STATE OF VERMONT AGENCY OF HUMAN SERVICES DEPARTMENT OF CORRECTIONS	Death Response and Review	Page 1 of 11
CHAPTER: HEALTH SERVICES	**#353**	**Supersedes:** #353 Terminal Illness and Inmate Death – Facilities, dated 3/29/06
Local Procedure(s) Required: No **Applicability:** All staff (including contractors and volunteers) **Security Level: "B" –** Anyone may have access to this document.		
Approved: SIGNED **James W. Baker, Commissioner**	May 26, 2021 **Date Signed**	6/10/2021 **Date Effective**

PURPOSE

The purpose of this policy is to establish the Department of Corrections' (DOC) approach to offender or inmate death or terminal illness. This policy also intends to establish a process for post-death review of individuals supervised in the field or incarcerated within a correctional facility.

AUTHORITY

18 V.S.A. §§ 5205, 9700 *et seq.*; 26 V.S.A. § 1443; 28 V.S.A. § 803; 28 V.S.A. § 808(e); 33 V.S.A. § 2301.

POLICY

The DOC prioritizes offender/inmate health, well-being, and dignity. It is committed to: (1) ensuring that offenders/inmates diagnosed with terminal illnesses are evaluated for release or supervision status based on their medical status and risk of reoffending; (2) providing all offenders and inmates the opportunity to create, or modify, pre-existing advance directives; (3) treating offenders and inmates appropriately and compassionately through their end-of-life; (4) immediately reporting offender/inmate deaths to the appropriate officials, promptly notifying the next-of-kin when appropriate, and investigating the circumstances of death; and (5) carrying out its duties with a trauma-responsive approach insofar as it does not interfere with the safety of staff, offenders/inmates, other constituents, or the public. The DOC is committed to responding to terminal illness and death among those in its care in a trauma-responsive way. It recognizes the impact of these events on those in its custody, their loved ones, and DOC staff members while prioritizing compassionate support for those impacted.

GENERAL GUIDELINES

A. Response to Notice of Offender/Inmate Death

1. Review Death Response and Review Checklist (see addendum)
2. Follow Checklist to track next steps

B. Notifications for Offender/Inmate Deaths (required, if applicable)

1. DOC Constituency Services
2. DOC Peer Support
3. Treatment providers
4. Courts
5. Parole Board
6. Next of kin (facility only)
7. Victim lead [e.g., Victims Services Unit, Probation or Parole (P&P) Officer, State's Attorney Victims Advocate]
8. Department of Children and Families (DCF)
9. Department of Mental Health
10. Department of Aging and Independent Living
11. Transitional housing

C. Facility Inmates with a Terminal Illness

1. Notification. The contracted health care provider shall be responsible for identifying and notifying the DOC of inmates who are terminally ill. Please refer to Directive #373.02, Medical Furlough, and related guidance.
2. Review for Release. When the contracted health care provider has identified an inmate as terminally ill, the DOC shall follow the medical furlough/parole process set forth in their respective directives.
3. Advance Directives.
    a. An advance directive is a written record executed pursuant to 18 V.S.A. § 9703 that may include appointment of an agent, identification of a preferred primary care clinician, instructions regarding health care wishes or treatment goals, an anatomical gift, final arrangements of inmate remains, and funeral goods and services. Advance directives may include documents designated under prior Vermont law as durable power of attorney for health care or a terminal care document.
    b. The DOC shall offer opportunities for inmates to retain control over their own end-of-life decisions through the use of advance directives.
    c. The contracted health care provider shall offer inmates the opportunity for discussion and completion of advance directives during their initial and subsequent annual exams, at the Chronic Illness Clinic, upon admission to an Infirmary, or any time such opportunities are requested. All completed advance directives shall be sent to the Vermont Ethics Network Registry.
    d. The contracted health care provider shall review advance directives with the inmate as circumstances warrant in accordance with prevailing medical standards.

e. If a terminally ill inmate has a properly executed advance directive, the inmate's end-of-life care shall be provided according to the terms of the advance directive and Vermont statutory and administrative law.
f. The contracted medical provider shall maintain properly executed advance directives, and the name of the person(s) to be notified in case of death or serious illness, in the inmate's Electronic Health Record (EHR). The medical provider shall regularly supply up-to-date advance directive information to the DOC's Health Services Division.
g. The DOC shall maintain the inmate's designated emergency contact in the Offender Management System (OMS).

4. Terminally ill inmates may request special and religious visits. The DOC shall engage this process as prescribed in the visitation directive.

