MADERA COUNTY DEPARTMENT OF CORRECTIONS
DEATH IN CUSTODY
DPPM 08-02

SUBJECT
DEATH IN CUSTODY

POLICY
INMATE DEATHS THAT OCCUR IN THE MADERA COUNTY DEPARTMENT OF CORRECTIONS WILL BE HANDLED IN A MANNER TO ENSURE COMPLIANCE WITH THE STATE OF CALIFORNIA MANDATES.

REFERENCES
C.A.C. 3-4E-45
TITLE 15 SECTION 1218
GOVERNMENT CODE 12525, 26643

GENERAL INFORMATION
INMATE DEATH

1. IN CASES WHERE CESSION OF LIFE IS NOT OBVIOUS, THE VICTIM WILL BE EXAMINED AT THE SCENE BY MEDICAL PERSONNEL WHO WILL MAKE A DETERMINATION REGARDING DEATH. SHOULD THERE BE ANY DOUBT ABOUT DEATH, APPROPRIATE EMERGENCY LIFE SAVING MEASURES WILL BE ADMINISTERED AND THE INMATE TRANSPORTED TO MADERA COMMUNITY HOSPITAL FOR MEDICAL TREATMENT.

2. IN CASES WHERE DEATH HAS ALREADY BEEN DETERMINED OR DEATH IS OBVIOUS, (POST-MORTEM LIVIDITY, RIGOR MORTIS ETC.). THE BODY WILL NOT BE DISTURBED OR MOVED FROM THE SCENE UNTIL APPROVED BY AND AT THE DIRECTION OF THE CORONER’S DIVISION OF THE MADERA COUNTY SHERIFF’S DEPARTMENT.

3. FACILITY STAFF WILL NOT MAKE ANY PUBLIC COMMENT REGARDING THE SITUATION OR THE INDIVIDUAL(S) INVOLVED. ALL INQUIRIES WILL BE REFERRED TO THE FACILITY DIRECTOR OR DESIGNEE.

4. THE MADERA COUNTY SHERIFF’S DEPARTMENT CORONER’S DIVISION IS RESPONSIBLE FOR THE NOTIFICATION OF NEXT-OF-KIN ON ANY INMATE.

5. IN THE EVENT THE OPERATIONS COMMANDER DETERMINES THAT AN INQUIRY IS BEING MADE BY NEXT-OF-KIN, THEY WILL CONTACT THE CORONER’S DIVISION FOR DIRECTION.

PROCEDURE 1
RESPONSIBILITIES OF STAFF DISCOVERING AN INMATE DEATH

1. THE STAFF MEMBER WILL ISOLATE AND PRESERVE THE SCENE AND EVIDENCE.

2. THE STAFF MEMBER WILL DETAIN, IDENTIFY AND SEPARATE ALL SUSPECTS AND WITNESSES.
3. THE STAFF MEMBER WILL SECURE INSTRUMENTS AND/OR MATERIALS USED TO AFFECT DEATH.

4. STAFF WILL INITIATE NOTIFICATION VIA CHAIN OF COMMAND FOR EACH IN-CUSTODY DEATH.
   - MEDICAL NURSES
   - WATCH COMMANDER
   - MEDICAL SUPERVISOR
   - OPERATIONS COMMANDER
   - INVESTIGATIONS
   - SHERIFF/CORONER
   - FACILITY’S ASSISTANT DIRECTOR
   - FACILITY’S DIRECTOR
   - FACILITY’S PHYSICIAN
   - MEDICAL HEALTH ADMINISTRATOR

5. INITIAL STAFF MEMBERS AND ALL RESPONDING STAFF MEMBERS WILL WRITE INCIDENT REPORTS IN THE JAIL MANAGEMENT SYSTEM (JMS) DETAILING THE CIRCUMSTANCES OF THE EVENT AND THEIR ACTIONS TAKEN.

