

CORRECTIONAL MANAGED HEALTH CARE POLICY MANUAL	Effective Date: 11/14/2017	NUMBER: A-11.1
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PROCEDURE TO BE FOLLOWED IN CASES OF OFFENDER DEATH		

PURPOSE: To outline procedures to be followed in the event of an offender's death.

POLICY: Pronouncement of offender deaths will be consistent with Chapter 671 of the Texas Health and Safety Code which allows a registered nurse or mid-level practitioner to determine and pronounce a person dead in certain situations. Death must be pronounced before artificial means of supporting a person's respiratory and circulatory functions are terminated. In the event of an offender's death or when a hospitalized offender is placed on the serious or critically ill list, the facility health administrator/practice manager will make the appropriate notifications.

DEFINITIONS:

Attending Physician—The Attending Physician is the physician with primary responsibility for the patient's care and treatment.

Death—An offender will be considered dead when, according to ordinary standards of medical practice, there is irreversible cessation of the person's spontaneous respiratory and circulatory functions.

Life-sustaining Procedure—A life-sustaining procedure is a medical procedure, treatment, or intervention that uses mechanical or other artificial means to sustain, restore, or supplant a spontaneous vital function and, when applied to a person in a terminal condition, serves only to prolong the process of dying.

PROCEDURES:

I. Pronouncement of Offender Death

Life-sustaining procedures will be initiated on all offenders unless there is a current, valid DNR order in the TDCJ health record. When a physician or mid-level practitioner is on-site, pronouncement of death is a medical responsibility. When a physician or mid-level practitioner is not on-site life-sustaining procedures shall be implemented and a physician or mid-level practitioner shall be contacted to obtain orders. The only exemption to this is for patients who have a valid, current DNR order in the health record. In this case, no life-sustaining procedures will be initiated and the RN on site can pronounce death.

When an offender is found hanging or is involved in an accident, attempted homicide or found unconscious in the housing or work area, medical personnel shall determine initially if the offender is dead prior to security securing the area for investigation. Life-sustaining procedures will be initiated on all offenders. Security officers should not interfere with initiating life-sustaining procedures prior to the declaration of death. After the declaration of death security officers can initiate an investigation as to the cause of death

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II. Notification

A. In the event of an offender death, the Warden/Facility Administrator or designee shall be immediately notified. The Warden/Facility Administrator shall implement the following steps based on the circumstances surrounding the offender death:

a. Natural Causes/Attended by Physician or Designated Nurse:

When an offender dies of natural causes while attended by a physician or registered nurse, the Warden/Facility Administrator or designee shall immediately notify the facility Chaplain and the Office of the Inspector General (OIG). The Chaplain will inform the next of kin of the offender's time of death. The Chaplain will explain that unless the next of kin objects within eight hours of the stated time of death, an autopsy will be conducted on the offender. The Warden/Facility Administrator should then notify the Carnes Funeral Home (1-888-822-7637) to make preliminary arrangements for removal of the body from the facility.

b. Deaths other than Natural or Unattended by a Physician or Registered Nurse:

When an offender's death occurs under any circumstances (such as suicide, homicide, accident, unexpected death or any death the physician is not willing to certify, or similar situations) other than those referenced in II.A.1. above, the Warden/Facility Administrator shall contact the precinct Justice of the Peace, the nearest Justice of the Peace serving the county, or the county judge if no Justice of the Peace is available and notify the Inspector General's office or local law enforcement, (as applicable based on the specific geographic location). The body should not be moved until an investigation is conducted by the Justice of the Peace, county judge or Medical Examiner and designated law enforcement officials. State law requires the Justice of the Peace or Medical Examiner to personally inspect the body and to conduct an inquest as to the cause of the death. The Justice of the Peace or Medical Examiner shall be requested to authorize a post mortem examination following the death of an offender except for deaths by lethal injection. The Warden/Facility Administrator should notify the Carnes Funeral Home (1.888.822.7637) to arrange for removal of the body from the facility. Transportation from the site of death to the post mortem examination site, if necessary, shall be coordinated through the Carnes Funeral Home. State law requires the Justice of the Peace or Medical Examiner and local law enforcement to be present prior to removal of the body. State Law permits a county to establish an adult fatality review team that may conduct reviews of un-expected deaths that

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occur within the county. If any facility warden or medical department is informed that an adult fatality.

