BOARD OF STATE AND COMMUNITY CORRECTIONS
TITLE 15, DIVISION 1, CHAPTER 1, SUBCHAPTER 4
MINIMUM STANDARDS FOR LOCAL DETENTION FACILITIES

FINAL STATEMENT OF REASONS

UPDATE TO INITIAL STATEMENT OF REASONS

The BSCC did not make any changes to the proposed regulation text as originally noticed on February 2, 2024.

LOCAL MANDATE DETERMINATION

Pursuant to Government Code Section 11346.9(a)(2), the Board of State and Community Corrections (BSCC) has determined that adoption, amendment, or repeal of these Title 15 regulations as proposed, do not impose a mandate on local agencies or school districts.

ALTERNATIVES DETERMINATION

Pursuant to Government Code section 11346.9, subdivision (a)(4), the BSCC has determined that no reasonable alternative it considered or that has otherwise been identified and brought to its attention would be more effective in carrying out the purpose for which the regulation is proposed, would be as effective and less burdensome to affected private persons than the proposed action, or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

There have been no updates to the original Economic Impact Analysis published in the Notice of Proposed Action on February 2, 2024. Pursuant to Government Code section 11346.9, subdivision (a)(5), the BSCC has determined that no reasonable alternative would lessen any adverse economic impact on small business; the BSCC did not receive any proposed alternatives.

DOCUMENTS INCORPORATED BY REFERENCE

No documents have been incorporated by reference during the 45-day public comment period or otherwise.

SUMMARY AND RESPONSE TO 45-DAY PUBLIC COMMENT

COMMENTER #1
Robert Michael Vanleeuwen
Received February 26, 2024

Summary of Comment
Policies and procedures related to investigating in-custody violence and deaths should include variables that incite violence, such as high levels of frustration, discontent with one's surroundings, having to hand-write letters or format legal documents without extreme effort, debt, or rule violations.

Mr. Vanleeuwen also commented on Title 15, section 1064, Library Services, the basis of convictions, pre-trial detention orders, prosecutor-requested bail, group punishments, and privileges in facilities. In accordance with Government Code section 11346.9(a)(3), the BSCC has determined these comments to be irrelevant as they are not specifically directed at the agency's proposed action or to the procedures followed by the agency in proposing or adopting the action.

COMMENTER #2
ACLU California
Received March 19, 2024, Via Email *(Letter erroneously dated March 19, 2023)*

Summary of Comment
Expand the list of information required for the initial review report to include:
- Case information, including date of arrest or admission, case status, bail amount (if pretrial), and any finding of incompetence to stand trial, whether the decedent was waiting for placement with the Department of State Hospitals, and the date of commitment to the Department of State Hospitals. Including case information will inform the Board's and Director of In-Custody Death's recommendations to address the in-custody death crisis.
- Details of the onset of illness or injury, and if death occurred in the hospital, onset of illness or injury that led to hospitalization, if death occurs while hospitalized. Including details for deaths that occur in hospitals reduces obscurity in reporting and prevents the potential for a facility to not report an in-custody death when the death occurs in the hospital because the location of the death is not within the detention facility.
- Date and time of the last safety check. Including safety check information will help the Board and Director of In-Custody Death evaluate problems related to custodial oversight.

COMMENTER #3
ACLU California Action et al.
Received March 20, 2024, Via Email

Summary of Comment
In addition to the recommendation summary for commenter #2, expand the list of information required for the initial review report to include disabilities and mental health diagnoses and relevant information relating to an individual's repeated time in custody until the date of their death, to provide a more comprehensive snapshot of individuals before an in-custody death occurs.

BSCC RESPONSE

The proposed changes to Title 15, section 1046, Death in Custody, include additional requirements for the initial review report that facility administrators must submit to BSCC within 60 days of a death in custody. BSCC has proposed a list of information that must be included in the initial review report, including but not limited to "Any relevant circumstances leading up to death, including behavioral health or medical issues." The proposed requirement is intentionally broad, so any relevant circumstances that occurred leading up to the death are provided rather than explicitly defined circumstances that would limit the scope of information provided to BSCC. Pursuant to Penal Code Section 6034(b), the scope of the director's review is limited to death incidents occurring within a local detention facility. Further, upon determination by the Board that it is necessary and appropriate, the director may conduct further review of a death incident, which allows for the Board and the director to determine what additional information is necessary and appropriate during further review of each individual incident.

