DPSCS Death Reporting Form

Last Name: _____ First Name: _____ CL/SID#: _____ Date of Admission: _____

Date of Birth: _____ Gender: _____ Sex: _____ Age: _____ Weight: _____ Eye Color: _____

Date of Death: _____ Time of Death: _____ Facility Name: _____ Region: _____

Race:

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black or African American, not of Hispanic origin
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White, Not Hispanic origin
- ☐ Other_____

Death Location:

- ☐ In general housing in the facility or on prison grounds
- ☐ In segregation unit
- ☐ In special medical unit/infirmary within the facility
- ☐ In a common area within the facility
- ☐ In a temporary holding area/lockup
- ☐ While in transit
- ☐ Non-departmental medical facility
- ☐ Elsewhere – specify: _____
- ☐ Other_____

■ What type of cell was the individual housed in at the time of death? ☐ Double cell ☐ Single cell ☐ Dorm

- ○ If housed in a double cell, were two individuals assigned to the cell? ☐ Yes ☐ No
- ○ If not housed in a double-cell, why?_____

Was an autopsy performed?: ☐ Yes ☐ No If No, is an autopsy planned?: ☐ Yes ☐ No

Manner of death:

- ☐ Illness/Natural
- ☐ Suicide
- ☐ Homicide committed by other incarcerated individual(s)
- ☐ Other Homicide – Describe: _____
- ☐ Accidental injury to self – Describe:_____
- ☐ Accidental injury by other – Describe: _____
- ☐ Other Causes – Specify: _____
- ☐ Unknown_____

Was the cause of death a result of a pre-existing medical condition or did the incarcerated individual develop the condition after admission?

- ☐ Pre-existing medical condition prior to admission
- ☐ Not applicable – cause: homicide, suicide, accidental, or undetermined
- ☐ Developed medical condition after admission
  - ○ Chronic ○ Acute Flare ○ Subacute
  - ○ Acute ○ Peracute

Goal of care or treatment: ○ Management and symptom control ○ Curative or full resolution ○ Comfort care ○ N/A

Answer the following questions based for the time period of *date of admission* to *date of death*.

Had the incarcerated individual been receiving treatment for the medical condition after admission to your facility?	☐ Yes	☐ No	☐ Unknown	☐ N/A
Was the individual evaluated by a physician/medical staff?	☐ Yes	☐ No	☐ N/A	
Did the incarcerated individual have any diagnostic tests (X-Rays, MRI, blood test)?	☐ Yes	☐ No	☐ N/A	
Did the incarcerated individual receive medications?	☐ Yes	☐ No	☐ N/A	
Did the incarcerated individual receive treatment/care other than medications?	☐ Yes	☐ No	☐ N/A	
Did the incarcerated individual have surgery?	☐ Yes	☐ No	☐ N/A	
Was the individual confined in a special medical unit?	☐ Yes	☐ No	☐ N/A	