4-10/050.00 Inmate Death - Reporting and Review Process

Scope of the Policy

The Inmate Death - Reporting and Review Process policy applies to all inmate deaths that occur in Custody Services Division jail facilities, Court Services Division lock-ups, and Patrol Operations Division station jails.

Community Based Alternatives to Custody (CBAC)

This policy also applies to inmates enrolled in the Community Based Alternatives to Custody (CBAC) program; however, CBAC inmate deaths shall not be included in the "in-custody" inmate death statistical totals. (See Custody Compliance and Sustainability Bureau's Staff Responsibility section in this policy for procedures pertaining to CBAC inmate deaths.)

This policy does not apply to prisoner deaths occurring under the jurisdiction of Patrol Operations.

UNIT WATCH COMMANDER RESPONSIBILITIES

Telephonic Notifications

In the event of an inmate/prisoner death in a Los Angeles County jail, the watch commander of the unit, at the time of the inmate death, shall be responsible for making a telephonic notification of the death and all pertinent information, as soon as possible, to the following:

- Concerned Custody Services Division Chief(s);
- Area Commander;
- Unit Commander;
- Homicide Bureau;
- Internal Affairs Bureau (IAB);
- Inmate Reception Center (IRC) Watch Deputy;
- Sheriff's Information Bureau (SIB) - Operations Center;
- Sheriff's Medical Command Center, Twin Towers Correctional Facility;
- Risk Management Bureau - Civil Litigation Unit;
- Custody Compliance and Sustainability Bureau (CCSB) or the on-call supervisor/manager (after hours.)

The following pertinent information shall be included:

- Name of the deceased;
- Race;
- Gender;
- Age and date of birth;
- Booking number;
- Arrest charge(s);
- Uniform Report Number (URN) assigned to the inmate death complaint report;

- Custody reference number;
- Facility or location where the death occurred;
- Time pronounced dead;
- Pronounced dead by;
- Any use of force;
- Title15 safety check intervals;
- Printout of the housing location inmate roster (FC05 screen) ~~of~~ from the Automated Justice Information System (AJIS);
- AJIS printouts related to inmate information (including SI01, SI03, MC01, MC07, IC10, IC12, DA01);
- Any unusual circumstances;
- A brief synopsis of the incident.

Written Notifications

A Chief's Memorandum will be written by the responsible unit when Homicide Bureau does not respond to an inmate death. Additionally, when directed by Homicide Bureau, the responsible unit will also complete a Chief's Memorandum (SH-AD-32A). In all other circumstances, Homicide Bureau will be responsible for completing the Inmate Death Notification Memorandum.

In addition to making the above telephonic notifications, the concerned watch commander shall promptly prepare and send, by electronic mail, the following written documents concerning the inmate death:

- a memorandum to the concerned Custody Services Division Chief(s) on an Office Correspondence form (SH-AD-32A), with a brief statement of facts;
- a Watch Commander's In-Custody Death Reporting Form (SH-J-431), to Custody Compliance and Sustainability Bureau - Death Review Team [REDACTED TEXT];
- an Internal Affairs Bureau – Mandatory Notification Form to the IAB email group, “IAB Mandatory Notification,” if applicable.

All other reporting procedures pursuant to the MPP section 4-19/010.00, "Person Dead," Custody Division Manual section 4-07/010.00, “Notification and Reporting of Significant Incidents,” and “Significant Incident Notification Matrix” shall apply.

Notifications for Minor (Juvenile) In-Custody Deaths

It is the responsibility of the shift watch commander of the concerned facility to notify the CCSB captain, or their designee, in the event of a death of a minor in a Custody Services Division jail facility, Court Services Division lock-up, or other facility where the minor is under the supervision of custody personnel, and where a representative from Homicide Bureau does not respond. The CCSB captain, or their designee, shall notify the Los Angeles County Department of Mental Health (DMH) Family Assistance Advocate (FAA) or designee, who will notify the deceased minor’s parent, guardian, person standing in loco parentis, or other appropriate next-of-kin, in accordance with Title 15, section 1047, “Serious Illness or Injury of a Minor in an Adult Detention Facility.”

The CCSB captain, or their designee, shall notify the minor’s court of jurisdiction of the minor’s death.

CCSB personnel shall conduct an administrative review for all juvenile in-custody deaths.

Inmate Reception Center - Head Clerk's Office - Records Section Responsibility

Upon notification of the inmate death, the Head Clerk's Office - Records Section, shall update AJIS, and forward the booking record to the State Prison Desk. The State Prison Desk shall reproduce the complete booking record and immediately forward a copy to CCSB for inclusion in the Executive Inmate Death Review.

