OREGON DEPARTMENT OF CORRECTIONS
Operations Division
Health Services Section Policy and Procedure #P-A-10

SUBJECT: PROCEDURE IN THE EVENT OF AN INMATE DEATH

POLICY: In the event of an inmate death, either within or outside the facility but within Oregon Department of Corrections custody, the medical examiner will be notified and a post mortem examination requested. A mortality review will be conducted by the Medical Director or designee.

REFERENCE: NCCHC Standard P-A-10
OAR 291-27-005
Health Services P&P #P-A-04, Administrative Meetings & Reports
Health Services P&P #P-A-06, Continuous Quality Improvement Program
ODOC Rule 291-027, Death (Inmate)

PROCEDURE:

A. Upon notification of an inmate death inside the institution, the Officer in Charge (OIC) is responsible for notifying the Officer of the Day (OD) and the Oregon State Police. The OD is then responsible for notifying the Superintendent and the next of kin.

B. The OIC is to assign security staff to remain with the body. All deaths inside the institution are considered homicides until the State Police rule differently.

C. Upon notification of an inmate death outside the institution, the escort officer will notify the OIC who will then notify the OD, Health Services and the State Police, if appropriate.

D. Upon notification of an inmate death occurring either within or outside the institution, the Health Service Manager or Charge Nurse will notify the county medical examiner and request a post-mortem examination if the State Police have not already done so. If the medical examiner declines to do the examination, the Health Service Manager will make a second request. This request(s) is to be documented on the Unusual Incident Report and in the health care record.

E. The charge nurse will notify the Health Services Manager or designee and the Chief Medical Officer.

F. At an appropriate hour of the day and at the earliest opportunity, the Health Service Manager will notify the Health Services Medical Director to initiate the death review process. See Attachment 1, Work Sheet – Inmate Death Review.

G. The OD, when cleared by the State Police, will notify the funeral home to pick up the body.

H. At the time of an inmate death, a copy of the inmate's health care record will be made and provided as requested to the State Police, medical examiner or any other party properly authorized to investigate the death. The record or a copy will be sent to the Medical Director. (If a patient has overflow records, only the most recent set of records need to be copied.)

I. Health Services staff are responsible for appropriate documentation in the health care record and completing any memorandums requested by Health Services and/or security supervisors.

J. The Health Services Manager will provide a chart summary. See Attachment 3, Death Report. QA/CQI, medical peer review, unusual incident evaluation or evaluation of emergency response will be done if indicated and a copy sent to Health Services Central Administration as requested.

K. If the death is a suicide, the Health Services Assistant Administrator for Correctional Treatment Services or designee will be asked to review the mental health aspects of the case for the purpose of a mortality peer review within 30 days of the death.

L. The Chief Medical Officer will conduct a mortality review, using the Mortality Case Review (Attachment 2), to include a determination of whether there were any opportunities to improve the level of care. The review will also examine the events immediately surrounding the death and determine if appropriate intervention occurred. The results of this review are to be submitted in writing to the Medical Director within 30 days of the death or no later than 10 days after the end of the reporting quarter.

M. The Medical Director will review the Health Service Manager's report and the Chief Medical Officer's report and compare it to other inmate deaths to determine if it is part of an emerging pattern.

N. The Health Services Manager or designee shall indicate the number of inmate deaths that occur each month on the monthly statistical report.

O. A report will be prepared for the Medical Director of all deaths occurring each quarter. This summary will include the age of the inmate at the time of death, the cause of death and the disposition of the remains. This report will be submitted to the Director who in turn will submit the report to the Speaker of the House of Representatives and the President of the Senate.

P. Refer to P&P #P-A-06, Continuous Quality Improvement Program for details pertaining to annual review requirements.

Effective Date: _____
Revision date: February 2007
Supersedes P&P dated: January 2006

ATTACHMENT 1
P&P P-A-10

Work Sheet - Inmate Death Review

_____ Notification of HS Medical Director, including whether death was unexpected or expected, and a one to ten line summary of cause.

_____ Chart copy to Chief Medical Officer, and prepared for State Police and Medical Examiner if requested.

The following need to be sent to Health Services Medical Director within 30 days.

_____ Chart copy

_____ HSM chart summary with QA/CQI comments on separate page.

_____ HSM evaluation of Emergency Response (if indicated)

_____ Chief Medical Officer review of death.

_____ Autopsy report

The Medical Director will ensure the completion of:

_____ Mental Health review in cases of suicide.

_____ Outside consult reviews as indicated.

_____ Medical Director compilation of cases to review for emerging patterns.

Institution_____

Name:_____

SID #:_____

DOB:_____

Mortality Case Review
(To the Medical Director for Supervisory and Peer Review purposes)

Inmate Name _____ Date of Death _____ Age _____

Death Occurred:

Within ODOC _____

_____ Infirmary
_____ Population
_____ Special Housing
_____ Work place
_____ Other (specify)

Outside ODOC _____

_____ Hospital
_____ Within 24 hours
_____ After 24 hours
_____ In Transit
_____ Other (specify)

History/past medical history/recent history/pertinent physical findings/medications at time of death/procedures/surgeries/consultations/diagnosis before death.

