



**SAN MATEO COUNTY
PROBATION DEPARTMENT
INSTITUTIONS SERVICES MANUAL**

**ARTICLE 4
Records and Public Information
§1341**

Topic Death or Serious Illness/Injury of a Youth While Detained

Policy It is the purpose of this policy to ensure the proper investigation and reporting in event of a death or serious illness or injury of a youth in custody. Staff shall report and respond to any event involving the death, serious illness or injury of a youth in custody in accordance with departmental procedure.

1341.1 DEATH OF A YOUTH IN CUSTODY

1. The Superintendent and/or the Deputy Chief Probation Officer shall submit a report to the Attorney General no more than ten (10) calendar days following the death of an in-custody youth. The report shall follow the format provided by the Office of the Attorney General and detailed in Government Code 12525. A copy of the report shall be forwarded to the Board of State and Community Corrections (BSCC) within ten (10) calendar days of the submission of the report to the Attorney General.
2. Upon receipt of a report of the death of a youth from the Superintendent, the BSCC may within 30 calendar days inspect and evaluate the juvenile facility.
3. The Probation Department shall accommodate any legal, judicial, or BSCC investigation of the death.
4. The San Mateo County Health Department, in cooperation with the facility Superintendent, has developed policies and procedures for the medical and operational review of all deaths in custody (Health Services Policies and Procedures, §0114.00, Medical Review of Juvenile In-Custody Deaths). The review team shall include the facility Superintendent and/or Institution Services Manager (ISM), the health administrator, the responsible physician and other health care and supervision staff who are relevant to the incident.
5. The San Mateo County Health Department, in cooperation with the facility Superintendent, has developed policies and procedures regarding suicide prevention and intervention (Health Services Policies and Procedures, §0312.00, Suicide Prevention; Hillcrest Mental Health Policy Number YSCMH 15-05, Suicide Prevention and Response Plan).

1341.2 IN-CUSTODY DEATH REVIEWS

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

- a. Intake records.
- b. Medical/mental health records.
- c. Youth requests, complaints, and grievances.
- d. Visitor logs.
- e. Phone calls and any other electronic communications.
- f. Inspection logs, notes, and corrective actions.
- g. Safety check logs.
- h. Daily activity logs and shift reports.
- i. Youth and Program attendance logs.
- j. Classification records.
- k. Use of force and restraints reports.
- l. Staff rosters.
- m. Staff statements or interviews (e.g., incident reports).
- n. Witness statements or interviews.
- o. Video footage.
- p. Youth records.
- q. Court records.
- r. Information about criminal charges (more relevant for death by suicide).
- s. Toxicology report.
- t. Coroner reports, including the autopsy report.
- u. Any other relevant records, reports, or interviews.

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

1341.3 IN-CUSTODY DEATH REVIEW TEAM

The Chief Probation Officer is responsible for establishing a team of qualified staff to conduct an internal review of every in-custody death. The review team can include (15 CCR 1341):

- a. Chief Probation Officer or the authorized designee.
- b. Legal counsel for the juvenile facilities.
- c. District Attorney.
- d. Investigative staff.
- e. Medical Director, qualified medical/mental health care professionals, supervisors, or other staff who are relevant to the incident.
- f. Internal Affairs Managers and investigators.
- g. Local law enforcement.
- h. Child welfare agency representative.

- i. Institution staff.

The in-custody death review should be initiated immediately, though it may take time to obtain all the relevant information for proper analysis (as listed above in Section A). The 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 necessary improvements can be implemented as soon as possible.

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

1341.4 SERIOUS INJURY OR ILLNESS OF A YOUTH IN CUSTODY

The ISM/Officer of the Day is responsible for notifying 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 in custody. The ISM/Officer of the Day shall complete an Information Report and a copy of the report shall be forwarded to the Superintendent and assigned probation officer for review. A copy of the report shall be placed in the youth's unit file.

See Procedures Manual on Death and Serious Illness or Injury of a Youth While Detained for further information.