Death of a Youth while Detained in a Juvenile Detention Center and/or Treatment Facility (Title 15, Section 1341)

707.1 PURPOSE:

The preservation of life supersedes all other procedures and all steps shall be taken to save a life. However, in the event of a youth's death while in custody in a Juvenile Detention and Assessment Center (JDAC) or Treatment Facility (TF), or during transport to a hospital, or while at a hospital, this procedure outlines the process to preserve and secure the scene, notify administration, required agencies, and the youth's parent/guardian or person standing in loco parentis.

707.2 DEFINITIONS:

Clinical Mortality Review: An assessment of the clinical care provided and the circumstances leading up to a death. Its purpose is to identify any areas of patient care or the system's policies and procedures that can be improved, as well as positive areas of care.

In-Custody Death Board of Inquiry: In the event the Board of State and Community Corrections (BSCC) requests a review, the Chief Probation Officer/designee shall convene an In-Custody Death Board of Inquiry consisting of a Deputy Chief Probation Officer, Division Director of Professional Standards/designee, Facility Superintendent or Division Director I, Medical Director, Health Services Manager/designee, Psychiatric Medical Director if deemed necessary by the Chief Probation Officer; and other health care or supervision personnel deemed relevant to the incident by the Chief Probation Officer.

Memorandum of Agreement Between San Bernardino County Sheriff's Department and San Bernardino County Probation Department (MOA): The MOA establishes investigation guidelines equitable to both agencies when a San Bernardino County Probation Officer is involved in an on-duty or off-duty Officer-Involved Shooting or is involved in an In-Custody Death that occurs within the Sheriff's geographical jurisdiction. As a public service, it will be the responsibility of the Sheriff's Specialized Investigations Homicide Detail to conduct the criminal investigation of all Officer-Involved Shootings and In-Custody Deaths without charge.

Review Team: The review team shall include the facility administrator, Health Services Manager, FAST Clinic Medical Director, the responsible physician, and other health care and custody staff who are relevant to the incident. The Review Team conducts the Immediate Operational Review and the Medical Review.

Scene/incident site: The room, area, or immediate vicinity in which the youth died.

Psychological Autopsy: A written reconstruction of an individual's life with an emphasis on factors that may have contributed to the youth's death. It is usually conducted by a psychologist or other qualified mental health professional.

707.3 GUIDELINES:

A. When a youth is transported by Emergency Medical Transport (EMT) and death is likely or has occurred, the incident site shall be immediately secured.

B. All communication regarding a youth's death shall be documented in Incident Reports.

C. The Peer Support Coordinator shall coordinate with the WC/IC to determine peer support needs and provide peer support services to all involved staff.

D. FAST shall provide individual and/or group therapy to youth as needed.

E. Attorney General/BSCC Report:

1. The following reports shall be submitted to the Attorney General per Government Code Section 12525 within ten (10) calendar days of the date of death.
   (a) Cover letter reporting the death and form BCIA 713.
   (b) All departmental and investigative agency reports.
   (c) Coroner's preliminary autopsy report.
2. A copy of this report shall be submitted to the BSCC within ten (10) calendar days after the date of death.

F. If the BSCC requests a review, the Chief Probation Officer shall convene an In-Custody Death Board of Inquiry consisting of a Deputy Chief Probation Officer, Division Director of Professional Standards or designee, Facility Superintendent or Division Director I, Medical Director, Health Services Manager or designee, Psychiatric Medical Director if deemed necessary by the Chief Probation Officer; and other health care or supervision personnel deemed relevant to the incident by the Chief Probation Officer.

707.4 RESPONSIBILITIES:

Responsibilities in a JDAC or TF:

I. First Person on scene shall:

A. Announce a Code Blue on the Handi Talkie (HT).

B. Follow the Code Blue and First Aid procedure, regarding the initiation of life-saving techniques and summoning medical and staff assistance.

