DEPARTMENT DIRECTIVE

Title: Executive Mortality Review and Quarterly Qualitative Death Reviews	**Directive Number:** **OPS.270.0003 - New**
Related MD Statute/Regulations: COMAR 10.35.01; COMAR 12.02.22; Correctional Services Article, §§9-602 and 9-602.1 42 U.S.C. § 1997 et seq.,Civil Rights of Institutionalized Persons Act	**Supersedes: OOS** IB # 2025-02 and 2025-04 **Authorized By:**
Related ACA and MCCS Standards: N/A	**David Greene** Deputy Secretary - Operations
Related Directives and Manuals: OPS.020.0003 - Reporting Serious Incidents IID.270.0001 - Reporting and Investigating Incarcerated Individual Deaths OCS.270.0001 - Clinical Services - Incarcerated Individual Death Manual OPS.270.0001 - Procedures for Handling Incarcerated Individual Death, and Serious Illness or Injury	**Issued Date: February 13, 2026** **Effective Date: February 17, 2026**
Variance: No Division or Facility directive is necessary to implement and comply with this directive.	**Number of Pages: 8**

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Acting Commissioner of Correction

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.01 Purpose.

The purpose of this policy is to establish an Executive Mortality Review Committee to identify, evaluate, and analyze any systemic problems or operational deficiencies that may have contributed to the death of an incarcerated individual in the custody of the Department of Public Safety and Correctional Services (Department).

.02 Scope.

The procedures in this directive apply to the members of an Executive Mortality Review Committee and the Quarterly Qualitative Mortality Review Team.

.03 Policy.

A. It is the policy of the Department to conduct a structured, multidisciplinary, and non-punitive review of deaths involving incarcerated individuals in the custody of the Department.

B. It is the Department's policy to align its procedures with applicable standards and guidance, including:

(1) National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Prisons and Jails (Mortality Review standards);

(2) American Correctional Association (ACA) accreditation standards related to serious incident and death reviews; and

(3) U.S. Department of Justice (DOJ) guidance, including Civil Rights of Institutionalized Persons Act (CRIPA) findings, suicide prevention guidance, and patterns-and-practices expectations for custodial death reviews.

.04 Definitions.

A. In this directive, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Attended death" means the death of a patient in which a licensed healthcare provider was providing ongoing medical care and the healthcare provider will certify the patient's manner of death was natural.

(2) "Death" has the meaning described in Health - General Article, §5-309, Annotated Code of Maryland.

(3) "Imminent Death" means a licensed healthcare provider has determined that a patient's death is likely to occur within the next 24 to 72 hours.

(4) "Investigator" means a department employee permanently assigned to or on special assignment to assist IID with the responsibilities specified under Correctional Services Article, §10-701, Annotated Code of Maryland.

(5) "Manner of death" means the way in which a death occurs and includes:

(a) Homicide;

(b) Suicide;

(c) Accidental;

(d) Natural; or

(e) Undetermined.

(6) Mortality Review.

(a) "Mortality review" means a structured, multidisciplinary, and non-punitive review of deaths involving incarcerated individuals under the custody or supervision of the Department.

(b) "Mortality review" means a coordinated effort by executives and administrators to identify systemic issues, deficiencies, or vulnerabilities within organizational structures, clinical processes, policies, staffing, training, communication, or resource allocation.

(7) "Unattended death" means an incarcerated individual's manner of death is:

(a) Undetermined, an accident, a suicide, or a homicide; or

(b) Cannot be readily certified by a healthcare professional.

.05 Responsibilities.

A. Executive Mortality Review Committee (EMRC).

(1) An EMRC shall meet to conduct a review of an incarcerated individual's death:

(a) Classified as an unattended death; or

(b) Identified by executive leadership as raising significant operational, medical, or public interest concerns.

(2) An EMRC is convened by a commissioner or the Director of Patuxent Institution and, at a minimum, includes:

(a) A Deputy Commissioner, as applicable;

(b) An Assistant Commissioner, as applicable;

(c) An Associate Director of Patuxent, as applicable;

(d) The Chief Medical Officer;

(e) The Director of Mental Health Services;

(f) The Executive Director of IID; and

(g) The facility managing official where the death occurred, or a managing official's designee.

