NEVADA COUNTY SHERIFF'S OFFICE

CORRECTIONS DIVISION DIRECTIVE
27
Effective Date
~~03/26/02~~
01/26/18

SUBJECT **ADULT IN-CUSTODY DEATH - 1046**

POLICY The Nevada County Corrections Division will develop and implement procedures for the reporting and investigation of any ADULT in-custody death. This Directive also applies to Truckee and the court holding facilities.

PURPOSE To insure prompt notification and documentation all facts concerning all adult in-custody deaths.

CODE REFERENCE California Penal Code 6030
California Code of Regulations, Title 15, Section 1046
California Government Code, Section 12525
Nevada County Coroner's Directive #22

CASE LAW

DEFINITIONS

PROCEDURE In the event of an adult in-custody death, the following procedures will be followed.

1. The watch commander or on-duty supervisor will have central control notify the following:

   a. Sheriff's dispatch (911). Inform the dispatcher that an adult in-custody death has occurred and a coroner's report is required.

   b. Sheriff and Undersheriff and Facility Commander.

   c. Facility Command Staff.

   d. Medical Program Manager.

   e. Chaplain

2. The California Department of Corrections (CDC) SHALL BE IMMEDIATELY NOTIFIED of an adult inmate with a CDC Detainer who dies in our custody. The CDC Detainer has the appropriate telephone number to call.

3. The watch commander or on-duty supervisor will have custody staff complete the following:

   a. Secure the scene until a deputy coroner arrives and initiates their investigation.

   b. Lockdown all inmates in the pod. Inmates will not be allowed out of lockdown until authorized by the watch commander or on-duty supervisor.

   c. Have all staff associated with the incident complete incident reports prior to leaving the facility. Reports will be given to the watch commander or on-duty supervisor.

   d. Ensure all video recordings of the incident are downloaded and saved to be turned over to investigators.

4. The watch commander or on-duty supervisor will:

   a. Compile and review all incident reports, then forward all reports to the facility commander.

   b. Assemble all staff involved in the incident for a Critical Incident Review. The Chaplain will be a part of this review.

   c. Provide appropriate counseling for all staff requiring or requesting help.

5. The Operations Lieutenant will:

   a. As required by Government Code Section 12525, prepare a report, which will be forwarded to the California Attorney General. This written report will be forwarded within 10 days of the adult in-custody death.

6. Within 30 days of the death, the facility administrator, health administrator, responsible physician, and other health care and supervision staff who are relevant to the

incident shall review the death to determine appropriateness of clinical care; whether changes to policies, procedures or practice are warranted; and to identify issues that require further study.