1.4.E.6 Death of an Offender or Unresponsive Offender

I Policy Index:

II Policy:

The Department of Corrections (DOC) assumes responsibility for the proper notification, investigation, reporting, and handling of incidents involving staff encounter of an unresponsive offender or death of an offender, including offenders in DOC custody.

III Definitions:

Determination of Death:
Any offender who has sustained either irreversible cessation of circulatory and respiratory functions, or irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death shall be made in accordance with accepted medical standards (See SDCL § 34-25-18.1).

Offender:
For the purpose of this policy, an inmate in the custody of the Department of Corrections (DOC) institutional system, an offender released to parole or suspended sentence who is under supervision of the South Dakota Parole Services, or a juvenile supervised by Division of Juvenile Services staff.

Scene:
The location where the incident took place. Comprises the area from which most of the physical evidence is contained.

IV Procedures:

1. Unresponsive Offender:

A. Staff encountering an unresponsive inmate within a DOC institution will immediately initiate the Incident Command System (ICS).

   1. Health Services staff, or outside emergency medical responders in the absence of Health Service staff, will be notified immediately by institutional staff upon the discovery of an unresponsive inmate.
2. When safe to do so, staff will assess the unresponsive inmate’s airway, breathing, circulation (ABC’s) and begin life-sustaining procedures, as deemed necessary by the responding staff member, while awaiting the arrival of health service staff or emergency responders. Basic first aid may be provided to the inmate, to the extent of the responding staff’s abilities and consistent with training provided by the DOC.

3. If an unresponsive inmate is found in a restricted unit cell, the cell door will not be opened until the unresponsive inmate’s cellmate(s) have been placed in restraints, or otherwise safely removed from the immediate proximity of the inmate.

4. Staff responding to a report of an unresponsive inmate will delay opening the door to any cell occupied by more than one inmate until a second staff member arrives at the scene.

5. When responding to a report of an unresponsive inmate, staff will assess the scene for possible safety concerns. The inmate will not be moved unless the scene is determined to be unsafe, or if ordered by responding Health Service staff or emergency responders.

B. Community Corrections staff discovering an unresponsive offender in the community will contact local emergency services (911) immediately.

1. If and when safe to do so, Community Corrections staff should provide basic first aid to the inmate, consistent with responding staff's training and abilities, including but not limited to, assessing the unresponsive offender’s airway, breathing, circulation (ABC’s) and beginning life-sustaining procedures. The offender will not be moved unless the scene is determined to be unsafe or as ordered by responding emergency responders. Staff will remain with the offender until emergency responders arrive on the scene.

2. If the offender is determined to be deceased, local authorities will assume jurisdiction over the body and shall direct and/or conduct any resulting investigation into the death. Only local authorities may request an autopsy. DOC staff have no authority to request or approve any request for an autopsy.

3. In the case an offender is deceased, the scene where the offender was located should be secured and preserved by responding Community Corrections staff until authority over the scene is transferred to responding law enforcement, or law enforcement determines preservation of the scene is not necessary.

C. In all cases involving the discovery of an unresponsive offender, determination of death is the responsibility of the pronouncing physician or designee. Under no circumstances will DOC staff make a determination of death.

D. The safety and physical wellbeing of staff is always first priority when responding to an unresponsive offender.

2. Preservation of Scene:

A. To the greatest extent possible, staff will preserve and secure the scene whenever there is evidence to support an unresponsive or deceased offender may be a victim of suicide, homicide, an accident, or the cause of the offender’s unresponsiveness or death is suspicious, unattended or cannot be immediately determined.

B. The scene shall be preserved and secured pending the arrival of investigating staff (Special Investigations Unit (SIU) at DOC institutions) or outside law enforcement personnel. Staff preserving and securing the scene will:
1. Restrict unnecessary access to and from the scene.

2. Prevent movement or removal of the body until receiving proper authority from medical staff, responding SIU staff or law enforcement.

3. If the offender is declared deceased, the following shall be observed by responding staff controlling the scene:
   a. In accordance with SDCL § 23-14-19, no dead body in which the cause of death is a matter of public interest, may be moved from the scene without permission from the law enforcement agency exercising investigative control of the scene, or the coroner, unless the location of dead body poses an immediate health hazard or obstructs a public transportation right-of-way.
      1) If the body or other physical evidence must be moved for health/safety or security reasons, staff should first note and document the location of the body (photograph and/or diagram sketch) before moving the body or related evidence.