Review team has been established, the TDCJ Division Director for Health Services, and the medical director of the university provider shall be informed within 24 hours by fax, email or telephone.

- B. Upon receipt of notification of an offender's death and within 72 hours following the time of death, the facility health administrator (TTUHSC)/practice manager (UTMB) shall send via email with the Initial Notification of Offender Death form (Attachment A) to the Death Records Technician and the regional health management teams for TTUHSC and UTMB.

- C. Offender deaths occurring in outside hospitals.
The facility health administrator (TTUHSC)/practice manager (UTMB) shall obtain outside hospital records within 7 days of the offender's death. Offsite hospital records shall be scanned into the EHR within 72 hours of receipt.

III. Funeral Arrangements

- A. At the time of the inquest, TDCJ officials are required to notify the Carnes Funeral Home with the name, address, and telephone number of the Justice of

- B. The Peace and the name of the appropriate registry (city or county) in which the death report must be filed.

- C. Transportation to a local funeral home for burial preparation must be coordinated by the Carnes Funeral Home. Correctional Managed Health Care ambulances may not be used to transport the deceased offender.

- D. The Carnes Funeral Home will forward State form #VS115, "Report of Death" to the proper registrar, making the Carnes Funeral Home the funeral home of record.

- E. The Carnes Funeral Home is responsible for burial arrangements in the prison cemetery if the remains of the deceased offender are not claimed. These arrangements must be coordinated with the Warden/Facility Administrator of the Huntsville Unit.

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- F. When a question arises concerning funeral arrangements or proper disposition of the deceased offender's remains, the Carnes Funeral Home should be contacted using the twenty-four hour telephone number, (1-888-822-7637).
- G. The Huntsville Unit shall not make arrangements to bury the offender until it receives either an email or fax from the family stating that it does not wish to claim the body or, in cases where the family cannot be located, an e-mail message from the Chaplain who tried to locate the family.

IV. Custodial Death Report (CDR)

A copy of the last 72 hours of a deceased offenders health records shall be provided by medical personnel to the Office of Inspector General (OIG) immediately upon request from an OIG investigator. All custodial deaths must be reported by OIG to the Attorney General's office.

V. Deaths in Custody State Prison Inmate Death Report for the U.S. Department of Justice (DOJ) Bureau of Justice Statistics (Attachment B)

Attachment B should be completed and faxed to the UTMB Death Record Technician (Fax 936.439.1350) within 10 days of the offender's death, so it can be forwarded to TDCJ Executive Services within a timely manner. Executive Services shall submit the required information to the Bureau of Justice Statistics as required.

VI. Clinical Summary and Review of an Offender's Death

- A. Every offender who expires within the Texas Department of Criminal Justice must have a clinical summary of death entered into the health record by a facility medical provider within 30 days.
- B. The facility medical director or designee must complete a death summary. The Death Summary (Attachment C) is to include the following information:
 - a. Brief summary of medical history and physical examination;
 - b. Outpatient course, which includes a summary of sick call visits and chronic care clinics;
 - c. Emergency room visits to include those at the facility of assignment and/or off site hospitals;
 - d. Inpatient courses to include infirmary care and/or offsite hospitalizations;
 - e. List of medication(s) the offender was receiving at the time of death;

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- f. Terminal events, both clinical and historical, that led up to the death and a description of the medical procedures utilized by staff in the Agonal event (physicians are to include the name(s) of staff who Participated in the events surrounding the offender's death); and
- g. Autopsy findings, if available.

- C. Each death on a facility will be reviewed by the facility practice manager within 30 days and corrective action will be initiated as needed. Deaths occurring off-site will be reviewed by the referring management team. If the medical management is determined to be improper or questionable, the case is forwarded to the Chairman of the appropriate Peer Review Committee.
- D. A copy of the death review will be scanned into the EHR sent to the Regional District Medical Director.