CUSTODY COMPLIANCE AND SUSTAINABILITY BUREAU (CCSB)

CCSB Lieutenant Responsibilities

Upon notification of an inmate death, the CCSB captain, or their designee, shall make an immediate notification to the Office of the Inspector General (OIG). The CCSB captain, or their designee, shall schedule a review which includes the following personnel: the unit commander of CCSB/Access to Care Bureau (ACB), the Director of Correctional Health Services (CHS) or their designee within two working days of the occurrence. The review will evaluate medical and mental health protocol, Department and Division policies and procedures, training issues, the need for immediate corrective or preventive action, if any, and risk management liability relating to the in-custody death.

The CCSB captain, or their designee, shall assess the circumstances of the in-custody death and notify the Custody Training and Standards Bureau (CTSB) captain, or the on-call training representative after hours, wherein a response from the CTSB representative is deemed warranted.

Upon notification of an inmate death, the CCSB on-call lieutenant, or their designee, shall make a determination, based upon the totality of the circumstances, whether an immediate response to the location of the inmate death is necessary. The lieutenant shall consider all the circumstances, particularly in the case of:

- homicide;
- suicide;
- inmate death at the hands of another inmate(s);
- inmate death at the hands of a deputy and/or other custody personnel;
- apparent natural causes death with unusual circumstances;
- inmate death from a known long-standing medical condition.

CCSB Supervisor Responsibilities

The CCSB on-call sergeant shall assign personnel to conduct a review of the in-custody death and prepare a comprehensive report.

CCSB STAFF RESPONSIBILITIES

Executive Inmate Death Review Book

CCSB personnel shall collect all related documentation concerning all inmate deaths and prepare a written review. The review shall address issues and make recommendations in an attempt to reduce future risk management liability to the Division and the Department. The review shall include, but not be limited to:

- witness interviews;
- training issues;
- policy and procedure issues;
- identification of potential medical and mental health issues.

A copy of the death review shall be forwarded to the concerned unit commander for review and response, which shall be reported back to the Area Commander and Division Chief within thirty (30) days on any corrective or preventive action taken. The unit commander's responses shall be filed with the in-custody inmate death review file at CCSB. The Custody Services Division Legal Advisor shall review and approve all recommendations and unit commander responses.

Those reviewing the Executive Inmate Death Review Book shall review and return it to CCSB within 10 days.

Community Based Alternatives to Custody (CBAC) Inmate Death Review Procedure

In cases of deaths involving inmates participating in CBAC programs, including Electronic Monitoring, Work Release, and Work Furlough, CCSB staff shall conduct a preliminary review of the circumstances. All available documentation including police reports, booking records and an analysis of any Department medical records shall be collected. Findings shall be reported to the concerned Custody Services Division Chief(s), in accordance with the Levels of Inmate Death Review and Reporting section of this policy. In conducting the preliminary review, particular attention shall be paid to the inmate's classification and qualifications to participate in a CBAC program.

The Executive Inmate Death Review briefing (see Levels of Inmate Death Review and Reporting), along with all documentation collected, and any follow-up, as directed by the concerned Division Chief(s), shall constitute the total CBAC Inmate Death Review package. In cases of natural/suicide death in which the inmate was absconding, and therefore not reporting as required, an Inmate Death Review Package will be completed; however, the reviews will not be conducted. In cases with extenuating circumstances, the full review procedures, as described above under Executive Inmate Death Review Book section, shall apply.

Electronic Notification

CCSB staff shall complete a "Custody Compliance and Sustainability Bureau In-Custody Death Reporting Form." The CCSB Area Commander, or other Custody Services Division Commander, shall review and approve the CCSB In-Custody Death Reporting Form, prior to its dissemination to the Department of Justice, the American Civil Liberties Union (ACLU), Office of the Inspector General (OIG), County Counsel, Risk Management Bureau, Jail Mental Health Services, the concerned Custody Services Division Chief(s), and the Board of State and Community Corrections (BSCC) (when the deceased is a juvenile inmate only.)

Within forty eight (48) hours following an inmate death, CCSB shall send a facsimile and/or email of the completed/approved form to the concerned Custody Services Division Chief(s) and the following entities:

- United States Department of Justice (all concerned offices)
- California State Department of Justice
- American Civil Liberties Union (ACLU)
- Office of Inspector General (OIG)
- Office of County Counsel

- Risk Management Bureau
- Jail Mental Health Services
- Board of State and Community Corrections (BSCC) (when applicable)

CCSB personnel will maintain a current notification list containing the preferred methods of contact for the above entities. A copy of the notification shall be retained in the Executive Inmate Death Review file at CCSB.

