I. AUTHORITY

The Commissioner of Corrections adopts this policy pursuant to the authority contained in 34-A M.R.S.A. Section 1403.

II. APPLICABILITY

All Departmental Juvenile Facilities

III. POLICY

It is the policy of the Department of Corrections, in the event that a death of a resident occurs while in the custody of Department of Corrections staff, to evaluate the circumstance surrounding the death, to ensure appropriate notifications are made to the Chief Administrative Officer, or designee, and state agencies as required by law, and to ensure that a proper response by staff was implemented.

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Procedure A: Determination and Notification
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V. ATTACHMENTS

None

VI. PROCEDURES

Procedure A: Determination and Notification
1. Only the facility physician, physician assistant, nurse practitioner or qualified emergency medical services personnel may make the determination that a resident has died at a juvenile facility. Only qualified emergency medical services or hospital personnel may make the determination that a resident in the custody of Departmental staff has died outside a juvenile facility.

2. Until a determination of resident death has been made as set out above, trained facility staff shall initiate emergency life saving measures unless the resident is decapitated, has dependant morbidity, or rigor mortis has set in. Once initiated, non-medical staff may not discontinue emergency life saving measures except at the direction of qualified facility medical staff or upon transfer of responsibility to qualified hospital or emergency medical services personnel. Facility medical staff shall direct the discontinuation of emergency life saving measures if a determination of death has been made as set out above or if the resident, who has attained the age of 18, has a current Advance Directive or a physician’s order to not resuscitate (DNR order), unless it appears to be a suicide attempt or the result of other self-injurious behavior.

3. Once the determination of death has been made as set out above, facility medical staff (or, if the death of a resident in custody of Departmental staff has occurred outside a juvenile facility, the custodial staff) shall immediately inform the Juvenile Facility Operations Supervisor that a death has occurred, and, if known, whether the death appears to have been of natural causes.

4. The Juvenile Facility Operations Supervisor shall notify:

   a. The Duty Officer; and

   b. The Chief Administrative Officer, or designee, who shall notify the Commissioner of Corrections, or designee, and the Department’s legal representative.

5. The Chief Administrative Officer, or designee, shall notify the Classification or Records Officer of the resident’s death by the next business day.

6. If the death might have been by suicide or otherwise might not have been of natural causes, the death scene shall not be disturbed. The resident’s body shall not be disturbed and the area shall be considered a potential crime scene in accordance with Departmental Policy 13.9, Emergency Situations.

7. If the death might not have been of natural causes, the facility Duty Officer shall ensure that the State Police, the facility investigator, and the Department’s Director of Operations are notified.
8. In any case of the death of a resident at a juvenile facility or otherwise in the custody of Departmental staff, the facility Duty Officer shall ensure that the Office of the Medical Examiner is notified.

9. In the case of resident death at a juvenile facility, the facility physician, physician assistant or nurse practitioner making the determination of death or, if death was determined by emergency medical services personnel, the most qualified facility medical staff shall document the death in the resident’s health care record, including the evidence supporting death, the time of the death, the circumstances surrounding the death, any emergency life saving measures taken, and, if possible, the apparent cause of death. If the death is determined by emergency medical services personnel, facility medical staff shall also obtain a copy of their documentation for inclusion in the resident’s health care record.

10. If death of a resident in custody of Departmental staff occurs outside the juvenile facility, the custodial staff shall document the circumstances surrounding the death, any emergency life saving measures taken, and any other actions taken, including, but not limited to, efforts to obtain the assistance of emergency medical services personnel or hospital personnel. The facility medical staff shall obtain a copy of any documentation by emergency medical services personnel or hospital personnel for inclusion in the resident’s health care record.

11. In any case of the death of a resident at a juvenile facility or otherwise in custody of Departmental staff, a printed copy of the health care record shall be made by medical department staff, with a notation as to who printed the copy and when. The original record shall be sealed, secured, and delivered to the Chief Administrative Officer, or designee. If any additional health care document is found or received after the record has been printed, it shall be labeled as to the date and circumstances of its discovery or receipt and forwarded to the Chief Administrative Officer, or designee.

12. When medical staff are informed of the death of a resident outside the juvenile facility but not in the custody of Departmental staff (e.g., while on furlough, work release, or in the custody of a deputy sheriff or staff from another jurisdiction), medical staff shall immediately inform the Juvenile Facility Operations Supervisor that a death has occurred.

13. The Juvenile Facility Operations Supervisor shall notify:

a. The Duty Officer; and

b. The Chief Administrative Officer, or designee, who shall notify the Commissioner of Corrections, or designee, and the Department’s legal representative.
14. The Chief Administrative Officer, or designee, shall notify the Classification or Records Officer of the resident’s death by the next business day.

15. In any case of resident death, whether or not the resident was in the custody of Departmental staff, the Unit Manager of the resident’s housing unit, or other staff designated by the Chief Administrative Officer, shall be responsible to notify the parent, legal guardian, if applicable, or other individual designated by the resident as the person to be contacted in the event of the death of the resident.

16. The designated staff shall inquire if the person notified wishes to claim the body and assume burial costs.

17. If no one wishes to claim the body, the Chief Administrative Officer, or designee shall direct cremation of the body and delivery of the remains to an appropriate person, unless the resident has indicated an objection to cremation in writing, the next of kin objects to cremation, or the resident is known to be a member of a religion that prohibits cremation.

18. In any case of resident death, the Chief Administrative Officer, or designee shall determine the disposition of the resident’s property, after consultation with the Department’s legal representative, and document the action(s) taken.

19. In any case of resident death, the Chief Administrative Officer, or designee shall determine the distribution of the resident’s funds, after consultation with the Department’s legal representative and document the action(s) taken.

Procedure B: Initial Mortality Review

1. The facility Health Services Administrator (HSA), or designee, shall ensure that the following materials are gathered or obtained in order to complete an initial mortality review within thirty (30) days of the death of a resident in the custody of Departmental staff.

   a. All resident health care records, and

   b. A copy of the Post-Mortem Report, if available.

2. If the resident death was by suicide, a psychological autopsy shall be conducted for consideration in the initial mortality review.

3. The HSA, or designee, shall include the health care staff as part of the initial mortality review and shall invite other staff as appropriate.
4. The initial mortality review shall consider events leading up to the death, including health care interventions and any emerging patterns that might be relevant to the death.

5. Upon completion of the initial mortality review, the results shall be communicated to all the health care staff and the written report shall be sent to the Chief Administrative Officer, or designee, and to the Commissioner, or designee.

6. The initial mortality review shall be presented at a Mortality and Morbidity meeting following its completion.

Procedure C: Final Mortality Report

1. Any information not included in the initial mortality review that is discovered or received at a later date shall be incorporated into a final report. If no other information is determined to be relevant to the death, the initial report shall stand as written with a notation to this effect.

2. The final report or the initial report noted to constitute the final report shall be sent to the Chief Administrative Officer, or designee, and to the Commissioner, or designee.

3. The resident’s health care record and the mortality report(s) shall be maintained in a secure location at the facility for seven (7) years following the resident’s death unless otherwise advised by the Attorney General’s Office. At the end of that time period, the record and reports shall be handled in accordance with Policy 13.9, Health Care Records.

VII. PROFESSIONAL STANDARDS

ACA:

4-JCF-4C-43 In the case of death of a juvenile, the juvenile’s parent, guardian, or legal custodian is promptly notified. Procedures specify and govern the actions to be taken in the event of the death of a juvenile.