Department of Public Safety and Correctional Services

Clinical Services & Inmate Health

Operations Manuals

Administration	Medical Records
Chronic Disease Management	Pharmacy Services
Infection Control	Pregnancy Management
Infirmary Care	Sick Call
Inmate Deaths	Substance Abuse
Medical Evaluations	

By signing this cover page, DPSCS officials responsible for the care and treatment of persons confined to their facilities give approval that the policies and procedures, reviewed and updated as needed annually and found herein, formally establish these processes to be acceptable to DPSCS.

Patricia Goins-Johnson, Executive Director Field Support Services

Sharon L. Baucom, MD Director of Clinical Services

Adaora Odunze, RN, PhD, Director of Nursing

Date Reviewed	1/2013
	11/2014
	1/2015
	2/20/2016

Department of Public Safety and Correctional Services

Clinical Services & Inmate Health

Inmate Deaths Manual

Date Reviewed	2/22/2012
	8/2013
	11/2014
	1/2015
	2/20/2016

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DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

INMATE DEATHS MANUAL

Chapter 1

INMATE DEATHS GENERAL

I. Policy: All inmate deaths shall be reviewed and documented by a physician in accordance with established procedures consistent with state law and regulations. Administrative and peer review of all inmate deaths shall occur as part of the DPSCS Quality Improvement Program.

II. Procedure:

A. A Physician Review of Inmate Death shall be completed within three (3) working days.

B. The regional medical director or on-call physician representative shall be notified immediately of all inmate deaths and apparent deaths. If the death occurs in a DPSCS facility, the Physician shall be responsible for completing the following tasks immediately upon such notification.

1. The regional medical director or on-call physician representative shall respond on-site to the facility housing the expired inmate unless a provider capable of responding is already on site.
2. The regional medical director or on-call physician representative shall assess the inmate and pronounce the death, as appropriate.
3. The regional medical director or on-call physician representative shall complete a death certificate for inmate deaths occurring in DPSCS facilities. If the death occurs at the University of Maryland Hospital, or other community hospital, the physician shall ensure that the hospital forwards a copy of the death certificate to medical records within sixty (60) days.
4. The regional medical director or on-call physician representative shall brief the medical examiner on all deaths occurring in DPSCS facilities. The medical examiner shall inform the physician if the death is a medical

examiner's case requiring formal investigation and a post-mortem examination. If internal investigation considers this may be a criminal case, they may request a postmortem.

5. The regional medical director or on-call physician representative shall review the inmate's medical care and the terminal events by telephone with the hospital physician for an inmate death occurring in any community hospital or off site facility.
6. The regional medical director or on-call physician representation shall review the inmate's medical record, medical care and the documentation of the terminal events preceding the inmate's death, including 911 directives.
7. The regional medical director or on-call physician representative shall document a closure note for the inmate death in the medical record. The closure note is to include at least the following information:
   a. Primary diagnosis and treatment plan
   b. Synopsis of medical care provided immediately prior to death
   c. Resuscitative efforts immediately prior to death
   d. Documentation of "Do Not Resuscitate" orders or other advance directives that directly relate to the level of ante mortem care provided
   e. Primary and secondary diagnoses as listed on the death certificate
   f. Documentation of telephone call to the medical examiner and the medical examiner's decision regarding post-mortem examination
8. The regional medical director/Statewide Contractor Medical Director shall verbally or by email notify the DPSCS Chief Medical Officer/designee of the death as soon as possible. Verbal notification of the death of terminal patients or anticipated, uncomplicated, deaths shall be completed within twenty-four (24) hours of the death maximum.
9. The regional medical director shall verbally notify the DPSCS mental health services/designee as soon as possible and within the hour, if suicide is suspected as the cause of death. Anticipated or uncomplicated deaths shall be reported within twenty-four (24) hours. Within thirty (30) days, of a suicide a psychiatrist will submit a "Psychological Mortality autopsy" report to the

DPSCS Director of mental health /designee with a copy to the office of the DPSCS Chief Medical Officer.

10. The regional medical director shall provide a completed Death Reporting Form (see Forms section of the DPSCS: CS Manual) as well as completed Morbidity and Mortality Conference Death Summary Form to:
    a. Office of the DPSCS Chief Medical Officer
    b. Agency Contact Operations Manager (ACOM)
    c. DPSCS Nurse Consultant or designee for DPSCS Clinical Services and Inmate health within five working days following the death,

C. After the telephone/email notification of the inmate's death to the office of the DPSCS Chief Medical Officer, the contractor's regional health care manager/designee shall complete Section A of the Morbidity and Mortality Conference Death Summary Form, and fax to the regional medical director's office within five (5) working days.

D. The Regional Inmate Death review shall be conducted within three working days of death. A copy of the medical record must be available at the review in order for the review to be considered an authorized mortality conference.
    1. Each region shall have Regional Mortality Review Committee. The committee shall consist of the departmental ACOM, the managing officer/designee, the Warden's designee, the regional medical director, the medical records supervisor, the contractors' administrators and the medical contractor's director of nurses.
    2. The committee shall be a subcommittee of the Regional Continuous Quality Improvement Committee.
    3. The committee shall review each death within three working days of the death to the death to identify clinical, administrative, personnel or environmental factors which may have contributed to the death.
        a. Membership in each Mortality and Morbidity conference shall consist of persons from every discipline involved in the care and/or end of life events. These include, but not limited to, medical, nursing, psychiatry, psychology, therapies of any type, custody and security.

b. There will be minutes for these meetings in addition to the final report (The M & M Report) generated for inclusion in the deceased's medical life.
    i. These minutes will be forwarded to DPSCS office of the Chief Medical Officer (CMO) within seven (7) days post death review meeting.
    ii. Minutes will be filed separately from the medical record so that any Serious Incident Reports available surrounding the death of the inmate can be kept confidential.
    iii. All Serious Incident Reports with the minutes of the morbidity and mortality (M & M) meetings should be sent to the Office of the Chief Medical Officer.
c. Each member of the committee shall include documentation of his or her findings in writing, sign the document and include the discipline the signer is representing. That document shall be presented to the committee's chairperson who will include those thoughts in minutes of the meeting.
d. Appropriate member(s) of the committee shall be assigned responsibility for correcting identified contributory factors.
e. If an extension beyond the required three (3) days is granted by DPSCS ACOM, it shall be documented in the medical record and on the minutes of the M & M Meeting at the time of the regional Morbidity and Mortality Review.

4. The death shall be reviewed in-depth prior to the *monthly* regional CQI meeting with a corrective action plan documented if indicated as part of the CQI agenda. The DPSCS CQI and Infectious Disease Nurse Manager and the Regional ACOM shall receive copies of the CQI minutes and Corrective Action Plan (CAP) related to deaths <u>monthly</u>.

E. The DPSCS Inmate Death Review will be conducted in several stages :
The initial DPSCS death review will be completed by the regional ACOM/designee prior to the 72 hour death review meeting chaired by the contractor regional medical director.

1. A DPSCS administrative review of the death will also be completed by contracted RN nursing staff consultants within 4-6 weeks of the death. If

hospital summaries or other external information pertinent to the death review are delayed, this time period may be extended.

2. The DPSCS administrative death review shall occur at the office of the Chief Medical Officer. The DPSCS Chief Medical Officer shall review the written ratings of the death assigned by the nurse consultants along with any pertinent notes submitted related to circumstances of events leading up to the death of the inmate. The purpose of the review is to identify clinical, administrative, personnel, or environmental factors, if any, which may have contributed to the death for the Chief Medical Officer (CMO) and to make a preliminary rating/severity code for review by the CMO. Informal meetings with the nurse consultant will be conducted if there are critical differences between the site reviews and the DPSCS nurse consultants and the review by the CMO. Any disagreements regarding the codes assigned will be verbalized to the nurse consultant as an educational opportunity. The rating of the Chief Medical officer is the final rating.
3. The departmental peer death review shall follow the administrative review based upon the time table for completion of the nurses' review and the receipt date of any additional external information from Community hospital records, consultant report, toxicology screening, or medical examiner's report. The purpose of the peer review will be to assign a final severity coding to the individual inmate's case and to review CAPS/make recommendations. This peer review should be completed within 45 -60 days of receipt of all of the information internal and external sources related to the inmate death following the completion of the nurse consultant's review.

Exceptions: an expedited death peer review may proceed prior to the review by the nurse consultant when the inmate death is considered a high profile death or information regarding the death is requested from the DPSCS Internal investigative unit or a request by the office of the Secretary surrounding the circumstances associated with the death. In those types of scenarios the death review by the CMO may by pass the facility ACOM review, nurse consultant

review and any reviews by the contractor medical team. This type of independent review may take place within 24-36 hours following the death.

4. Severity Codes will be assigned as follows:
    a. 0= Care appropriate, no evidence of process issues contributing to sub-standard care
    b. 1= Process and documentation gaps found (vital signs inconsistently done, laboratory studies were missed; progress notes were not located in the medical record etc.))
    c. 2= System process breakdown found that contributed to care issues (medications not received consistently, chronic care appointments not scheduled, specialty addressed despite sick call slips, not scheduled for follow up etc.
    d. 3= System process breakdowns found that contributed to preventable adverse patient outcomes (care management not consistent with clinical pathways, failure to follow protocols, discontinuity of care)
    e. 4= Non-adherence to systemic clinical pathways of disease management processes which were directly connected to the patients' health care needs (did not receive vital medications, did not address or document gross abnormalities in patient's condition. Special health care needs were not managed effectively and significant delays in care results in bad outcomes including death. Unethical behavior is reportable to the Board of Quality Assurance.

F. The following procedures shall govern the management of the deceased inmate's medical record;

1. The original medical record shall not be removed from the medical records department of the institution where the death occurred unless otherwise authorized by the DPSCS Chief Medical Officer/designee. The original medical records shall be sent to the DPSCS Chief Medical Officer at the Office of Programs and Services: Clinical Services within five (5) working days.