D. Inmate Death in a Vermont Facility (see Section J. for Out-of-State Inmate Death)

1. Securing the Scene.
   a. In the case of an inmate death, the Shift Supervisor shall assign a staff member to secure the scene and restrict access to the area until it is released by the Medical Examiner, law enforcement, or other designated investigating authority. Please see Directive #409.08 Crime Scene Preservation & Evidence Collection.
   b. The staff member designated to secure the scene shall initiate a separate log to document the incident. Staff shall include in the log the name, time, and purpose of any individual who enters or exits the scene and any items brought into, or removed from, the scene.
   c. Only staff assigned to the scene, or health care personnel engaged in performing their duties (e.g., documentation of death condition), shall be allowed in the area until the Medical Examiner, law enforcement, or designated investigating authority releases the scene.
   d. If lifesaving measures have been performed, the DOC staff assigned to the scene shall thoroughly document the scene's condition describing such measures in their log and recording them digitally by taking pictures or video.
   e. DOC staff shall preserve all physical evidence outside of the secure crime scene that may be relevant to the inmate's death and initiate a Chain of Custody form to document how this evidence is handled.
   f. As much as possible, individuals present at the time of an unexpected death, or who may have information about such death, shall be separated from each other until after they have been interviewed by the investigating authority.
2. Notifications.
   a. Whenever an inmate death occurs, the Shift Supervisor shall immediately notify the Facility Superintendent, the Medical Examiner, and, in instances of unexpected or suspicious deaths, the Vermont State Police.
   b. The Superintendent shall immediately notify the Facilities Director or designee in accordance with Directive #405, Incident Reporting, and related guidance.
   c. The Superintendent or Facilities Director shall immediately notify a) the DOC Director of Health Services; Medical Director; Director of Nursing; Chief of

Operations; Director of Classification; Commissioner, Deputy Commissioner, or their designees; and b) the inmate's next-of-kin; or a person designated by a court to make decisions or have custody of the inmate's remains.

d. The Superintendent or Facilities Director shall notify the Office of Professional Standards and the Corrections Investigations Unit (CIU) no later than the following day.
e. The Facilities Director, or designee, shall notify the Defender General in accordance with statute.

3. Pronouncement of Death. A qualified emergency services worker, physician, or medical examiner, shall pronounce the inmate's death. For expected deaths occurring after hours, the provider on call is expected to respond to the facility to make the pronouncement. Nursing Staff are not authorized to pronounce death for inmates.
4. Criminal Investigations. The decision to proceed with a criminal investigation is made by the Medical Examiner and State's Attorney's Office. The Superintendent shall provide them with access to the facility as needed. The CIU shall be responsible for coordination between the DOC and any law enforcement investigators.
5. Facility Support. The Superintendent or designee, in consultation with the Facilities Director and/or Health Services Director or their designees, shall ensure that employee assistance, including peer support and clinical support, is made available to staff and that grief counseling is offered to inmates/offenders.

E. Inmate Death in a Hospital or During Transportation

1. When an inmate dies in a hospital, DOC staff shall defer to all hospital procedures. DOC staff shall also notify the on-duty Shift Supervisor and begin arrangements for disposition of the inmate's remains in accordance with this directive.
2. Whenever a DOC staff member suspects that an inmate has died during transport, they shall immediately call 911 for assistance and begin any appropriate first aid measures. They shall also notify the Shift Supervisor.

F. Internal Reviews of Inmate Deaths in a Vermont Facility

1. The CIU shall be responsible for coordinating and tracking internal reviews. The CIU shall create a file for all completed reviews for each death.
2. When an inmate dies in DOC custody, the Health Services Director or designee shall ensure that:
   a. The medical contractor completes a mortality review within thirty (30) days of the death unless otherwise agreed to by the contractor and the DOC. The DOC may extend this period, and notify the contractor of the extension, if a law enforcement investigation is required or other circumstances necessitate an extension.
   b. The DOC's contracted Health Services Monitor provides an independent review for, at minimum, all unexpected inmate deaths.
   c. The Health Services Division completes a medical care review within 30 days of receipt of the two reviews outlined above and, if an autopsy is required, within

thirty (30) days of the autopsy report. If the mortality review or contracted Health Services Monitor's review is not received within 90 days of the inmate's death, the Health Services Director or designee shall notify the Deputy Commissioner of the delay in writing. This notification shall indicate the cause of any delay along with anticipated date(s) for report(s) completion.

d. All findings of clinical misconduct are reported to the governing entity (e.g., the Office of Professional Regulation or Medical Practice Board).