Two Day Executive Inmate Death Review

Within two working days, excluding weekends and holidays, CCSB personnel shall conduct an initial review after an inmate death occurs to share findings and to review the circumstances surrounding the death. The OIG shall be invited to each review. The review shall be attended by personnel from the following units:

- concerned Custody Services Division Chief's office;
- Area Commander's office;
- Custody Services Division facility, Court Services Division facility or Patrol Operations station where the inmate death occurred;
- medical personnel;
- mental health personnel;
- Custody Compliance and Sustainability Bureau;
- Custody Support Services Bureau (CSSB);
- County Counsel;
- Homicide Bureau (when applicable).

Personnel shall attend as required by criteria delineated in the "Executive Inmate Death Review Attendees" chart. A review concerning an apparent or suspected suicide will include a discussion of the inmate's mental health status known at the time of the suicide.

Any issue that requires immediate corrective or preventive action shall be directed to the concerned Division Chief(s).

Seven Day and Thirty Day Executive Inmate Death Reviews

CCSB shall conduct a death review within seven (7) working days and again within thirty (30) working days, excluding weekends and holidays, after an inmate's death to share additional findings and discuss the status of any corrective or preventive actions taken since the previous review. The OIG shall be invited to each review. The reviews shall be attended by personnel from the following units:

- concerned Custody Services Division Chief's Office;
- Area Commander's Office
- Custody Services Division facility, Court Services Division facility or Patrol Operations station where the inmate death occurred;
- medical personnel;
- mental health personnel;
- Custody Compliance and Sustainability Bureau;

- Custody Support Services Bureau (CSSB);
- County Counsel;
- Homicide Bureau (when applicable).

Personnel shall attend as required by criteria delineated in the “Executive Inmate Death Review Attendees” chart.

A review concerning an apparent or suspected suicide will include a discussion of relevant information known at that time, including the events preceding and following the suicide, the inmate’s incarceration, mental health and health history, and the need for additional corrective or preventive action if necessary.

Any issue that requires immediate corrective or preventive action shall be directed to the concerned Division Chief(s).

Retention of In-Custody Death Records

All Inmate Death Reviews conducted by CSSB or CCSB, audio and video recordings, documents, memorandums, interviews, and other written administrative documents concerning the inmate death, shall be maintained as follows:

- inmate deaths occurring prior to July 1, 2015 shall be maintained by CSSB;
- inmate deaths occurring on or after July 1, 2015 shall be maintained by CCSB.

Additionally, Inmate Death Reviews concerning an apparent or suspected suicide shall include recent telephone records of the deceased inmate, when available.

The CHS Health Information Management unit shall retain all medical records related to in-custody inmate deaths.

All Death Reviews and associated materials are confidential, attorney-client privileged, and shall not be released to any non-Department member without the consent of the concerned Custody Services Division Chief(s), and county counsel.

All in-custody inmate death records shall be maintained for a period of seven (7) years. After seven (7) years, all in-custody inmate death records will be forwarded to the Sheriff's Records and Identification Bureau for archive retention.

Correctional Health Services Responsibilities

A representative from CHS shall conduct a Clinical Mortality Review of all inmate deaths which occur in the jail as directed by the CHS Director. A copy of the written report and findings shall be forwarded to the unit commander of CCSB/ACB. A copy of the Clinical Mortality Review shall be forwarded to CCSB, for inclusion in the Executive Inmate Death Review Book.

Apparent or Suspected Suicides

Executive Inmate Death Reviews concerning an apparent or suspected suicide shall include a Psychological Autopsy, completed by Jail Mental Health Services, and a Clinical Mortality Review, completed by CHS staff.

A copy of both written reports and findings shall be forwarded to the chief psychiatrist of DMH. A copy of both the Psychological Autopsy and Clinical Mortality Review shall be forwarded to CCSB, for inclusion in the Executive Inmate Death Review Book.

LEVELS OF INMATE DEATH REVIEW AND REPORTING

Level I Review and Reporting

A Level I Review is the lowest level review. A Level I Review consists of an Executive Inmate Death Review for the concerned Custody Services Division Chief(s).

Most inmate deaths, attributed to natural causes, occurring in a hospital or medical facility, and deaths of inmates who are participating in a Community Based Alternative to Custody (CBAC) program, will qualify for a Level I Review.

Level II Review and Reporting

A Level II Review is a more formal and detailed level of review and reporting than a Level I Review.

Inmate deaths including suicides, homicides, and some natural cause inmate deaths with unusual or extenuating circumstances, shall generally require a Level II Review.

Level III Review and Reporting

A Level III Review is the highest level of Departmental review and reporting.