2. The original medical record shall be made available within the medical records department to the DPSCS Internal Investigative Unit (IIU), Regional Medical Director, ACOM, other duly authorized investigative agencies, and the medical examiner upon written request to the medical records' department in accordance with DCD 270-1.
3. During non-business hours, agency representatives reviewing a deceased inmate's medical record shall:
    a. Review the file in the medical records department
    b. Sign the medical record log on the log-in/log-out form.
4. One copy of the pertinent sections for death review purposes of the medical record shall be made available to:
    a. The DPSCS nurse consultants/designee, ACOM in the Office of Clinical Services/Inmate Health within twenty-four hours following the death. The entire record may be copied and provided within forty eight (48) hours.
    b. The DPSCS Internal Investigative Unit upon request, within the next business day; medical records department may provide a copy of the entire medical record.
    c. The contractor medical/mental health designee within twenty-four (24) hours unless the DPSCS Chief Medical Officer allows an extension by request in which case the entire record with forty-eight (48) hours
    d. Additional copies of the medical record shall be made available if determined necessary by the DPSCS Chief Medical Officer/designee.
5. The record shall be sealed and the original, complete medical record shall be temporarily transferred to the custody of DPSCS by the regional medical records supervisor to the Office of Clinical Services/Inmate Health _ DPSCS Chief Medical Officer/designee within five (5) working days unless otherwise requested for an expedited review. Otherwise, all death records shall be forwarded to case management for placement in the deceased inmate's base file within thirty (30) days.

G. No one shall release information concerning deceased inmates to anyone other than DPSCS personnel without a written request to the managing officer of the facility.

H. Medical Staff shall use the attachment (Attachment A) below from the Pre-Trial Directive (Attached B) on the chain of information regarding notification of deaths.

1. The form shall be completed with the appropriate phone numbers for the facility.
2. The form shall be hung or posted in a location convenient to medical staff for use in the event of each inmate or detainee death.

I. Medical, Mental Health Staff shall notify custody of all deaths as soon as they are known in keeping with attachment A below. Custody will notify all appropriate agencies as directed in DPDSC 270.00.1.

III. References:

A. ACA Standard 3-4375
B. NCCHC Standard P-A-10
C. CS 270 Clinical Services Inmate Death Manual
D. DPDS 270 Notification to Next of Kin
E. DCD 270-1; DPDS 270-3
F. Death Reporting Form
G. Morbidity and Mortality Conference Death Summary
H. Medical Record Sign-Out/Sign-In Log
I. PDSD 270-3 “Resident Deaths”

IV. Rescission:

DCD 130-100 Section 166 dated November 4, 1997
DCD 130-100 Section 114 dated September 11, 1992
130-100-114 all issuances and versions

V. Issued: July 15, 2007

VI. Revised: December 29, 2010
July 2013
November 17, 2014
Review /revised 3 -30-15 (original revisions 2014 not completed were modified incompletely 11-2014)

Reviewed: December 2015

Attachment A

ALL DEATHS, including SUICIDES	Shift Commander or designee	COMMAND STAFF, DUTY OFFICER	IMMEDIATE
		Dir. Clinical Services DPSCS Office: Debbie Highstein 410-585-3377	business hours only
		Dir. Mental Health Services, DPSCS Office: Beeper: Regional /Chief Psychologist	IMMEDIATE
		Director of Nurses DPSCS Office: Mobile:	IMMEDIATE
		Regional ACOM Office: Beeper:	IMMEDIATE
		Regional Health Care Manager contractor Office: (410) Beeper: (410)	IMMEDIATE
		Regional Director of Nursing (vendor)	business hours only
		DPDS Central Records Dir. (or designee)	Within 24 hrs. of the death, via e-mail or in writing.
	DOC / IU	OFFICE OF THE STATE MEDICAL EXAMINER	IMMEDIATE
	Health Care Provider	Contractor Statewide and Regional Mental health and Medical Director	IMMEDIATE
	See PDSD# 270-1 for instruction	**Next of Kin**	Per Procedures in PDSD #270-1

Attachment B (Policy Portion of DPDS 270-1)

STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
DIVISION OF CORRECTION

DIVISION OF CORRECTION DIRECTIVE

PROGRAM:	**INMATE DEATHS**	
DCD #:	**270-1**	
TITLE:	**Procedures for Handling Inmate Deaths**	
ISSUED:	**May 15, 2007**	
AUTHORITY:		**James V. Peguese** **ASSISTANT COMMISSIONER**
APPROVED:		**John A. Rowley** **ACTING COMMISSIONER**

I. References:

A. DCDs 20-3, 140-156, 220-004 and 270-2; DCM 95-1
B. DPSCSD 130-100, Sect. 166 – Inmate Deaths
C. COMAR 12.02.22; 10.35.01.18
D. MCCS .02T
E. ACA Standard 4-4425

II. Applicable to: DOC Headquarters and all Division of Correction Institutions and Facilities

III. Purpose: To establish procedures to follow in the event of an inmate death.

IV. Definitions: None

V. Policy:

It is the policy of the Division of Correction that inmate deaths are reported immediately to appropriate officials, that the cause of death is investigated, that the inmate's designated emergency contact person is notified promptly, and that the release of the inmate's property is processed in an orderly and timely fashion.

