In-Custody Deaths and Serious Illness or Injury of a Youth (Title 15, § 1341)

523.1 PURPOSE AND SCOPE

This policy provides direction for notifications, reporting, and review of in-custody deaths, and notifications for serious illness or injury of a youth (15 CCR 1341).

523.2 DEFINITIONS

Definitions related to this policy include:

BSCC - California Board of State and Community Corrections

In-custody death - The death of any youth, for whatever reason (natural causes, suicide, homicide, accident), who is in Probation Department custody, including youth who are detained, committed, under arrest, in the process of being arrested, en route to be incarcerated, incarcerated at any correctional facility including any juvenile facility, attending an in-custody court appearance or is in a medical facility while in Probation custody (See Penal Code 10008(c)).

Internal review (also known as **administrative review**) - An assessment of whether a facility's standards, training, or supervision are adequate, and whether changes should be made.

Provider mortality review - An assessment of the medical care, including mental health care, provided to a youth who later died in custody. It should analyze the care provided, or care that should have been provided, to prevent the death. A medical provider mortality review should address areas where improvements can be made.

Psychological autopsy - An assessment performed for suicide deaths to illuminate the stressors that could have contributed to the suicide. It is usually conducted by a psychologist or other qualified mental health professional.

Serious illness or injury - Any illness or injury that requires hospitalization, is potentially life threatening, or that potentially will permanently impair the use of a major body organ, appendage, or limb.

Serious Offense - Any offense that is chargeable as a felony and that involves violence against another person.

523.3 POLICY

It is the policy of this San Diego County Probation Department to follow state and local guidelines regarding notifications and reporting in the event of an in-custody death or serious illness or injury of a youth and to review in-custody deaths to avoid preventable deaths.

523.4 RESPONSIBILITIES

(a) The Deputy Chief, in cooperation with the Health Services Administrator and the behavioral/mental health director, must develop written policies and procedures in the event of the death of a youth while detained or committed, which include notifications to necessary parties, which may include the Juvenile Court, the parent, guardian or person standing in loco parentis and the youth's attorney of records (15 CCR 1341(1)(a)).

(b) The Health Services Administrator, in cooperation with the Deputy Chief, must develop written policies and procedures to assure there is a medical and operational review of every in-custody death of a youth. The review team must include the facility administrator and/or facility manager, the health administrator, the responsible physician and other health care and supervision staff who are relevant to the incident (15 CCR 1341(1)(b)).

(c) The Deputy Chief, or Administrative Division Chief must report in writing to the California Attorney General within 10 calendar days after the death. The Deputy Chief, or Administrative Division Chief must provide to the BSCC a copy of the report submitted to the California Attorney General under Government Code § 12525 within 10 calendar days after the death (15 CCR 1341(1)(c)).

(d) The Deputy Chief, in cooperation with the Health Services Administrator, must develop written policies and procedures for the notification to necessary parties, which may include the Juvenile Court, the parent, guardian or person standing in loco parentis and the youth's attorney of record in the case of a serious illness or injury of a youth (15 CCR 1341(2)(a)).

523.5 NOTIFICATIONS FOR IN-CUSTODY DEATHS

(a) Upon determining that a death of any youth has occurred while in the custody of this Department, the Chief Probation Officer is responsible for ensuring that all appropriate investigative authorities, including the Medical Examiner, are notified without delay.

(b) The Chief Probation Officer must also promptly ensure that any other notifications required by policy or direction are made. The Deputy Chief must observe all pertinent laws and allow appropriate investigating and reviewing agencies full access to all facts surrounding the death.

(c) If the deceased youth is housed in this facility under a bed rental agreement with another agency, the Deputy Chief must notify that agency so it can assume responsibility for making required notifications.

(d) The Deputy Chief or the authorized designee must notify the Juvenile Court and any other court of jurisdiction and ensure notification to the youth's parent/guardian, or person standing in loco parentis, and the youth's attorney of record (15 CCR 1341(1)(a)).

(e) The Deputy Chief or the authorized designee must report in writing to the California Attorney General within 10 days after the death, all facts known concerning the death as provided by Government Code § 12525(a). A copy of this written report must also be provided to the BSCC within 10 calendar days after the death (15 CCR 1341(1)(c)).

(f) Any change or new information that becomes available after the initial reporting to the Attorney General must be updated to the report and provided to the Attorney General within 10 days of the date of change or the date the new information becomes available (Government Code § 12525(b)).

(g) Upon receiving a report of the death of a youth from the administrator, the BSCC may, within 30 calendar days, inspect and evaluate the juvenile facility, jail, lockup or court holding facility pursuant to the provisions of 15 CCR Div. 1, Ch. 1, Sub ch. 5. Any inquiry made by the BSCC must be limited to the standards and requirements set forth in these regulations (15 CCR 1341(1)(d)).

(h) Pursuant to Article 37 of the Vienna Convention on Consular Relations 1963, in the case of the death or serious injury or illness of a foreign national, any required notifications will be made to the appropriate consulate post as soon as practicable.

(i) The deceased youth's personal belongings must be disposed of in a responsible and legal manner. All property and records must be retained according to established records retention schedules.

(j) During an investigation or review, all inquiries regarding the death must be referred to the Public Information Officer. Staff members must not make public comments relating in any way to the investigation or review.

523.5.1 IN-CUSTODY DEATH REVIEW TEAM

The Chief Probation Officer, or authorized designee, in cooperation with the Health Services Administrator, is responsible for establishing a team of qualified staff members to conduct an internal review of every in-custody death. The review team must include (15 CCR 1341(1)(b)):

(a) The Chief Probation Officer and/or the Deputy Chief.

