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(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2005-06
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on Corrections and the Courts...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (August 2012)

Assembly

Record of Committee Proceedings

Committee on Corrections and the Courts

Assembly Bill 480

Relating to: review of deaths at correctional institutions.

By Representatives Wasserman, Bies, Benedict, Berceau, Black, Colon, Cullen, Fields, Grigsby, Turner and Young; cosponsored by Senators Taylor, Carpenter, Erpenbach, Lassa and Risser.

June 14, 2005 Referred to Committee on Corrections and the Courts.

September 7, 2005 **PUBLIC HEARING HELD**

Present: (10) Representatives Bies, Gundrum, Underheim, Owens, Suder, LeMahieu, Pope-Roberts, Wasserman, Seidel, Parisi.

Absent: (0) None.

Appearances For

- Sheldon Wasserman — Rep., 22nd Assembly District
- Peggy Swan — Incarceration Coalition
- Ronald Solinger

Appearances Against

- None.

Appearances for Information Only

- David Burnett — WI Dept. of Corrections

Registrations For

- Susan McMurray — AFSCME

Registrations Against

- None.

November 2, 2005 **EXECUTIVE SESSION HELD**

Present: (9) Representatives Bies, Gundrum, Owens, Suder, LeMahieu, Pope-Roberts, Wasserman, Seidel and Parisi.

Absent: (1) Representative Underheim.

Moved by Representative Wasserman, seconded by Representative Bies that **Assembly Bill 480** be recommended for passage.

Ayes:	(8)	Representatives Bies, Gundrum, Owens, LeMahieu, Pope-Roberts, Wasserman, Seidel and Parisi.
Noes:	(1)	Representative Suder.
Absent:	(1)	Representative Underheim.

PASSAGE RECOMMENDED, Ayes 8, Noes 1

Andrew Nowlan
Committee Clerk

Assembly Committee on Corrections and the Courts

DATE
Moved by Was Seconded by Bies
AB 480 SB _____ Clearinghouse Rule _____
AJR _____ SJR _____
A _____ SR _____ Other _____
A/S Amdt _____
A/S Amdt _____ to A/S Amdt _____
A/S Sub Amdt _____
A/S Amdt _____ to A/S Sub Amdt _____
A/S Amdt _____ to A/S Amdt _____ to A/S Sub Amdt _____

Be recommended for:

- ☑ Passage
- ☐ Introduction
- ☐ Adoption
- ☐ Rejection
- ☐ Indefinite Postponement
- ☐ Tabling
- ☐ Concurrence
- ☐ Nonconcurrence

	Committee Member	Aye	No	Absent	Not voting
1.	Rep. Garey Bies, chair	1			
2.	Rep. Mark Gundrum, vice-chair	2			
3.	Rep. Greg Underheim				
4.	Rep. Carol Owens	3			
5.	Rep. Scott Suder		1		
6.	Rep. Daniel LeMahieu	4			
7.	Rep. Sondy Pope-Roberts	5			
8.	Rep. Sheldon Wasserman	6			
9.	Rep. Donna Seidel	7			
10.	Rep. Joe Parisi	8			
	Totals				

MOTION CARRIED ☐ MOTION FAILED ☐

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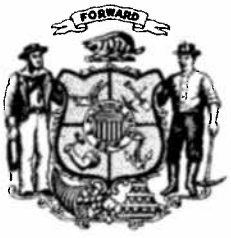
WISCONSIN STATE LEGISLATURE


FORWARD

Testimony of Dr. David Burnett, Medical Director, Wisconsin Department of Corrections
AB 480, Relating to Review of Deaths at Correctional Institutions
Assembly Committee on Corrections and the Courts
September 7, 2005

Good morning, Chairman Bies and Committee members. I am Dr. David Burnett, Medical Director for the Wisconsin Department of Corrections. Thank you for the opportunity to testify on behalf of the Department for information only on Assembly Bill 480, relating to the formation of an inmate and resident death mortality board to review deaths at state correctional institutions. Given the legislation's focus on the internal and external review of inmate deaths, the purpose of my testimony today is to provide the Committee with information about the Department's current efforts in this area.

As you know, providing inmate health care is a very challenging part of our business. Offenders come to DOC after several years of inadequate health care and many have chronic conditions such as HIV, Hepatitis, Diabetes and Asthma. In addition, as a result of longer sentences, the inmate population is getting older, a demographic change that naturally results in additional health care problems. The percentage of inmates over the age of 40 has gone from 21% in 1999 to 30% in 2004.

