MONTANA STATE PRISON
OPERATIONAL PROCEDURE

Procedure:	**MSP HS A-09.0 PROCEDURES IN THE EVENT OF AN INMATE DEATH**
Effective Date:	11/01/2010 Page 1 of 2
Revision Date(s):	04/15/2022; 06/30/2026
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I. PURPOSE

Establish requirements to thoroughly review all deaths in custody in an effort to improve care and prevent future deaths and to notify appropriate administrators, next of kin, and local authorities in the event of the death of an inmate.

II. DEFINITIONS (see Glossary)

III. PROCESS

A. Notifications

1. In the event of an inmate death:
   a. The nurse or staff in charge must, as soon as possible, but no more than eight hours later, notify the MSP Health Services Manager, the appropriate physician, and the Warden.
   b. The MSP Health Services Manager must notify the Medical Director and the Health Services Bureau Chief.
   c. The Health Services Bureau Chief will:
      1) consult with the Medical Director and decide whether to request a postmortem examination (unattended deaths and suicides require a postmortem examination); and
      2) immediately notify the Department Director by phone of any inmate death.

B. Progress Notes and Incident Reports

1. Medical staff will complete progress notes as soon as possible, but no later than the end of the shift, citing witnessed facts about:
   a. time of expiration;
   b. nature of death;
   c. circumstances surrounding nature of death at that time;
   d. treatment rendered (if any);
   e. persons notified of death; and
   f. whether an autopsy was requested.

2. All staff who witnessed the death will complete incident reports as soon as possible, but no later than the end of their shift.

C. Release of Information

1. Employees must not release information about inmate death to outside media, for example, newspapers, reporters, etc.

2. Employees must refer all questions to the Warden or Department Communications Director.

D. Report of Inmate Death and Health Record

1. Within 24 hours or the next business day, the MSP Health Services Manager will complete and forward the report of inmate death and a copy of the inmate's health record to the Health Services Bureau Chief and the Investigations Bureau Chief.
2. The MSP Health Services Manager will ensure:
   a. all health record entries are complete;
   b. all pages are numbered; and
   c. the original inmate health record is kept in a locked cabinet on-site.

E. Psychological Autopsy

1. A psychological autopsy will be performed on all deaths by suicide within 30 days.
2. The psychological autopsy is performed by a psychologist or a Qualified Mental Health Professional (QMHP) trained in performing psychological autopsies.
3. A psychological autopsy will contain no less than the following:
   a. detailed review of all file information on the inmate;
   b. a careful examination of the suicide site; and
   c. interviews with staff, inmates, and family members familiar with the deceased inmate.

F. Mortality Review

1. The Medical Director and/or the Health Services Bureau Chief will:
   a. coordinate a multi-disciplinary mortality review that includes a clinical mortality review and a psychological autopsy review (if the death was by suicide) within 30 working days of an inmate's death *(see MSP HS A-09 (A) MSP Mortality and Morbidity Review)*;
   b. notify all the necessary disciplines involved, for example, legal, medical, mental health, and custody staff, that the review will be conducted to determine:
      1) if there was a pattern of symptoms that may have precipitated an earlier diagnosis and intervention; and
      2) whether the events immediately surrounding the death show the appropriate interventions occurred.
2. When the medical autopsy is completed after the clinical mortality review has occurred, the review is appended with information from the autopsy report.
3. For expected deaths, a modified death review process, which focuses on the relevant clinical aspects of the death and preceding treatment, may be followed.
4. Once completed, the clinical mortality review and administrative review results are communicated to the unit health staff involved through the monthly Medical Review Panel.
5. Corrective action identified through the mortality review process is monitored and reviewed as needed through the facility CQI process *(see HS A-06.0 Continuous Quality Improvement Program)*.
6. The medical examiner or coroner will review all inmate deaths and subsequent reports.

IV. REFERENCES

A. *§§ 46-4-122 and 50-22-101 MCA*
B. *DOC 4.5.34 Offender Death*
C. *NCCHC Standard P-A-9, 2018*

V. CLOSING

Questions about this procedure should be directed to the Medical Health Services Manager.

VI. FORMS

MSP HS A-09.0 (A) MSP Mortality and Morbidity Review

MSP HS A-09.0 (B) Death in Custody: Inmate Death Report