4. Detain or note the presence of any individual(s) at the scene when staff arrived. Staff will attempt to identify and document any potential witnesses. Staff will obtain the name and other identifying information of any potential witness.
   a. Staff will determine the perimeter of the scene and maintain control of the scene until investigating staff assume control. Staff may be directed to keep a log of those allowed admittance to the scene, including investigators, outside law enforcement and medical staff. A record of the time which responders arrived and departed shall be kept by the Control Room.
   b. Staff will identify, secure and separate any possible suspects or witnesses.
      1) Suspects will only be questioned by those investigating staff/outside authorities.
   c. Staff will obtain the name and location of the facility where the offender is taken.

5. Staff will preserve the integrity of all possible evidence, including maintaining a proper chain of custody. Staff will not remove or move objects in proximity to where the body was located until instructed by investigators with authority over the scene, unless doing so is essential to the safety of persons present or the objects pose a threat to security. Staff will:
   a. Minimize contamination of physical evidence. Nothing at the scene will be moved, touched/handled, cleaned, removed, or otherwise disturbed until proper authorization is received; or if maintaining the scene causes a threat to safety or security.
   b. Establish physical barriers and scene perimeter with ropes, cones, barrier tape or other approved methods to protect evidence from contamination and limit unauthorized access and/or disturbance to the scene. If possible, the door(s) leading to/from the scene shall be secured.
   c. Instruct responding medical staff not to clean or otherwise disturb potential evidence at the scene, to the extent possible.

6. Staff will brief SIU staff and/or outside responding law enforcement of the facts associated with the incident and assist in controlling the scene, as directed. Staff will remain on-site until dismissed.
C. Whenever an offender dies outside the attendance of a licensed physician, physician assistant or nurse practitioner, the person in charge of the body shall notify the county coroner and sheriff of the offender’s death (See SDCL § 34-25-21) to aid in the completion of the medical certificate to be filed by the coroner regarding the facts of the death.

D. Staff will document inmate deaths when the apparent attributing cause of death is suicide, accidental, criminal in nature or otherwise unattended, by completing a Major Incident Report and reporting the death in accordance with DOC policy 1.1.A.3 Reporting Information to DOC Administration. The Major Incident Report will include at a minimum the following information:

1. Staff observations upon arrival at the scene. What lead to staff’s response to the incident or discovery of the incident?
2. Known facts surrounding the incident, such as description of the scene/location, time, date, presence of smells, sounds, liquids and objects/evidence.
3. List of possible witnesses, victims, suspects.
4. Actions taken by staff and others responding to or present at the scene.

3. Reporting the Death of an Inmate:

A. Upon confirmation by Health Service/medical staff an inmate has been determined deceased, the nurse in charge will notify the site physician, the Officer in Charge (OIC) and Responsible Health Authority, who will in turn, notify the Director of Nursing and Health Administrator of the death (See DOH policy P-A-09 Procedure in the Event of an Inmate Death).

B. If a Major Incident Report is required, this will be completed by the OIC in accordance with DOC policy 1.1.A.3 Reporting Information to DOC Administration. The report shall be distributed to the Major Incident group. In addition, the OIC will ensure the following are notified of the death:

1. The Division of Criminal Investigation (DCI) and local law enforcement, as directed by the Warden or designee.
2. The nurse in charge, if not already notified (See DOH policies P-A-09 Procedure in the Event in an Inmate Death).
3. DOC Central Records staff.
4. The DOC Corrections Specialist in the DOC Administration office.
5. The Office of Risk Management (See DOC policy 1.1.A.3 Reporting Information to DOC Administration).
6. The county coroner/medical examiner.

C. Upon notification an inmate has been determined deceased, the Warden or designee will contact the coroner/medical examiner’s office in the county where the death occurred (See SDCL § 24-1-27 and 1 HC-7A-05).

1. Designated DOC staff and/or the county coroner will arrange to have the body delivered to the local morgue. A funeral home may be contacted to arrange for transport of the
body. No action will be taken that will affect the validity of the autopsy results, including preparing the body for burial or embalming without the express authority of the investigating coroner (SDCL § 23-14-19).

D. The DOC Corrections Specialist assigned to the DOC Administration office is responsible for documenting and reporting deaths of inmates in DOC custody on a quarterly basis, as required by the Federal Death in Custody Reporting Act of 2000, Public Law 106-297.

1. The Major Incident Report, or subsequent report prepared by institutional staff (security or HS staff) that includes essential facts and information regarding the death shall be provided to the DOC Corrections Specialist. The report must, at a minimum, include the following information:

a. Name, gender, race, ethnicity and age of the inmate.

b. Date, time and location of death.

c. Brief description of the circumstances surrounding the death.

d. Cause of death, which for these reporting purposes, shall be one of the following:
   1) Illness
   2) AIDS
   3) Suicide
   4) Homicide
   5) Drugs/alcohol intoxication
   6) Accident
   7) Other/Don’t know

4. Reporting the Death of an Offender on Supervision:

A. Following medical confirmation of the death of a juvenile offender under the supervision of the Division of Juvenile Services or an adult offender on supervised release (parole, suspended sentence, compassionate parole or extension of confinement (EC)), the supervising agent will ensure the following are notified of the death:

1. The regional supervisor.

2. Major Incident Reporting group, if warranted, dependent on the circumstances of the death.

3. In the case of the death of an inmate on extension of confinement (EC), the supervising parole agent or parole supervisor will notify the Control Room officer at the institution the inmate was released from as soon as possible.