No modifications will be made to the proposed regulation text.

ROBERT MICHAEL VANLEEUWEN (TAFOYA) #BS8619
P.O. BOX 1050 (SVSP-A2-132)
SOLEDAD, CA - 93960

COMMENT ON '2024-5-CRLB-131'
- COMMENT PERIOD: 2-2-24 ~ 3-20-24

WITH RESPECT, THIS BOARD CONTINVES TO ACT WITH THE BEST INTENTIONS YET SOMEHOW IGNORES THE QUALITY OF LIFE ISSUES AND THE MODERNIZATION DISPARITY PREVELANT IN STATE AND COMMUNITY FACILITIES.

SECTION § 1064 REMAINS INCOMPLETE, OPEN ENDED AND UTTERLY USELESS IN DEFINING THE MOST IMPORTANT MINIMUM STANDARDS FOR INMATE ACCESS TO, NOT ONLY INFORMATION, BUT LEGAL AND EDUCATIONAL MATERIAL.

IT IS 2024, YET TO SUBMIT A TYPED LETTER, DOCUMENT OR COURT PLEADING WE MUST PAY $400.00 FOR A TYPEWRITER, WHICH NO INMATE CAN AFFORD WITHOUT ANY ASSISTANCE OR PAY OTHER INMATES TO COMPLETE THE MOST BASIC TYPING TASK. IN STATE FACILITIES, COMPUTERS PROVIDE LEGAL ACCESS, BUT NO MEANS OF USING MICROSOFT OFFICE WORD OR OPENSOURCE ALTERNATIVE. THESE COMPUTERS SIT IN A ROOM WITH A PRINTER, YET NO ATTEMPT TO PROVIDE MODERN ACCESS TO OFFICE APPLICATIONS OR PRINT SERVICES HAS EVER BEEN ATTEMPTED. IN COUNTY JAIL, MOST COMPUTERS ARE NOT ALLOWED TO BE USED WITH A MOUSE OR KEYBOARD.

ONE SENTENCE IN SECTION § 1064 CAN CHANGE THINGS.

WHILE THE BSCC CONTINUES TO SEEK IMPLEMENTATION OF POLICY AND PROCEDURE TO PROTECT INMATES, INVESTIGATE IN CUSTODY VIOLENCE AND DEATHS,.. SOME OF THE ATTENTION SHOULD BE PLACED ON THE VARIABLES THAT INCITE VIOLENCE - A HIGH LEVEL OF FRUSTRATION, DISCONTENT WITH ONES SURROUNDINGS WHEN A PERSON CANNOT MICROWAVE A BAG OF POPCORN, WRITE A LETTER OR FORMAT APPROPRIATE LEGAL DOCUMENTS, ETC... WITHOUT EXTREME EFFORT, DEBT OR RISK OF RULE-VIOLATIONS IN THE CASE OF CONDUCTING RISKY BUSINESS WITH OTHER INMATES.

SINCE THE LATE 1970'S AND THE DAWN OF "INFERRED LIABILITY", WE MUST NOT FORGET THAT A GROWING PERCENTAGE OF CONVICTIONS ARE BASED ON AN LACK OF ABILITY TO PAY FOR A SERIOUS DEFENSE, PLEAS OF GUILT TO AVOID UNJUSTIFIED PENALTY, AND CLASS ISSUES. YET INMATES ARE OFTEN PUNISHED AS A GROUP IN FACILITY ADMINISTRATION, WHERE EVEN WHEN SOMETHING CAN BE PROVIDED, IT ISN'T, SIMPLY BECAUSE REGULATIONS DON'T SPECIFY IT. MANY OF US MAY NOT BE IN THIS PLACE IF WE HAD MINIMUM STANDARDS TO INCLUDE SPECIFIC PRIVILEGES. A SET OF PRIVILEGES MANY MAY FEEL ARE INCLUSIVE, OBVIOUS, BUT DENIED OUT OF HATE, ILL-WILL, A LACK OF REQUIREMENT.

DARE WE ALSO BRING UP SELF-REPRESENTATION OR THE PENALTY OF COUNTY-JAIL THAT HAS PROSECUTORS REQUESTING HIGH-BAIL OR ABSURD PRE-TRIAL DETENTION ORDERS BECAUSE IT GUARANTEES (1) THE PERSON LOOKS GUILTY, (2) YOU CAN MONITOR CONTACT WITH LEGAL ISSUES, (3) LIMIT DEFENSE ABILITY TO FIND OR LOCATE WITNESSES, (4) TORTURE A PERSON THROUGH THE DAY-TO-DAY TO INCITE A PLEA OF GUILT, (5) MAKE RESEARCH VIRTUALLY IMPOSSIBLE... THE LIST GOES ON... THE "GUILTY" RECEIVE MORE PRIVILEGES THAN THE "INNOCENT" IN OUR STATE / COMMUNITY FACILITIES - BUT THE "GUILTY" MAY NEVER HAVE BEEN FOUND "GUILTY" HAD BASIC PRIVILEGES OR QUALITY OF LIFE ISSUES BEEN DIFFERENT.

HAVING SPENT 3 YEARS IN COUNTY AND GOING ON 2 IN STATE - I AM A VICTIM OF THE AMBIGUITY AND LACK OF MINIMUM STANDARDS.

RESPECTFULLY,

ROBERT MICHAEL VANLEEUWEN

x

* IT TOOK 2.5 HRS TO LEGIBLY WRITE THIS LETTER.
+1 HOURS TO GO OVER IT A 2nd TIME TO DARKEN SO COPY MACHINE WONT DEGRADE.

= 3.5 HRS.

ROBERT M. VANLEEUWEN (TAPOYA) #B58619
P.O. BOX 1050 (SVSP-A2-132)
SOLEDAD, CA- 93960

SAN JOSE CA 950
12 FEB 2024 PM 4 L

STATE PRISON
GENERATED MAIL

AMANDA FERREIRA, AGPA
2590 VENTURE OAKS WAY #200
SACRAMENTO, CA - 95833

95833-328850

PUB. COMMENT - PROPOSED REGULATION 2024-5 CRLB 131

March 19, 2023

VIA EMAIL

Amanda Ferreira
Associate Governmental Program Analyst
Board of State and Community Corrections
2590 Venture Oaks Way, Suite 200
Sacramento, CA 95833
regulations@bscc.ca.gov

Re: Proposed Amendment of Section 1046 of Title 15 – Written Public Comment and Request for Public Hearing

Dear Ms. Ferreira,

For the past 50 years, the American Civil Liberties Union (ACLU) has led litigation, monitoring efforts, and legislative lobbying regarding conditions in carceral facilities in California. Relevant bills ACLU Cal Action has sponsored include AB 732 (Strengthening Reproductive Healthcare for People in Jails and Prisons) and SB 132 (Transgender Respect, Agency, and Dignity Act). ACLU SoCal currently maintains hotlines for people incarcerated in Los Angeles and Orange County jails and is plaintiffs' counsel for four conditions-related lawsuits stemming from issues within the Los Angeles County Jails.

Our affiliates closely track in-custody death trends and have worked with coalitions across the state to bring attention to the sharp rise in in-custody deaths over the last five years.[1] We applaud SB 519 (Corrections) and hope the new Director of In-Custody Death position at the Board of State and Community Corrections (Board) will bring much needed oversight to this issue and, ultimately, save lives.

We write to provide public comment on the proposed amendment of section 1046 of Title 15, Division1, Chapter 1, Subchapter 4 of the California Code of Regulations and to request a public hearing.

