

**DEATHS IN CUSTODY
STATE PRISON INMATE
DEATH REPORT FOR BUREAU OF JUSTICE STATISTICS**

FORM COMPLETED BY:

Name		Title	
Official Address		Telephone	
City		Fax	
State	Zip	E-mail	

1. What was the inmate's name:

Last	First	MI

2. TDCJ #

3. On what date did the inmate die?

Month	Date	Year					

4. Where did the inmate die?

<input type="checkbox"/>	In a general housing unit in the facility or on prison grounds
<input type="checkbox"/>	In a segregation unit
<input type="checkbox"/>	In a special medical unit/infirmery within your facility
<input type="checkbox"/>	In a special mental health services unit within your facility
<input type="checkbox"/>	In a medical center outside your facility
<input type="checkbox"/>	In a mental health center outside your facility
<input type="checkbox"/>	While in transit
<input type="checkbox"/>	Elsewhere <input style="width: 600px;" type="text" value="Please specify:"/>

5. Where did the incident (e.g., accident, suicide or homicide take place?)

<input type="checkbox"/>	NOT APPLICABLE – Cause of death was illness, intoxication or AIDS related
<input type="checkbox"/>	In the prison facility or on the prison grounds
<input type="checkbox"/>	In the inmate's cell/room
<input type="checkbox"/>	In a temporary holding area/lockup
<input type="checkbox"/>	In a common area within the facility (e.g., yard, library , cafeteria
<input type="checkbox"/>	In a special medical unit/infirmery
<input type="checkbox"/>	In a special mental health services unit
<input type="checkbox"/>	In a segregation unit
<input type="checkbox"/>	On death row, special unit awaiting capital punishment
<input type="checkbox"/>	Elsewhere within the prison facility <input style="width: 400px;" type="text" value="Please specify:"/>
<input type="checkbox"/>	Outside the prison facility (e.g., while on work release or on work detail)
<input type="checkbox"/>	Elsewhere <input style="width: 600px;" type="text" value="Please specify:"/>

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<input type="checkbox"/>	
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6. When did the incident (e.g., accident, suicide or homicide) causing the inmate's death occur?

- NOT APPLICABLE – Cause of death was illness, intoxication or AIDS related
- Morning (6 am to Noon)
- Afternoon (Noon to 6 pm)
- Evening (6 pm to Midnight)
- Overnight (Midnight to 6 am)

7. Are the results of a medical examiner's or coroner's evaluation (such as an autopsy, postmortem exam) available to establish an official cause of death?

- Autopsy pending
- No evaluation is planned

8. Based on available information, what was the cause of death?

(Select categorical cause in box on left and specify actual cause of death in box on right.)

<input type="checkbox"/>	Illness-Exclude AIDS-related deaths <i>[Specify]</i>	
<input type="checkbox"/>	Acquired Immune Deficiency Syndrome (AIDS)	
<input type="checkbox"/>	Accidental alcohol/drug intoxication <i>[Specify]</i>	
<input type="checkbox"/>	Accidental injury to self <i>[Describe]</i>	
<input type="checkbox"/>	Accidental injury by other (e.g., vehicular accidents during transport) <i>[Describe]</i>	
<input type="checkbox"/>	Suicide (e.g., hanging, knife/cutting instrument, intentional drug overdose) <i>[Describe]</i>	
<input type="checkbox"/>	Homicide <i>[Describe]</i>	
<input type="checkbox"/>	Other cause(s) <i>[Specify]</i>	

9. Was the cause of death the result of a pre-existing medical condition or did the inmate develop the condition after admission? If multiple conditions caused the death and any of the conditions were pre-existing, mark "Pre-existing medical condition".

- NOT APPLICABLE – Cause of death was accidental injury, intoxication, suicide or homicide
- Pre-existing medical condition
- Deceased developed condition after admission
- Could not be determined

10. Since admission, did the inmate ever stay overnight in a mental health facility?

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- Yes
- No
- Don't know

11. Excluding emergency care provided at the time of death, did the deceased receive any of the following medical services for the medical condition after admission to your facility?

NOT APPLICABLE – Cause of death was accidental injury, intoxication, suicide or homicide

	YES	NO	DON'T KNOW
a. Evaluated by physician/medical staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diagnostic tests (e.g., X-rays, MRI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Treatment/care other than medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Confinement in a special medical unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please add any additional notes regarding this death here:

Signature Title Date