VI. Procedure:

A. Inmate deaths due to execution are exempt from the provisions of this directive. Division of Correction Manual 110-2 provides procedures for executions of inmates under sentence of death.

B. In all instances of inmate deaths that occur in an institution, including homicide, suicide, accident, illness, and instances where the cause of death is unknown, the following actions shall be taken:

1. The shift commander shall officially designate the location of an inmate death as a crime scene, until determined otherwise, assign a supervisor to secure the

scene and restrict access to the area until it is released by the Internal Investigative Unit (IIU). The assigned supervisor shall establish and maintain a log for the crime scene to include the specific location, the name of the victim, the time and the names of any persons who enter or leave the crime scene.

a. No one shall be allowed at the scene, other than qualified medical personnel performing lifesaving measures, until the assigned IIU investigator or the designated law enforcement investigator arrives.

b. If lifesaving measures have been performed, the supervisor assigned to the scene shall document in detail the condition of the scene and any changes that occurred as a result of providing medical assistance.

c. The supervisor assigned to the scene shall preserve all physical evidence such as clothing, ligatures, weapons, etc., and shall initiate chain of custody forms.

2. The IIU shall be notified immediately. When the assigned investigator arrives, he or she shall contact the office of the chief medical examiner and advise the medical examiner of the circumstances surrounding the death and the condition of the body. The assigned investigator shall also contact the Maryland State Police, who will only conduct an investigation if the death is believed to be a homicide.

a. If the medical examiner determines that the death will be examined as a medical examiner's case, the medical examiner will transport the body for autopsy. If necessary, the warden may have the body removed to another location after release by the IIU investigator, pending pickup by the medical examiner.

b. If the medical examiner determines that the death will not be examined further, the IIU investigator, prior to departing the institution, shall release the body to the warden for disposition.

3. The following staff shall be notified of all inmate deaths:

a. Warden
b. DOC Headquarters duty officer
c. DOC public information officer
d. Assistant warden
e. Chief of security
f. Facility chaplain
g. DPSCS Director of Inmate Health Care Services
h. Chief psychologist
i. Regional health care administrator

4. The inmate's designated emergency contact person shall be notified by the appropriate faith chaplain in accordance with DCD 140-156.

   a. Where death occurs as a result of a suspected crime, circumstances surrounding the death shall not be disclosed to the inmate's designated emergency contact person. The emergency contact person will be advised that the death is being investigated.

   b. If the chaplain is unable to contact the inmate's designated emergency contact person, the shift supervisor/designee shall contact the state or local police to assist.

   c. If the chaplain is unavailable, the warden/facility administrator/designee shall make the death notification to the inmate's designated emergency contact person.

5. The deceased inmate's personal belongings shall be secured, inventoried and handled in accordance with the provisions of DCD 220-004 after clearance has been received from the IIU investigator.

6. The original medical records shall be sent to the medical director, DPSCS Office of Inmate Health Care Services (the last volume within one day following the death; the remaining volumes within three working days in accordance with DPSCSD 130-100, Sect. 166).

7. The deceased inmate's medical files shall be turned over to the IIU investigator for review upon request.

8. All staff having knowledge of the circumstances surrounding the death shall prepare detailed reports, including the names of any witnesses. These reports shall be submitted prior to staff leaving the institution. The original reports shall be turned over to the IIU investigator.

C. Death of Inmate Housed at Institutional or Outside Hospitals or Out of State

1. The death of an inmate housed in an institutional hospital for illness shall be handled in accordance with the procedures in section VI. B. of this directive.

2. The death of an inmate housed at an outside hospital or out of state shall be handled in accordance with the procedures in section VI.B (except B.1.) of this directive.

D. Fingerprinting of Deceased Inmates

1. A deceased inmate will only be fingerprinted in a situation where the inmate's identity is in doubt.

   a. Fingerprints shall not be obtained until after the autopsy has been

completed and the office of the chief medical examiner has released the body.

b. The institutional identification officer for institutions located in Jessup and Baltimore will respond to the medical examiner's office to obtain fingerprints after the autopsy is completed. The identification officer for the Metropolitan Transition Center shall take the fingerprints for deceased inmates at the office of the chief medical examiner for facilities located outside the Jessup and Baltimore areas.

2. When the deceased inmate's identity is not in doubt, institutional staff shall copy the original set of inmate fingerprints and place the copy in the inmate's base file with a notation of the date that the originals were sent to the Criminal Justice Information System (CJIS). The warden shall complete the form memo provided in Appendix 2, verifying that the inmate is deceased, and send it to CJIS with the original fingerprint card.