The Department takes all inmate deaths, both anticipated and unanticipated, very seriously. An anticipated death is defined as any death where the inmate was in the terminal stage of illness and had an anticipated life expectancy of 12 months or less. An unanticipated death is any death which occurs where there was no diagnosis by a physician of a terminal medical condition or where the physician had indicated the anticipated life expectancy should be 12 months or longer with a terminal medical condition. In 2003 and 2004, there were 41 and 40 total deaths, respectively, about half of which were anticipated. To date in 2005, there have been 16 total deaths, 8 unanticipated (50%).

In the event of an inmate or youth death in the Department's custody, the Department has procedures in place for both an internal review of the circumstances surrounding the death, and an external peer review performed by an established Committee on Inmate/Youth Deaths. The appropriate DOC Division designates a mortality review team that is required to conduct a review of the circumstances surrounding the individual's death. The mortality review team then submits its findings, and, where appropriate, an action plan to the Department's Committee on Inmate/Youth Deaths. The Committee on Inmate/Youth Deaths is responsible for conducting an independent peer review of the death, and provides recommendations to the Department for the purpose of improving the quality of health care.

Under Secretary Frank's leadership, the Department has strengthened these processes. The Secretary's changes include an expedited timeframe for completion of an internal investigation, a higher level staff review at all stages of the process, and greater personal communication with the families of the deceased.

In addition, Secretary Frank has strengthened the outside Committee on Inmate/Youth Deaths, and has expanded its membership to include new membership. The nine member committee now includes:

- A member of the general public
- A forensic pathologist
- A physician from the UW Hospital or UW Foundation
- A physician from the Medical College of Wisconsin
- A physician from a private health care organization
- A nurse clinician from a private health care organization
- A nurse clinician from another state agency
- A Warden or Superintendent
- A DOC Health Services Manager

The most recent appointments to the Committee were made in December 2004 and include:

- Dr. Stephen Hargarten, Professor and Chairman of the Department of Emergency Medicine at the Medical College of Wisconsin.
- Dr. Jeffrey M. Jentzen, Professor of Pathology from the Medical College of Wisconsin, Milwaukee.
- Orlando Rice, a Milwaukee Fire Department Captain and a certified Paramedic, as a public member.

The Committee on Inmate/Youth Deaths meets quarterly and conducts reviews of all deaths in the previous quarter. It makes additional recommendations for changes in policies or procedures to improve the quality of health care provided. Each of the Committee's members have the talent, expertise and insight needed to take an outside look at the reasons for deaths that occur within our system, and make recommendations to the Department for changes in policies and procedures, if needed.

The Committee on Inmate/Youth Deaths is a tremendous enhancement to the current system. It is not a substitute for a thorough internal review of an inmate death. Good medical management includes peer review, and another level of accountability that will build confidence in DOC's health care system in the legislature, public and the families of offenders. The work of the Committee greatly enhances our efforts to ensure continuous quality improvement in health services for inmates and youths entrusted to our custody and care.

For the committee's information and review, I am providing a copy of Secretary Frank's executive directive codifying the Department's internal review procedures, as well as a list of the current members of the Committee on Inmate/Youth Deaths.

Thank you for the opportunity to discuss the current efforts underway in the Department of Corrections to ensure proper review of inmate deaths that occur within our system. I welcome any questions you may have.


FORWARD

WISCONSIN
STATE
ASSEMBLY

SHELDON
WASSERMAN
STATE REPRESENTATIVE

September 7, 2005

Testimony of Representative Sheldon Wasserman
Before the Assembly Committee on Corrections and the Courts
In Support of Assembly Bill 480

Good morning, Chairman Bies and my fellow committee members. Thank you for the opportunity to testify in favor of Assembly Bill 480 today.

I am sure that you all remember the story of Taycheedah inmate Michelle Greer from a few years ago. Ms. Greer was born in Taycheedah, and she died there in February 2000 of an asthma attack on a cafeteria floor. The questionable circumstances surrounding her death spurred numerous newspaper reports and an audit of the delivery of health care and emergency response protocol in Wisconsin's prisons.