C. Submit to an interview by the coroner.

D. Remain with the youth until directed otherwise by the Watch Commander/ Incident Commander.

E. Follow all instructions from the Watch Commander/Incident Commander and/or Health Services Manager.

II. Watch Commander (WC)/Incident Commander (IC):

A. Stabilize and secure the scene.

B. Confirm emergency medical and law enforcement has been summoned.

C. Ensure only necessary personnel are present at the incident site.

D. Assign staff to record the names/titles, date/times, and purpose of all persons who entered and exited the scene.

E. Notify Medical Services and FAST to secure the health record.

F. Ensure closed-circuit television (CCTV) videotapes and handheld videos are logged and secured.

G. Ensure all involved staff complete incident reports and other documentation as required.

H. Contact the Superintendent/Division Director/On-Call Director and Health Services Manager and inform them of the situation.

III. Medical Services:

A. Supervising Correctional Nurse/designee shall activate the "Inmate Death" flag in the electronic health record, package and seal any other medical health records and send to the WC/IC as soon as possible but no later than thirty (30) minutes after notification.

IV. Forensic Adolescent Services Team (FAST):

A. Package and seal mental health records and send to the WC/IC as soon as possible but no later than thirty (30) minutes after notification during business hours and within one (1) hour outside of business hours.

V. Superintendent/Division Director/On-Call Director:

A. Gather all information pertaining to the incident as soon as possible following notification of the incident by the WC/IC. This may include, but is not limited to: Incident Reports, offsite documentation, copies of facility files, health record, videos of the incident if they exist, and any pertinent logs and/or information.

B. Request a list of those accessing the youth's Caseload Explorer record from Automated Systems.

C. Be the liaison between family members and the Probation Department, until the responsibility is reassigned by the Chief Probation Officer/designee.

D. At the direction of the Chief Probation Officer/designee, notify BSCC Field Representative.

E. At the direction of the Chief Probation Officer/designee, submit a report to the Attorney General pursuant to the Guidelines section of this procedure.

VI. Professional Standards Unit:

A. Assist in gathering of information pertaining to the incident.

B. Secure the information until needed by the In-Custody Death Board of Inquiry.

Responsibilities in a hospital:

I. Staff Assigned to the Youth:

A. Adhere to the Hospital Watch procedure.

B. Remain in direct supervision of the youth's body until relieved by another staff or the coroner takes custody of the body.

1. Accompany the youth at all times except when the staff's presence would directly impede the medical treatment of the youth.

(a) In such a circumstance, the staff shall stay at the nearest distance from the youth that can be arranged with the hospital personnel in order to provide supervision.

2. Ensure the youth's body is not disturbed.

(a) If restraints were used, authorization and approval by the coroner must be given prior to the removal of restraints.

(b) Personal items shall not be removed from the body.

3. Obtain approval from the WC/IC prior to allowing the presence of anyone in the room with the youth not acting in their official capacity.

C. Notify the WC/IC when the coroner takes custody of the body.

1. Submit to an interview by the coroner.

2. Return to the JDAC/TF and submit the hospital watch file and/or electronic media and all documentation to the WC/IC.

II. Watch Commander (WC)/Incident Commander (IC):

A. Assign officers to follow the ambulance to the hospital in a separate vehicle and instruct officers not to disturb the youth's body, unless given authorization by the coroner, including the removal of restraints.

B. Ensure officers take a hospital watch file and/or electronic media and instruct officers to document all events.

III. Superintendent/Division Director/On-Call Director:

A. Adhere to Responsibilities in a JDAC or TF, Superintendent/Division Director/ On-Call Director, Section V. of this procedure.

IV. Professional Standards Unit:

A. Adhere to Responsibilities in a JDAC or TF, Professional Standards Unit, Section VI. of this procedure.

When death of a youth is a result of use of force:

I. Staff shall adhere to the MOA:

A. Watch Commander (WC)/Incident Commander (IC):

1. Stabilize and secure the scene.

2. Notify the San Bernardino Sheriff's Department dispatch center.

3. Ensure personnel do not enter the scene until the arrival and approval of the Sheriff's Homicide Detail supervisor.

4. Brief the Sherriff's Homicide investigators of the incident.

5. Adhere to the Responsibilities in a JDAC or TF, Watch Commander/ Incident Commander Section II. in this procedure.

B. Involved officer:

1. The involved officer may be removed from the scene and transported to another location to await investigators.

2. The involved officer should be made comfortable, allowed to call family, but should remain dressed in the same clothing and equipment as was worn during the incident.