The Board's Notice of Proposed Action and Amendment of Regulations lists anticipated benefits of the proposed amendments to Title 15. The Board notes that the revisions should result in "improved investigative accountability and transparency in reporting, and the necessary data and reporting to

[1] See, for example, Care First California, *A Decade of Lives Lost: a Report of In-Custody Deaths in California between 2011-2022*, at https://carefirstca.org/wp-content/uploads/2024/02/InCustodyDeaths.pdf.

support the enhanced mission of the BSCC to review, inspect, and promote legal and safe conditions in local detention facilities."[2]

The proposed regulations, while constructive, contain gaps that will hinder the Board's mission and, particularly, the ability of the new Director of In-Custody Death to determine the nature of the problems in detention facilities. We recommend revisions to proposed subdivisions (c) and (d) of section 1046, noted in red below.

1046. Death in Custody

(c) The facility administrator shall submit a copy of the initial review report of every in-custody death to the BSCC within 60 days of the death. The facility administrator shall provide a copy of the initial review report that comports with the disclosure requirements of section 832.10 of the Penal Code.

The initial review report shall contain the following information:

(1) Demographic information
- (A) Full name of the decedent
- (B) Date of birth
- (C) Date of death
- (D) Time of death
- (E) Gender
- (F) Race and ethnicity
- (G) Relevant medical history

(2) Case Information
- (A) Date of arrest or admission
- (B) Case status
- (C) Bail amount (if pretrial)
- (D) Any finding of incompetence to stand trial, whether decedent was waiting for placement with the Department of State Hospitals, and the date of commitment to the Department of State Hospitals

~~(2)~~ (3) Facility Information
- (A) Name and location of the detention facility where death or onset of illness or injury occurred
- (B) Description of the location where the death or onset of illness or injury occurred within the detention facility
- (C) If death occurred in the hospital, ~~D~~ date and time of the incident, onset of illness or injury that led to hospitalization
- (D) Detention facility personnel (including names and roles) involved in the reporting of the death or incident

~~(3)~~ (4) Any relevant circumstances leading up to death, including behavioral health or medical issues and date and time of last safety check.

~~(b) Death of a Minor~~

(d) In any case in which a minor dies while detained in a jail, lockup, or court holding facility, or in a hospital after being injured or falling ill while detained in a jail, lockup or court holding facility~~:~~ the BSCC

[2] BSCC, Notice of Proposed Action and Amendment of Regulations, p. 3, at https://www.bscc.ca.gov/wp-content/uploads/2024/02/B.NOPA_T15AdultReg1046_FINAL.pdf.

may inspect and evaluate the jail, lockup, or court holding facility pursuant to the provisions of this subchapter within 30 calendar days of the death. Any inquiry made by the Board shall be limited to the standards and requirements set forth in these regulations.

The changes proposed in red above are necessary if the Board is to achieve its goal of robust data collection that will allow the Director of In-Custody Death to address root causes of death in detention facilities.

1. Deaths in hospital obscure problems in detention facilities.

Frequently, people who are injured or fall ill while in a detention facility ultimately die in a hospital. When local agencies are only required to report the location of the death, they simply report the name of the hospital. As a result, local agencies with multiple detention facilities can escape effective oversight because the number of deaths per facility is obscured.

For example, Los Angeles County has reported five in-custody deaths so far this year.[3] Four out of the five deaths occurred at Los Angeles General Medical Center. Without the name and location of the detention facility where the onset of illness or injury occurred or any description of the location where the onset of illness or injury occurred, the Board and Director of In-Custody Death will not be able to identify problems or trends in the individual detention facilities. Only requiring the location of death obscures this vital information when someone dies in a hospital. All information about whether a person fell ill or was injured or assaulted in a cell, living area, or recreation yard is lost when an agency only has to report that a person died in a hospital ward.

Similarly, the provision in subdivision (d) related to juvenile facilities currently fails to give the BSCC power to inspect jail, lockups, or court holding facilities if a minor dies in a hospital.