Shortly after Ms. Greer's death, former Representative Scott Walker and I co-authored a bill to address public concerns about prison death investigations in particular. While our original proposal did not advance past the committee stage that session, a similar bill I introduced last session passed the full Assembly, but stalled in the Senate. Over the last few years, the Department of Corrections (DOC) has made some improvements in response to Ms. Greer's passing and the debate over this legislation. I have toured four prisons since then and have been impressed with many of the things I have seen and the people I have met. However, there is still more that can be done to improve the current inmate death review process.

The current DOC inmate mortality review panel meets quarterly and at times can consider 30 cases or more. In my view the panel's membership lacks necessary independence, and its investigative and advisory capabilities fall short.

An internal panel cannot truly and independently review inmate deaths, and it invites public distrust. It would serve both the inmate population and the department well - politically, legally and ethically - to form an external review board as proposed in my legislation.

I have met with DOC Secretary Matt Frank, his staff, the Legislative Reference Bureau and other interested parties. Working together, we have amended the original proposal to address a number of DOC issues, while preserving my goal of forming an independent medical review panel.

The bill will make several key improvements to the current process:

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WEB PAGE: http://www.legis.state.wi.us/assembly/asm22/news/

HOME:
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MILWAUKEE, WISCONSIN 53211
(414) 964-0663

AB 480 creates a new Inmate and Resident Mortality Board within DOC. The board will be made up of 12 members appointed to staggered 4-year terms:

- 8 members appointed by the governor, including 2 physicians from the UW Medical School, 2 from the Medical College of Wisconsin, one physician from a health care provider other than the UW or MCW, an RN employed by a private HMO, an RN employed by a private hospital, and one at-large member of the public.

- 4 members appointed by the DOC secretary, including a warden, a manager of a Health Services Unit, a health care provider who is employed by DOC, and a correctional officer.

- At least one of member of the board must be a board-certified forensics pathologist.

The board's duties and abilities would include:

- The responsibility of preparing reports on every inmate death to be submitted to a relative of the deceased, the DOC secretary, and if appropriate, the district attorney and the attorney general. The chair and ranking member of the appropriate assembly and senate committees will also receive these reports.

- Making recommendations to the department regarding medical and other prison procedures based on its medical review, and the work performance of department staff.

- Forwarding a complaint to the appropriate credentialing board if a medical provider is found negligent.

- DOC is required to cooperate with the board and provide any assistance the board requests to review the circumstances of a death. Specific timelines are set for the notification of inmate deaths, and when reports must be submitted.

All records prepared by and for the board will be exempt from Wisconsin's open records law. This ensures the confidentiality of medical and personnel records.

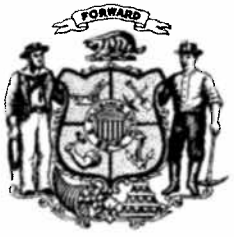
The bill also gives the attorney general the same power to order an inquest that district attorneys have under current law. This provides an additional avenue whereby an inquest may be requested aside from the local district attorney. If there is a criminal investigation pending on an inmate death, the board must wait until that investigation is concluded before issuing its final report on the death.

Having all of this spelled out in the statutes will provide continuity through changes in the administration. It will bring more accountability and structure to the process of reviewing inmate deaths, with a focus on the expertise of independent medical professionals. It will serve the government and the public well.

Assembly Bill 480 is the product of years of work with the Department of Corrections, several inmate advocacy groups and other interested parties. Some of these groups will testify today in favor of the bill. I look forward to your questions, and hope that the committee will also support this effort.

Thank you.

WISCONSIN STATE LEGISLATURE



Assembly Republican Majority
Bill Summary

AB 480: Review of Inmate Deaths
Relating to: review of deaths at correctional institutions.

Introduced by Representatives Wasserman, Bies, Benedict, Berceau, Black, Colon, Cullen, Fields, Grigsby, Turner and Young, cosponsored by Senators Taylor, Carpenter, Erpenbach, Lassa and Risser.

Date: April 25th, 2006

BACKGROUND

Under current law, if a person dies while confined in a correctional facility, the coroner or medical examiner for the county where the death occurred must conduct an autopsy. In addition, the person in charge of the facility is required to notify the appropriate relative of the inmate of the death. The Department of Corrections (DOC) must also provide the relative with written notification that DOC, upon request, will provide the relative with a copy of the autopsy report or any other report or information regarding the inmate's death.