B. The supervising agent may notify an offender’s emergency contact or next of kin if known, and appropriate.
5. **Notifying an Inmate’s Emergency Contact or Next of Kin:**

A. In the case of the death of an inmate, including an inmate on EC, the Warden or designee will promptly direct designated institutional staff to notify the inmate’s emergency contact or next of kin (if known and/or documented within the inmate’s records or telephone list), pursuant to SDCL § 24-1-27.

1. The person notified will be informed of the time, date and location of death, current location of the body and advised that an autopsy will be requested by the DOC.

2. In the absence of a health care directive or other documentation in the inmate’s records specifying post-death instructions and arrangements, staff will offer to have the body delivered to a funeral home designated by the emergency contact person or next of kin, following notification by the coroner’s office that the body is released and the inquest completed (See SDCL § 34-26-14) or if no autopsy has been ordered.

   a. If DOC staff is notified the inmate’s family or other person wishes to take possession of the body, staff may assist with transferring custody of the body to the specified funeral home.

3. If attempts to call the emergency contact person or next of kin are unsuccessful within 24-hours of an inmate's death, staff will send written and/or electronic notification to the last known address on file for the emergency contact or next of kin and advise them to contact the institution.

4. If all attempts to reach the emergency contact or next of kin are unsuccessful, or those contacted decline to take possession of the body, or there is no emergency contact/next of kin listed in the inmate’s records and no one could be contacted, or those contacted have not responded after 48 hours have passed since notification was sent, designated DOC staff will make arrangements for the disposition of the body in accordance with SDCL § 24-1-27.

5. Unclaimed inmate bodies will be cremated (includes inmates on EC). Staff will arrange to have a cremation order signed by the Warden.

   a. Staff will contact the funeral home to sign the cremation order. Designated staff will “X” out and initial the hold harmless clause on the order.

   b. Staff may make arrangements to have the body transported to an appropriate location for the cremation to be completed.

   c. Staff will complete the personal information on the death certificate and fax, mail or deliver the completed cremation order and death certificate to the funeral home.

   d. Staff will determine if any party shall take possession of the ashes.

      1) If there is a request for the cremation ashes, staff will make the appropriate arrangements regarding the transport/delivery of the ashes.

      2) If there is no request to claim the ashes, staff will direct the funeral home to have the ashes placed at the county burial site in the county/locality where the death occurred.
6. The person requesting receipt of the body or cremation ashes is responsible for all expenses associated with delivery of the body or ashes, and any arrangements thereafter involving the body or ashes (See SDCL § 24-1-27).

7. The Warden or designee must notify the federal authority of the death of a federal inmate in state custody. The Federal Bureau of Prisons does not pay for cremation of deceased federal inmates.

8. When the emergency contact or next of kin is notified of an inmate’s death, the contact/next of kin will be advised a press release will be issued by the DOC regarding the death. The emergency contact or next of kin may request a delay in the press release to notify immediate family.
   a. The delay will typically not exceed forty-eight (48) hours, unless the emergency contact or next of kin presents a bona fide reason justifying the additional time, and the reason for delay is supported by the Secretary of Corrections or designee.

6. Autopsy:

A. An autopsy may be ordered by the state’s attorney, sheriff or coroner of the jurisdiction where the death occurred if there is reason to believe any inmate/offender died by unlawful means (See SDCL § 23-14-9.1).

B. As a matter of public interest, the county coroner shall investigate the death of any inmate in DOC custody. Does not include inmates released to EC. The coroner may order an autopsy in accordance with SDCL § 23-14-18(3) (ACA #1-HC-7A-05, 4-4425).
   1. The county coroner shall prepare a medical certificate in accordance with chapter 34-25, for all inmate deaths while in DOC custody.
   2. If the coroner has reason to believe the inmate’s death may not be from natural causes, the case may be referred to the state’s attorney, sheriff or police (See SDCL § 34-25-22).
   3. Media inquiries received by the DOC regarding an inmate/offender death will be directed to the DOC Communications and Information Manager.

C. As a matter of standard operating procedure, the Warden will request the respective coroner conduct a forensic autopsy or other scientific or medical test(s) on the body of any inmate whose death occurred while in DOC custody (does not include inmates on EC). The coroner retains all rights to conduct an examination of the body (See SDCL § 34-26-5).