3. The Facilities Director shall ensure that an After-Action Review of correctional and emergency response actions is completed.
4. The CIU, in conjunction with the Chief of Operations or designee, shall conduct a comprehensive administrative review and issue a report that incorporates the key findings of the above reviews and provides a complete account of the inmate's death. This comprehensive review may conclude with a meeting of appropriate DOC Directors, management, and staff to debrief and make recommendations for further action or propose changes to law, policy, or practice.
5. Any of the above reviews, and resulting reports, conducted and completed to evaluate and improve health services or to determine that such services met the applicable standard of care shall be treated as confidential and privileged in accordance with 26 V.S.A. § 1443.

G. Processing and Release of Inmate's Remains

1. Following a physician's examination, and Medical Examiner's consent, the inmate's remains may be released to their next-of-kin. The Superintendent or designee shall advise the next-of-kin whom they should notify to arrange the release.
2. The next-of-kin is responsible for arranging removal of the inmate's remains from the specified location (e.g., hospital, facility, medical examiner's office) to a funeral home, except in the case where an inmate dies in an Out-of-State (OOS) facility. The DOC shall arrange and fund transportation from an OOS facility, as set forth in this directive. The next-of-kin is responsible for costs resulting from burial or services after receipt of the inmate's remains.
3. When staff cannot locate or contact the next-of-kin, or the next-of-kin refuses to claim the inmate's remains from the specified location, the DOC may release the remains to a licensed funeral director.
4. If the next-of-kin refuses to claim the inmate's remains, staff shall ask for a refusal in writing. Staff shall place this written refusal, or a note that no written refusal was provided, in the inmate's Offender Local Record or OMS.
5. When an inmate dies but has insufficient known assets for burial costs, or there is no next-of-kin, the facility shall arrange, and fund, the burial and related graveside service, if any.
6. The final disposition of unclaimed inmate remains shall be left to the discretion of the funeral director.

H. Disposition of an Inmate's Personal Property

1. At the time of the inmate death notification, the Superintendent or designee shall

arrange for the decedent's personal effects to be transferred to their next-of-kin.
2. If the next-of-kin is unwilling, or unable, to claim the decedent's personal effects from the facility, the Superintendent shall, within seven calendar days, mail them a certified letter advising that they have 30 calendar days to claim the property.
3. If the next-of-kin has not claimed the inmate's personal effects within the 30 days, the Superintendent shall dispose of the effects accordance with Directive #321.01 Handling of Personal Property in Vermont Correctional Facilities).

I. Records

1. The inmate's EHR shall be retained in accordance with the records retention schedule.
2. The Superintendent shall retain the inmate's Offender Local Record, along with copies of incident reports and other documentation pertaining to their death, in a locked space at the facility until after consulting with the Office of the Attorney General and in accordance with the records retention schedule.

J. Inmate Death in an Out-of-State Facility

Upon notice of the death of an inmate housed in an out-of-state facility, the DOC Out-of-State Unit shall:

1. Immediately notify a) the DOC Director of Health Services; Medical Director; Director of Nursing; Chief of Operations; Director of Classification; Commissioner, Deputy Commissioner, or their designees; the CIU; Facilities Director; and b) the inmate's next-of-kin or a person designated by a court to make decisions or have custody of the inmate's remains.
2. Review the investigation reports from the facility and determine if a DOC internal review and/or investigation are necessary.
3. Assist the CIU as it conducts, in conjunction with the Facilities Director or designee, a comprehensive administrative review of the case with assistance from members of the OOS Unit and law enforcement, as needed. The CIU shall issue a report that incorporates the key findings of its review and provides a complete account of the inmate's death. This comprehensive review may conclude with a meeting of appropriate DOC Directors, management, and staff to debrief and make recommendations for further action or propose changes to law, policy, or practice.
4. Arrange for transportation of the inmate's remains to Vermont, or a mutually agreeable alternative destination, in accordance with this directive. The DOC shall pay for all costs to transfer the remains from the OOS facility to a funeral home.
5. Obtain the inmate's personal property and funds from the OOS facility. The OOS shall handle disposition of the inmate's personal property in accordance with this directive.

K. Terminal Illness or Death of Field Supervisee

1. Field Response to Notice of Terminal Illness. P&P officers shall take into account any terminal illness with which their supervisees have been diagnosed when assessing compliance with parole or probation conditions.