E. After the physician pronounces the inmate dead and the required immediate actions have been taken, notifications made, and the disposition of the body turned over to the warden, the warden/designee shall:

1. Arrange with the inmate's designated emergency contact person for release and disposition of the body.

a. Initiate the provisions of DCD 270-2 in cases where the inmate's designated emergency contact person intends to claim the body but the inmate's designated emergency contact person and the deceased inmate are both indigent.

b. If there is no inmate's designated emergency contact person, or if the inmate's designated emergency contact person has refused to claim the body, arrangements shall be made with the University of Maryland Mortuary, Anatomy Board for acceptance.

c. If the inmate's designated emergency contact person refuses to claim the body, the inmate's designated emergency contact person shall note the refusal in writing.

2. In accordance with DCD 220-004, release the inmate's personal property and money to the inmate's designated emergency contact person, or advise the inmate's designated emergency contact person to contact the local Office of the Register of Wills for the procedures to follow. Receipts shall be obtained and filed in the inmate's base file for all items released.

3. Obtain a copy of the death certificate from the Division of Vital Records. The original shall be placed in the inmate's base file and a photocopy shall be included with the serious incident report. If a copy of the death certificate is

requested by the inmate's designated emergency contact person, staff is to advise him/her to obtain the document by contacting the Division of Vital Records, 6550 Reisterstown Road, Baltimore, MD 21215.

F. The shift commander shall ensure that OBSCIS I, screen 02, Maintain Alerts, is reviewed. If the inmate had a victim alert, code 41 entered, the shift commander shall submit this information in writing to the warden so that commitment procedures and the provisions of DCM 95-1 can be initiated.

G. The shift commander shall complete page one of Appendix 1, Inmate Death Checklist, to document the time that each task was completed. The checklist shall be forwarded with the serious incident report to the warden via the chief of security.

H. The warden/designee shall complete page two of Appendix 1 to document the date and time that each task was completed. The original Appendix 1 shall be included with the final serious incident report.

I. A Death Review Panel comprised of the following staff shall be convened to review the death of the inmate:

a. Warden
b. Shift commander
c. Facility chaplain
d. IIU investigator
e. Case manager
f. Property officer

J. Each warden shall issue an institutional directive to implement and comply with this DCD.

VII. Attachments:

A. Appendix 1, Inmate Death Checklist
B. Appendix 2, Sample Form Memo of Fingerprint Transmittal to CJIS

VIII. Rescission: DCD 270-1, dated April 1, 2005

Distribution: A
L

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

INMATE DEATHS MANUAL

Chapter 2

AUTOPSIES

I. Policy: Inmates who are residing in DPSCS facilities and expire, shall be examined by the medical examiner in Office of the Chief Medical Examiner, pursuant to the annotated Code of Maryland, COMAR 10.35.01, Department of Health and Mental Hygiene and any other applicable law or agency.

A death in a State-funded or State-operated facility which constitutes a medical examiner's case as defined in Health General Article, §5-309, Annotated Code of Maryland, shall be investigated by the Office of the Chief Medical Examiner.

II. Procedure:

A. Upon notification that a resident of a DPSCS facility has been confirmed dead, the contract vendor's regional medical director of the facility in which the inmate had resided, shall notify the Office of the Chief Medical Examiner.

1. A brief discussion of the circumstances of the events leading up to the death that identifies the inmate by name, age and sex, the time of discovery of the death, the place where the body was discovered, and the provider who evaluated the inmate at the time of the discovery.
2. At a minimum, the discussion will include the identification of any chronic diseases and treatments or medications.
3. This discussion assists in ascertaining a decision regarding the need for an autopsy.

B. The vendor's contracted medical staff shall transmit to the medical examiner's office any and all information pertaining to:

1. The circumstances of a death appearing to be of sudden, unexpected suspicious, or unusual nature, accidental, a therapeutic mishap;

2. An inmate is dead on arrival once transported to an area hospital; and,
3. Any information not contained within the medical record at the time of death that could contribute additional information to potential risk.

C. The contracted vendor's medical staff shall copy all information that is part of the investigative information for the medical examiner. They shall document all of the information transmitted to the medical examiner's office in the inmate's medical record.

D. If the death is not a medical examiner's case, the vendor's contracted physician fills out a death certificate and signature and includes his or her title, date and time, along with the primary diagnosis and other medical problems that may have been contributing factors to the death of the inmates.
   1. A medical examiner's review information shall be gathered in course of the postmortem examination, including testing for contagious disease or viruses.
   2. The Office of the Chief Medical Examiner shall verbally notify the agency-designated representative within forty-eight (48) hours after confirmation of the diagnosis, and if the death is not determined to be a homicide.
   3. A written request for any needed information shall be made to the Office of the Chief Medical Examiner for a copy of the autopsy report in a manner that protects the confidentiality of the patient.
   4. A designated agency representative shall notify any individual believed to have been exposed to the contagious disease or virus from the deceased.