6. IN ALL INMATE DEATH CASES, THE OPERATIONS COMMANDER OR DESIGNEE WILL NOTIFY THE INVESTIGATION DIVISION AND THE SHERIFF/CORONER.

PROCEDURE 2  DECEASED INMATE’S PERSONAL PROPERTY

1. THE OPERATIONS COMMANDER WILL ENSURE THAT THE FOLLOWING ARE COMPLETED FOR, AND TURNED OVER TO, THE SHERIFF/CORONER.
   - SECURE ANY SUICIDE NOTE
   - SECURE ANY MEDICATION
   - SECURE ALL CLOTHING, PERSONAL PROPERTY AND MONEY.
   - MAKE COPIES OF DOCUMENTS VERIFYING CUSTODY STATUS AND IDENTIFICATION (REMANDS, COMMITMENTS, WARRANTS, BOOKING SHEET, MUG SHOT, MEDICAL RECORDS, ETC.)
PROCEDURE 3  INMATE DEATH-INCIDENT AND RELATED REPORTS

1. AN INCIDENT REPORT WILL BE INITIATED BY THE OFFICER WHO HAD SUPERVISION OF THE INMATE WHEN THE DEATH ORIGINATED OR WAS DISCOVERED.

   • SUBSEQUENT FOLLOW-UP INVESTIGATION WILL BE HANDLED BY THE INVESTIGATION DIVISION OR CORONER’S DIVISION AS DEEMED APPROPRIATE.

2. THE DIRECTOR SHALL WRITE A REPORT AND FORWARD TO THE ATTORNEY GENERAL WITHIN TEN (10) DAYS OF THE INMATE DEATH EXPLAINING THE CIRCUMSTANCES OF THE DEATH.

PROCEDURE 4  DEBRIEFING

1. INITIAL DEBRIEFING - AT THE CONCLUSION OF THE INCIDENT AND/OR PRIOR TO ANY INVOLVED STAFF MEMBER DEPARTING THE FACILITY, ANY AND ALL OFFICERS INVOLVED IN THE INCIDENT WILL ATTEND AN INITIAL DEBRIEF MEETING.

   • THIS IS A TIME WHEREIN INQUIRIES ARE MADE AS TO THE WELL BEING OF EACH STAFF MEMBER/MEDICAL STAFF INVOLVED.
   • STAFF MEMBERS WILL BE INFORMED THAT THERE IS COUNSELING AVAILABLE SHOULD THEY NEED/WANT IT.

2. FORMAL DEBRIEF - AT A DESIGNATED TIME AFTER THE INCIDENT, THE FACILITY ADMINISTRATOR AND/OR MANAGER, THE HEALTH ADMINISTRATOR, THE RESPONSIBLE PHYSICIAN, AND ANY OTHER HEALTH CARE AND SUPERVISION STAFF WHO ARE RELEVANT TO THE INCIDENT WILL PARTICIPATE IN A FORMAL DEBRIEFING WHEREIN THE FOLLOWING ISSUES MAY BE DISCUSSED:

   • GENERAL OVERVIEW OF THE INCIDENT
   • WHAT WAS DONE CORRECTLY/INCORRECTLY
   • CRITIQUE OF STAFF MEMBERS/MEDICAL ACTIONS
   • CRITIQUE OF REPORTS
   • FOLLOW-UP ON STAFF MEMBERS WELL BEING
MADERA COUNTY DEPARTMENT OF CORRECTIONS
DEATH IN CUSTODY
DPPM 08-02

EFFECTIVE: 01-27-2005  REVIEWED: 05-03-2005  REVISED: 05-03-2005

06-16-2014  09-15-2014

GENERAL INFORMATION

POLICY UPDATE

1. THIS POLICY AND PROCEDURE SHALL BE REVIEWED ANNUALLY AND UPDATED AS NEEDED.

APPROVED DATE: 9-29-14

M. PEREZ, DIRECTOR