2. Field Response to Notice of Supervisee Death
    a. See General Guidelines in this directive, Section A. Response to Notice of Offender/Inmate Death.
    b. P&P officers shall notify the CIU any time they are made aware that any of their supervisees has died.
3. The P&P Officer shall create an incident report for all offender deaths including, at minimum:
    a. How DOC was notified of the death;
    b. The steps taken to verify the death; and
    c. The circumstances of the death known or reported to DOC.
4. Death Reviews
    a. The District Manager of the office supervising the deceased supervisee shall conduct a review of the offender's record upon notice of death.
    b. The Offender Death Review shall include, at a minimum, information on the following:
        i. Offender's known medical issues impacting supervision or death;
        ii. History of DOC supervision (e.g., legal status, compliance, pending charges);
        iii. Process by which the DOC was notified about the offender's death;
        iv. Living situation (e.g., transitional housing, living alone); and
        v. Release date and plan (if history of incarceration).
    c. The Field Services Director shall consider the following to determine the depth to which the review is conducted:
        i. All relevant medical or police documentation;
        ii. Timeline of supervision;
        iii. Case work history;
        iv. Treatment history;
        v. Release planning/issues;
        vi. Compliance history;
        vii. Involvement of community partners;
        viii. Process review, analysis of contributing factors impacting death;
        ix. Recommendations for improvement, if applicable; and
        x. All relevant medical or police documentation.
    d. The CIU shall, in conjunction with the Field Services Director or designee, conduct a comprehensive administrative review for all deaths where the offender has been released from incarceration fewer than 31 days prior to the date of death. The CIU shall issue a report that incorporates the key findings of its review and provides a complete account of the inmate's death. This comprehensive review may conclude with a meeting of appropriate DOC Directors, management, and staff to debrief and make recommendations for further action or propose changes to law, policy, or practice.
    e. The CIU shall conduct a comprehensive administrative review for all deaths where the offender was residing at transitional housing that is funded, operated, or overseen by DOC regardless of how much time has lapsed since the offender's most recent incarceration. The CIU shall issue a report that incorporates the key

findings of it review and provides a complete account of the inmate's death. This comprehensive review may conclude with a meeting of appropriate DOC Directors, management, and staff to debrief and make recommendations for further action or propose changes to law, policy, or practice.

ADDENDUM

Death Response and Review Checklist

CFSS Actions (Facility)

Category	**Action**	**Date/Time[1]**	**Who Completed**	**Who Received[2]**
Crime Scene	Secure Scene			
	Secure Paperwork			
	Physical evidence			
	Separate Witnesses			
Notify	Superintendent			
	Medical Examiner			
	VSP			
Staff Support	Offer EAP			
	Offer Peer Support			
	Offer Clinical Support			
Inmate Support	Mental Health			
Reports	Ensure All Staff Complete Reports			
Booking	Booking Out Inmate			
Review	Video Footage			
Investigative (where death was unexpected)	Inmate Email/ Tablet			
	Inmate Phone Calls			
	Inmate Outgoing Mail			

Notifications to be Made by Administrators (Facility)

To be completed by	To Whom	Date/Time[1]	Who Completed	Who Received[2]
Superintendent	Facilities Director			
	Next of Kin			
	Peer Support			
Facilities Director	Chief of Operations			
	Director of Health Services			
	Director of Nursing			
	Medical Director			
	Director of Classification			
Chief of Operations	Deputy Commissioner			
	Commissioner			
	Defender General			
	Constituency Services			

Notifications (Field)

To be completed by	To Whom	Date/Time[1]	Who Completed	Who Received[2]
First Staff Aware	Probation Officer			
Probation Officer	District Manager			
District Manager	Field Director[4]			
District Manager	VSP (If appropriate)			
	Peer Support			
	Constituency Services			

Notifications to be Reviewed/Completed by CSS/PO

	Date/Time[1]	Who Completed	Who Received[2]
Victim (Check with VSS)			
Treatment Providers			
Courts (If Open Cases)			
Parole Board (If on Parole)			
DCF[3]			
DMH (IF DPP)			
DAIL			
Transitional Housing			

1. If this item is not relevant, please mark as Not Applicable (N/A)
2. For notification items, please enter to whom the notification was made
3. DCF should be notified if offender/inmate was: youthful offender, juvenile, minor/dependent, had an open/active case with DCF
4. Field Director will assess and determine what other administrative notifications are appropriate based on what is known about the offender and manner of death.