POLICY DIRECTIVE

Policy:	**DOC 4.5.34 OFFENDER DEATH**
Effective Date:	05/01/1998 Page 1 of 2
Revision Date(s):	04/19/2021; 04/24/2026
Department Director Signature:	/s/ Eric Strauss, Director
Medical Director Signature:	/s/ Dr. Paul Rees, MD
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN

I. POLICY

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

II. APPLICABILITY

Secure facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Notifications

1. Within 8 hours of an offender death, the nurse or staff in charge must notify the designated health authority, 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 shift. The 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 (for example, hanging, respiratory failure);
   g. nature of death (for example, 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 about offender death to outside media; all information releases will comply with *DOC 1.1.8 Media Relations*.

D. Report of Offender Death and Health Record

1. Within 24 hours or the next business day, the facility designated health authority, or designee, will complete and forward the *Death in Custody: Inmate Death Report* to the warden, Department Director, the Health Services Bureau Chief, and the Investigations Bureau chief.

2. The facility designated health authority 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 Case Review* within 30 working days of an adult or youth offender's death; and
   a. notify all the necessary disciplines involved (for example, 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; 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 about this policy should be directed to the Health Services Bureau Chief

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, 2022*