	County of Sacramento **Department of Health Services** **Division of Primary Health** **Policy and Procedure**	Policy Issuer (Unit/Program)	**JCH**
		Policy Number	**A10-1341**
		Effective Date	**12-93**
		Revision Date	**07-19**
Title: **Procedure in the Event of A Juvenile Death**		Functional Area: Governance and Administration	
Approved By: Pamela Gandy-Rosemond, MSN RN, CCHP Health Administrator Approved By: Scarlett Ong, BSN RN Clinic Manager			

Policy:

It is the policy of Juvenile Correctional Health (JCH) to provide complete and transparent communication with the Sacramento Probation Department and San Joaquin County Coroner's Office, in the event of an in Custody Death of a resident.

The prompt securing of the residents medical record, will be done by the Health Program Manager (or his/her designee).

A copy of the current Medical Record will be sent to the San Joaquin Corner's office, to assist in the inquest.

Procedures:

A. The Medical staff will respond to all Medical emergencies, including possible deaths.
    1. Upon responding, if the Medical Doctor determines that no response is necessary due to obvious death, the MD may defer any further attempts to revive the resident. If the MD feels that attempt to revive is needed he/she will take control until the EMT's arrive to transport to a hospital.
    2. If there is no MD in-house, the RN in charge will start the resuscitation efforts and continue until the EMTs arrive. As soon as the resident is either pronounce dead or transported to the hospital, the Program Manager or his/her designee will secure the medical chart in the Electronic Medical Record program. A copy of the chart will be made (electronic or physical) and sent with the resident to the San Joaquin Hospital Coroner's Office.

B. The chart will be secured by the Health Program Manager (HPM) or their designee.

C. The Health Program Manager, along with the Lead Physician and any other medical staff needed will be members of the Death Review Committee.

D. All deaths are reviewed within 30 days.

E. A death review will consist of:
    a. Assessment of correctional and emergency response actions surrounding the death of the juvenile to identify facility operations, policies and procedures improvement.
    b. Assessmento f the clinical care provided and the circumstances leading to the death of the juvenile to identify areas of patient care or policies and procedures that can be improved.
    c. Psychological autopsy with emphasis on factors contributing the juvenile's death.

F. Information regarding the clinical mortality review and administrative review findings will be given to treating staff.

References:
See Probation Policy – Death/Suicide within the facility

NCCHC, Y-A-10

Title 15, Article 4, Section 1341

Attachments:

Sacramento County Probation Department Policy an dProcedure – Death within the institution

Contact:
Pamela Gandy-Rosemond, Health Program Manager
Scarlett Ong, Clinic Manager

SACRAMENTO COUNTY PROBATION DEPARTMENT
POLICY AND PROCEDURE – JUVENILE HALL

DEATH / SUICIDE WITHIN THE INSTITUTION – TITLE XV 1341
Reviewed 01/08/2014 Approved by C. Kagel

Discussion:

The saving of a life is the priority in any emergency situation. Should a detainee death occur, documentation, preservation of the scene, and notification of the proper authorities is imperative.

In the event such an event does occur; the emotional backlash which follows for detainees and staff can be traumatic. It is important that those post-traumatic issues are acknowledged and addressed.

GUIDELINE: Duties and Responsibilities

A. Staff Discovering A Suspected Detainee's Death Shall:
    1. Immediately, activate the security alarm and summon other staff for assistance.
    2. Intervene to safe life, by administering C.P.R./First Aid unless immediate intervention jeopardizes the safety of staff or other detainees.
    3. Summon internal medical assistance, if available.
    4. Call 911 for emergency assistance.
    5. Lock down other minors for a minimum period and secure the area.
    6. Notify supervisors or other units appropriate.
    7. PRESERVE THE SCENE: The highest ranking staff shall preserve the scene and direct other staff as the need arises. Once the immediate emergency is defused, the entire area shall be secured. No individual shall change, alter or move any object, item, clothing, furniture, etc., until cleared to do so by the scene manager.
        a. Immediately collect and secure all records, logbooks, room/hall check sheets, casework file, bed chart, etc.
        b. Take photographs of scene, if possible.
        c. Maintain a time/actions sequence log. Initiate as soon as possible. Identify person responsible for maintaining.
        d. Get written statements of all involved staff and witnesses prior to their leaving facility.

B. Notifications:
    1. Sheriff's Department: In the event a detainee's death occurs, the circumstances and conditions surrounding the death shall be investigated by the Sheriff's Department and the Coroner's Office per Section 27401 of the Government Code.