D. A copy of any postmortem exam will be forwarded to the nurse in charge and/or Director of Nursing for placement in the inmate’s medical file.

7. Disposition of Inmate Personal Property:

A. Upon the death of an inmate, designated staff will arrange to have the inmate’s property immediately isolated, inventoried packed and delivered to the property office or other designated location.

B. Pursuant to SDCL § 24-5-5, the Warden may apply any funds remaining in the deceased inmate’s DOC institutional account(s) towards his/her obligations, as provided in SDCL § 24-2-29 (See DOC policy 1.1.B.2 Inmate Accounts and Financial Responsibility).
1. If the remaining funds exceed the inmate’s obligations, the excess balance will be given to the heir(s) of the inmate’s estate, or disposed of in accordance with the inmate’s documented pre-death instructions, provided such instructions exist and are known by DOC staff at the time of disposition.

2. In the absence of a directive or other documentation from the inmate specifying post-death instructions/directions, DOC staff will contact the inmate’s emergency contact, legal next of kin, or in their absence, any known immediate family member, to confirm whether they intend to claim the inmate’s personal property.

C. If the inmate’s heir cannot be identified and located within a reasonable amount of time, as set forth by the Warden or his/her designee, and no documentation exists specifying post-death instructions, the excess balance of funds will be deposited into the state general fund.

1. If the inmate’s family confirms claim to the inmate’s personal property, staff will make arrangements to have the family pick up the property or ship the property to the family, with the delivery costs deducted from the inmate’s institutional account balance, pursuant to SDLC § 24-2-28. If retained by the DOC, the inmate’s driver’s license, state ID or birth certificate will be forwarded to the inmate’s family or next of kin or placed with the inmate’s personal property to be claimed by the family or next of kin.

   a. Social Security cards must be returned by Central Records staff to the issuing Social Security office within 30-days of the inmate’s death.

   b. In the case of a pending investigation into the cause of death, SIU staff and/or DCI shall be contacted prior to final disposition of the inmate’s property (certain property items may be considered evidence).

2. At the Warden’s discretion, tangible personal property of value, not claimed by the inmate’s family or next of kin, may be sold, donated to charity, discarded, returned to the executor or personal representative of the offender’s estate, or used for the benefit of the facility (See DOC policy 1.3.C.4 Inmate Personal Property and SDCL § 24-5-5).

8. Anatomical Gift by an Inmate:

A. The DOC will honor appropriately documented and filed requests/arrangements for anatomical gifts made by an inmate prior to his/her death, or such requests received by the inmate’s family, in accordance with SDCL §§ 34-26-52 and 34-26-56.

   1. Response to, and accommodation of, such requests, shall be limited to those actions determined to be reasonable by the Warden. Any action taken shall be consistent with the legitimate penological interests of the DOC.

   2. The DOC will not accept or incur any financial responsibility or costs associated with any anatomical gift procedure(s) on behalf of a deceased inmate.

   3. The process and procedure of harvesting organs from an inmate shall not impede, obstruct or otherwise interfere with any investigation conducted by the DOC, law enforcement or coroner’s office involving the death.
B. The DOC does not assume any liability or responsibility in the procedures for the taking, giving or receiving of a deceased offender/inmate’s anatomical gift or the refusal/failure to take such.

9. Mortality Review of an Inmate Death:

A. Designated staff within the Department of Health Correctional Health Services, DOC and Behavioral Health Services (as deemed necessary) will conduct and participate in a mortality review (an assessment of the clinical care provided and circumstances leading up to the death of the inmate in DOC custody, including the death of a CTP offender or detainee housed at a DOC facility, and an administrative review (assessment of correctional and emergency response surrounding the death of the inmate). The reviews will be conducted within thirty (30) days of the death (NCCHC P-A-10).

1. The Warden or designee and staff who had regular contact with the deceased inmate will attend the review.

2. Those attending may refer to and/or be represented by reports, documents and files that are relevant to the death, however, reference to these documents will not be made in any written summary.

3. The Department of Health Correctional Health Services staff will complete a written summary of the mortality review.

B. The purpose of the review is to look for trends in inmate deaths, assess the clinical care provided to the inmate and identify the circumstances leading to or proximate to the inmate’s death. Compliance with applicable policies, procedures, OMs and practices will be reviewed, including any safety concerns. The review does not constitute an official investigation into the inmate’s death or indicate or support any wrongdoing or negligence, or an official determination of the cause of death.