VII. Death Certificates

- A. Except in specific situations described below, the attending physician will be responsible for signing death certificates of those offenders that died from natural causes and were under his/her care. Exceptions include:
 - 1. A physician assistant or advanced practice registered nurse may complete the medical certification if an offender who has executed a written certification of a terminal illness has elected to receive hospice care and is receiving hospice services or palliative care at the time of death.
 - 2. An associate physician, the chief medical officer of the institution where the death occurred, or the physician who performed an autopsy on the decedent may complete the medical certification if:
 - a. The attending physician, physician assistant, or advanced practice registered nurse is unavailable;
 - b. The attending physician, physician assistant, or advanced practice registered nurse approves; and
 - c. The person completing the medical certification has access to the medical history of the case and the death is due to natural causes.
- B. The attending physician, physician assistant, or advanced practice registered nurse shall complete the medical certification no later than five days after receiving the death certificate.
- C. Texas state law requires, effective September 1, 2008 that all death certificates are to be filed electronically utilizing the Texas Electronic Registrar for offenders that expire of natural causes and were under the care of a facility physician, physician assistant, or advanced practice registered nurse.

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The physician, physician assistant, or advanced practice registered nurse will receive notification via E-mail that the medical certification portion of the death certificate is ready to be completed electronically. Each physician, physician assistant, or advanced practice registered nurse must have a user ID, password and pin to access the Texas Electronic Registrar to complete the electronic death certification of the death certificate. The instruction packet for the “Texas Electronic Registrar – Certifying TER Death and Cause of Death can be found on the CMC website. For assistance with the Texas Electronic Registrar, or username, password and pin, please contact the Assistant Director of Health Information Management at 936-437- 3612.

- E. A copy of the death certificate for an offender who dies while in the custody of the TDCJ shall be maintained by the death records technician. Upon notification of an offender’s death, the death records technician shall initiate a request for a copy of the death certificate from the county in which the death occurred.
- F. In the event a cost is associated with obtaining the death certificate, a copy of the request and notification of the cost are sent to the Chief Financial Officer (TTUHSC)/Director of Financial Services (UTMB).
- G. The Death Records Technician will forward a copy of the offender's death certificate to the Director of Classification and Records (or appropriate division records coordinator).

VIII. Postmortem Suicide Review

If death was (or is suspected to be) due to suicide, a post mortem psychological evaluation will be completed. The report will include at a minimum: relevant social history data, a chronological review of the offender's involvement in mental health treatment (if any), and a post mortem psychological evaluation.

The completed report will be submitted to: A) The Division Director for Health Services, B) the Medical Directors for UTMB and TTUHSC or designee, and C) the responsible facility medical director. This report is for Quality Improvement/Quality Management and is therefore not part of the offender’s permanent health record.

IX. Joint Mortality Review Committee

- A. A Joint Mortality Review Committee will review each offender death. This mortality review is in addition to any unit-level death review that is performed.
- B. The chairs of the Joint Mortality Review Committee is designated by the TDCJ Joint Directors Medical Group and approved by the chair of the Correctional Managed Health Care Committee (CMHCC).
- C. Membership of the Committee includes at least one physician/mid-level provider and other licensed providers except dentists as designated by each of the joint medical directors from the TTUHSC, UTMB and TDCJ Health Services Division.

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- D. Meetings of the Committee should occur at least monthly via teleconference or video conference. At least two physician/midlevel providers must be present for a meeting.

A copy of the review will be sent to the Regional Medical Director (TTUHSC)/Cluster Medical Director (UTMB).

- E. The function of the Committee is a quality assurance/improvement activity that is protected from disclosure under Chapter 161.031-161.032 of the Texas Health and Safety Code.

X. Adult Fatality Review Team

Texas Health and Safety Code §§ 672.001-.013 permit a county to establish an adult fatality review team that may conduct reviews of un-expected deaths that occur within the county. If any warden or medical department becomes aware that an adult fatality review team has been established regarding a death on the unit, the Health Services Division Director, the unit medical director, and the unit medical administrator shall be informed within 24 hours by e-mail, phone, or fax.

Reference: Texas Health and Safety Code, Chapter 671 HB 2866
TDCJ AD-03.29 Procedures to be Followed in Cases of
Offender Death
ACA Standard 4-4395 (Ref.3-4374)
ACA Standard 4-4410 (Ref. New) Mandatory ACA
Standard 4-4425 (Ref.3-4375)
Texas Health and Safety Code, Chapter 193