DIVISION OF IMMIGRATION HEALTH SERVICES

Detainee Mortality Review Form

Date of review _____ *Detainee Label*
Detention Facility_____
Reviewer _____

Date of Death _____

Place of Death ( ) SPC ( ) Hospital ( ) Jail

Name of Hospital or Jail _____

Nature of Death
( ) Natural--acute or chronic (circle one)
( ) Accidental _____
( ) Homicide
( ) Suicide: Method _____

Cause(s) of Death:_____
_____
_____
_____

Narrative Summary

Date of camp arrival _____

Status
( ) Inpatient at: ( ) infirmary ( ) hospital
( ) Ambulatory

Significant Medical/Psychiatric conditions identified on arrival:

1. _____
2. _____
3. _____
4. _____

Initial screening, history and physical exam forms completed, signed, and dated in chart?
( ) Yes ( ) No Comments:
_____
_____

Patient had been diagnosed, treated, and followed appropriately?
( ) Yes ( ) No Comments:
_____
_____

Death Certificate in record	( ) Yes	( ) No
Autopsy performed	( ) Yes	( ) No
Autopsy results in record	( ) Yes	( ) No

At the back of this form you will find a blank page. Please use this page to describe the course of illness and cause of death in sufficient detail to indicate the circumstances of death, including treatments, medications, diagnostic testing, etc. Give findings of diagnostic exams.

If the patient died at a SPC/Jail, please complete the following:

Was the patient admitted to the Short Stay Unit (infirmary) ( ) Yes ( ) No
Working diagnosis in the infirmary _____

Were all diagnostic services and treatments prior to the death appropriate?
( ) Yes ( ) No Comment:_____
_____
_____

Was the death expected? ( ) Yes ( ) No
If yes, was the patient offered Advanced Directives? ( ) Yes ( ) No

If emergency services were rendered at the SPC/Jail immediately prior to the time of death please complete the following:

Was the death related to a medical emergency? ( ) Yes ( ) No

Was the response to the medical emergency notification timely on the part of the:

Physician	( ) Yes	( ) No	( ) NA
NP/PA	( ) Yes	( ) No	( ) NA
Nurse(s)	( ) Yes	( ) No	( ) NA

CPR used? ( ) Yes ( ) No

ACLS used—list protocols ( ) Yes ( ) No
_____
_____
_____
_____

Please describe any problems encountered during the medical emergency (e.g., equipment, communications, transportation) _____
_____
_____

If the patient died in the hospital please complete the following:

Type of admission: ( ) Routine ( ) Emergent
Diagnosis _____
Prognosis: ( ) Poor ( ) Good ( ) Unknown

Upon review of the record or discharge summary was the treatment timely and appropriate? ( ) Yes ( ) No Comments _____
_____
_____
_____

REVIEW SUMMARY

Documentation in medical record reviewed by: ( ) Local PI Committee ( ) MCC ( ) Attending physician at hospital

Was the documentation found to be within acceptable limits? ( ) Yes ( ) No
If no, explain:
_____
_____
_____
_____
_____
_____
_____

Did patient receive appropriate and adequate health care consistent with community standards during his/her detention in the INS/DIHS ( ) Yes ( ) No
If no, explain:
_____
_____
_____
_____

Recommendations
_____
_____
_____
_____

_____ _____
Signature Local PI Committee Chair/ MCC/Attending Physician Date

REVIEW OF DIHS MEDICAL DIRECTOR

Comments: ( ) Agree with PI Committee/MCC/Attending Physician
( ) Disagree with PI Committee/MCC/Attending Physician

_____
_____
_____
_____

_____ _____
Signature DIHS Medical Director Date

REVIEW BY MEDICAL RECORDS

Comments:_____
_____
_____
_____

_____ _____
Signature Medical Records Consultant Date

REVIEW BY INDEPENDENT REVIEWER

Comments:_____
_____
_____
_____

_____ _____
Signature of Independent Reviewer Date

REVIEWED BY NATIONAL PERFORMANCE IMPROVEMENT COMMITTEE

Comments: ( ) Agree with above findings
( ) Disagree with above findings

_____
_____

Morality Review Summary sent to Executive Council? ( ) Yes ( ) No
Date Sent _____

_____ _____
Signature Chair, National PI Committee Date

Please describe course of illness and cause of death in the space provided below. You may use extra sheets of paper if needed.