Conversely, if hospitals are not explicitly included in the reporting requirement, local agencies may not report an in-custody death at all. In 2022, Riverside County publicly reported 18 deaths in custody, yet failed to publicly report[4] an additional death that occurred in a local hospital.

2. Lack of case information will prevent the Board and Director of In-Custody Death from offering a full range of recommendations to address the in-custody death crisis.

Basic case information is important in understanding the context of the in-custody death and can help the Board more effectively advocate for alternatives to incarceration that will address the in-custody death crisis.

Arrest date and case information matter when determining reasons for death and recommending changes in the custodial setting to prevent certain types of death. A United States Department of Justice

[3] Los Angeles County Sheriff's Department, In-Custody Deaths Current Year: 2024, at https://lasd.org/transparency/icd/.

[4] Albani-Burgio,Paul, "*Amid overdose, man was arrested, sat in Riverside County jail cell and died, lawsuit says,"* Desert Sun, Septembere 11, 2023, at: https://www.desertsun.com/story/news/crime_courts/2023/09/11/police-riverside-county-deputies-let-inmate-die-in-riverside-county-after-overdose-new-lawsuit-says/70823193007/

study found that two-thirds of deaths by suicide in local jails occurred within the first 30 days of admission.[5] The same study found that 77% of the people who died by suicide were unconvicted.

Data collected must also help the Board and Director of In-Custody Death determine whether lives can be saved by investing more in alternatives to incarceration and shortening wait times for state hospitals. Realignment tasked local law enforcement with "managing offenders in smarter and cost-effective ways."[6] Community Corrections Partnership Plans submitted to the Board demonstrate law enforcement efforts to create alternatives for incarceration, particularly for those with mental illness. For example, the primary goal in San Diego County CCPP is "to enhance prevention, diversion, and alternatives to custody; reserve jail for individuals posing a serious risk to public safety or sentenced for serious crimes." County of San Diego, Community Corrections Partnership Plan FY 2022-23, p. 10, at https://www.bscc.ca.gov/wp-content/uploads/San-Diego-Updated-Annual-Plan-22-23.pdf. The same plan includes a Behavioral Health Court that provides "treatment in lieu of detention" for people diagnosed with severe mental illness. *Id.*, p. 27. Information related to a person's involvement in a mental health court will help the Board determine whether more robust alternatives to incarceration are needed to address the in-custody death crisis.

The Board must also be able to determine whether a person who dies should have been in local custody at all. The California Department of State Hospitals (DSH) treats people charged with felonies yet found incompetent to stand trial (IST).[7] Because DSH does not have enough beds, and there is insufficient use of noncustodial responses to IST determinations. People declared IST languish in local detention facilities for months. In response to a Public Records Act request submitted by ACLU of Northern California in 2023, DSH admitted that at least 35 people died in local custody between 2018 and late last year while awaiting treatment at a state hospital.[8] The Board must identify people who died while waiting for DSH placement, and have access to sufficient information about the circumstances of their deaths, in order to understand all factors at play when someone dies in a local detention facility.

3. Information on safety checks will help the Board and Director of In-Custody Death evaluate problems related to custodial oversight.

Title 15 requires safety checks at least hourly for adults (section 1027.5), at least every 30 minutes for minors (section 1104), and every 15 minutes if the minor displays outward signs of being under the influence of any substance (section 1151). Because effective safety checks should reduce the incidence of death in detention facilities, it is imperative for the Board to know whether missed safety checks played a role in any in-custody death.[9]

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[5] U.S. Dep't of Just., *Suicide in Local Jails and State and Federal Prisons, 2000-2019 – Statistical Tables* (Oct. 2021), p. 3, at https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/sljsfp0019st.pdf.

[6] BSCC, Realignment & Community Corrections Partnerships, at https://www.bscc.ca.gov/m_realignment/.

[7] California Legislative Analyst Office, The 2021-22 Budget: Behavioral Health: Community Care Demonstration Project, p. 1, at https://lao.ca.gov/reports/2021/4382/behavioral-health-CCDP-021921.pdf#page=3.