C. Corrective actions will be implemented and monitored by Correctional Health.

D. If the cause of death is suspected to be suicide, the provisions contained within Section 8 of DOC policy 1.4.E.7 Offender Suicide Prevention and Intervention shall apply. A psychological autopsy- the reconstruction of the inmate’s life and identification of the factors that may have contributed to his/her death, will be conducted by Behavioral Health Services (NCCHC P-A-10).

10. Case Management Review of a Juvenile Offender Death:

A. The Director of Juvenile Services will ensure a case management review is conducted and a final Case Management Review Report is completed in the event of the death of a juvenile under the supervision of the Division of Juvenile Services. The Case Management Review Report (See Attachment 1) shall be submitted to the Secretary of Corrections within ten (10) days of official notice/confirmation of the juvenile offenders’ death.

1. The regional supervisor will meet with the Juvenile Corrections Agent assigned to the deceased juvenile offender within two (2) business days of the death notice to complete the Case Management Review Report.

a. A historical review of the immediate three (3) months prior to the juvenile’s death will be completed, to include all case management activities.
b. The regional supervisor will submit the Case Management Review Report to the Director of Juvenile Services at the initial case management review meeting.

2. The Director will conduct an initial case management review meeting with the regional supervisors within five (5) business days of the death notice.

   a. This initial review will include but is not limited to an examination of the information contained in the Juvenile Comprehensive Offender Management System (COMS):
      1) All types of contact made and the content;
      2) A determination of compliance with applicable DOC policies and operational memorandums in regard to supervision and contact standards; and
      3) Any other applicable aftercare expectations.

B. The purpose of the review is to look at case management activities immediately prior to the death and for any existing trends.

   1. This review does not constitute any type of investigation into the juvenile’s death or indicate or support any wrongdoing or negligence or determine the cause of death.

11. Public Announcement:

   A. The DOC Communications and Information Manager is responsible for issuing a press release regarding the death of an inmate in DOC custody (See DOC policy 1.1.A.4 Relationship with News Media, Public and Other Agencies).

      1. If DOC staff is advised the deceased inmate’s family or next of kin has requested additional time to notify immediate family of the death, staff will contact the Communications and Information Manager immediately. Additional time may be approved by the Secretary of Corrections or designee.

      2. If attempts to contact the inmate’s emergency contact person(s) or next of kin are unsuccessful, and at least forty-eight (48) hours has elapsed since the time of death, the Communications and Information Manager may issue the press release.

   B. A DOC generated press release will normally not be issued for the death of an offender under the supervision of Parole Services or the Division of Juvenile Services, or those housed in a contract facility or out of state placement (interstate compact).

   C. The Secretary of Corrections must approve the release of information to the media or public relating to the death of an offender in the community, i.e. parole, contract placement, out of state placement, EC inmate, or juvenile.

   D. Certain individually identifiable information pertaining to an offender and the facts and circumstances of the offender’s death may be protected by Health Insurance Portability Accountability Act (HIPAA) privacy rules/confidentiality requirements. The DOC and DOH health service staff providing health care to an offender are covered entities and must comply with confidentially requirements regarding protected health information.

   E. Any member of the public requesting information from the DOC or DOH specific to the cause and/or manner of an offender death, will be referred to the County Coroner/Medical Examiner’s Office in the county where the death occurred. Certified copies of the final Coroner’s report may be available from the County Coroner/Medical Examiner’s office if/when
the death is determined to be public record. The DOC will not issue public statements regarding the cause of death.

F. Immediate family, next of kin and authorized/designated agents of the deceased offender may contact the South Dakota Department of Health Vital Records office to request informational or certified death certificates/records of death.

12. Staff Counseling:

A. Staff directly responding to or otherwise impacted by the unexpected death of an offender, may be referred to a specialist or licensed counselor for post-critical incident counseling. Staff may request counseling on their own behalf.

1. Counseling shall be provided for support purposes.

2. Participation in post-critical incident counseling may be mandatory for staff responding to an offender death, as determined by the Director or Warden.

V Related Directives:


DOC policy 1.1.A.3 – Reporting Information to the DOC Administration
DOC policy 1.1.A.4 – Relationship with News Media, Public and Other Agencies
DOC policy 1.1.B.2 – Inmate Accounts and Financial Responsibility
DOC policy 1.3.B.1 – Emergency Response
DOC policy 1.3.C.4 – Inmate Personal Property
DOC policy 1.4.E.7 – Offender Suicide Prevention and Intervention
DOH policy P-A-09 – Procedure in the Event of an Inmate Death

VI Revision Log:

July 2005: Changed the policy statement. Added a definition for offender. Added sections for mortality review and organ donation. Revised the disposition of personal property. Added references to DOH policy and current SDCL.