E. The report of the administrative head of a facility where the death occurred shall contain all information set out in Health-General Article. §10-714, Annotated Code of Maryland. The report:
   1. May be oral, if following a written report within five (5 working days from the date of the death, or written and
   2. Shall contain the following relevant information:
      a. The name, age, and sex of the deceased;
      b. The time of the discovery of the death;
      c. The deceased's place of residence at the time of the death;

d. The place where the body was found, if in a place other than the residence
e. The name of the person who took custody of the body;
f. The name of the person evaluating the death, if known:
g. Whether an autopsy is being performed, if known;
h. The name, address, and telephone number of the next of kin or legal guardian, if known; and
i. Other information the administrative head of the facility determines should be provided to the medical examiner

F. The report of the investigation by the Office of the Chief Medical Examiner constitutes an individual file of the chief Medical Examiner not subject to disclosure under State Government Article §10-611et seq., Annotated Code of Maryland.

III. References: COMAR 10.35.01 Medical Examiners Cases
IV. Rescissions: None
V. Date Issued: July 15 (revised December 29, 2010)
Reviewed: October 3, 2012
July 2013
December 2015

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

INMATE DEATHS MANUAL

Chapter 3

REPORTS TO THE MEDICAL EXAMINER

I. Policy: Inmates who are residing in DPSCS facilities and expire, shall be examined by the medical examiner in the Office of the Chief Medical Examiner, pursuant to the Annotated Code of Maryland, COMAR 10.35.01, Department of Health and Mental Hygiene and any other applicable law or agency. A death in a State-funded or State-operated facility which constitutes a medical examiner's case as defined in Health General Article, §5-309, Annotated Code of Maryland, shall be investigated by the Office of the Chief Medical Examiner.

II. Procedure:

A. Upon notification that a resident of a DPSCS facility has been confirmed dead, the regional medical director for the contractor of the facility shall notify the county medical examiners' office.

1. A brief discussion of the circumstances of the events leading up to the death that identifies: the name, age and sex of the deceased, the time of discovery of the death, the place where the body was discovered, the provider who evaluated the inmate at the time of the discovery, along with the identification of any chronic diseases, and treatments or medications, at a minimum, shall be discussed with the medical examiner, in order to ascertain a decision regarding the need for an autopsy.
2. If, after discussion with the agency Internal Investigative Unit, the physician is advised that the circumstances of a death appear to be of a sudden, unexpected, suspicious, or unusual nature, accidental, or a therapeutic mishap, or an inmate is dead on arrival after being transported to an area hospital, the contracted medical staff shall transmit the information to the

medical examiner's office to facilitate the decision for an autopsy to be performed.

B. Any information, not contained within the medical record at the time of death, that could contribute additional information of potential risks, shall be copied and made part of the investigative information for the medical examiner
   1. The medical contractor staff shall document in the record all of the information transmitted to the medical examiner's office.
   2. The medical contractor physician shall fill out a death certificate and signature with title, date and time along with the primary diagnosis and other medical problems that may have been contributing factors.

C. A medical examiner shall review information gathered in the course of the postmortem examination, including testing for contagious disease or viruses.
   1. The Office of the Chief Medical Examiner shall verbally notify the agency-designated representative within forty-eight (48) hours after confirmation of the diagnosis, and subsequently confirm the notice, in writing, and in a manner that protects the confidentiality of the patient.
   2. The agency representative shall notify the individual believed to have been exposed to the contagious disease or virus.

D. The report of the administrative head of a facility where the death occurred shall contain all information set out in Health-General Article. §10-714, Annotated Code of Maryland. The report:
   1. May be oral, if followed by a written report within five (5) working days from the date of the death, or written; and
   2. Shall contain the following relevant information:
      a. The name, age, and sex of the deceased
      b. The time of discovery of the death
      c. The deceased's place of residence at the time of the death
      d. If the death occurred in a place other than the residence of the deceased, the location of the body at the time of discovery
      e. The place where the body was found
      f. The name of the person who took custody of the body

g. The name of the person evaluating the death, if known
h. Whether an autopsy is being performed, if known
i. the name, address, and telephone number of the next of kin or legal guardian, if known; and
j. other information the administrative head of the facility determines should be provided to the medical examiner

E. The report of the investigation by the Office of the Chief Medical Examiner constitutes an individual file of the Chief Medical Examiner and is not subject to disclosure under State Government Article § 10-611 et seq., Annotated Code of Maryland.

III. References: COMAR 10.35.01 Medical Examiners Cases
IV. Rescission: None
V. Date Issued: July 15, 2007
VI. Reviewed: October 13, 2010
October 11, 2011
October 15, 2012
July 2013
November 19, 2014
December 2015

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

INMATE DEATHS MANUAL

Chapter 4

MORBIDITY AND MORTALITY REVIEW

I. Policy: Deaths shall be examined by the medical examiner in the Office of the Chief Medical Examiner in Baltimore pursuant to the Annotated code of Maryland, COMAR 10.35.01, Department of Health and Mental Hygiene and any other applicable law or agency if any of the following conditions exist;

- Inmates who are residing in DPSCS facilities, and die as a result of a homicide, poisoning, suicide, criminal abortion, rape, drowning, or dying in a suspicious or unusual manner, or
- Death of an apparently healthy individual or a case where an inmate is dead on arrival at the hospital.