(a) A member or members of the Peer Support Team may be dispatched to the scene at the discretion of the WC/IC and be available to assist on an ongoing basis unless the officer declines their assistance. A member of the Peer Support Team may be assigned to remain with the officer to provide aid and assistance without discussing the circumstances of the incident. If the officer needs transportation, a member of the Peer Support Team shall be assigned to provide transportation. The involved officer should avoid driving. It is imperative peer supporters offer comfort and support without compromising the investigation, as there is no legal privilege to communications with peer supporters. The contract counseling agency may also be contacted for assistance by the Director when appropriate.

3. The involved officer should refrain from talking about the incident except with their legal representative and/or the Sheriff's Homicide investigators.

4. If the staff requests to speak to or have present legal counsel during the interview, the Sheriff's Homicide investigators will honor the request.

5. The Sheriff's Homicide investigators will allow the officer involved to watch video recordings of the incident prior to the interview.

6. The Sheriff's Homicide investigators will only interview the involved staff if the statement from the officer is voluntary.

C. Public Information Officer:

1. Shall be responsible for all information given to the media.

2. All questions by the media will be referred to the Public Information Officer.

Notifications:

I. Chief Probation Officer:

A. Contact Risk Management, County Counsel, the Presiding Juvenile Judge of the Superior Court, and BSCC.

B. Ensure an investigation is conducted in response to every in-custody death. May elect not to convene the In-Custody Death Board of Inquiry if it is determined that such a review would be redundant, or interfere with an investigation by the Coroner's Office or Law Enforcement Investigators.

II. Deputy Chief Probation Officer (DCPO) of the Detention Corrections Bureau (DCB) shall notify:

A. Chief Probation Officer/designee.

B. Department Public Information Officer (PIO).

C. The youth's parent/guardian or person standing in loco parentis.

III. Superintendent/Division Director/On-Call Division Director shall notify:

A. Chief Probation Officer/designee and/or DCPO of the DCB.

B. The assigned Probation Officer and their Supervising Probation Officer.

IV. Watch Commander (WC)/Incident Commander (IC) shall notify:

A. Local Law Enforcement (Local Law Enforcement and the Coroner's office shall investigate the circumstances per Government Code Section 27491).

B. If the death is a result of use of force, contact the San Bernardino Sheriff's Department dispatch center as outlined in the MOA.

C. Superintendent/Division Director and/or On-Call Director (after business hours)

D. Health Services Manager/designee

E. Ombudsman

F. Peer Support Coordinator regarding peer support needs.

V. Probation Officer I/II/III/Supervising Probation Officer (SPO) shall:

A. Request a court hearing as soon as possible.

B. Submit a report to the court providing notification of the youth's death.

C. Notify the youth's attorney of record.

VI. Health Services Manager/designee shall notify:

A. Coroner

B. Medical Director

C. FAST Clinic Medical Director

D. FAST Program Manager

Internal Inspections:

I. Immediate Operational Administrative Review/Debriefing:

A. Consists of all staff relevant to the incident pursuant to Incident Report procedure, for the purposes of determining:

1. Circumstances surrounding cause of death.
2. Contributing factors.
3. Identification of emergency procedures that may need to be implemented.

II. Medical Review:

A. A medical and operational review shall take place with every in-custody death of a youth.

1. The Review Team shall conduct an inquiry and submit a report to the Chief Probation Officer that reviews the circumstances and probable causes of the death, focusing on a medical and operational review. The report may suggest medical or operational procedural changes, if any are identified.

B. A physician shall perform a clinical mortality review for each death within thirty (30) days.

1. The review shall be documented and shared with treating staff.
2. A modified clinical mortality review process may be used for expected deaths.

C. Corrective action shall be taken when necessary.

III. Critical Incident Review:

A. As determined by the Deputy Chief Probation Officer, a critical incident review shall occur after the investigation is completed.

IV. Psychological Autopsy:

A. Shall be conducted within 30 days if death is by suicide.