(3) If a commissioner, deputy commissioner, assistant commissioner, Director of Patuxent, or associate director, is not available, that individual shall delegate the responsibility to a designee.

(4) An EMRC shall identify and correct unique and systemic issues, policy or practice gaps, training needs, as well as engage in opportunities for continuous quality improvement in correctional operations, healthcare delivery, and interagency coordination.

(5) The EMRC may not function as a disciplinary, criminal investigative, or fault-finding body.

(6) The EMRC may not replace or satisfy the requirement for a clinical Morbidity/Mortality Review as established in *OCSM.270.0001 – Clinical Services Death Procedure Manual.*

B. Quarterly Qualitative Mortality Review Committee (QMRC).

(1) A QMRC shall meet quarterly to review all incarcerated individual deaths that occurred during the preceding calendar quarter.

(2) A QMRC shall conduct regular statistical analyses of deaths of incarcerated individuals and review aggregated EMRC reports to identify patterns, trends, and systemic factors contributing to such deaths.

(3) A QRMC shall review and audit the completion of facility corrective action plans related to prevention of unattended incarcerated individual deaths.

(4) QMRC is convened by the Deputy Secretary of Operations (DSO) and, at a minimum includes:

(a) Assistant Secretary of Data, Policy, and Grants;

(b) Assistant Secretary of Programs, Treatment, and Reentry;

(c) Executive Director of IID;

(d) Executive Director of the Public Safety Education and Training Center;

(e) Agency Counsel;

(f) Commissioners; and

(g) Director of Patuxent Institution.

(5) A DSO may invite as appropriate, the following:

(a) Prison Rape Elimination Act (PREA) Director;

(b) Chief Medical Officer;

(c) Director of Mental Health;

(d) Director of Social Work;

(e) Director of Substance Use Treatment; or

(f) Other employees as needed.

.06 PROCEDURES.

A. Timeline of All Internal Department Death Reviews, Investigations, and Reports.

(1) In accordance with OPS.020.0003 §.05A(2), a facility shift supervisor shall complete a Preliminary Serious Incident Report before the end of the shift during which the Priority 1 incident occurred.

(2) In accordance with IID.270.0001, an Intelligence and Investigation Division (IID) detective shall submit a report summarizing initial investigative findings to the designated detective lieutenant within 24 hours.

(3) In accordance with IID.270.0001, an IID detective Lieutenant shall:

(a) Initiate an administrative investigation reviewing staff actions for the period beginning no less than the 24 hours preceding the incarcerated individual's death; and

(b) Provide the preliminary administrative findings report to the designated IID Captain within 48 hours.

(4) In accordance with IID.270.0001, an IID Captain shall provide consolidated preliminary findings to the Executive Director of IID within 72 hours.

(5) In accordance with OPS.270.0001§.05P, the managing official shall conduct a Facility Death Debriefing with custody staff within 72 hours of an incarcerated individual's death.

(6) In accordance with *OCSM.270.0001 – Clinical Services Death Procedure Manual*, the Regional Medical Director shall conduct a Facility Morbidity/Mortality Review within three business days of each incarcerated individual's death.

(7) In accordance with OPS.020.0003 §.05C(6), the managing official shall submit a Final Serious Incident Report to the Director of Security Operations and the responsible Commissioner/Director, within 5 business days of an incarcerated individual's death for review and discussion by the EMRC.

(8) In accordance with *OCSM.270.0001 – Clinical Services Death Procedure Manual*, if an incarcerated individual's death is ruled a suicide, the Director of Mental Health Services shall complete and submit a psychological mortality autopsy report within 30 calendar days.

(9) In accordance with IID.270.0001, an IID Director shall:

(a) Forward the findings of the administrative investigation to the appointing authority and the responsible executive or Commissioner for review; and

(b) Complete and forward administrative overview upon request to the Secretary and Chief of Staff within 90 days.

