

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
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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
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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.

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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.

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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.