I. PURPOSE

It is the policy of the Department of Corrections to review unexpected inmate deaths. The purpose of this policy is to establish a review process to identify potential modifications to safety and security practices.

II. DEFINITIONS


III. POLICY

A. Inmate Death Review Team

1. Review of Inmate Death: When an unexpected inmate death occurs, a formal review will be completed as assigned by the Inspector General, including a review of the inmate’s incarceration history and associated records.

   a. The review will be conducted by an Inmate Death Review Team comprised of the East/Westside Institutions Administrator or designee, Medical Services Manager or designee, Behavioral Health Services Manager or designee, SIU Inspector, STM Lieutenant, and any other DOC employees deemed necessary by the Inspector General.

   b. The Inspector General will appoint the chair of the team.

   c. At the conclusion of the review, the Inmate Death Review Team will prepare a report and submit it to the Inspector General.

   d. The Inspector General will submit the report to the Policy Group and functional unit manager and distribute accordingly.

B. Team Responsibilities

When an Inmate Death Review Team is assigned, a review will begin within seven days of being assigned, unless otherwise directed by the Inspector General. Members of the Inmate Death Review Team shall conduct interviews, review all documentation
associated with the inmate death, and pursue any other inquiry deemed necessary. The Inmate Death Review Team shall use the Inmate Death Review Team Checklist (CD1695) to ensure all forms and notifications are completed.

1. Inspector General: The Inspector General or his/her designee is responsible for appointing the Inmate Death Review Team chairperson, assigning team members, reviewing documents, and collecting any outside agency reports (such as police reports and the chief medical examiner’s report).

2. Inmate Death Review Team Chair: The chairperson will make assignments, ensure deadlines, and review work submitted to the Inmate Death Review Team, including the final report to be submitted to the Inspector General.

3. Eastside/Westside Institutions Administrator (Depending on location of the incident): The administrator will provide a security review to the Inmate Death Review Team. This will include an Unusual Incident Report, staff memorandums, misconduct report (if applicable), and any staff interviews conducted by the administration.

4. Medical Services Manager: The Medical Services Manager will provide a medical services review to the Inmate Death Review Team.

5. Behavioral Health Services Manager: The Behavioral Health Services Manager will provide a review to the Inmate Death Review Team.

6. Inspector: The Inspector 3 will collect all related documents necessary to complete the investigative report and submit the report to the Inmate Death Review Team.

7. Security Threat Management (STM) Lieutenant: The STM Lieutenant who is duty stationed where the death occurred, will assist with interviews and may be assigned additional duties as directed by the Inmate Death Review Team.

8. Information Technology Services: Upon request, Information Technology Services shall provide technological data to the Inmate Death Review Team.

9. Office of Population Management: Upon request, the Office of Population Management shall provide all documents related to the housing history and classification records of the deceased inmate to the Inmate Death Review Team.

10. Policy Group: The Policy Group will meet to review the Inmate Death Review Team report and direct modifications of policies, procedures, post orders, or practices if deemed necessary.

11. Outside Agency: For a case involving an outside agency as the primary investigator, the Inmate Death Review Team shall not begin their review until receiving consent from the outside agency and the Inspector General.

C. Preliminary Review

The Inspector General shall initiate a preliminary review meeting with the Policy Group, functional unit manager, DAS Risk Management representative, and DOJ
representative no later than 10 days after the Inmate Death Review Team has finished its review. The purpose of the preliminary review is to identify any modification of policies, procedures, post orders, or practices to accomplish sound correctional practices.

D. Final Policy Group Meeting

1. The Inspector General will set a date to meet with the Policy Group and functional unit manager or his/her designee of the unit where the death occurred to discuss the final investigative report. This report will include all security documents, medical and mental health documents, outside agency reports, video recordings, Policy Group recommendations, and implementation of those recommendations.

2. This meeting will be scheduled no later than 10 days after the report is completed. Once the Policy Group has approved the final report, it will be returned to the Inspector General and reviewed by DOJ for approval and distribution.

IV. IMPLEMENTATION

1. The Inspector General shall schedule meetings with the Policy Group and the functional unit manager, if necessary, to discuss the estimated time it will take to implement the Policy Group’s directives and to identify any new issues that need to be addressed. The Inspector General will continue to update Policy Group on implementation strategy and timelines to ensure the modifications are successfully implemented.

2. The Inspector General’s Office will conduct an audit – or request periodic auditing from another source – of recommendations to ensure the changes have been completed as directed.

Certified: ____________________________
Birdie Worley, Rules Coordinator

Approved: ____________________________
Mitch Morrow, Deputy Director