B. Executive Morbidity/Mortality Review.

(1) Upon receiving notification of an incarcerated individual's death, the Commissioner or the Director of the Patuxent Institution, as applicable, shall:

(a) Convene an EMRC meeting within 24 hours, or the next business day following weekend, of receipt of the reviews, investigations and reports identified in §.06A(5)—(7) and (9) of this directive; and

(b) Ensure completion of an EMR as instructed by *OPS.270-3aR – EMRC Discussion Checklist* (Appendix A).

(2) As part of the EMR, an EMRC shall review and evaluate the following information, to the extent available at the time of review:

(a) The information provided, if available, in §.06A(5)—(7) and (9) of this directive;

(b) The decedent's complete medical and mental health record for at least the 6 months immediately preceding the date of death;

(c) Administrative Remedy Procedure (ARP) requests and grievances filed by the decedent for at least the 6 months immediately preceding the date of death;

(d) Video footage depicting the decedent for at least the 48 hours preceding the time of death, and verification with the investigating authority that all relevant footage has been preserved in accordance with OPS.110.0032 – Video and Photograph Procedures; and

(e) Relevant facility maintenance requests submitted for at least the 6 months immediately preceding the date of death;

(f) Death notification documentation, in accordance with procedures established in OPS.270.0001; and

(g) Relevant incarcerated individual management records, including infractions, PREA complaints, classification records, cell assignment, and traffic history.

(3) If any required information is unavailable at the time of review, the EMRC shall document the reason for the unavailability and any plans for supplemental review in the EMR report.

(4) At the conclusion of the EMR, the EMRC shall issue a final report and corrective action plan using the Department approved *OPS.270-3bR – Executive Mortality Review Final Report and Corrective Action Plan Template* (Appendix B) as instructed by *OPS.270-3cR – Instructions - Executive Mortality Review - Final Report Template* (Appendix C).

(5) The Commissioner or Director shall submit the EMR report and corrective action plan to the DSO within 7 business days of the EMR.

C. Quarterly Qualitative Mortality Review (QMR).

(1) The DSO shall conduct a quarterly QMR for each incarcerated individual death that occurred during the preceding calendar quarter.

(2) As part of the quarterly QMR, the QMRC shall review and evaluate the following information, to the extent available at the time of review:

(a) Aggregated findings from all EMR reports completed during the review period;

(b) Office of the Chief Medical Examiner reports, when available;

(c) Maryland State Police reports or statements of charges, when the manner of death is determined to be a homicide, when available;

(d) Additional findings from any ongoing IID investigation; and

(e) Other pertinent documentation relevant to identifying systemic trends, risks, or improvement opportunities.

(3) At the conclusion of a quarterly QMR, the DSO shall submit any emergent recommendations to the Secretary, regarding:

(a) Recommended changes or additions to Department policy and procedures;

(b) Updates to training requirements or training modules;

(c) Modifications to Department contracts or agreements;

(d) Identification and remediation of emergent facility maintenance issues; and

(e) Other corrective or preventive actions intended to reduce life threatening conditions within Department facilities.

(4) QMRC Review Schedule. Deaths occurring the:

(a) First quarter of the calendar year shall be reviewed in May;

(b) Second quarter of the calendar year shall be reviewed in July;

(c) Third quarter of the calendar year shall be reviewed in October; and

(d) Fourth quarter of the calendar year shall be reviewed in January of the following year.

D. QMRC Annual Report.

(1) On July 15 of each year, the DSO, in cooperation with the QMRC, shall submit an Annual QMRC Report to the Secretary.

(2) The Annual QMRC Report shall:

(a) Summarize statistical trends and aggregated mortality review findings for the reporting year, including comparative analysis with prior years;

(b) Identify systemic factors that may have contributed to unattended deaths, delayed care, or adverse health outcomes;

(c) Evaluate the implementation and efficacy of prior QMRC recommendations and corrective actions;

(d) Identify barriers to implementation of reforms and strategies to address those barriers;

(e) Recommend policy, operational, training, contractual, or resource changes intended to reduce preventable deaths and improve the health and safety of incarcerated individuals;

(f) Identify data limitations, information gaps, or deficiencies in data collection, and recommend improvements to enhance further mortality reviews; and

(g) Outline planned priorities or focus areas for the upcoming reporting year.

