

COMMONWEALTH OF MASSACHUSETTS DEPARTMENT OF CORRECTION
HEALTH SERVICES DIVISION
103 DOC 622
DEATH PROCEDURES

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| MASSACHUSETTS DEPARTMENT OF CORRECTION | DIVISION: HEALTH SERVICES |
| TITLE: DEATH PROCEDURES | NUMBER: 103 DOC 622 |

PURPOSE: To establish Department of Correction ("Department") guidelines in the event of the death of an inmate or in the event of the death of an employee while performing his/her duty.

REFERENCES: M.G.L. c. 40, §36A; M.G.L. c. 124, § 1 (c), (q); M.G.L. c. 127, § 117; M.G.L. c. 38 §§ 3, 5 and 6; NCCHC 2008 Standards for Health Services in Prisons, ACA Standards for Adult Correctional Institutions 4th Edition.

APPLICABILITY: Staff **PUBLIC ACCESS:** Yes

LOCATION: Department's Central Policy File
Each Institution's Policy File
Health Services Division's Policy File

RESPONSIBLE STAFF FOR IMPLEMENTATION AND MONITORING OF POLICY:

- Deputy Commissioner for Classification, Programs and Reentry
- Assistant Deputy Commissioner of Clinical Services
- Superintendent

EFFECTIVE DATE: 10/11/2014

CANCELLATION: 103 DOC 622 cancels all previous Department policies, statements, bulletins, directives, orders, notices, rules and regulations regarding planning that are inconsistent with this policy.

SEVERABILITY CLAUSE: If any part of 103 DOC 622 is for any reason held to be in excess of the authority of the Commissioner, such decision will not affect any other part of this policy.

622.01 Definitions

Assistant Deputy Commissioner, Clinical Services - The executive staff person who reports to the Deputy Commissioner of the Classification, Programs and Reentry Division. The duties of the Assistant Deputy Commissioner, Clinical Services, include, but are not limited to, the management of the Health Services Division and the oversight of the Department's health services contracts.

Assistant Deputy Commissioner, Northern Sector - The senior level manager who reports to the Deputy Commissioner, Prison Division and is responsible for ensuring policy compliance and standardization of procedures for facilities, in such areas as staff development, labor management, disorder management, and overall operations. The facilities include: Boston Pre-Release Center, MCI-Concord, MCI-Framingham, North Central Correctional Institution, Northeastern Correctional Center, Lemuel Shattuck Hospital Correctional Unit, MCI-Shirley, South Middlesex Correctional Center and Souza Baranowski Correctional Center.

Assistant Deputy Commissioner, Southern Sector - The senior level manager who reports to the Deputy Commissioner, Prison Division and is responsible for ensuring policy compliance and standardization of procedures for facilities, in such areas as staff development, labor management, disorder management, and overall operations. The facilities include: Bay State Correctional Center, Bridgewater State Hospital, Massachusetts Alcohol & Substance Abuse Center, Massachusetts Treatment Center, MCI-Cedar Junction, MCI-Norfolk, MCI-Plymouth, Old Colony Correctional Center and Pondville Correctional Center.

Code 99 - The designated terminology used to report a life threatening medical emergency situation.

Commissioner - The Chief Executive Officer of the Department of Correction.

Criminal Offender Record Information ("CORI") - Records and data in any communicable form compiled by a criminal justice agency that concern an identifiable individual and relate to the nature or disposition of a criminal charge, an arrest, a pre-trial proceeding, other judicial proceedings, sentencing, incarceration, rehabilitation, or release.

Deputy Commissioner, Classification, Programs and Reentry Division - The executive staff person who reports to the Commissioner, and whose duties include, but are not limited to the management of the Classification Division, Female Offender Services, Inmate Education and Training Division, Reentry and Program Services Division and the Health Services Division.

Deputy Commissioner of the Prison Division - The Executive Staff person who reports to the Commissioner, whose duties include but are not limited to the management of: Assistant Deputy Commissioners of the Northern and Southern Sectors, the Community Work Crew Central Division, Office of Investigative Services, the Central Inmate Disciplinary Unit, the Central Transportation Unit, and the Special Operations Unit

Duty Officer - The individuals designated as Duty Officer shall ordinarily be responsible to work approximately fourteen (14) calendar days or two tours of duty per year in this capacity, as designated by the Deputy Commissioner of the Prison Division. These individuals during their tour of duty evaluate information provided by an institution to the Department duty station of an incident that occurred during non-business hours. The Duty Officer coordinates and ensures appropriate action has been taken and directs any follow-up that may be needed.

Duty Station - The station within the Department through which all significant occurrences as defined by 103 DOC 105.00, Officer of the Day and Department

Duty Station, shall be reported twenty four (24) hours per day, seven (7) days per week.

General Counsel - The executive staff person who reports to the Commissioner, and is the chief legal counsel for the agency, overseeing the attorneys in the Department's Legal Division.

Inmate Management System ("IMS") - The Department's electronic information system that provides processing, storage and retrieval of inmate-related information needed by Department personnel and other authorized users within the criminal justice system.

Medical Investigation Response Team(MIRT) - A specially trained team activated to investigate a death of an inmate that is comprised of at least one individual from the Office of Investigative Services and at least one Health Services Regional Administrator.

Office of Investigative Services: The office that is comprised of the following units: Central Intelligence Unit ("CIU"), Fugitive Apprehension Unit ("FAU") and the Criminal Prosecution Unit ("CPU").

Open Mental Health Case - An inmate who is diagnosed with a mental illness or determined to be in need of mental health intervention on an ongoing basis. At any time during his/her incarceration, an inmate may become an open mental health case ("OMH") based on a mental health crisis, including suicidal threats or self-injurious behavior and/or the display of signs and/or symptoms of mental illness or emotional distress. Based upon clinical indications and within the discretion of the Primary Care Clinician ("PCC"), in consultation with the site Psychiatrist, if on medication, and/or Site Mental Health Director, an inmate may also be removed from the active mental health caseload. However, any inmates carrying the Gender Identity Disorder ("GID") diagnosis will remain an open mental health case. In the case that an inmate is suspected to no longer meet the clinical criteria for a GID diagnosis, approval to change the

diagnosis must be granted by the GID Treatment Committee, with consultation from the contractual GID consultant, as deemed necessary.

Serious Mental Illness ("SMI") - For purposes of assessing whether segregation may be clinically contraindicated, or whether an inmate in segregation should be placed in a specialized treatment unit, the term "Serious Mental Illness" shall be defined as the following:

1. An inmate determined by the Department's mental health vendor to have a current diagnosis or a recent significant history of any of the following types of DSM-V diagnoses:
 - a. Schizophrenia
 - b. Delusional Disorder
 - c. Schizophreniform Disorder
 - d. Schizoaffective Disorder
 - e. Brief Psychotic Disorder
 - f. Substance-Induced Psychotic Disorder (excluding intoxication and withdrawal)
 - g. Psychotic Disorder Not Otherwise Specified
 - h. Major Depressive Disorder
 - i. Bipolar Disorder I and II

For purposes of this definition, "recent significant history" shall be defined as a diagnosis specified above in section (1)(a)-(i) upon discharge within the past year from an inpatient psychiatric hospital.