Separately, current law establishes procedures for inquests, which apply to inmates and non-inmates alike. Under current law, if the district attorney has notice that the death of a person may have been the result of a homicide or suicide or may have occurred under unexplained or suspicious circumstances, the district attorney may order an inquest to determine the cause of the person's death. If a coroner or medical examiner has similar knowledge about a person's death, the coroner or medical examiner is required to notify the district attorney of the circumstances surrounding the death and may request that the district attorney order an inquest. The district attorney may order an inquest based on that information and may request that the coroner or medical examiner conduct a preliminary examination and report back to the district attorney. If the district attorney does not order an inquest, the coroner or medical examiner may petition the circuit court to order an inquest.

SUMMARY OF AB 480

This bill expands the scope of the provision requiring autopsies for persons who die while confined in a state correctional facility so that it applies to a person in DOC's custody who dies while temporarily confined in, and under a DOC contract with, a county jail or house of correction. In addition, the bill requires the coroner or medical examiner to notify the attorney general (as well as the district attorney) when such a person or a person confined in a state correctional institution dies if the death is one that would permit the district attorney to order an inquest. Moreover, the bill gives the attorney general the same powers as the district attorney to order and conduct an inquest when notified of that death.

The bill also creates an Inmate and Resident Mortality Board, which is composed of 12 members and attached to DOC. Under the bill, if a person in DOC custody dies while in an in-state or out-of-state correctional institution, a county jail, or a house of corrections, the board must review the circumstances of the person's death. Within three business days after the person's death, DOC must send a written notice to each member of the board of the death and provide them with a summary of information regarding the death, including the date, time, and place of the death. Upon request, DOC must also provide a board member with the records that are in the custody of DOC (including medical and mental health records) regarding the person who died and with any information obtained as the result of DOC's internal review of the death.

In addition, DOC is required to provide any assistance the Inmate and Resident Mortality Board needs to review the circumstances of the death. Beyond reviewing information from DOC, the board may also review

any medical and mental health records of the inmate or resident in the custody of a medical or mental health treatment provider; with the approval of the district attorney or attorney general, medical and mental health records in the custody of a law enforcement agency; information obtained by the coroner or medical examiner regarding the death; and information collected as a result of the autopsy.

The bill requires the board to issue a report regarding its review of an inmate's death within 30 days after the meeting at which the board completes its review and to submit that report to a relative of the deceased person, to members of the appropriate standing committees of the senate and assembly, to the secretary of DOC, and to the district attorney or attorney general, if appropriate. The bill also requires the board to submit to DOC any recommendations that it has regarding medical and other prison procedures, and rules to implement them, based on the board's review of the death. If the board determines during its review of a person's death that a medical provider failed to provide appropriate, proper, and necessary medical care, the board is required under the bill to prepare and forward a complaint to the appropriate credentialing board.

Meetings of the Inmate and Resident Mortality Board are not subject to the Open Meetings Law. Records prepared by the board are not subject to the Open Records Law.

FISCAL EFFECT

A fiscal estimate was prepared for Assembly Bill 480 by the Department of Corrections. The fiscal estimate indicated that the legislation would result in an increase of costs for the Department at the state level; however, the amount was indeterminate. The increased costs associated with this legislation would be attributed to per diem costs of the Board members as well as record review costs and travel expenses.

PROS

1. In independent medical board for review of inmate deaths
2. Provides an additional avenue whereby an inquest may be requested aside from the local district attorney.
3. Result of work between the Department of Corrections, several inmate advocacy groups and others.
4. Records of the medical board are exempt from open records law to protect confidentiality.

CONS

1. Additional bureaucracy

SUPPORTERS

Representative Sheldon Wasserman, lead author; Senator Lena Taylor, lead co-sponsor; Incarceration Coalition; Ronald Solinger; AFSCME.

OPPOSITION

No one testified or registered in opposition.

HISTORY

Assembly Bill 480 was introduced on June 14, 2005, and referred to the Assembly Committee on Corrections and the Courts. A public hearing was held on September 7, 2005. On November 2, 2005, the Committee voted 8-1 [Rep. Suder voting No; Rep. Underheim absent] to recommend passage of Assembly Bill 480.