(3) Upon receipt of the Annual QMRC Report, the Secretary may direct further analysis, corrective action planning, or implementation measures, as appropriate.

.07 Appendix.

OPS.230-3aR – EMRC Discussion Checklist

OPS.230-3bR – Executive Mortality Review Final Report and Corrective Action Plan Template

OPS.230-3cR – Instructions - Executive Mortality Review - Final Report Template

.08 History.

This directive supersedes provisions of any other prior existing Department or unit communication with which it may be in conflict.

.09 Correctional Facility Distribution Code.

A
L

Executive Mortality Review Committee Checklist

A. Staffing and Deployment

- Staffing levels at the time of the incident were sufficient for the housing unit's security classification level and the known risk factors of the incarcerated individuals (e.g. suicidality, mental illness, medical instability)
- Posts were filled in accordance with approved staffing plans
- Relief coverage was available during counts, meals, and shift changes
- Staff assigned to the post had appropriate experience and training
- Overtime or extended shifts did not impair supervision or response

ACA Alignment: Staffing plans, post assignments, supervision adequacy
EMRC Use: Identify whether staffing structures contributed to delayed response or inadequate observation

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B. Training and Competency

- Custody staff had current training in emergency response procedures
- Suicide prevention training was current and role-appropriate
- Staff were trained to recognize medical distress, withdrawal, and overdose symptoms
- Staff understood custody responsibilities within medical and mental health protocols
- Refresher or scenario-based training had been provided within required timeframes

ACA Alignment: Staff training, emergency preparedness, suicide prevention
EMRC Use: Assess whether training gaps contributed to missed warning signs or response delays

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C. Observation and Supervision

- Required rounds were conducted at mandated intervals
- Rounds were actively performed and not merely logged
- Observation levels matched documented risk assessments
- Documentation accurately reflected observation practices
- Changes in incarcerated individual behavior or condition were identified and acted upon

ACA Alignment: Supervision, rounds, inmate safety
EMRC Use: Evaluate supervision effectiveness and compliance with observation standards

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D. Communication and Information Sharing

- Relevant clinical or safety alerts were communicated to custody staff
- Shift-to-shift handoffs included critical safety information
- Custody staff communicated observed concerns to healthcare promptly
- Communication followed formal, documented processes
- No critical information gaps were identified

ACA Alignment: Interdisciplinary communication, continuity of operations
EMRC Use: Identify breakdowns between custody and healthcare coordination

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E. Policy and Procedure Compliance

- Applicable post orders were clear and up to date
- Policies governing emergencies, supervision, and escalation were followed
- Conflicting or unclear policies were identified
- Staff understood and followed escalation requirements
- Policies adequately addressed the risk presented

ACA Alignment: Written directives, staff compliance
EMRC Use: Determine whether policy design—not staff conduct—was inadequate

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F. Emergency Response

- Emergency was recognized promptly by custody staff
- Emergency notifications were made without delay
- Custody staff initiated appropriate life-saving actions
- Emergency equipment was available and functional
- Roles during the emergency were clear and coordinated

ACA Alignment: Emergency response, life safety
EMRC Use: Assess systemic readiness for medical and mental health emergencies

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Executive Mortality Review Committee Checklist

G. Environmental and Facility Design

- Housing design supported adequate observation
- Lighting and sightlines were sufficient
- Fixtures and furnishings minimized self-harm risk
- Distance to medical services did not impede response
- Environmental risks were known and mitigated

ACA Alignment: Facility safety, suicide prevention
EMRC Use: Identify structural risks requiring capital or operational remedies

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H. Supervision and Oversight

- Supervisory staff were present or available
- Supervisors verified compliance with rounds and post duties
- Known system deficiencies had been previously identified
- Corrective actions from prior reviews were implemented
- Deviations from policy were addressed consistently

ACA Alignment: Supervision, accountability
EMRC Use: Evaluate management oversight and pattern recognition

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I. Organizational Culture

- Staff felt empowered to report concerns
- Health complaints were taken seriously
- Custody and healthcare collaboration was evident
- Informal “workarounds” were not normalized
- Safety was prioritized alongside security

