

## Instructions -DPSCS EMR – Final Executive Report

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### 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.

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### **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.