2. An inmate diagnosed with disorders that are commonly characterized by the mental health vendor with other DSM-V breaks with reality, or perceptions of reality, that lead the individual to experience significant functional impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or physical health.
3. An inmate diagnosed by the Department's medical or mental health vendor with a developmental disability, dementia or other cognitive disorders that result in a significant functional impairment involving acts of self-harm or other

behaviors that have a seriously adverse effect on life or on mental or physical health.

4. An inmate diagnosed by the Department's mental health vendor with a severe personality disorder that is manifested by episodes of psychosis or depression, and results in significant functional impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or physical health.

Significant Functional Impairment - Factors for consideration when assessing significant functional impairment shall include the following:

- a. The inmate has engaged in self harm which shall be defined as a deliberate act by the inmate that inflicts damage to, or threatens the integrity of, one's own body. Such acts include but are not limited to the following behaviors: hanging, self-strangulation, asphyxiation, cutting, self-mutilation, ingestion of a foreign body, insertion of a foreign body, head banging, drug overdose, jumping and biting.
- b. The inmate has demonstrated difficulty in his or her ability to engage in activities of daily living, including eating, grooming and personal hygiene, maintenance of housing area, participation in recreation, and ambulation, as a consequence of any DSM V disorder.
- c. The inmate has demonstrated a pervasive pattern of dysfunctional or disruptive social interactions including withdrawal, bizarre or disruptive behavior, etc. as a consequence of any DSM V disorder.

Shift Commander - The staff member designated by a superintendent/designee to be responsible for the supervision of all subordinate security staff and the care and custody of all inmates housed within the institution during an assigned shift.

Superintendent - The chief administrative officer of a correctional institution.

622.02 General Policy

Each superintendent shall develop written procedures to be followed in the event of an employee or inmate death. The procedures shall include the following provisions:

1. If a contractual physician is available on-site at the time of the occurrence, he/she shall report to the scene to render medical care and/or pronounce the victim dead.
2. If a contractual physician is not available on-site at the time of the occurrence, the on-call physician shall be paged to the scene to render medical care and/or pronounce the victim dead.
3. If the death occurs at an outside hospital, including the Lemuel Shattuck Hospital, the death procedures of that hospital shall be followed in conjunction with this policy.

622.03 Notification

Upon the death of an inmate or the death of a Department or contractual employee while performing his/her duties, notifications shall be promptly made in accordance with procedures defined in 103 DOC 105, Officer of the Day and Department Duty Station.

1. During business hours, Monday through Friday, 9:00 AM to 5:00 PM, excluding Holidays, the superintendent or designee of the institution where the inmate is housed shall initiate the following notifications:

- a. The appropriate Assistant Deputy Commissioner of the Northern or Southern Sector, the Assistant Deputy Commissioner of Clinical Services and the Office of Investigative Services.
 - b. The appropriate Assistant Deputy Commissioner shall notify the Deputy Commissioner of the Prison Division and Deputy Commissioner for Classification, Programs and Reentry Division.
 - c. The Deputy Commissioner of the Prison Division shall notify the Commissioner.
 - d. The Commissioner or designee, shall then notify the Secretary of the Executive Office of Public Safety and Security and follow up with a memorandum describing the circumstances.
 - e. The Assistant Deputy Commissioner of Clinical Services shall notify the Executive Program Director of the contractual health care provider or designee.
 - f. The superintendent shall immediately notify the chief medical examiner or the medical examiner designated to the location where the death occurred of the known facts concerning the time, place, manner, circumstances and cause of death. The superintendent or designee may request that the Medical Examiner view the body.
2. During non-business hours, the shift commander of the institution where the inmate is housed shall initiate the following notifications:
 - a. The institution Duty Officer;
 - b. The Department Duty Station. The Department Duty Station shall ensure that all notifications shall be made as defined in

103 DOC 105, Officer of the Day and Department Duty Station.

- c. The Assistant Deputy Commissioner of Clinical Services shall notify the Executive Program Directors of the contractual health care provider;
 - d. The superintendent or designee of the institution shall immediately notify the Medical Examiner and District Attorney and/or State Police CPAC Unit of the district wherein the inmate body lies. Notification shall include the time, place, manner, circumstances and cause of death, if known. The superintendent or designee may request that the Medical Examiner view the body.
3. The superintendent or designee at the Bridgewater State Hospital shall report any death to the Board of Registration in Medicine that meets the criteria of the Qualified Patient Care Assessment Plan found in 243 CMR 3.00.
 4. The superintendent or designee of the institution having custody of the inmate shall be responsible for notifying the Victim Services Unit and/or the Criminal Offender Record Information ("CORI") Petitioner pursuant to 103 DOC 407, Victim Services Unit.

622.04 Notification of Next of Kin

The superintendent of each institution shall establish written procedures for notifying an inmate or employee's next of kin. The procedure shall include the following provisions:

1. Each inmate shall complete and sign an emergency notification card ("ENC"), upon admission to the institution. The ENC shall include the name, address and phone number of the individual whom the inmate designates as his/her next of kin, along with a space for the inmate's signature.

In the event that the inmate desires no such notification, the word "none" shall be entered into the space for next of kin. Whenever possible, permission for notifications shall be obtained from the inmate prior to need, e.g., major surgery, terminal illness.

This information shall be documented on the Inmate Management System ("IMS") Inmate's Family Information Screen.

2. The superintendent or designee shall ensure that employee emergency notification data is up-to-date.
3. Each institution shall maintain up-to-date records of the next of kin for each Department employee. These records are to be immediately available in the institution's files.
4. The Executive Program Director of the contractual health care provider shall maintain up-to-date records of the next of kin for each contractual employee. These records shall be kept on file at the main office of the contractual health care provider and the information shall be made available to the superintendent or designee in the event of an emergency.
5. Following the death of an inmate or employee, the superintendent or designee shall immediately notify the next of kin, as identified, by telephone. A letter with confirmation shall be sent to the proper address via certified mail. When and by whom the letter was sent shall be documented. In the event that an employee is pronounced dead at an outside hospital emergency room, the next of kin information shall be made available to the emergency room staff. The superintendent or designee shall keep in contact with the family as necessary.
6. The superintendent or designee of the Lemuel Shattuck Hospital Correctional Unit shall notify

the sending institution's superintendent or designee upon the occurrence of a death of an inmate at the Lemuel Shattuck Hospital. The superintendent of the Lemuel Shattuck Hospital Correctional Unit or designee shall make all further notifications as required by this section.

