

Idaho Department of Correction 	Standard Operating Procedure Operations Division Operational Services	Control Number: 401.06.03.011	Version: 2.4	Page Number: 1 of 7
		Title: Death: Procedure in the Event of an Offender's		Adopted: 11-12-1998 Reviewed: 6-11-2012 Next Review: 6-11-2014

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Open to the general public: Yes No

If no, is there a redacted version available: Yes No

BOARD OF CORRECTION IDAPA RULE NUMBER 401

[Medical Care](#)

POLICY CONTROL NUMBER 401

[Clinical Services and Treatment](#)

DEFINITIONS

[Standardized Terms and Definitions List](#)

Clinical Mortality Review: An assessment of (a) the clinical care provided; (b) the circumstances leading up to death; and (c) any areas of offender healthcare, policies, or procedures that can be improved.

Contract Medical Provider: A private company or other entity that is under contract with the Idaho Department of Correction (IDOC) to provide comprehensive medical, dental, and/or mental health services to the IDOC's incarcerated offender population.

Facility Health Authority: The contract medical provider employee who is primarily responsible for overseeing the delivery of medical services in an Idaho Department of Correction (IDOC) facility.

Facility Medical Director: The highest ranking physician in an Idaho Department of Correction (IDOC) facility.

Health Authority: The Idaho Department of Correction (IDOC) employee who is primarily responsible for overseeing or managing the IDOC's medical services. (The health authority is commonly referred to as the health services director.)

PURPOSE

The purpose of this standard operating procedure (SOP) is to establish procedures that must be followed as a result of an offender's death, to include but not limited to, clinical mortality reviews, psychological reconstructions, and postmortem examinations.

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SCOPE

This SOP applies to all Idaho Department of Correction (IDOC) healthcare services staff, offenders, contract medical providers, and subcontractors.

RESPONSIBILITY

Health Authority

The health authority is responsible for:

- Monitoring and overseeing all aspects of healthcare services, and
- The implementation and continued practice of the provisions provided in this SOP.

When healthcare services are privatized, the health authority will also be responsible for:

- Reviewing and approving (prior to implementation) all applicable contract medical provider policy, procedure, and forms; and
- Monitoring the contract medical provider's performance, to include but not limited to reviewing processes, procedures, forms, and protocols employed by the contract medical provider to ensure compliance with all healthcare-related requirements provided in respective contractual agreements, this SOP, and in *National Commission on Correctional Healthcare (NCCHC) standard P-A-10, Procedure in the Event of an Inmate Death*. (See [section 5](#) of this SOP.)

Contract Medical Provider

When healthcare services are privatized, the contract medical provider is responsible for:

- Implementing and practicing all provisions of this SOP, unless specifically exempted by written contractual agreements;
- Ensuring that all aspects of this SOP **and** *NCCHC standard P-A-10* are addressed by applicable contract medical provider policy and procedure;
- Ensuring that procedures are in place to immediately notify the health authority of an offender's death and provide pertinent information regarding the conditions and events related to the offender's death;
- Ensuring facility health authorities utilize all applicable contract medical provider policy, procedure, forms, and educational information to fulfill all healthcare-related requirements provided in this SOP, *NCCHC standard P-A-10*, **or** as indicated in their respective contractual agreement(s); and
- Ensuring all applicable contract medical provider policy, procedure, and forms are submitted to the health authority for review and approval prior to implementation.

Note: Nothing in this SOP shall be construed to relieve the contract medical provider(s) of any obligation and/or responsibility stipulated in respective contractual agreements.

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Facility Medical Director

The facility medical director **and** facility health authority (or designees) will be jointly responsible for convening a clinical mortality review within 30 days of the offender's death, and preparing a narrative for the contract medical provider's Clinical Mortality Review Report.

Facility Health Authority

The facility health authority will be responsible for:

- Ensuring the presence of an adequate number of appropriately trained staff and materials are available to meet the requirements of this SOP;
- Establishing and monitoring applicable contract medical provider policy and procedure to ensure that all elements of this SOP **and** *NCCHC standard P-A-10* are accomplished as required;
- Ensuring that within 24 hours of the offender's death, written notification is provided to the health authority;

In addition, the facility health authority **and** facility medical director (or designees) will be jointly responsible for convening a clinical mortality review within 30 days of the offender's death, and preparing a narrative for the contract medical provider's Clinical Mortality Review Report.

Facility Head

The facility head will be responsible for following SOP [312.02.01.001](#), *Death of an Offender*.

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GENERAL REQUIREMENTS

1. Notification Requirements

When an offender who is under the jurisdiction of the IDOC dies in a non-IDOC facility or IDOC facility, healthcare services staff shall notify the following personnel, **in the order provided**:

- Shift commander (shall notify the facility head)
- Health authority (or designee), and
- Director of the Education, Treatment, and Reentry Bureau (or designee).

Note: Whenever there is a death to an offender, steps must be taken to ensure the death is reported in accordance with SOP [105.02.01.001](#), *General Reporting and Investigation of Major Incidents*.

Note: As applicable to healthcare services staff **and** facility administrative staff, SOP [312.02.01.001](#), *Death of an Offender*, or SOP [401.06.03.010](#), *Next of Kin: Emergency Notification*, should also be referred to.

Note: If the offender is a foreign national, the facility head will be required to contact the nearest consulate representing the offender's country of origin. (See SOP [312.02.01.001](#), *Death of an Offender*.)