December 2006: Added a section on public announcement of offender death. Changed Director of Classification/Community Services to Director of Juvenile Community Corrections. Revised the definition of offender. Changed the term “offender in DOC custody” to “individual” in the first part of the section on DOC Facility Unattended Deaths or Deaths Involving Possible Criminal Action.


September 2008: Revised formatting of policy in accordance with DOC policy 1.1. A.2. Added STAR, SDSP, MDSP and SDWP when referencing OM’s in ss (C and E of Reporting the Death of an Offender at a DOC Facility). Added DOC policy, SDWP OM, MDSP OM, SDWP OM and STAR Academy OM in section V.

September 2009: Replaced “will” with “must”, replaced “immediately” with “promptly”, deleted Medical Director within ss (B), deleted coroner being contacted prior to the removal of the body from the scene in ss (B2) and replaced Sioux Falls with Pierre as it relates to Corrections Specialist in ss (D) all within Reporting the Death of an Offender at a DOC Facility. Deleted reference to sold and behalf of the facility and replaced heir with executor or personal rep. of inmate’s estate within ss (A1 and A2) both within Disposition of Personal Property…DOC Facility. Revised title of SDSP OM 2.4.G.2 to be consistent with OM. Added hyperlinks.

September 2010: Revised formatting of Section I. Added new ss (B of Disposition of Personal Property for an Offender Who Dies at a DOC Facility) regarding contacting CSA.

September 2012: Deleted “Management of Offender Deaths” and Replaced with “Death of an Offender” in title of policy. Deleted “or both if instructed to do so” and Replaced with “as directed by the Special Security officer or authorized staff” in Section 1 A. 3. Deleted “or the attending medical personnel” and Replaced with “per SDCL” in Section 1 B. Deleted “a juvenile facility” and Replaced with “STAR Academy” in Section 2 C. Added New D. and Renumbered D to E. and E. to F. in Section 2. Added “attempt to” and “or next of kin (if known)” in Section 3 A. Added “or next of kin after notification by the county coroner’s office” in Section 3 A 1. Added a.-d. to Section 3 A. 1. Added “next of kin” and “designated” to Section 3 A. 2. Deleted “Whoever” and Replaced with “DOC staff member who” and Added “or next of kin” and Deleted “in the near future” and Replaced with “by the DOC regarding the offender’s death” in Section 3 A. 4. Deleted “DOC staff will work with the emergency contact person as much as possible to ensure timely notifications are made” and Replaced with “The Secretary of Corrections will determine if a press release will be issued in the case of a juvenile offender’s death” in Section 3 A. 4. b. Added “and/or coroner’s office in accordance with the facility’s ERM” in Section 4 A. Deleted “written informational” and Replaced with “major incident report” in Section 4 C. Added D. to Section 4. Deleted “or other personal property of value” in Section 5 A. Added New B. and B. 1. a. B 1. a. and B. 3. Added “not claimed by the adult offender’s family or next of kin” and “or used for the benefit of the facility” to previous A. 1. and moved this to B. 2. in Section 5. Deleted “Organ donation” and Replaced with “Anatomical Gift” in Section 6. Added “use of any state resources” in Section 6 A. 1. Added “on behalf of a deceased offender” in Section 6 A. 2. Added “Clinical/Administrative” to title of Section 7. Added “including any recommendations for corrective actions identified by the review” in Section 4 A. 3. Added “access the clinical care provided to the offender and circumstances leading to the death and facility and staff compliance with applicable policies, procedures, OMs and practices” in Section 7 B. Deleted “Juvenile Offender Tracking System” and Replaced with “Information contained in COMS, including but not limited to” in Section 8 A. 2. a. Added new Section 10.

October 2013: Deleted “at a DOC Facility” from Section titles and Replaced with “Offender in DOC Custody” Deleted “1. It is the responsibility of the Warden, Superintendent or his/her designee to ensure the coroner is notified by one of the above listed officials, so the coroner can perform his/her duties” in Section 1 B Added New C. to Section 1 Deleted F. “Adult facilities will refer to their respective OMs for additional procedures” in Section 1. Added “After the investigating coroner has released custody of the body and the inquest has been completed” in Section 3 A.1. Deleted b. “If the family declines possession of the body, staff will determine if the deceased offender has been neglected of abandoned by his family, as described in SDCL 34-26-6” in Section 3 A. 1 Deleted “or Deaths Involving Possible Criminal Action” from title of Section 4 Deleted “that may have involved criminal action of another individual” and Added “will activate the facility’s emergency response procedures in accordance with the facility’s ERM or contact local law enforcement (in the case of an offender death occurring in the community)” to Section 4 A Added a. to Section 4 B. 2 Added new C. and Renumbered sections that followed in Section 4. Added new Section 5 and Renumbered sections that follow. Added new A. to Section 6 and Renumbered sections that followed Deleted “that occurs in the DOC facility or DOC contracted facility, including a hospital, nursing home, etc.

