



CORRECTIONS MEDICINE
Procedures in the Event of a Patient Death
ACA Standard: 4 ALDF – 4D – 23

Effective: May 2000

Revised: July 2011, Apr 2016, May 2019, July 2019

Reviewed: May 2013, Mar 2015, Apr 2017, May 2018

Policy Number:
CM – 11

- I. **PURPOSE:** To assure that in the event of the death of a patient at the Buzz Westfall Justice Center the appropriate parties are immediately notified and an investigation occurs.
- II. **POLICY:** All patient deaths are reviewed to determine the appropriateness of clinical care; to ascertain whether changes to policies, procedures or practices are warranted, and to identify opportunities to improve patient care.
- III. **RESPONSIBILITY:** All Corrections Medicine Staff are responsible for the content of this policy and procedure as well as adherence to the policy.
- IV. **PROCEDURE:**
 - 1. The Saint Louis County Department of Justice Services (DJS) has in effect a written policy assuming responsibility for notification of next-of-kin or emergency contact, and the request of a post mortem examination. DJS assumes responsibility to contact the City of Clayton Police Department. Upon arrival, the Clayton Police Department will contact the Chief Medical Examiner’s (CME) Office. The CME’s Office will send a forensic investigator to conduct an investigation. A Corrections Medicine provider, manager, supervisor or charge nurse shall be present and available to the forensic investigator during the investigation.
 - 2. The Morbidity and Mortality Review will be conducted by Department of Public Health (DPH) Corrections Medicine staff members, and will include all parties who participated in the care of the patient, the medical and mental health providers, the DPH Chief Medical Officer, and select members of the DJS Administration as soon as possible after the patient’s death.
 - 3. There shall be a review of all care and incidents leading up to the time of the patient’s death. Recommendations will be discussed regarding changes to current processes and/or policies and procedures to improve patient care and to reduce the risk for similar incidents to occur. Results of the Morbidity and Mortality Review will be communicated in writing to the Director of DPH. Timelines will be assigned to recommendations with weekly follow up until all recommendations are completed.
- V. **REFERENCES:**
 - Department of Justice Services Policy 838: Inmate Death
 - Department of Justice Services Policy 839: Notification of Next of Kin for Death or Serious Illness/Injury
 - National Commission on Correctional Health Care, 2015 Jail Standards; Standard J-A-10
 - American Correctional Association, Performance-Based Standards for Adult Local Detention Facilities, Fourth Edition, Standard ALDF- 4D-23