7. All inquiries regarding the death of an inmate or employee shall be referred to the superintendent's office.

622.05 Discovery of a Death

1. 103 DOC 562, Code 99 Emergency Response Guidelines, is to be followed in the event that an inmate or staff person experiences a medical emergency. Unless a contractual physician is on the scene and pronounces the victim dead, immediate life saving measures shall be started and continued EVEN IF THE VICTIM APPEARS DEAD, unless one or more of the following is present:
 - a. Obvious mortal wounds, characterized by decapitation or incineration of the body, or several body injuries so extensive such as a crushing injury to the head or chest that cardiopulmonary resuscitation ("CPR")_ cannot be performed effectively;
 - b. When an emergency medical technician ("EMT") Level 2 and/or paramedic assumes control of the emergency response or determines lifesaving measures are no longer needed; or
 - c. Obvious decomposition of the body
2. In the event that an inmate is pronounced dead by the contractual physician, an EMT Level 2 and/or a paramedic, a Department employee shall remain at and preserve the scene of death until such time as the Medical Examiner determines to take jurisdiction in accordance with M.G.L. c. 38, § 4.
3. In the event that the Medical Examiner takes jurisdiction, the body shall not be moved from the

scene until the Medical Examiner or the District Attorney authorizes the removal of the body, in accordance with M.G.L. c. 38, § 4. In the event that the Medical Examiner declines to take jurisdiction, the superintendent or designee shall authorize removal of the body.

4. In the event that the inmate is pronounced dead and the Deputy Commissioner of the Prison Division, following consultation with the Deputy Commissioner of Classification, Programs and Reentry, has determined that a special investigation is needed in accordance with section 622.08 of this policy, the body shall not be disturbed and the scene of death shall not be disturbed until such action is authorized by the superintendent or designee, as well as by the Medical Examiner and the District Attorney, as required above.

622.06 Disposition of the Body

1. As soon as removal of the inmate's body is authorized in accordance with the above procedures, the superintendent or designee, or the Medical Examiner shall make arrangements with the family or a local mortuary to take charge of the body pending further disposition. The names and numbers of at least two funeral homes where agreements have been reached shall be identified in the institution's procedures.
2. The superintendent or designee shall request written documentation by the Health Authority verifying the death of the inmate.
3. Following release of the body by the Medical Examiner, the inmate's body shall be released to the next of kin. If the body is not claimed by the next of kin, the superintendent or designee shall make arrangements for burial or cremation at the Department's expense.

4. In the event of an employee death, the superintendent or designee, shall make arrangements with the family to take charge of the body.

622.07 Reports and Documentation

1. The Assistant Deputy Commissioner of Clinical Services shall provide a copy of the deceased inmate's medical record to the Chief Medical Examiner upon request.
2. The Assistant Deputy Commissioner of Clinical Services, through the Health Services Division ("HSD") shall also request and maintain a copy of the autopsy report from the Chief Medical Examiner in accordance with policies and procedures of the Office of the Chief Medical Examiner and the "Memorandum of Understanding" between the Department and the Chief Medical Examiner. This report shall be used by the Assistant Deputy Commissioner of Clinical Services for performance improvement activities and shall be kept confidential.
3. The Department's HSD shall complete a United States Department of Justice's Death in Custody Report and send it to the appropriate government officials. (See Attachment A.) The Department's HSD shall supplement the Death in Custody Report with the Department of Justice should additional information and/or documentation become available after the initial submission.
4. All observers of the death/emergency and responders shall complete incident reports and submit them to the superintendent's office or designated area before the end of the shift. Reports shall be specific regarding the observer's role, witnesses and other responders, actions taken and timing of events. The superintendent or designee shall submit a critical incident debriefing report to the Commissioner; the appropriate Deputy

Commissioner; the appropriate Assistant Deputy Commissioner; the Assistant Deputy Commissioner of Clinical Services and General Counsel within forty-eight (48) hours of the incident.

4. In the event that life-saving measures were attempted by contractual medical staff, a contractual medical staff member shall be required to document a chronology of the treatment given. All treatment procedures and an objective description of the incident shall be documented appropriately in the inmate's medical record by medical staff before leaving the institution at the end of the shift.
5. The superintendent or designee shall secure the deceased inmate's complete medical and mental health record. The six-part folder; visiting card and any other pertinent documentation shall be confiscated by security staff immediately following the incident. Contractual medical staff shall have access to the medical record only under supervision of Department personnel; however, a final entry of medical and mental health information shall be made in the medical record. The deceased inmate's medication shall be secured and disposed of in accordance with pharmacy procedures, State Office of Pharmacy Services, unless determined by the superintendent or designee that the medications be confiscated for purposes of investigation.
6. The superintendent or designee shall secure the deceased inmate's property and mail it immediately following the incident. The secured property and mail shall be logged and documented.
7. The superintendent or designee shall obtain a security staff roster and a medical staff roster documenting all staff members at the institution at the time of the death.

8. The appropriate Regional Administrator shall prepare a confidential report detailing information on the inmate's death.
9. Copies of records and reports
 - a. The superintendent shall ensure that the original medical record and three copies (four copies in the event of a suicide) are immediately made and forwarded to the Assistant Deputy Commissioner of Clinical Services for all deaths that occur at the institution or within seventy-two (72) hours of the inmate being sent to an outside hospital. (If there are any questions about documentation to be copied from the medical record, the superintendent's office shall contact the HSD's Regional Administrator assigned to the institution.)

The copies forwarded to the Assistant Deputy Commissioner of Clinical Services shall be provided to:

- i. The Chief Medical Examiner upon request;
- ii. The Department's Senior Medical Consultant; and
- iii. The Senior Psychiatric Consultant, in the event of a suicide.

Additionally, the superintendent shall retain two full copies of the medical record; one copy for the purpose of investigation, if warranted; and the other copy of the medical record shall be provided to the on site contractual medical provider.

- b. Copies of all Department incident reports, including confidential incident reports, related to the death are to be made immediately available to the Assistant Deputy Commissioner of Clinical Services or designee.

- c. The superintendent or designee shall complete an urgent matter report following the death in accordance with 103 DOC 105, Officer of the Day and Department Duty Station. The urgent matter report shall be drafted as soon as practical during business hours. During non-business hours, the report shall be drafted the next business day. The urgent matter report shall:
 - i. Be drafted on the database located on the Intranet Urgent Matter Application;
 - ii. Indicate location of the death;
 - iii. Indicate the date of report and the date of the death;
 - iv. Indicate the type of death (i.e. unattended, expected, suspicious, suicide);
 - v. Describe in detail the incident;
 - vi. Include the deceased inmate's information;
 - vii. Document outside assistance;

- d. The superintendent shall forward, upon receipt, a copy of the death certificate to the Assistant Deputy Commissioner of Clinical Services.