March 2014: Added new A. and Renumber subections that followed in Section 1. Deleted “The death of an offender in DOC custody shall be immediately reported to the following” and Replaced with “The OIC will ensure the offender death is immediately reported to the following:” in Section 1 B. Deleted “attending medical personnel” and Replaced with “and/or Clinical Supervisor” in Section 1 A. 6. Deleted “the offender’s body may not be embalmed” and Replaced with “No action will be taken that will affect the validity of the autopsy results, including preparing the body for burial and/or embalming” in Section 1 C. Added “will inform those
contacted on behalf of the deceased offender that an autopsy will be conducted” in Section 3 A. 1. **Added** “b. to Section 3 A. 1. **Added** “ashes” to Section 3 A. 4. **Added** definition of “Scene”. **Added** “and Preservation of Scene” to title of Section 4. **Added** “ICS” to Section 4 A. **Added** 1. to Section 4 A. **Added** new B. to Section 4 A. and **Renumbered** sections that follow. **Added** a. and b. to Section 4 C. 2. “where the death occurred” and **Replaced** with “at the scene” and **Deleted** “any behavior on the part of” in Section 4 C. 3. **Added** a. and b. and b. 1) to Section 4 C. 3. **Added** “including maintaining the chain of custody for any evidence collected” to Section 4 C. 4. **Added** a. b. c. to Section 4 C. 4. **Added** 5. to Section 4 C. **Added** “unattended” “responded to by staff” and “and reporting the death” to Section 4 E. **Added** “forensic” to Section 5 A. **Deleted** “his/her designee” and **Added** “and/or other related scientific or medical tests on the body of any offender” and **Added** “No authorization from the offender’s next of kin/family is required” in Section 5 B. **Added** 1-4. to Section 4 E. **Added** a. to Section 6 C. 1. **Deleted** Section 11 and moved info, to Section 1 A. 7. **Deleted** “Warden or Superintendent” and **Replaced** with “The DOH Correctional Health Services” in Section 8 A. and 8 A. 3. **Added** Attachments 2-4. **September 2015: Moved** Section 4 to Section 1. **Removed** “Unattended Death” from title of Section 1. **Added** “or outside emergency medical responders, in the absence of Health Service staff” in Section 1 A. 1. **Added** “i.e. resuscitation of the unresponsive offender while awaiting the arrival of health service staff or emergency responders” in Section 1 A. 2. **Added** new 3. to Section 1 A. **Added** “cell door in a segregation/restricted unit occupied by offenders” in Section 1 A. 5. **Deleted** “life saving measures” and **Replaced** with “life-sustaining procedures” in Section 1 B. **Added** “if safe to do so” and **Added** “Staff will remain with the offender until emergency responders arrive on the scene.”. In the case of death, local authorities will assume jurisdiction over the body. Staff will ensure the scene is preserved and secured until authority over the scene is assume by responding law enforcement” to Section 1 B. 1. **Added** new Section 2 “Preservation of Scene” using existing language and **Added** new language. **Added** “(This does not typically apply to offenders in custody as death is not pronounced by Health Service staff)” in Section 2 b. 2. **Deleted** “In the event an” and **Replaced** with “Upon confirmation by Health Services or medical staff an” in Section 3 A. **Added** new D. to Section 3. **Added** “has been pronounced deceased” in Section 3 C. **Added** “medical confirmation” in Section 4 A. **Deleted** “All offender deaths that occur when” and **Replaced** with “Following the death of a” in Section 3 A. **Deleted** “those contacted on behalf of the deceased offender” and **Replaced** with “emergency contact/next of kin” and **Added** “of the time and date of death, the location of the body and” and **Added** “In the absence of a health care directive and/or other documentation in the inmate’s records specifying post-death instructions and arrangements” in Section 5 A. 1. **Added** “to a funeral home designated by the emergency contact or next of kin” in Section 5 A. 1. a. **Added** “or emergency contact is listed in the inmate’s records and no next of kin can be located” in Section 5 A. 2. **Added** “or other person” in Section 5 A. 2. a. **Added** “or those contacted decline to take possession of the body” in Section 5 A. 3. **Added** 5. to Section 5 A. **Deleted** b. in Section 5 A. 2. **Added** C. to Section 6. **Added** “In the absence of a directive or other documentation from the offender specifying post-death instructions/directions regarding the deceased’s property” and **Added** “emergency contact, legal next of kin or in their absence, an immediate family member” to Section 7 C. **Added** C. to Section 9. **Added** “(an assessment of the clinical care provided and the circumstances leading up to the death of the offender) and an administrative review (assessment of correctional and emergency response surrounding the death of the offender)” in Section 9 A. **Added** “A psychological autopsy- the reconstruction of the offender’s life and identification of the factors that may have contributed to death will be conducted by qualified mental health staff (NCCHC P-A-10)” in Section 9 C. **Added** “or who is housed in a contact facility/jail or out-of-state/interstate compact.” to Section 11 B. **March 2015: Deleted** “superintendent” from within policy. **Replaced** term “offender” with “inmate” throughout the policy where appropriate. **Deleted** D. “In the case of the death of a juvenile offender committed to the DOC, all the above steps shall apply” in Section 3. **Deleted** 1. “If the juvenile was placed in a DOC facility, the JCM will be notified of the death pursuant to STAR OM 5.3. E.2. **Deleted** “Additionally, in the case of a juvenile offender death at STAR Academy, staff will complete parent/guardian notifications in accordance with DOC policy. This
statute applies specifically to inmates; however, the procedures described within shall also apply
to the death of a juvenile in DOC custody (ACA-4395)” in Section 5 A. Deleted “In the case of a
juvenile offender death, the Superintendent will turn over any funds in the offender’s DOC
account or other personal property of value to the offender’s parent(s), guardian(s) or known
immediate family member” in Section 7 C. Deleted “The decision of which family member or
guardian receives the funds or personal property of value will be made on a case-by-case basis,
with preference given to the juvenile offenders primary care provider” in Section 7 C. 1. Added
“or in the temporary custody of an outside law enforcement agency” in Section 11 B. Added C.
and D. to Section 11.