Events leading to the Terminal Event:

Diagnosis as established at the time of this review:

Category of Death:

_____ Natural
_____ Chronic Illness, normal progression
_____ Acute Illness, less than 24 hours ill
_____ Suicide, without recent warning signs
_____ Other (specify)

_____ Accidental
_____ Chronic Illness, acute exacerbation
_____ Acute Illness, more than 24 hours ill
_____ Suicide, with recent warning signs

Reviewer's opinion of Community Standards Rating:
(1 to 5 scale, with one = excellent, 2 = exceeded, 3 = met, 4 = may not meet, 5 = not met)

PRODROME PERIOD

_____ Diagnosis timely
_____ Diagnosis accurate
_____ Treatment timely
_____ Treatment appropriate
_____ Preventive measures taken
_____ Staff response appropriate
_____ Level of housing/care appropriate

TERMINAL EVENT PERIOD

_____ Diagnosis timely
_____ Diagnosis accurate
_____ Treatment timely
_____ Treatment appropriate
_____ Preventive measures taken
_____ Staff response appropriate
_____ Level of housing/care appropriate

Conclusions - Narrative:

Reviewer's Recommendations:

Reviewer's Signature _____ Date _____

EXAMPLE

DATE: January 8, 2003

TO: Steve Shelton, Medical Director
Health Services Section

FROM: H. Villanueva, Health Services Manager
Two Rivers Correctional Institution

RE: Quarterly Death Report – Oct. '02 through Dec. '02

Two Rivers Correctional Institution had one death to report this quarter:

Name and Institution Number: John E. Doe #1234567

Sex: Male

Race: Caucasian

Date of Birth: 12-18-57 according to the DOC 400. He, however, claimed he was actually born in 1957.

Date of Death: December 4, 2002

Time of Death: 9:13 p.m.

Location of Death: EOCI's Infirmary

Brief Summary of Incarceration:

John Doe was received by the Oregon Correctional Intake Center on Nov. 13, 1997 from Deschutes County as a parole violator. He was serving time for Child Sex and Promoting Prostitution. He spent time at the Oregon State Penitentiary and the Oregon State Correctional Institution before being transferred to Two Rivers Correctional Institution in March of 2002.

Mr. Doe was diagnosed with the following: (1) Insulin Dependent Diabetes Mellitus, (2) Diabetic Neuropathy, (3) Right Chronic Otitis Media with Perforation of the Right Tympanic Membrane, (4) Peri-Rectal Abcess, (5) Dysthymia, (6) Post Traumatic Stress Disease, and (7) End Stage Renal Failure. He started receiving dialysis treatments in March of 1999 through QualiCenter in Salem and continued these until his transfer to TRCI when his dialysis treatments were continued via NaphCare. He was extremely non-compliant with his treatment and had been for years and years. He frequently refused insulin, dialysis, medication, and laboratory studies.

Circumstance of Death:

Mr. Doe's general state of health was of concern for the last several years of his life and this was due to not only the disease processes that he suffered but also because of his non-compliance to treatment which only compounded the disease process. There was a considerable amount of time invested by health care staff, including nurses, practitioners and mental health providers, discussing with him the risks he was taking due to his non-compliance

and that his non-compliance would eventually end his life sooner than would normally be expected.

Mr. Doe began having seizures on Dec. 1st at approximately 5:00 p.m. He was sent to Good Shepherd Medical Center, via ambulance. He was stabilized there and then transferred to Kadlec Medical Center in Richland, Washington. While at Kadlec, he refused all treatment and all tests including an MRI of the brain. He was subsequently released and sent back to TRCI on Dec. 2nd.

On Dec. 3rd, several of us met with Mr. Doe to discuss his non-compliance to treatment. In attendance were B. Whelan - Nurse Manager, Dr. G. Lytle – staff Physician, N. Sundell – Physician Asst., M. Gutierrez – CTS, and L. Schwarz – Chaplain. It was explained to Doe that he had put us in a difficult position as we were unable to provide health care that we could not monitor due to his non-compliance. He was told that he needed to decide to accept all the health care offered to him, or, none of it as we were unable to provide care that could not be monitored due to his non-compliance. He understood this and said he didn't want to die. He was advised that if he didn't want to die than he needed to cooperate with us. Later that day, he was scheduled to receive his evening insulin and he refused, indicating, once again, that he was going to continue to be non-compliant with treatment.

Mr. Doe began having seizures on Dec. 4th at approximately 4:00 a.m. The decision was made to transfer him to the infirmary at Eastern Oregon Correctional Institution for terminal care. He was transferred, via ambulance, and arrived there that afternoon. He was unresponsive and continued to have intermittent seizures. His seizure activity was treated with Valium as a comfort measure and Mr. Doe expired at 9:13 p.m.

Cause of Death:

End stage renal failure. The Medical Examiner, Dr. J. Diehl, was asked on two separate occasions to perform a post mortem examination and Dr. Diehl did not feel it was indicated.

Disposition of Remains:

Mr. Doe's body was picked up by Burn's Mortuary. The body was cremated and claimed by Doe's son, Jesse D. Doe.

cc: file