- e. The superintendent or designee shall make a report of the death, identifying the deceased and describing the circumstances of the death. One copy of said report, together with copies of any incident reports pertaining thereto, shall be forwarded to the medical examiner's office in the county where

the death occurred within seven (7) days of the death.

- f. A copy of all Department reports shall be forwarded to the respective Assistant Deputy Commissioner of either the Northern or Southern Sector subsequent to every death.

622.08 Investigation

1. Upon notification of an inmate death, the Deputy Commissioner of the Prison Division may activate the Medical Investigation Team, see Attachment B.
2. The Deputy Commissioner of the Prison Division shall notify the appropriate Assistant Deputy Commissioner of the Northern or Southern Sector, the Assistant Deputy Commissioner of Clinical Services and the Chief of the Office of Investigative Services of the decision to activate the Medical Investigation Response Team. The appropriate Assistant Deputy Commissioner of the Northern or Southern Sector shall notify the superintendent of the involved institution.

622.09 Performance Improvement Mortality Review Committee

In the event of a suicide or death occurring within seventy-two (72) hours of being sent to an outside hospital, the Assistant Deputy Commissioner of Clinical Services shall designate a Performance Improvement Mortality Review Committee that shall convene at the institution where the deceased inmate had been assigned at the time of death or prior to death. In certain cases when an inmate has been chronically ill and/or terminally ill and end of life is apparent and imminent, the Deputy Commissioner of Classification, Programs and Reentry may waive the requirement of performing the Performance Improvement Mortality Review. A Request to Waive the Performance

Improvement Mortality Review (Attachment E) will be completed in these cases.

In the event of a suicide or death occurring at the Bridgewater State Hospital, a Root Cause Analysis and a Performance Improvement Mortality Review shall be conducted. If the patient was chronically ill and/or terminally ill and the end of life was apparent and imminent preceding the death, the Deputy Commissioner of Classification, Programs and Reentry shall have the discretion to waive the Performance Improvement Mortality Review requirement.

1. The Director of Clinical Services or Director of Behavioral Health, in the case of a suicide, shall be responsible for coordinating the Performance Improvement Mortality Review Committee meeting. Every effort shall be made to schedule the Performance Improvement Mortality Review within thirty (30) days of the inmate's death. (See Attachment D, Performance Improvement Mortality Review/Psychological Review, for deaths by suicide and Attachment E, Performance Improvement Mortality Review, for all other deaths.) All pertinent documentation related to the case shall be made available for the committee's review.
2. The contractual health care Executive Program Director shall ensure that a review of the death is conducted by the provider's Morbidity-Mortality Review Committee pursuant to a policy statement approved jointly by the Assistant Deputy Commissioner of Clinical Services and the contractual health care provider. The Morbidity-Mortality Review Committee shall conduct a peer review of clinical care provided to the deceased inmate. The contractual health care provider shall within thirty (30) days provide the Assistant Deputy Commissioner of Clinical Services with an executive summary which contains at a minimum, a statement that a

review did occur, the date of the review and the names of the attendees.

3. The membership of the Performance Improvement Mortality Review Committee is described in Attachments D and E. The Director of Clinical Services or Director of Behavioral Health may request that other individuals participate as members of the committee. The committee shall convene at the institution where the inmate was assigned.
4. A written Mortality Review Report shall be signed by the medical or mental health consultant and the Assistant Deputy Commissioner of Clinical Services. The completed report shall be sent to the Deputy Commissioner of Classification, Programs and Reentry for final approval. Copies of the final report will be sent to the Commissioner, the Deputy Commissioner of the Prison Division, the appropriate Assistant Deputy Commissioner of the Northern or Southern Sector, the superintendent and the Executive Program Directors of the contractual health care provider.
5. Recommendations for performance improvement that result from the review shall be disseminated to the appropriate parties for action. All recommendations shall be responded to within thirty (30) days and returned to the Director of Clinical Services or Director of Behavioral Health for corrective action review. The corrective action will be monitored by the Director of Clinical Services or Director of Behavioral Health. A report delineating the status of the recommendations shall be prepared and submitted to the Assistant Deputy Commissioner of Clinical Services and Deputy Commissioner of Classification, Programs and Reentry Services.

622.10 Inmate Burials

The superintendent shall develop institutional procedures which designate the staff person(s) responsible for the following:

1. Contacting the institution's Fiscal Director for notification of the funeral home so that the inmate's remains may be removed to be prepared for burial.
2. Requesting funds to bury the inmate.
3. Scheduling the funeral and preparing the burial site to include the burial permit.
4. Sending a letter to the morgue or hospital in possession of the inmate's remains and requesting the release of the body to the identified funeral home. (Attachment F).
5. Once the funeral home has possession of the remains, the institution shall be required to complete the Statement of Identification (Attachment G). This paperwork is necessary for the funeral director to obtain the death certificate.
6. Designate the person responsible for ensuring that a Department clergy member, preferably of the inmate's religion, is present for burial services.
7. Ensure that the grounds of the Department's cemetery are maintained appropriately, including development of a maintenance schedule.
8. Maintain a plot plan for the Department's burial grounds to include, to the degree possible, the names of the deceased already buried in the cemetery. Burial plot sizes should be 7' x 3' in order to accommodate a standard casket.

9. Ensure that the casket is placed into the ground and the grave is covered.
10. Ensure that the burial is appropriately recorded into the log (Attachment H) and numbered plot plan.

The procedure shall be approved by both the superintendent and the Assistant Deputy Commissioner of Clinical Services.

622.11 Inmate Cremations

1. Inmates who are ill and wish to be cremated must sign the Consent to Cremation form (Attachment I) prior to death.
2. If the inmate's family does not want to assume responsibility of the body, but wants the inmate to be cremated by the Department, they must sign the Consent to Cremation form (Attachment I).
3. If the inmate or the family does not sign the Consent to Cremate form, the Department shall bury the inmate in accordance with the provisions of 103 DOC 622.10.
4. The superintendent shall develop institutional procedures, which designate the staff person(s) responsible for the following:
 - a. Contacting the institution's Fiscal Director for notification of the funeral home, so that the funeral home can obtain an authorization to cremate from the Medical Examiner's Office.
 - b. Requesting funds for cremation and burial of the ashes.

- c. Scheduling the funeral and preparing the burial site to include the burial permit.
- d. Sending a letter to the morgue or hospital in possession of the inmate's remains and requesting the release of the body to the identified funeral home. (Attachment F)
- e. Once the funeral home has possession of the remains, the institution shall be required to complete the Statement of Identification (Attachment G). This paper work is necessary for the funeral director to obtain the death certificate.
- f. Ensure that the Department clergy member, preferably of the inmate's religion, is present for burial services.
- g. Ensure that the grounds of the Department's cemetery are maintained appropriately, including development of a maintenance schedule.
- h. Maintain a plot plan for the Department's burial grounds to include (to the degree possible) the names of the deceased already buried in the cemetery. Burial plot sizes must now include the size needed for the burial of the cremation container of remains.
- i. The cremation container of remains must be placed into the ground and covered.
- j. Ensure that the burial is appropriately recorded into the log (Attachment H) and numbered plot plan.

5. This procedure shall be approved by both the superintendent and the Assistant Deputy Commissioner of Clinical Services.

ATTACHMENT A

DEATH IN CUSTODY- STATE PRISON INMATE DEATH REPORT

(Not available on the Intranet. Available in the Department of
Correction's Health Services Division only.)

ATTACHMENT B

Medical Investigation Response Team

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MASSACHUSETTS DEPARTMENT OF CORRECTION
DIVISION OF HEALTH SERVICES

ACTIVATION OF MEDICAL INVESTIGATION RESPONSE TEAM

Definition: Medical Investigation Response Team

The Commissioner may designate a Medical Investigation Response Team to investigate a death. This specially trained team will be comprised of at least one individual from the Office of Investigative Services and at least one manager from the Health Services Division.

Activation of a Medical Investigation Response Team

Upon notification of an inmate death, the Commissioner may activate a Medical Investigation Response Team when the death appears to be any of the following:

- an unattended death in a institution
- a suicide
- a death which involves drug diversion or misuse
- any other suspicious or unnatural circumstances.

The Commissioner will notify the appropriate Deputy Commissioner, Assistant Deputy Commissioner of Clinical Services, Chief of Investigative Services and the appropriate Assistant Deputy Commissioner of his/her decision to activate a team. The Assistant Deputy Commissioner will notify the appropriate superintendent.

The Medical Investigation Response Team will report at once to the institution where the death occurred.

ATTACHMENT B
Medical Investigation Response Team

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Medical Investigation Procedure

1. When an inmate death occurs, the superintendent or designee shall immediately confiscate and secure the following:
 - six part folder
 - medical record
 - medication administration record
 - inmate housing roster
 - pertinent logs
 - medical shift roster
 - unit log books, if applicable
 - all prescribed medication, including blister packs
 - all pertinent documentation and incident reports, including preliminary reports and chronology of events.
 - IMS Forms
 - visiting card
 - mental health record
 - security shift roster
 - employee training records
2. Upon the Medical Investigation Response Team's arrival at the institution, the superintendent or designee shall turn over all confiscated and secured materials to the team.
3. The superintendent shall ensure that the Medical Investigation Response Team has access to available resources (i.e., personnel, clinical support, etc.)
4. The Medical Investigation Response Team shall provide an initial report to the Commissioner within twenty-four (24) hours of their activation. As the investigation continues, the Commissioner shall receive daily briefings.
5. A Health Services Division Manager, as a member of the Medical Investigation Response Team, shall attend the Performance Improvement Mortality/Suicide Review.

ATTACHMENT B
Medical Investigation Response Team

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6. The Medical Investigation Response Team shall conduct, control and manage the investigation and available resources (i.e., IPS). At the conclusion of an investigation, a written report shall be submitted to the appropriate Deputy Commissioner. The Performance Improvement Mortality Review/Psychological Autopsy shall take place prior to the conclusion of the investigation.

7. The written investigation report shall follow on "executive summary" format which shall address, but not be limited to the following topics:
 - Chronology of Events
 - Medical History
 - Mental Health History
 - Prior Medical Treatment
 - Prior Mental Health Treatment
 - Medications Prescribed
 - History of Suicide Attempts
 - History of Substance Abuse Emergency Reports
 - Autopsy Results
 - Toxicology Results
 - Criminal Background
 - Training
 - Sentence Structure
 - Operational Policy & Procedure
 - Disciplinary History
 - Contracted Medical Provider Procedures
 - Classification History
 - All Incident Reports

ATTACHMENT C

MASSACHUSETTES DEPARTMENT OF CORRECTION
DIVISION OF HEALTH SERVICES

Request to Waive Performance Improvement Mortality Review

Inmate's Name: _____

Commitment Number: _____

Date of Birth: _____

Institution: _____

Location Where Death Occurred: _____

Date of Death: _____

Justification for Waiver:

Submitted by: _____

Director of Clinical Services or
Director of Behavioral Health

Reviewed by: _____

Assistant Deputy Commissioner of Clinical Services

Approved by: _____

Deputy Commissioner of Classification, Programs
and Reentry

ATTACHMENT D

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MASSACHUSETTS DEPARTMENT OF CORRECTION
Performance Improvement Mortality/Psychological Review

Inmate Name:
Commitment Number:
Institution:
Type of Housing:
Date of Birth:
Date of Death:
Time Discovered:
Method:

Standing members of the Performance Improvement Mortality Review Committee (the "Committee") shall include the following individuals:

From Department of Correction's Health Services Division:

- Director of Behavioral Health or designee;
- Mental Health and Medical Regional Administrator assigned to the site

From the Department of Correction Institution:

- Superintendent or designee

From the health care vendor:

- Psychiatric Medical Director
- Director of Clinical Programs
- Statewide Medical Director
- Chief Nursing Officer

The Director of Behavioral Health for the Department of Correction's ("Department") Health Services Division shall chair the Performance Improvement/Psychological Autopsy Committee and will determine what other personnel, Department staff, contractual staff or consultants from other state agencies or non-governmental organizations, should participate as a member of the Performance Improvement Committee on a case by case basis. This may include selected contractual staff from the facility where the suicide occurred, such as the Mental Health Director or the Health Service Administrator. Additionally, the

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Director of Behavioral Health may choose to request selected staff to be interviewed by the work group as deemed necessary.

I. The following topics shall be discussed during the performance review:

A. INCIDENT:

Narrative of the suicide event including date and time the inmate was discovered; location of death; method of causing death; who discovered inmate and under what circumstances; details of the code response to include correctional staff's response, as well as medical staff's response; medical interventions utilized and outcomes; details relevant to the scene of the death including the presence or absence of a suicide note; time and location of pronouncement of death; statement as to whether the case was referred to the medical examiner's office for an autopsy.

B. AUTOPSY/TOXICOLOGY FINDINGS:

To be included after the autopsy is received. Should include significant findings such as signs of trauma to the body; results of drug screens to include presence or absence of recreational drugs, alcohol, or prescription medication; cause of death; mode of death and approximate time of death.

C. CRIMINAL HISTORY:

Inclusive of committing offense, length of prison sentence, date of commitment to the Department, reference to prior arrests and convictions including prior commitments to jail or prison and prior admissions to the Bridgewater State Hospital ("BSH") (male) or to a Department of Mental Health facility ("DMH") (female).