CONTACT: Andrew Nowlan, Office of Rep. Garey Bies


FORWARD
E PLURIBUS UNUM

COMMITTEE ON INMATE/YOUTH DEATHS

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(Updated 5/25/05)

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FORWARD

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Governor

Matthew J. Frank
Secretary

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Executive Directive #58

SUBJECT: Department of Corrections Review of Inmate/Youth Deaths

I. Policy

Upon the death of an inmate/youth in the custody of the Department of Corrections, (DOC) the appropriate DOC Division shall designate a mortality review team which shall conduct a review of the circumstances surrounding the individual's death and submit its findings and, when appropriate, an action plan to the Committee on Inmate/Youth Deaths (COIYD). The COIYD shall conduct an independent peer review of the individual's death and provide recommendations to the DOC for the purpose of improving the quality of health care provided inmates/youth in its custody. This peer review process shall be conducted in conformity with Sec. 146.37 and 146.38, Wis. Stats.

II. Definitions

"Anticipated death" means any death where the inmate/youth was in the terminal stage of illness and had an anticipated life expectancy of 12 months or less.

"Unanticipated death" means any death which occurs where there was no diagnosis by a physician of a terminal medical condition or where the physician had indicated the anticipated life expectancy should be 12 months or longer with a terminal medical condition.

III. Facility Review Process

A. Upon the death of an inmate/youth, the DOC Division responsible for the custody of the inmate/youth shall designate a mortality review team which shall initiate a review of the circumstances surrounding the individual's death, with emphasis on the health care provided and when appropriate, submit an action plan to the COIYD, with recommendations for the improvement of health care. The review shall be completed within 10 working days of the individual's death for unanticipated deaths and 20 working days for an anticipated death. Each Division responsible for the custody of inmates/youths shall promulgate internal management procedures establishing the makeup and responsibilities of the mortality review teams.

B. A copy of the mortality review team report shall be forwarded to the COIYD, the Secretary and the appropriate Division Administrator within 10 working days of completion of the team's review. The report provided to the Secretary and Division Administrator shall have the identity of the decedent withheld in compliance with Sec. 146.38(3) stats.

C. The DOC mortality review team shall include at a minimum the following members:
- Warden/Superintendent from that institution/facility
- A security representative
- A physician
- A nursing representative
- Psychological Services (for suicides and others as requested)
- Others as determined.

The DOC employees serving on the COIYD shall not participate in reviews of deaths which occurred at the facilities where they work.

The DOC mortality review team shall also include the following members for all unanticipated deaths:
- Bureau of Health Services (BHS) Director
- DOC Medical Director
- Mental Health Director (for suicides and others as requested)
- BHS Nursing Coordinator
- Assistant Administrator or DOC Security Chief (as determined by the Division Administrator)

D. In its review, the DOC mortality review team may look at the following issues, among others:

- Adequacy of care practices.
- Clinical judgment.
- Utilization of expertise
- Staff training
- Staffing issues
- Presence and appropriateness of internal policies
- Implementation of internal policies and procedures
- Notification and involvement of appropriate family members
- Notification of external agencies
- Reporting of the death to the DOC facility review team.

E. Families will be notified of the inmate's/youth's death according to DOC 306 IMP 1.

IV. Committee on Inmate/Youth Deaths

A. The purpose of the COIYD is to:

1. Conduct independent reviews of inmate/youth deaths occurring at adult correctional facilities, juvenile correctional facilities, correctional centers, and private out-of-state contracted facilities housing Wisconsin offenders, in conformity with Secs. 146.37 and 146.38 stats.

2. Review the causes and circumstances surrounding deaths with particular attention to those considered to be unusual or unexpected.

3. Make recommendations for changes in policies or procedures designed to improve the quality of health care provided.

4. Ensure that information relating to deaths is properly communicated so that health care can be improved.

5. Conduct its reviews in the interest of public safety and the effective health care of inmates/youths.

6. Review issues relating to the deaths of DOC inmates/youths from a systemic point of view.

B. COIYD composition and organization.

1. The COIYD shall be composed of no more than nine voting members. The Secretary shall appoint:
   - A Warden/Superintendent
   - Health Services Manager
   - A member of the general public
   - A forensic pathologist

   The Secretary shall request the following agencies to select a licensed health care provider, as designated, to serve on the committee:
   - Physician from University of Wisconsin Hospital/UW Foundation
   - Physician from Medical College of Wisconsin
   - Physician from a private health care organization.
   - Nurse Clinician from a private health care organization.
   - Nurse Clinician from another state agency.

2. The Secretary shall designate a Bureau of Health Services Nursing Coordinator to act as a facilitator and advisor to the committee.

3. The Department of Corrections Medical Director shall attend committee meetings as a non-voting participant when requested by the COIYD.