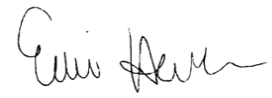
[8] DSH response to public records act request on file with ACLU NorCal.

[9] See, for example, the LA County Office of the Inspector General noting "several missed Title 15 safety checks" prior to a December 2023 death at the North County Correctional Facility. Office of the Inspector General of Los Angeles County, *Reform and Oversight Efforts: Los Angeles County Sheriff's Department, October 2023 through December 2023*, p. 36, at https://assets-us-01.kc-usercontent.com/0234f496-d2b7-00b6-17a4-b43e949b70a2/431627bf-2e3d-4e27-b83b-

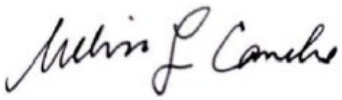
While these recommendations reflect our work and experience with those incarcerated in detention facilities throughout California, we do not speak for those directly impacted. ACLU formally requests a public hearing so that the Board can discuss these suggested amendments and hear from people who have lost loved ones in-custody.

We are grateful for the opportunity to submit public comment and would be pleased to discuss any of these recommendations further.

Sincerely,



Eric Henderson
ACLU Cal Action



Melissa L. Camacho
ACLU of Southern California

Yoel Y. Haile
ACLU of Northern California

/s Branden Sigua
Branden Sigua
ACLU of San Diego and Imperial Counties

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COMMUNITIES UNITED FOR RESTORATIVE YOUTH JUSTICE
CURYJ


Starting Over, Inc.
Transitional Housing, Reentry Services,
Advocacy and Civic Engagement


YOUNG WOMEN'S
FREEDOM CENTER


FREEDOM
4YOUTH


COMMUNITY
INTERVENTIONS

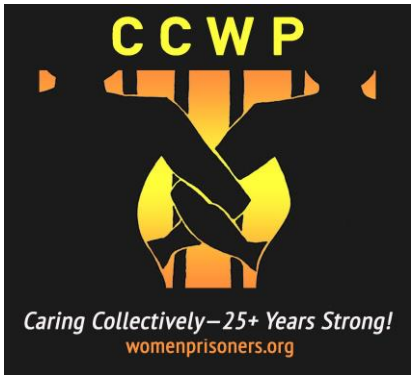

NORTH COUNTY
EQUITY & JUSTICE
COALITION


CARCERAL ECOLOGIES

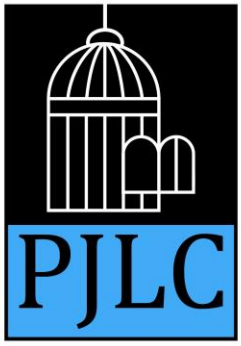

ELLA BAKER
CENTER for
HUMAN RIGHTS
She led. So can you.


MILPA


repair


CCWP
Caring Collectively—25+ Years Strong!
womenprisoners.org


ACLU CALIFORNIA
ACTION


PJLC


BEND THE ARC
jewish action
southern california


Racial Justice Coalition of SD
RJC

Amanda Ferreira
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regulations@bscc.ca.gov

Re: Proposed Amendment of Section 1046 of Title 15 – Written Public Comment

Dear Ms. Ferreira and Board,

On behalf of the undersigned organizations, we are writing regarding the proposed changes and revisions to section 1046 of Title 15, Division 1, Chapter 1, Subchapter 4 of the California code of regulations. Our collective of organizations has been working with families who have lost loved ones in custody alongside advocates who have done intensive reviews and analysis of death reporting data.

We are happy to see the proposed changes include critical data points missing from current regulations. However, additional points should be included to ensure that the BSCC and the new incoming Director of In-Custody Death Reviews have the required amount of information to be able to conduct thorough analyses of each death and provide comprehensive recommendations.

