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?
   - In a general housing unit in the facility or on prison grounds
   - In a segregation unit
   - In a special medical unit/infirmary within your facility
   - In a special mental health services unit within your facility
   - In a medical center outside your facility
   - In a mental health center outside your facility
   - While in transit
   - Elsewhere Please specify:

5. Where did the incident (e.g., accident, suicide or homicide take place?)
   - NOT APPLICABLE – Cause of death was illness, intoxication or AIDS related
   - In the prison facility or on the prison grounds
     - In the inmate’s cell/room
     - In a temporary holding area/lockup
     - In a common area within the facility (e.g., yard, library, cafeteria
     - In a special medical unit/infirmary
     - In a special mental health services unit
     - In a segregation unit
     - On death row, special unit awaiting capital punishment
     - Elsewhere within the prison facility Please specify:
   - Outside the prison facility (e.g., while on work release or on work detail)
   - Elsewhere Please specify:
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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.)
   - Illness-Exclude AIDS-related deaths [Specify]
   - Acquired Immune Deficiency Syndrome (AIDS)
   - Accidental alcohol/drug intoxication [Specify]
   - Accidental injury to self [Describe]
   - Accidental injury by other (e.g., vehicular accidents during transport) [Describe]
   - Suicide (e.g., hanging, knife/cutting instrument, intentional drug overdose) [Describe]
   - Homicide [Describe]
   - Other cause(s) [Specify]

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?
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

<table>
<thead>
<tr>
<th>Service Description</th>
<th>YES</th>
<th>NO</th>
<th>DON’T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Evaluated by physician/medical staff</td>
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<td>b. Diagnostic tests (e.g., X-rays, MRI)</td>
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<td>c. Medications</td>
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<td>d. Treatment/care other than medications</td>
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<td>e. Surgery</td>
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<td>f. Confinement in a special medical unit</td>
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</tbody>
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Please add any additional notes regarding this death here: