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  
_____ Accidental

_____ Chronic Illness, normal progression  
_____ Chronic Illness, acute exacerbation

_____ Acute Illness, less than 24 hours ill  
_____ Acute Illness, more than 24 hours ill

_____ Suicide, without recent warning signs  
_____ Suicide, with recent warning signs

_____ Other (Specify) ______________________________________________________

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)

<table>
<thead>
<tr>
<th>PRODROME PERIOD</th>
<th>TERMINAL EVENT PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ Diagnosis timely</td>
<td>_____ Diagnosis timely</td>
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<tr>
<td>_____ Diagnosis accurate</td>
<td>_____ Diagnosis accurate</td>
</tr>
<tr>
<td>_____ Treatment timely</td>
<td>_____ Treatment timely</td>
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<tr>
<td>_____ Treatment appropriate</td>
<td>_____ Treatment appropriate</td>
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<tr>
<td>_____ Preventive measures taken</td>
<td>_____ Preventive measures taken</td>
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<tr>
<td>_____ Staff response appropriate</td>
<td>_____ Staff response appropriate</td>
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<tr>
<td>_____ Level of housing/care appropriate</td>
<td>_____ Level of housing/care appropriate</td>
</tr>
</tbody>
</table>

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