As such, we are suggesting the following revisions to the proposed regulations that we have marked in red below:

§ 1046 (c)(1) Demographic Information

(A) Full name of the decedent
(B) Date of birth
(C) Date of death
(D) Time of death
(E) Gender
(F) Race and ethnicity
(G) Relevant medical history, **including disabilities and mental health diagnoses.**
(H) Relevant information relating to an individual's repeated time in custody until the date of their death
(I) Date of arrest
(J) Case status
(K) Bail amount, if pretrial
(L) Any finding of incompetence to stand trial, whether decedent was waiting for placement with the Department of State Hospitals, and the date of commitment to the Department of State Hospitals

Reasoning for additions and changes:
We have included the revisions in red that can help provide a more comprehensive snapshot of the individuals before an in-custody death occurs. For example, the date of initial arrest is often omitted in most public reporting, but it can help provide more context as to what interventions the custodial facility engaged in before the individual passed. Information like case status and bail amount can help show the concerning trends across the state of individuals dying in county jails while being detained pre-trial.

> **§ 1046 (c)(2) Facility Information**
> (A) Name and location of the detention facility **where death or onset of illness or injury occurred**
> (B) Description of the location where the death or **onset of illness or injury** occurred within the **detention** facility
> **(C) If death occurred in a hospital, the date and time of onset of illness or injury that led to hospitalization**
> (D) Detention facility personnel (including names and roles) involved in the reporting of the death or incident
>
> **§ 1046 (c)(4) Any relevant circumstances leading up to death, including behavioral health or medical issues and the time last safety check was conducted**

Reasoning for additions and changes:
Often the information that is reported fails to include information as to where the onset of illness occurred or where injuries were sustained. These incidents ultimately result in deaths at hospitals, but no information is provided as to what led to the hospitalization. Current requirements only mandate the location of death which obscures county jail systems that have a multitude of detention facilities. Los Angeles County is a perfect example: the county has reported five in-custody deaths so far this year, out of which four deaths occurred at Los Angeles General Medical Center.[1]

Without this crucial background, the Board and future Director of In-Custody Death will not be able to identify problems or trends in the detention facilities. Only requiring that localities submit the location of death obscures this vital data point. Conversely, if hospitals are not explicitly included in the reporting requirement, local agencies may not report an in-custody death at all. For example, in 2022, Riverside County publicly reported 18 deaths in custody yet failed to publicly report an additional death that occurred in a local hospital.[2]

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[1] Los Angeles County Sheriff's Department, In-Custody Deaths Current Year: 2024, at https://lasd.org/transparency/icd/.
[2] Albani-Burgio,Paul, "*Amid overdose, man was arrested, sat in Riverside County jail cell and died, lawsuit says,*" Desert Sun, Septembere 11, 2023, Available at: https://www.desertsun.com/story/news/crime_courts/2023/09/11/police-riverside-county-deputies-let-inmate-die-in-riverside-county-after-overdose-new-lawsuit-says/70823193007/

§ 1046 (d)

In any case in which a minor dies while detained in a jail, lockup, or court holding facility, **or in a hospital after being injured or falling ill while detained in a jail, lockup or court holding facility**: the BSCC may inspect and evaluate the jail, lockup, or court holding facility pursuant to the provisions of this subchapter within 30 calendar days of the death. Any inquiry made by the Board shall be limited to the standards and requirements set forth in these regulations.

Reasoning for additions and changes:

As stated above, the issue of under-reporting deaths in hospitals and/or not counting those deaths properly is a data point that should be extended to juvenile facilities to best capture a wide breadth of information relating to the minor who dies in custody.

We hope that the BSCC can take the above additions into consideration, and we look forward to working with you to ensure that our state is properly capturing all this critical information.

Sincerely,
ACLU California Action
Bend the Arc Southern California
Black Men Build - Los Angeles
California Coalition for Women Prisoners
Care First California
Carceral Ecologies
Community Interventions
Communities United for Restorative Youth Justice
Ella Baker Center
Freedom 4 Youth
Fresh Start Training & Employment Services
Justice2Jobs Coalition
LOVE Center
MILPA
North County Equity & Justice Coalition
Peace and Justice Law Center
Racial Justice Coalition of San Diego
Repair
Sheriff Accountability Coalition (Riverside)
Starting Over, Inc.
Young Women's Freedom Center