4. Upon the request of the COIYD, the Secretary may designate other individuals to serve as advisors to assist the COIYD in the performance of its functions.

5. Members are appointed for staggered terms of three years. Members chosen to fill vacancies created other than by expiration of term shall be appointed for the unexpired term of the member for whom she/he is to succeed. Members may be reappointed to serve additional terms.

6. A chairperson shall be selected by the full Committee. A member may serve as chairperson for no more than two years.

7. A quorum shall consist of two-thirds of the members then in office. While most actions are determined by consensus, a majority of those voting shall be required to adopt motions and approve actions. If a quorum is not present, the COIYD members present may proceed with the meeting as specified by the agenda and recommend actions to be ratified by the COIYD, if it has a quorum, at the next meeting. If the chair is absent from a committee meeting, the COIYD may designate one of its members to be the acting chair during that meeting.

8. COIYD members must be present personally to count for a quorum and to participate in decision-making. Members may not send alternates or designees without the prior approval of the Chair.

C. Confidentiality.

1. All information generated by, or on behalf of the Committee, including but not limited to, Committee reports (except its annual report), proceedings of the Committee regarding the cases it reviews, and deliberations, shall be kept confidential by COIYD and mortality review team members, in accordance with Sec. 146.37 and 146.38 Wis. Stats., and the confidentiality agreements signed by each Committee member. Consultants, advisors, committee staff and other individuals with specialized expertise who participate in a review or otherwise provide support to the Committee shall be required to sign a confidentiality agreement.

D. Procedures of the COIYD.

1. The COIYD shall meet at least quarterly unless there were no deaths in the previous quarter. The Secretary or Chair may call additional meetings.

2. Minutes shall be kept at each meeting and shall include:

   - Records of all death reports reviewed by the COIYD.
   - Records of all actions taken by the COIYD.
   - The status of all pending reviews.

3. Minutes shall be ratified by the COIYD.

4. Members of the COIYD may visit and inspect any DOC facility and shall have access to all records and data necessary to conduct a review.

5. The COIYD may request other persons having relevant information to appear before the Committee as part of a review.

6. The COIYD shall establish the format for all mortality review team reports, including the information to be included, and the timelines under which the mortality review team will present its reports regarding the cause and circumstances of death.

7. The COIYD may request persons with specialized expertise to serve as consultants and participate in a review. If the consultant requires compensation, that must be pre-approved by the Secretary.

8. The COIYD shall review all documents and information deemed relevant for purposes of conducting its review, including but not limited to the review and recommendations of the mortality review team and reports, if any, from external agencies.

9. In its review, the COIYD may look at the following issues, among others:

   - Adequacy of care practices.
   - Clinical judgment.
   - Utilization of expertise
   - Staff training
   - Staffing issues
   - Presence and appropriateness of internal policies
   - Implementation of internal policies and procedures
   - Notification and involvement of appropriate family members
   - Notification of external agencies

10. When the COIYD is satisfied that it can make no recommendations, or no further recommendations, it shall consider the review closed and communicate the closure to the DOC administration.

11. The COIYD shall issue an annual report summarizing its work and identifying any significant trends and make the report available to outside agencies as requested.

12. The COIYD may require institution staff to provide additional review or assistance as necessary to ensure full cooperation with the DOC facility review team. If the COIYD believes there is an attempt to influence or interfere with the DOC facility review team the COIYD shall refer the complaint to the Secretary for immediate review and follow up.

V. Recommendations and Actions

A. Within 20 days from the date of the meeting at which they are finalized, the designated Nursing Coordinator shall communicate recommendations from the COIYD to the Secretary, the applicable Division Administrator, and other appropriate persons within the department for follow-up.

B. The Division Administrator shall assign appropriate staff to implement the recommendations to the extent feasible and ensure the implementation process is completed on a timely basis.

C. The Nursing Coordinator shall be notified as the recommendations are implemented and notify the appropriate Division Administrator of lack of response or any inappropriate responses.

D. The Nursing Coordinator shall provide the Secretary an annual summary of the changes resulting from the implementation of the COIYD's recommendations.

E. The Nursing Coordinator shall maintain records reflecting the status of cases pending before the COIYD, recommendations made by the COIYD and whether its recommendations have been implemented. These records shall be accessible to the Secretary, Division Administrator, Medical Director and Bureau of Health Services Director.

Originated by: Bureau of Health Services

Matthew J. Frank, Secretary

February 22, 2005
Date