D. INSTITUTIONAL ADJUSTMENT/FUNCTIONING:

Inclusive of chronology of facility placements within the Department; reference to overall level of adjustment to

incarceration including disciplinary record; participation in programming such as education and vocational training; job assignments; extracurricular activities and frequency and type of visits.

E. MENTAL HEALTH HISTORY:

To include mental health treatment while in the community and throughout incarceration; history of drug/alcohol abuse; family history of mental illness/suicide; family upbringing and current family situation; prior suicidal or self-injurious behavior; transfers to inpatient psychiatric facilities including the BSH for male inmates and DMH hospital(s) for female inmates (reasons for and disposition upon discharge); summary of initial mental health appraisal upon reception into the Department; current mental health treatment; compliance with treatment plan and medication orders; findings of most recent assessment/mental status exam and current diagnosis; details of the last contact with a mental health professional; overall summary of mental health treatment during current incarceration; summary of any legal issues such as Probate Roger's Order (whether the order was current and enforced), Myers Order, or guardianship.

F. MEDICAL HISTORY: Summary of major medical issues/problems and treatment during incarceration.

The following sections may be completed by the designated Mental Health Regional Administrator (but otherwise may be more appropriately discussed as a function of the Performance Improvement Committee).

G. PRECIPITATING EVENTS:

Major life stressors (e.g., physical/sexual assault, threats against life, dissolution of significant relationship, crisis in family such as death of a loved one, added time to sentence, convicted of additional crime, loss of appeal, diagnosis of a serious medical condition or anniversary dates {e.g., crime, conviction, commencement of

prison term, birthdays of significant people, death of loved one, wedding}; acute onset of mental illness or exacerbation of mental disorder {e.g., agitated psychosis with depression and command hallucinations to kill oneself} or longstanding mental illness {e.g. break up with significant other or abandonment of family}).

H. PRESUICIDAL FUNCTIONING:

Changes in mental status (e.g. acute deterioration in mental functioning, onset of major mental illness, agitated psychosis with command hallucinations, psychosis with depression and severe depression); behavior (e.g. social withdrawal, agitation, provocativeness, increased or decreased appetite, disturbed sleep, etc.); mood (e.g. depression, hopelessness, helplessness, fearfulness, unfounded happiness, lability, anger, hostility, and impulsivity); and attitude (unrealistic sense of the future, apathy, overly optimistic and overly pessimistic). Specific behaviors suggestive of suicide planning (e.g. giving away possessions, saying good-bye to friends, telephoning or writing to family and/or friends to say good bye, talking about death and/or suicide, rehearsing suicidal act, asking about ways to die and accumulating the means to kill oneself, asking about the frequency and timing of security rounds, threatening suicide).

II. The following sections to be discussed by the Committee at the review:

A. ISSUES FOR REVIEW:

1. STAFFING:

- Was the facility and incident site adequately staffed at the time of the incident (i.e. security, medical, mental health staffing)?
- Did staffing have proximal affect on the outcome of the incident?

- Did staffing have a distal affect on this incident? Did it affect the ability of staff to provide an appropriate level of contact and/or supervision with and to the inmate?

2. TRAINING

- Had all staff involved in the incident and who had contact with the inmate received appropriate training in suicide prevention, including recognizing signs and symptoms of mental illness?
- Had all staff who responded to the Code 99 been trained (including current certification) in CPR and First Aid?
- Was the facility up to date with their Code 99 response drills including suicide scenarios and emergency cell entry?

3. EQUIPMENT

- List all equipment used including medical equipment, such as AED, Ambu Bag, portable oxygen and suctioning; and security equipment, such as emergency cell entry tools, radios, keys and emergency keys, shields, restraints and cut down shears.
- Was the equipment available?
- Was the equipment in good working order?
- Had the equipment been tested and calibrated in accordance with policy and manufacturer's recommendations?
- Did staff demonstrate competency in using the equipment?

4. IDENTIFICATION/REFERRAL/ASSESSMENT

- Were systems in place to appropriately screen the inmate for potentially suicidal behavior?

- Was the inmate appropriately screened upon intake and referred for a mental health evaluation as needed?

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- Were efforts made to attain prior mental health records (if applicable)?
- If the inmate requested or was referred for mental health services, was his/her request triaged appropriately and was he/she seen within a reasonable time frame?

5. COMMUNICATION

- Was there information regarding the inmate's prior and/or current suicide risk from outside agencies or another Department facility that was not communicated to the current correctional facility?
- Was there information regarding the inmate's prior and/or current suicide risk from correctional, mental health and/or medical personnel that was not communicated throughout the facility to appropriate personnel?
- Did the inmate engage in any type of behavior that might have been indicative of a potential risk of suicide? If so, was this observed behavior communicated throughout the facility to appropriate personnel?

6. HOUSING

- Where was the inmate housed and why was he/she assigned to this housing unit?
- Had the inmate's housing assignment, facility or cell location recently changed?
- If placed in a special management unit ("SMU") or the department disciplinary unit ("DDU"), had the inmate received the appropriate level of screening prior to his/her placement and was he/she seen on rounds, per protocol by medical and mental health staff?
- Was there anything regarding the physical design of the inmate's cell and/or housing unit that

contributed to the inmate's suicide (e.g., poor visibility, protrusions in cell conducive to tying off a ligature)?

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7. LEVELS OF SUPERVISION

- What level of frequency of supervision was the inmate under prior to the incident?
- Given the inmate's observed behavior prior to the incident, was the level of supervision adequate?
- When was the inmate last physically observed by and correctional staff prior to the incident?
- Was there any reason to question the accuracy of the last reported observation by correctional staff?
- If the inmate was not physically observed within the required time interval prior to the incident, what reason(s) was determined to cause the delay?
- If the inmate was not on suicide precautions at the time of the incident, should he/she have been?

8. MENTAL HEALTH TREATMENT

- Was the inmate on the open mental health caseload and/or designated as having a Serious Mentally Illness ("SMI") according to the Department's definition? If so, what was the frequency of contact and type of contact, e.g. individual v. group, per the treatment plan?
- When was the inmate last seen by mental health staff, crisis clinician, primary care clinician and the psychiatrist if applicable?
- Was the inmate being seen according to his/her treatment plan, and if not, what was the reason(s) determined for the delay?
- If the inmate was not on the open mental health caseload or identified as SMI, had he/she previously been on the caseload, should he/she have been?

- If the inmate was not being prescribed psychotropic medication, should he/she have been?
- Was the inmate's treatment plan appropriate given his/her presentation?

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- Was the inmate's diagnosis accurate and appropriate, and was his/her consensus among the treatment team and the system?
- Had the inmate's psychiatric diagnosis been changed, frequency, by what process?
- Had the inmate been appropriately assessed for suicide risk on an ongoing basis?
- If the inmate had requested or been referred for mental health services, was this request/referral triaged appropriately?
- Were there any mental health issues or factors that contributed to the incident that were not appropriately addressed by mental health staff?
- Was the inmate being prescribed the appropriate psychotropic medication and was the inmate being compliant with his/her medications? If not, was this being tracked and communicated to the appropriate provider? If so, was there a clinical intervention by the psychiatrist or advanced practitioner?

9. MEDICAL TREATMENT

- What diseases are listed on the Problem List?
- Was the inmate being seen at appropriate intervals in the Chronic Disease Clinic?
- What was the most recent degree of control (good, fair, poor) for the inmate's chronic disease(s)?
- What medications and treatments were ordered for the inmate? Did the inmate have access to these medications and treatment? Was the inmate compliant with the ordered treatment regiment?

- Had the inmate received any information, positive or negative, regarding a change in his medical condition? A new or terminal diagnosis?
- When did the inmate last have contact with a healthcare provider? What was the nature of the contact, the assessment of the inmate's presenting problem and the intervention?
- Had the inmate recently submitted a "sick slip"? How was it triaged, by whom?

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- Were there any recent specialty consults recommended? What was the status?
- Did the inmate complain of physical pain? How was any such complaint being managed? Was the inmate on a controlled substance or other chronic medication for pain management? If so, what medication?
- Were the inmate's activities or daily living impaired by disease or disability?
- Had the inmate or a family member/friend expressed recent concern about the inmate's medical care via a formal grievance, "management access", correspondence or telephonic communication?

10. INTERVENTION/CODE RESPONSE

- Did the staff member(s) who discovered the inmate follow proper intervention procedures (e.g. survey the scene; initiate a Code 99 response; breach the cell door in a timely manner ensure that medical staff were promptly notified; were safety shears on site in a timely fashion; did first responders initiate CPR; was the AED utilized, and if so, by whom; when medical staff arrived did they take charge of the medical response)?
- Was 911 called in a timely manner?
- Were there any delays in the arrival of the EMT's to the scene; were there delays in entry and egress to and from the facility?

- Was the first responders' interventions affected and/or compromised by the inmate's medical condition?

11. FOLLOW-UP

- Were all affected staff and inmates offered critical incident stress debriefing? By whom?
- Were there any findings and/or recommendations from previous mortality reviews of inmate suicides that are relevant to this mortality review?

12. RECOMMENDATIONS:

Based upon the review of the total incident, include a list of recommendations specific to the circumstances of the suicide as they relate to the findings of the mortality review panel. They may include recommendations for mental health and medical standards of care, suicide prevention policy and procedures, changes in environmental design or training. These recommendations may address immediate, proximal issues related to the incident or more indirect, systemic, and distal factors. For each recommendation, indicate the action and individual or staff member identified as responsible. If after consideration of the recommendation, a decision is made not to act upon the proposed recommendation, attach the rationale for the decision at this time. All recommendations shall be realistic, achievable, objective and measurable. Consider whether pilot testing of a planned improvement should be conducted. Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred.

13. REVIEW AND SIGNATURES:

The mortality review should be signed by the Director of Behavioral Health. The Assistant Deputy Commissioner of Clinical Services shall review and sign the report and the independent consultant.

ATTACHMENT E

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MASSACHUSETTS DEPARTMENT OF CORRECTION
Performance Improvement Mortality Review

Inmate Name:
Commitment Number:
Institution:
Type of Housing:
Date of Birth:
Date of Death:
Time Discovered:
Method:

Standing members of the Performance Improvement Mortality review Committee (the "Committee") shall include the following individuals:

From Department of Correction's Health Services Division:

- Director of Clinical Services and/or Regional Administrator

From Department of Correction's Institution:

- Superintendent or designee

From the health care vendor:

- Statewide Medical Director
- Chief Nursing Officer

The purpose of this procedural statement of the Committee is to identify the proximal and distal factors of an inmate death and to identify performance improvement actions that would minimize the occurrence of another similar incident in the future. The Director of Clinical Services for the Department of Correction's ("Department") Health Services Division shall chair the Committee and will determine what other personnel, Department staff, contractual staff or consultants from other state agencies or non-governmental organizations, should participate as a member of it on a case by case basis. This may include a Department Health Services Division Regional Administrator - Nursing and/or Mental Health or selected contractual staff from the facility where the death occurred. Additionally, the

Director of Clinical Services may choose to request selected staff to be interviewed by the Committee as deemed necessary.

I. The following topics shall be discussed during the performance review.

A. INCIDENT:

Narrative of the event, including date and time the inmate was discovered; location of death; method of causing death; who discovered the inmate and under what circumstances; details of the Code 99 response, to include correctional staff's response as well as medical staff's response; medical interventions utilized and outcomes; details relevant to the scene of the death, including the presence or absence of a suicide note; time and location of pronouncement of death; statement as to whether the case was referred to the medical examiner's office for an autopsy.

B. AUTOPSY/TOXICOLOGY FINDINGS:

To be included after the autopsy is received. The findings should include significant findings, such as signs of trauma to the body; results of drug screens, to include present or absence of recreational drugs, alcohol, or prescription medication; cause of death; mode of death and approximate time of death.

C. MEDICAL HISTORY/MEDICAL TREATMENT:

- What diseases are listed on the Problem List?
- Was the inmate being seen at appropriate intervals in the Chronic Disease Clinic?
- What was the most recent degree of control (good, fair, poor) for the inmate's chronic diseases?
- What medications and treatments were ordered for the inmate? Did the inmate have access to these medications and treatment? Was the inmate compliant with the ordered treatment regimen?

- Had the inmate received any information, positive or negative, regarding a change in his medical condition? A new or terminal diagnosis?
- When did the inmate last have contact with a healthcare provider? What was the nature of the contact, the assessment of the inmate's presenting problem and the intervention?
- Had the inmate recently submitted a "sick slip"? How was it triaged? By whom?
- Were there any recent specialty consults recommended? What was the status?
- Did the inmate complain of physical pain? How was any such complaint being managed? Was the inmate on a controlled substance or other chronic medication for pain management? If so, what medication?
- Were the inmate's activities of daily living impaired by disease or disability?
- Had the inmate or a family member/friend expressed recent concern about the inmate's medical care via a formal grievance, "management access period", correspondence or telephonic communication?

D. MENTAL HEALTH HISTORY:

Summary of major mental health issues/problems and treatment during incarceration, including commitments to Bridgewater State Hospital ("BSH") (males) and a Department of Mental Health facility ("DMH") (female).

II. OPERATIONAL ISSUES FOR REVIEW:

A. STAFFING:

- Was the facility and incident site adequately staffed at the time of the incident (security, medical, mental health staffing)?
- Did staffing have proximal affect on the outcome of the incident?
- Did staffing have a distal affect on this incident? Did it affect the ability of staff to provide an

appropriate level of contact and/or supervision with and to the inmate?