All deaths shall be treated as important, and the cases of those deceased will receive a thorough examination.

II. Procedure:

A. A multidisciplinary review of an inmate death shall be completed within three (3 working days by the agency's medical, mental health, pharmacy, and dental, contractor staff, Agency Contract Operations Manager (ACOM), custody staff and any other entity designated as needed for disposition of the review. The ACOM, as part of the process, will review the record and document the review on the agency designated form. The ACOM can alert the DPSCS medical director of the need to expedite the departmental review secondary to serious concerns related to the clinical case review.

B. The regional medical director or on-call physician representative shall be notified immediately of all inmate deaths. If the death occurs in a DPSCS facility, the

physician shall be responsible for completing the following tasks immediately upon such notification:

1. The regional medical director or on-call physician representative shall respond on-site to the facility housing of the expired inmate unless a provider capable of responding is already on site.
    a. The nurse on duty may telephone the on-call physician and report the facts of the situation including but not limited to the recorded last vital signs taken, the time the inmate was found to be non-responsive, any efforts made to resuscitate, and the outcome of all efforts taken to assist the inmate until efforts were ceased.
    b. Following the verbal direction of the on-call physician, the nurse on duty shall afford a resting location with respect and allowing for final dignity for the inmate, and provide for immediate care of the body as appropriate to the conditions of the death (Any suspicious death shall be treated as a "crime' scene until cleared by custody and no movement shall occur).
2. The regional medical director or on-call physician representative shall assess the inmate and pronounce the death, as appropriate at the earliest possible moment, which may in some cases require a wait until daytime hours.
3. The regional medical director or on-call physician representative shall complete a death certificate for inmate deaths occurring in DPSCS facilities. If the death occurs at the University of Maryland Hospital or other community hospital, the physician shall ensure that the hospital forwards a copy of the death certificate to medical records within sixty (60) days.
4. The regional medical director or on-call physician representative shall brief the medical examiner on all deaths occurring in DPSCS facilities. The medical examiner shall inform the physician if the death is a medical examiner's case requiring formal investigation and post-mortem examination. If an internal investigation considers this a criminal case, they may request a postmortem.
5. The regional medical director or on-call physician representative shall review the inmate's medical care and the terminal events by telephone with the

hospital physician for an inmate death occurring in any community hospital or off-site facility.

6. The regional medical director or on-call physician representative shall review the inmate's medical record, medical care, and the documentation of the terminal events preceding the inmate's death, including 911 directives.
7. The regional medical director or on-call physician representative shall document a closure note for the inmate death in the electronic medical record. This closure note is to include at least the following information:
    a. Primary diagnosis and treatment plan
    b. Synopsis of medical care provided immediately prior to death
    c. Resuscitative efforts immediately prior to death
    d. Documentation of the status of "Do Not Resuscitate" orders or other advance directives that directly relate to the level of ante mortem care provided
    e. Primary and secondary diagnoses as listed on the death certificate
    f. Documentation of telephone call to the medical examiner and the medical examiner's decision regarding post-mortem examination
8. The regional medical director shall verbally notify the DPSCS Chief Medical Officer/designee of the death as soon as possible. Verbal notification of the death of terminal patients or anticipated, uncomplicated, deaths shall be completed within twenty-four (24) hours of the death.
9. The regional medical director shall verbally notify DPSCS mental health services/designee as soon as possible and within the hour, if suicide is suspected as the cause of death. Anticipated or uncomplicated deaths shall be reported within twenty-four (24) hours. Within thirty (30) days, a psychiatrist will submit a "Psychological Mortality Autopsy" report to the DPSCS medical director.
10. The regional medical director shall provide a completed Death Reporting Form (see forms section of the OPS:CS Manual) as well as a completed Morbidity and Mortality Conference Death Summary Form to:
    a. DPSCS Chief Medical Officer/designee

b. Agency Contract Operations Manager (ACOM)
c. DPSCS director of nurses or designee at clinical services within five working days following the death

C. After telephone/e-mail notification of the inmate's death to the DPSCS Chief Medical Officer/designee, the contractor's regional health care manager/designee shall complete Section A of the Morbidity and Mortality Conference Death Summary Form, and fax to the regional medical director's office within five (5) working days.

D. The regional Inmate death review shall be conducted within three working days of the death. A copy of the medical record must be available to be at the review or it is not an authorized mortality conference.
   1. Each region shall have a Regional Mortality Review Committee. The committee shall consist of the department ACOM, the Warden or designee, the Regional Medical Director, the Medical Records Supervisor, the facility's Medical and Mental Health Contractors' Administrators, State Psychology representative, and the Medical Contractor's Regional Director of Nurses. Other clinical services vendors and personnel may be invited as needed.
   2. This committee shall be a subcommittee of the Regional Continuous Quality Improvement Committee.
   3. The committee shall review each death within three working days of the death to identify clinical, administrative, personnel or environmental factors which may have contributed to the death. The appropriate member(s) of the committee shall be assigned responsibility for correcting lapses identified in the medical record at the time of the regional morbidity and mortality death review.
   4. The medical vendor (or mental health vendor if it is a suicide related death) shall provide written minutes of the Regional Morbidity and Mortality Review to the ACOM within five business days following the death review. The minutes shall summarize relevant discussions at the death review and memorialize any corrective action plans recommended by the committee.