ACA Alignment: Institutional culture, professionalism
EMRC Use: Identify cultural barriers contributing to systemic risk

DPSCS Executive Mortality Review – Final Executive Report

Facility: _____ Housing Unit: _____

Incarcerated Individual: _____

SID: _____ DOB: _____ DOD: _____

Manner of Death: _____

Date EMRC Convened: _____

Report Prepared by:

Name: _____ Title: _____

Report Submitted by:

Name: _____ Title: _____

Submission Date: _____

I. Purpose and Authority

This Final Executive Mortality Review Report is submitted in accordance with **Department Directive OPS.270.0003**. The Executive Mortality Review Committee (EMRC) conducted a structured, multidisciplinary, and non-punitive review to identify systemic, operational, or policy deficiencies that may have contributed to the death of an incarcerated individual while in Department custody.

This review does not determine individual fault or substitute for criminal or administrative investigations.

II. EMRC Composition

[List required EMRC participants]

III. Materials Reviewed

[List all records reviewed per directive]

IV. Incident Summary

[Insert factual summary of incident]

DPSCS Executive Mortality Review – Final Executive Report

V. EMRC Findings (A–I)

A. Staffing and Deployment
[Insert findings here]

B. Training and Competency
[Insert findings here]

C. Observation and Supervision
[Insert findings here]

D. Communication and Information Sharing
[Insert findings here]

E. Policy and Procedure Compliance
[Insert findings here]

F. Emergency Response
[Insert findings here]

G. Environmental and Facility Design
[Insert findings here]

H. Supervision and Oversight
[Insert findings here]

I. Organizational Culture
[Insert findings here]

VI. Causation Determination

[Insert proximate cause and contributing risk factors]

VII. Corrective Action Plan

Corrective Action	Individual Responsible	Timeline	Status Measure	Notes

DPSCS Executive Mortality Review – Final Executive Report

VIII. Final Executive Determination

[Insert final determination statement]

Instructions -DPSCS EMR – Final Executive Report

Instructions for Completing the Executive Mortality Review Template

This guidance supports completion of the Executive Mortality Review (EMR) Final Report in accordance with OPS.270.0003 and DOJ/ CRIPA standards. The report is non-punitive and focuses on systemic risk.

General Principles

- Focus on systems, not individual blame.
- Distinguish proximate cause from contributing risk factors.
- Use objective, evidence-based language.
- Avoid conclusory or speculative statements.

Section IV. EMRC Findings—Guidance

A. Staffing and Deployment: Evaluate whether staffing levels, post coverage, and deployment met approved plans and whether deviations increased risk.

B. Training and Competency: Assess whether staff possessed required, current training and whether any gaps affected performance.

C. Observation and Supervision: Review rounds, observation levels, and supervisory presence for adequacy and compliance.

D. Communication and Information Sharing: Examine custody-healthcare communication, handoffs, alerts, and escalation pathways.

E. Policy and Procedure Compliance: Determine whether policies were clear, current, and followed; distinguish design gaps from compliance issues.

F. Emergency Response: Assess recognition, notification, response actions, and equipment functionality.

G. Environmental and Facility Design: Identify physical plant, surveillance, or design factors that affect safety or observation.

H. Supervision and Oversight: Review supervisory awareness, verification, and mitigation of known risks.

I. Organizational Culture: Assess whether practices, norms, or tolerance of degraded operations affect safety.

Instructions -DPSCS EMR – Final Executive Report

Section V. Causation Determination—Guidance

Clearly state the proximate cause of death. Identify contributing conditions as risk-enhancing factors without stating or implying direct causation unless supported by evidence.

The proximate cause of death is the initial disease, injury, or event that starts an unbroken chain of events leading to death, representing the fundamental starting point, unlike the immediate cause, which is the final event (e.g., pneumonia from head trauma). It's the underlying condition, like a gunshot wound or heart disease, that sets the fatal sequence in motion, making it crucial in legal and medical contexts to determine responsibility.

Section VI. Corrective Action Plan—Guidance

Each corrective action should be specific, assign an individual responsible for the action, include a measurable timeline, and identify how completion will be verified.