September 2016: Added HIPPA language to Section 11 C. Added Section 12.
September 2017: Added 3. to Section 8 A. Added 2. to Section 3 C.
September 2018: Deleted “If possible” in Section 1 A. 5. Deleted “The inmate will not be
moved unless the scene is determined unsafe” in Section 1 A. 5. Added “and when” and Added
“training” and Added “The offender will not move moved unless the scene is determined unsafe”
in Section 1 B. Added “or deceased” and Added “death” and Added “unattended” in Section 2
A. Added “unless doing so is essential to the safety of persons present” in Section 2 A. 5.
Added “and ensure the report is sent to the Major Incident group, in accordance with policy. In
addition, the OCI shall ensure the following is notified of the offender death” in Section 3 B.
Added “compassionate parole or extension of confinement” and Added 3. in Section 4 A. Added
3. and 4. in Section 5 A. Added “The DOC will not issue public statements regarding the cause
or possible cause of an offender’s death” in Section 11 C.

May 2019: Added “and shall direct and/or conduct any resulting investigation into the death” in
Section 1 B. 2. Added “(Special Investigations Unit (SIU) at DOC institutions)” in Section 2 B.
Added 4. to Section 3 B. Added 1. to Section 3 D. Added 4. to Section 4 A. Added “into the
state general fund” and Deleted “in the institution’s benevolent fund” in Section 7 C. Added “or
determine the cause of death” in Section 9 and 10 B. Added C. to Section 11.

October 2019: Added “death of a CTP offender or detainee housed at a DOC facility” in Section
9 A.

December 2019: Added “only local authorities may request an autopsy. DOC staff have not
authority to request or approve any request for an autopsy” in Section 1 B. 2. Added 2. to
Section 4 A. Added new B. to Section 4. Added “including an inmate on EC” in Section 5 A.
Added “or if no autopsy has been ordered” in Section 5 A. 2. Added “Unclaimed inmate bodies
will be cremated (includes inmates on EC) in Section 5 A. 5. Added new b. to Section 5 A. 5.
Added “Does not include inmates on EC” in Section 6 B and C. Added “EC inmate” in Section 11
C.

<table>
<thead>
<tr>
<th>Mike Leidholt (original signature on file)</th>
<th>12/04/2019</th>
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<tbody>
<tr>
<td>Mike Leidholt, Secretary of Corrections</td>
<td>Date</td>
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Attachment 1: Case Management Review Report

The Case Management Review Report form is at

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The gray areas indicate the information that is to be entered.
Attachment 2: Release of Deceased Inmate’s Body to the Coroner

The Release of Deceased Inmate’s Body to the Coroner form is located at:

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Attachment 3: South Dakota Coroner—Order for Autopsy

The South Dakota Coroner-Order for Autopsy form is located at:
http://www.sanfordhealth.org/Content/PDFs/MedicalServices/Pathology/PERMIT_BY_SOUTH_DAKOTA_CORONER_FOR_AUTOPSY.pdf
Attachment 4: Death of an Inmate Checklist

The Death of an Offender in Custody Checklist form is located at:

M:\DOC\DOC Policies\Agency\DOC Policies\Attachment Templates\Death of an Inmate Checklist.doc