5. The death shall be reviewed in-depth prior to the monthly regional CQI meeting with the corrective action plan documented as part of the CQI agenda/minutes. The DPSCS director of nurses and the regional ACOM shall receive copies of the CQI minutes and Corrective Action Plans (CAPS) related to deaths monthly.

E. The DPSCS Inmate Death review will be documented in the CQI monthly meeting minutes.
   1. The death review shall consist of two components:
      a. An administrative review conducted by DPSCS nursing; and
      b. A departmental review for deaths designated as pretrial inmates or deaths with a severity code disposition of 3 or greater by DPSCS nursing administrative review conducted by the DPSCS chief medical officer.
      c. Death records for these types of categories will be reviewed by the DPSCS chief medical officer/designee within 30 days of the final DPSCS nursing rating and documented on Agency approved forms.
   2. The DPSCS administrative death review shall occur at DPSCS headquarters by the CQI nursing staff. The purpose of the review is to identify clinical administrative, personnel, or environmental factors, if any, which may have contributed to the death. Additionally, the review will include the assignment of a severity code to the individual inmate's case and to review CAPs/make recommendation etc. At any time in the review process, the DPSCS Chief Medical officer may be alerted to the need to expedite a departmental review by the DPSCS nurse reviewer. That *expedited* review will take place within 5 working days and documented on the same form.
   3. The departmental death review shall follow the administrative review for pretrial inmate deaths within 30 days of the final nursing review
   4. Severity Codes will be assigned as follows:
      a. 0= care appropriate, no evidence of process issues contributing to sub-standard care

b. 1= Process and documentation gaps found (vital signs inconsistently done, laboratory studies were missed; progress notes were not located in the medical record etc.)
c. 2= System process breakdowns found that contributed to care issues (medications not received consistently, chronic care appointments not scheduled, specialty care appointments were missed, complaints not addressed despite sick call slips, not scheduled for follow up etc.
d. 3= System process breakdowns found that contributed to preventable adverse patient outcomes (care management not consistent with clinical pathways, failure to follow protocols, discontinuity of care)
e. 4= Non-adherence to systemic clinical pathways of disease management processes which were directly connected to the patients' health care need (Did not receive vital medications, did not address or document gross abnormalities in patient's condition, special health care needs were not managed effectively, and significant delays in care resulted in bad outcomes including death. Unethical behavior is reportable to the Board of Quality Assurance.

F. The following procedures shall govern the management of the deceased inmate's medical record:
1. The original medical record shall not be removed from the medical record department of the institution where the death occurred unless otherwise authorized by the DPSCS chief medical officer/designee. The original medical record shall be sent to the DPSCS chief medical officer/designee at the Office of Programs and Services: Clinical Services within five (5) working days.
2. The original medical record shall be made available within the medical records department to the DPSCS Internal Investigative Unit, (IIU), regional medical director, ACOM, other duty authorized investigative agencies, and the medical examiner upon written request to the medical records' department with a copy to the DPSCS chief medical officer's office.

3. During non-business hours, agency representatives reviewing a deceased inmate's medical record shall:
    a. Review the file in the medical record department; and
    b. Sign the medical record log on the log-in/log-out form
4. One copy of the pertinent sections of the medical records shall be made available to the following for death review purposes:
    a. The ACOM within twenty-four hours following the death. The entire record may be copied and provided within forty eight (48) hours as requested
    b. The DPSCS Internal Investigative Unit. Upon request within the next business day; the medical records department may provide a copy of the entire medical record.
    c. The contractor medical/mental health designee; within twenty-four (24) hours, the entire record within forty-eight (48) hours
    d. Additional copies of the medical record shall be made available if determined necessary by the DPSCS medical director/designee
5. The record should be sealed and the original, complete medical record shall be temporarily transferred to the custody of DPSCS by the regional RHIT to the unit's medical director/designee within five (5) working days unless otherwise requested for an expedited review. All death records shall be forwarded to case management for placement in the deceased inmate's base file within thirty (30) days.

G. No one shall release information concerning deceased inmates to anyone other than DPSCS personnel without a written request to the lead medical records manager of the facility.

III. References:

A. ACA Standards 3-4375
B. NCCHC Standards P-A-10
C. DPSCSD 130-100, Section 160-Do Not Resuscitate Policy
D. DCD 140-156 Compassionate Notification for Injury, Illness or Death
E. DCD 270-1; DPDS 270-3
F. Death Reporting Form
G. Morbidity and Mortality Conference Death
H. Medical Record Sign-Out/Sign-In Log

IV. Rescission: DCD 130-100 Section 166 dated November 4, 1997
DCD 130-100 Section 114 dated September 11, 1992
130-100-114 all issuances and versions

V. Date Issued: July 15, 2007
VI. Reviewed: September 2009
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