Level III Reviews shall be conducted for all inmate deaths that occur at the hands of a deputy or other custody personnel, or as designated by the concerned Custody Services Division Chief(s).

Executive Inmate Death Reviews shall be attended by the following personnel as soon as possible following the inmate death:

Executive Inmate Death Review Attendees	**Level I**	**Level II**	**Level III**
Sheriff or designee			x
Assistant Sheriffs			x
Custody Services Division Chief(s)			x
CHS- Correctional Health Director			x
Area Commander	x	x	x

Division Risk Management Commander		x	x
Concerned Custody Unit Commander	x	x	x
Custody Compliance and Sustainability Bureau/Access to Care (ACB) (CCSB) Unit Commander	x	x	x
Custody Training and Standards Bureau Unit Commander		x	x
Risk Management Bureau (RMB) Unit Commander			x
County Counsel	x	x	x
CHS - Chief Physician	x	x	x
CHS - Quality Assurance Nurse	x	x	x
CHS - Clinician from Jail Mental Health Services	x	x	x
Homicide Bureau Lieutenant		x	x
Internal Affairs Bureau Lieutenant (*if necessary)		x*	x
RMB - Civil Litigation Lieutenant	x	x	x
CCSB - Staff Conducting the Inmate Death Review	x	x	x
Representative from Custody Support Services Bureau (CSSB)	x	x	x
Probation Department Representative (deceased inmate in a CBAC program only)	x	x	
Division Chief, Court Services (deceased inmate in court lock up only),		x	x
Division Chief, Patrol Operations (deceased inmate in station jail only)		x	x
Patrol Operations Station Unit Commander (deceased inmate in station jail only)		x	x
Advanced Officer Training Unit Sergeant			x

All Level I, II, and III Reviews which require any action and/or task items identified during the review shall be assigned for follow-up. Issues discussed during the Executive Inmate Death Review, and documentation of any corrective or preventive action and/or task items and assignments, shall be recorded and maintained in the review file. This will be the responsibility of CCSB.

Nothing in this policy shall preclude the level of review being changed to a different level, based upon additional facts, after an initial review.

INDEPENDENT RISK MANAGEMENT DEATH REVIEW

Following every in-custody inmate death, the concerned Custody Services Division Chief(s) may determine the need for an independent death review, conducted by a professional risk management organization, contracted with the Sheriff's Department's Risk Management Bureau. This decision will consider all of the facts surrounding an inmate's housing, treatment, and nature of any medical problems.

The independent risk management organization conducting the death review will be requested to provide a comprehensive review of the inmate death, within four (4) to six (6) weeks.

The review shall include areas of medical treatment, medications, and methodologies, as compared to current medical protocols. The review should also make recommendations for improvements, or outline areas of failure, in a medically approved fashion.

Any request for an independent death review shall be directed to the Risk Management Bureau via memorandum by the unit commander of CCSB/ACB, at the direction of the concerned Custody Services Division Chief(s).

Independent Risk Management Death Review Follow-up

The results of the independent death review shall be forwarded to CCSB/ACB for review and follow-up. This review and any follow-up action shall be documented in a closure memorandum to the concerned Custody Services Division Chief(s). A copy of the closure memorandum and the Independent Risk Management Death Review report will be forwarded to CCSB for retention in the in-custody inmate death review file.

Review of Coroner's Report by Medical Services

Representatives from CCSB shall be responsible for ordering the coroner's report for review by the concerned Custody Services Division Chief(s). A copy of the report shall be forwarded to CHS for review by the chief physician.

APPARENT OR SUSPECTED SUICIDE - FINAL REPORT

A final written report shall be prepared within six months for Executive Inmate Death Reviews concerning an apparent or suspected suicide. The following, where applicable, shall be included in the Executive Inmate Death Review Book:

- Incident reports and any supplemental reports with the same Uniform Reference Number (URN) regarding the incident from custody staff who were directly involved in and/or witnessed the incident;
- A timeline regarding the discovery of the prisoner and any responsive actions or medical interventions;

- Copies of a representative sample of material video recordings or photographs (excluding items that may interfere with any criminal investigation);
- A reference to, or reports if available, from Homicide Bureau;
- A reference to the Internal Affairs Bureau (IAB) or other personnel investigations and findings, if any;
    - **Note: the names of employees who are subjects of any such investigations should not be included within this reference.**
- A Coroner's report; if it is not available, a summary of efforts made to obtain the report;
- A summary of relevant information discussed at the prior review meetings, or otherwise known at the time of the final report, including analysis of housing or classification issues if relevant;
- A Clinical Mortality Review;
- A Psychological Autopsy;
- A summary of corrective actions taken and recommendations regarding additional corrective actions if any are needed.