When an Offender who is Housed in an IDOC Facility Dies

Within 24 hours of the offender's death, the facility health authority (or designee) shall provide written notification to the health authority (or designee) that includes, but is not limited to, the following:

- The offender's name and IDOC number;
- The date, time, and location of the offender's death;
- The cause of death (if known); and
- All known medical diagnoses.

When an Offender who is Housed in a Non-IDOC Facility Dies

Contact the health authority (or designee), who will begin the notification process described above. The health authority shall ensure that all notifications (verbal and written), postmortem examinations, clinical mortality reviews, and psychological reconstructions are requested or conducted as described in this SOP.

2. Healthcare Record Handling

Within two (2) hours of an offender's death, healthcare services staff shall place the offender's complete healthcare record in a bag (orange in color), envelope, or box.

Note: The complete healthcare record shall include any of the following as applicable: the current file, all extended files, infirmary or long-term care (LTC) files, and all loose filings.

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Note: The healthcare record shall not include any other documentation (written notifications, postmortem examination, clinical mortality review report, memoranda, and information reports) described in this SOP.

Healthcare services staff shall ensure that the bag, envelope, or box is locked and/or sealed (as applicable) and delivered to the shift commander. The shift commander, in consultation with the health authority (or designee), shall make arrangements to transfer the bag, envelope, or box to the Medical Unit (located at Central Office). The transfer of the healthcare record shall be in accordance with the special conditions identified in SOP [120.03.05.002](#), *Central and Medical Files: Control, Maintenance, and Disposition of* (see the applicable appendix).

3. Postmortem Examination Requirements

The facility health authority (or designee) shall (a) request that the coroner perform a postmortem examination, and (b) provide documentation of the request to the health authority.

Upon receipt of the written postmortem examination, the facility health authority shall provide a copy to the health authority (or designee).

When the Coroner Declines to Conduct a Postmortem Examination

If the coroner declines to perform a postmortem examination, the facility health authority shall write a statement regarding that fact, attach it to the request, and submit both to the health authority.

4. Suicides

If the cause of death is suicide, the IDOC's chief psychologist (or designee) will schedule and perform a psychological reconstruction, to include all elements required by policy [315](#), *Suicide Risk Management*, and directive [315.02.01.001](#), *Suicide Risk Management and Intervention Program*.

5. Clinical Mortality Review Report Requirements

Within 30 days of the offender's death, the facility health authority and facility medical director (or designees), shall jointly conduct a clinical mortality review, and submit a written report to the health authority. Both individuals shall ensure that the report is complete and accurate (based on the information available to them before the report is completed), and contains the following:

- The offender's name and IDOC number;
- The offender's age;
- The date, time, and location of the offender's death;
- Past medical history, recent medical history, pertinent physical findings, and medications prescribed at the time of death;
- Procedures, surgeries, consultations, and clinical diagnoses prior to death;
- Events leading to the terminal event;

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- Diagnosis as established at the time of the clinical mortality review;
- The primary cause of death, to include one of the following:
 - ◆ Natural;
 - ◆ Normal progression of a chronic illness;
 - ◆ Acute exacerbation of a chronic illness;
 - ◆ Acute illness—onset less than 24 hours prior to death;
 - ◆ Acute illness—onset more than 24 hours prior to death;
 - ◆ Suicide;
 - ◆ Accidental; or
 - ◆ Other.
- For the period prior to the terminal event—the timeliness and appropriateness of diagnoses, treatments, preventive measures taken, and staff responses;
- For the period of the terminal event—the timeliness and appropriateness of diagnoses, treatments, preventive measures taken, and staff responses;
- The reviewer's opinion of whether the level of housing and available healthcare was appropriate; and
- A narrative—prepared and signed by the facility medical director and other participants in the clinical mortality review process, to include conclusions, findings, and the reviewer's recommendations for improvement.

Review of the Report

The health authority (or designee) shall review the completed and signed Clinical Mortality Review Report (and other relevant documentation) to determine whether the death may be part of an emerging pattern or indicative of opportunities for improvement in the overall healthcare delivery system.

Pertinent Information Received after Report Completed

In the event pertinent information (e.g., the completed postmortem examination report, memoranda, information reports) is received after completion of the Clinical Mortality Review Report, the facility health authority (or designee) shall update the report, append the new information, and resubmit to the health authority in as timely of a manner as possible.

6. Compliance

Compliance with this SOP and all related IDOC-approved protocols will be monitored by the health authority (or designee) by using various sources to include: this SOP, clinical practice guidelines, routine reports, program reviews, and record reviews.

The health authority (or designee) must conduct two (2) audits per year, per facility (or more frequently as desired based on prior audit results). The audits must consist of monitoring applicable contract medical provider, IDOC policy and procedures, applicable NCCHC standards, and the review of all deaths that occurred over a 12-month period.

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REFERENCES

Directive [315.02.01.001](#), *Suicide Risk Management and Intervention Program*

National Commission on Correctional Health Care (NCCHC), *Standards for Health Services in Prisons*, Standard P-A-10, Procedure in the Event of an Inmate Death

Policy [315](#), *Suicide Risk Management*

Standard Operating Procedure [105.02.01.001](#), *General Reporting and Investigation of Major Incidents*

Standard Operating Procedure [312.02.01.001](#), *Death of an Offender*

Standard Operating Procedure [401.06.03.010](#), *Next of Kin: Emergency Notification*

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