(b) The Health Services Administrator.

(c) The Medical Director or authorized designee.

(d) Other health care and supervision staff members relevant to the incident. Additional members of the death review team may include, as appropriate:

1. Investigative staff members.
2. Healthcare Administrator, qualified medical/mental health care professionals, supervisors, or other staff members and individuals who are relevant to the incident.
3. Internal Affairs & Backgrounds Unit investigators.
4. Local law enforcement.
5. Child welfare agency representatives.

523.5.2 IN-CUSTODY DEATH REVIEW

(a) The in-custody death review should be initiated immediately, though it may take time to obtain all the relevant information for proper analysis. The provider mortality review should be completed within 30 days. Depending on the nature of the death, the administrative review and/or psychological autopsy may take longer than 30 days to

complete; however, every effort should be made to complete the review in a timely manner so that necessary improvements can be implemented as soon as possible.

(b) The review team must evaluate the in-custody death to determine whether laws, regulations, and policies and procedures were followed, and whether any policies or procedures should be changed. A report must be prepared by the review team of any findings of the review.

(c) In conducting a death review, the Chief Probation Officer or the authorized designee should immediately collect all relevant information, including but not limited to:

1. Intake records.
2. Medical/mental health records.
3. Youth requests, complaints, and grievances.
4. Visitor logs.
5. Phone calls and any electronic communications.
6. Inspection logs, notes, and corrective actions.
7. Safety and Welfare check logs.
8. Daily activity logs and shift reports.
9. Program attendance logs.
10. Classification records.
11. Use of force and use of physical restraints reports.
12. Staff member rosters.
13. Staff member statements or interviews (e.g., incident reports).
14. Witness statements or interviews.
15. Video footage.
16. Youth records.
17. Court records.
18. Information about criminal charges (more relevant for suicide).
19. Toxicology reports.
20. Medical Examiner reports, including the autopsy report.
21. Any other relevant records, reports, or interviews.

523.6 WEBSITE POSTING (PENAL CODE 10008)

(a) When there is an in-custody death as defined in 523.2 above, the Department must, consistent with reporting requirements of Government Code 12525, post all of the following on its internet website (Penal Code 10008(a)(1)-(7)):

1. The full name of the agency with custodial responsibility at the time of death.
2. The county in which the death occurred.

3. The facility in which the death occurred, and the location within that facility where the death occurred.
4. The race, gender, and age of the decedent.
5. The date on which the death occurred.
6. The custodial status of the decedent, including, but not limited to, whether the person was awaiting arraignment, awaiting trial, incarcerated, detained or committed.
7. The manner and means of death.

(b) (1) Subject to paragraph (2), the information must be posted for the public to view on the agency's internet website within 10 days of the date of death. If any of the information changes, including, but not limited to, the manner and means of death and the date on which the death occurred, once determined by a medical examiner or similar entity, the agency must update the posting within 30 days of the change. (2) If the agency seeks to notify the next of kin and is unable to notify them within 10 days of the death, the agency must be given an additional 10 days to make good faith efforts to notify next of kin before the information must be posted for the public to view on the agency's internet website.

(c) These materials should be well-organized with a written factual overview of the relevant events in the timeline leading up to the death and the response in the time frame after the death. The overview should be prepared with the expectation that the material will be reviewed by the Chief Probation Officer, outside agencies, lawyers, policy makers, and state and federal court judges. In the case of suicide, this material should be provided to the medical or mental health professional who will be preparing the psychological autopsy.

(d) Notification should be sent to all relevant individuals instructing them to preserve all records related to the decedent's detention.

523.7 IN-CUSTODY DEATH PUBLICATION

The Deputy Chief or the authorized designee should ensure that all specified information relating to the in-custody death is posted on the Department's website as prescribed and within the time frames provided in Penal Code § 10008. This includes, but is not limited to, the name of the custodial agency, county and facility of death (including the specific location), decedent's race, gender, age, date of death, custodial status, and the manner and means of death. The initial posting must occur within 10 days of the death, with updates made within 30 days of any changes. If notification to next of kin is delayed beyond 10 days, the department is granted an additional 10 days to complete a good faith effort to notify them before posting.

523.8 NOTIFICATIONS FOR IN-CUSTODY SERIOUS INJURY, SERIOUS ILLNESS OR OFFENSE COMMITTED AGAINST YOUTH (WELFARE & INSTITUTIONS CODE 223)

(a) (1) The parents or guardians of any detained or committed youth, if they can reasonably be located, must be notified within 24 hours by the Watch Commander or

authorized designee of any serious injury, serious illness or serious offense committed against the youth, upon reasonable substantiation that a serious injury or offense has occurred. (2) This section must not apply if the youth requests that their parents or guardians not be informed and the Watch Commander or authorized designee determines it would be in the best interest of the youth not to inform the parents or guardians.

(b) For purposes of this section, "serious offense" means any offense that is chargeable as a felony and that involves violence against another person. "Serious injury" means, for purposes of this section, any illness or injury that requires hospitalization, is potentially life threatening, or that potentially will permanently impair the use of a major body organ, appendage, or limb (Welfare & Institutions Code § 223(b)).

523.9 REFERENCES

Date Last Reviewed	12/19/2025
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Policy and Procedure References	Procedure 523 Reporting In-Custody Deaths and Serious Illness or Injury of a Youth (Title 15, § 1341)
Attachments/Links	Welfare & Institutions Code § 223 Penal Code 10008 Government Code 12525 15 CCR 1341