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B. TRAINING:

- Had all staff who responded to the Code 99 been trained (including current certification) in CPR and First Aid?
- Was the facility up to date with its Code 99 response drills including emergency cell entry?

C. EQUIPMENT:

- List all equipment used including medical equipment, such as AED, Ambu Bag, portable oxygen and suctioning; and security equipment, such as emergency cell entry tools, radios, keys and emergency keys, shields and restraints.
- Was the equipment available?
- Was the equipment in good working order?
- Had the equipment been tested and calibrated in accordance with policy and manufacturer's recommendations?
- Did staff demonstrate competency in using the equipment?

D. IDENTIFICATION/REFERRAL/ASSESSMENT:

- Were systems in place to appropriately screen the inmate for medical problems?
- Was the inmate appropriately screened upon intake and referred for further assessments and interventions, as needed?
- Were efforts made to attain prior medical records? Were follow up efforts made if needed?
- If the inmate requested or was referred for medical services, was his/her request triaged appropriately and was the inmate seen within a reasonable time frame?

E. COMMUNICATION

- Was there information regarding the inmate's prior and/or current medical problems from outside agencies or another Department facility that was not communicated to the current correctional facility?

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- Was there information regarding the inmate's prior and/or current medical problems from correctional, mental health and/or medical personnel that was not communicated throughout the facility to appropriate personnel?

F. HOUSING

- Where was the inmate housed and why was he/she assigned to this housing unit?
- Had housing assignment, facility or cell location recently changed?
- If placed in a special management unit ("SMU") or the department disciplinary unit ("DDU"), had the inmate received the appropriate level of screening prior to their placement and was he/she seen on rounds, per protocol by medical and mental health staff?
- Was there anything regarding the physical design of the inmate's cell and/or housing unit that contributed to the inmate's death and exacerbated the response of correctional and medical staff to the inmate?

G. LEVELS OF SUPERVISION

- What level of frequency of supervision was the inmate under prior to the incident?
- Given the inmate's condition and observed behavior prior to the incident, was the level of supervision adequate?
- When was the inmate last physically observed by medical and correctional staff prior to the incident?
- Was there any reason to question the accuracy of the last reported observation by medical and correctional staff?
- If the inmate was not physically observed within the required time interval prior to the incident, what reason(s) was determined to cause the delay?

H. INTERVENTION/CODE RESPONSE

- Did the staff member(s) who discovered the inmate follow proper intervention procedures (e.g. survey the scene; initiate a Code 99 response; breach the cell door in a timely manner ensure that medical staff were promptly notified; were safety shears on site in a timely fashion; did first responders initiate CPR; was the AED utilized, and if so, by whom; when medical staff arrived did they take charge of the medical reasons)?
- Was 911 called in a timely manner?
- Were there any delays in the arrival of the EMTs to the scene; were there delays in entry and egress to and from the facility?
- Were the first responders' interventions affected and/or compromised by the inmate's medical condition?
- What was the chronology of events by hours and minute by responders to the incident?

I. FOLLOW-UP

- Were all affected staff and inmates offered critical incident debriefing?
- Were there any findings and/or recommendations from previous mortality reviews of inmate suicides that are relevant to this mortality review?

J. RECOMMENDATIONS:

Based upon the review of the total incident, include a list of recommendations specific to the circumstances of the death as they relate to the findings of the mortality review panel. The recommendations may include recommendations regarding medical standards of care, healthcare policy and procedures, changes in environmental design or training. These recommendations may address immediate, proximal issues related to the incident or more indirect, systemic and distal factors. For each recommendation, indicate the action and the expected individual or staff member identified as responsible. If after consideration of the recommendation, a decision is

made not to act upon the proposed recommendation, attach the rationale for the decision at this time. All recommendations shall be realistic, achievable, objective and measurable. Consider whether pilot testing of a planned improvement should be conducted. Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred.

K. REVIEW AND SIGNATURES:

The mortality review should be signed by the Director of Clinical Services. The Assistant Deputy Commissioner of Clinical Services and the independent consultant shall also review and sign the report.

ATTACHMENT F
Funeral Home Notification

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(DATE)

(Name of Hospital or Morgue)
(Address)
(City, State, Zip Code)

Dear ():

I am writing to inform you that you may release the body of (Inmate's Name) to (Name, Address, City, State, Zip Code of funeral home).

Please be advised that a good faith effort has been conducted to search for any known relative of (Name of Inmate). I must now inform you that no relatives have been located who wish to assume responsibility for the deceased.

As the Superintendent of (Name of Institution), I am hereby responsible for his/her burial and I authorize (Name of Funeral Home) to bury (Name of Inmate).

Sincerely,

(Superintendent's Name)
(Title)

Signed before me this _____ day of (Month, year)

(Name of Notary Public)

My commission expires: _____

ATTACHMENT G

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STATEMENT OF IDENTIFICATION

| | | | |
|-------------------------------------|------------------------|-----------------------------------|-----------------------|
| <u>Commitment Number</u> | | <u>U.S. War Veteran (War)</u> | |
| <u>First Name</u> | <u>Middle</u> | <u>Last Name</u> | <u>Sex</u> |
| <u>Town/City Residence</u> | <u>State</u> | <u>Zip Code</u> | <u>Race</u> |
| <u>Place of Death</u> | <u>County of Death</u> | | <u>Marital Status</u> |
| <u>Husband of</u> | | | |
| <u>Wife of</u> | | | |
| <u>Date of Birth</u> | <u>Date of Death</u> | <u>Highest Grade Comp.</u> | |
| <u>Social Security No.</u> | | <u>SS Notified Y/N</u> | |
| <u>Birthplace</u> | | | |
| <u>Name of Father</u> | | <u>Birthplace of Father</u> | |
| <u>Maiden Name of Mother</u> | | <u>Birthplace of Mother</u> | |
| <u>Informant's Name</u> | | <u>Relationship</u> | |
| <u>Place of Burial or Cremation</u> | | <u>Casket or Urn</u> | |
| <u>Lot Information</u> | | <u>Lot Number</u> | |
| <u>Date of Disposition</u> | | <u>Physician</u> | |
| <u>Disease or Cause of Death</u> | | | |
| <u>Funeral or Memorial Service</u> | | <u>Time of Visiting</u> | |
| <u>Place of Visiting</u> | | <u>Date of Funeral</u> | |
| <u>Time of Funeral</u> | | <u>Clergyman</u> | |
| <u>Billed to</u> | | <u>Billing Address</u> | |

ATTACHMENT I

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CONSENT TO CREMATION

I, _____, being of sound mind, hereby knowingly and willing state my desire to be cremated by the Massachusetts Department of Correction following my death. I understand that following my cremation, the Massachusetts Department of Correction will bury my ashes in one of the cemeteries that it uses for inmate burials.

Signed this _____ day of _____.

NAME

DATE

WITNESS

DATE

WITNESS

DATE