EXAMPLE Executive Mortality Review – Final Executive Report

Facility: Eastern Correctional Institution **Housing Unit:** Unit C

Incarcerated Individual: JOHN DOE

SID: 11122231 **DOB:** November 10,1985 **DOD:** March 13, 2025

Manner of Death: Homicide

Date of EMRC Convening: March 17, 2025

Report Prepared by: Executive Assistant to the Commissioner of Correction

Report Submitted by:

Name: _____ Title: _____

Submission Date: _____

I. Purpose and Authority

This Final Executive Mortality Review Report is submitted in accordance with **Department Directive OPS.270.0003**. The Executive Mortality Review Committee (EMRC) conducted a structured, multidisciplinary, and non-punitive review to identify systemic, operational, or policy deficiencies that may have contributed to the death of an incarcerated individual while in Department custody.

This review does not determine individual fault or substitute for criminal or administrative investigations.

II. EMRC Composition

The EMRC was convened within the required **timeframe** and included the following members:

- Acting Commissioner Dickens
- Deputy Commissioner DOE
- Assistant Commissioner Armstead
- Chief Medical Officer Nimely
- Director of Mental Health Services Bonieskie
- Executive Director, Investigative Intelligence Division (IID) Bauer
- Facility Managing Official DOE

EXAMPLE Executive Mortality Review – Final Executive Report

III. Materials Reviewed

In compliance with OPS.270.0003, the EMRC reviewed:

- Final Serious Incident Report and supporting documentation
- IID Initial Investigative Findings and Consolidated Findings
- Medical and mental health records for the six months preceding death
- ARP requests and grievances filed by the decedent within six months' prior
- Video footage for the 72 hours preceding the incident and documentation regarding camera functionality
- Death notification documentation
- Facility staffing rosters, post assignment records, round logs, and emergency response documentation

IV. Incident Summary

On March 13, 2025, an incarcerated individual was discovered unresponsive in his assigned cell during overnight hours. Custody staff initiated emergency procedures and notified medical personnel. Despite lifesaving efforts, the incarcerated individual was pronounced deceased.

The Office of the Chief Medical Examiner determined the manner of death to be homicide**,** caused by intentional suffocation with a pillow by the incarcerated individual's cellmate**.**

Investigative findings confirmed that, at the time of the incident**,** multiple custody posts within the housing unit were collapsed due to staffing shortages**,** and one fixed surveillance camera covering the housing unit was inoperable**.** These conditions reduced the level of supervision and situational awareness within the unit during the overnight shift.

V. EMRC Findings.

A. Staffing and Deployment:

Staffing levels fell below approved plans, resulting in collapsed posts. These conditions did not cause the homicide but materially increased environmental risk by reducing supervision and situational awareness.

B. Training and Competency:

Staff training was current and appropriate. No training deficiencies contributed to the incident.

C. Observation and Supervision:

Reduced staffing limited observational capacity, increasing vulnerability to spontaneous violence but not constituting a failure to conduct required rounds.

D. Communication:

No communication failures were identified. Emergency communication was timely and appropriate.

E. Policy and Procedure Compliance:

Emergency policies were followed. Staffing deployment policies were not fully met, contributing to elevated systemic risk.

F. Emergency Response:

Response actions were timely and appropriate and did not contribute to the outcome.

H. Environmental and Facility Design:

An inoperable surveillance camera compounded reduced supervision and limited situational awareness.

I. Supervision and Oversight:

Oversight gaps existed in mitigating risk during staffing shortages.

J. Organizational Culture:

Normalization of operating under degraded conditions requires remediation.

VI. Causation Determination:

The proximate cause of death was homicide by another incarcerated individual. Staffing and surveillance deficiencies increased risk but did not directly cause death.

EXAMPLE Executive Mortality Review – Final Executive Report

VII. Corrective Action Plan:

Corrective Action	Individual Responsible	Timeline	Status Measure	Notes
Repair or Replace Camera	Director Capital Construction	2 weeks	Camera Operational	
Increase number of Drafted employees on specified housing unit that holds special needs individuals	Warden	Immediately	Increased rounds	

VIII. Final Executive Determination:

Corrective actions have been initiated to address identified systemic risks.