

	State of Indiana Indiana Department of Correction Division of Youth Services	Effective Date  4/1/2022	Page 1 of  2	Number  2.27Y
<b>HEALTH CARE SERVICES          DIRECTIVE-YOUTH SERVICES          Manual of Policies and Procedures</b>				

Title <b>PROCEDURE IN THE EVENT OF THE DEATH OF A YOUTH</b>
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Legal References (includes but is not limited to)  11-8-2-5	Related Policies/Procedures (includes but is not limited to)  01-02-101	Other References (includes but is not limited to)  National Correctional Healthcare Standards
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I. PURPOSE:

The purpose of this Health Care Services Directive (HCSD) is to provide direction regarding actions taken after the death of youth.

II. PROCEDURE:

**In all cases of medical emergencies when CPR is indicated 911 must be called and the clinician notified.**

**In the event that clear signs of death are present but CPR was initiated, CPR must continue until time of death is called by a practitioner.**

A. Upon learning of a youth death (on-site or off-site) the nurse in charge shall:

1. Notify the highest-ranking on-site Operations staff and the facility physician;
2. Document immediately and fully in the youth's health record;
3. Inform other Health Services staff as appropriate;
4. Secure the health record.

B. The Warden or designee shall:

1. Inform the youth's legal guardian using the procedure outlined in HCSD 1.20Y, "Notification in Emergencies;"
2. Notify the Executive Director of Youth Services;
3. Request the Coroner's Office or Medical Examiner (depending on the locality) and the State Police to review the circumstances surrounding the death, if the death occurred on-site and was unexpected or under

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suspicious circumstances (the Medical Examiner acts as an agent of the Coroner). Until the Coroner's/Medical Examiner's Office and State Police permit otherwise, the area in which the death occurred shall remain secured and intact (unless safety and security considerations make this impossible);

4. May request through the Coroner's/Medical Examiner's Office that an autopsy be performed; however, the Coroner's/Medical Examiner's Office has final authority regarding whether an autopsy is performed. In the event that an autopsy is completed, a copy of the Coroner's report is to be forwarded to the facility's Health Services Administrator (HSA), Health Services vendor's Regional Director of Nursing, and the Executive Director of Physical Health.
  5. If the death occurred in a hospital or other location the Coroner's/Medical Examiner's responsibilities are accomplished by the hospital.
  6. Autopsies are always encouraged by the Department; and upon receipt of a copy of the official Certificate of Death and/or Autopsy Report, if applicable, the Warden shall provide a copy of each document with a corresponding cover letter addressed to the Executive Director of Youth Services and the Executive Director of Physical Health that summarizes the youth's sentencing information, cause of death, and any additional information deemed relevant in the matter.
- C. Department employees are expected to fully cooperate with the Coroner's/Medical Examiner's Office and the State Police. Access to the health record as necessary for investigation shall be provided within the limits of the applicable rules and regulations.
- D. The HSA shall alert the Executive Director of Physical Health and the Chief Medical Officer (CMO) of the death, including the time of death (the Warden carries out a similar notification through their chain-of-command), and schedule a Clinical Critical Incident review in accordance with HCSD 2.24Y, "Clinical Critical Incident Review," within 30 days of the youth's death.

### III. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to youth.

signature on file

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Kristen Dauss, MD  
Chief Medical Officer

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Date