not applicable cause of death was illness, intoxication, or AIDS-related

15. **Where did the incident (e.g., accident, suicide or homicide) take place?**

01 ☐ In the prison facility or on prison grounds Specify: _____
a.☐ In the inmate's cell/room
b.☐ In a temporary holding area/lockup
c.☐ In a common area within the facility (e.g. yard, library, cafeteria, day room, recreational area, or workshop)
d.☐ In special medical unit/infirmary
e.☐ In special mental health services unit
f.☐ In a segregation unit
g.☐ On death row, special unit awaiting capital punishment
h.☐ Elsewhere within the prison facility Specify: _____
01 ☐ Outside the prison facility (e.g. while on work release or on work detail, under community supervision, or in transit) Specify: _____
02 ☐ In the prison facility or on prison grounds Specify: _____
09 ☐ Not applicable – cause of death was illness, intoxication, or AIDS-related

Notes

State of Montana
DEPARTMENT OF CORRECTIONS
MORTALITY CASE REVIEW

(To the Medical Director for Supervisory and Peer Review Purposes)

INMATE NAME _____ _____ _____
(LAST) (FIRST) (MI)

AO# _____ DATE OF DEATH: _____/_____/_____
AGE AT DEATH: _____

Death Occurred:

Within ODOC _____	Outside ODOC _____
_____ Infirmary	_____ Hospital
_____ Population	_____ Within 24 hours
_____ Special Housing	_____ After 24 hours
_____ Work place	_____ In Transit
_____ Other (specify)	_____ Other (specify)

History/past medical history/recent history/pertinent physical findings/medications at time of death/procedures/surgeries/consultations/diagnosis before death:

Events leading to the Terminal Event:

INMATE NAME _____ _____ _____
(LAST) (FIRST) (MI)

AO# _____

Diagnosis as established at the time of this review:

Category of Death:

_____ Natural
_____ Chronic Illness, normal progression
_____ Acute Illness, less than 24 hours ill
_____ Suicide, without recent warning signs
_____ Other (Specify) _____

_____ Accidental
_____ Chronic Illness, acute exacerbation
_____ Acute Illness, more than 24 hours Ill
_____ Suicide, with recent warning signs

Reviewer's opinion of Community Standards Rating:
(1 to 5 scale, with 1 = excellent, 2 = exceeded, 3 = met, 4 = may not meet, 5 = not met)

PRODROME PERIOD

_____ Diagnosis timely
_____ Diagnosis accurate
_____ Treatment timely
_____ Treatment appropriate
_____ Preventive measures taken
_____ Staff response appropriate
_____ Level of housing/care appropriate

TERMINAL EVENT PERIOD

_____ Diagnosis timely
_____ Diagnosis accurate
_____ Treatment timely
_____ Treatment appropriate
_____ Preventive measures taken
_____ Staff response appropriate
_____ Level of housing/care appropriate

INMATE NAME _____ _____ _____
(LAST) (FIRST) (MI)

AO# _____

Conclusions – Narrative:

Reviewer's Recommendations:

Reviewer's Signature	Date
Facility Health Services Administrator's Signature	Date
Health Services Bureau Chief's Signature	Date